

OMHRC Summary

Purpose: The purpose of the OMHRC is to facilitate understanding and communication about the possible need for a mental health referral for a youth in the juvenile justice system. It was not designed for clinical decision making, but simply to structure observation about a number of symptoms or problems which may indicate a referral is warranted. In order to facilitate understanding, the OMHRC comes in three versions: one completed by the staff, another by the youth's parent, and one for the youth self-report. The three forms are parallel in content. Each provides valuable information when used separately, but it is better when all three are considered. The second purpose of the OMHRC is to facilitate communication between service systems. This is done by administering the instrument on three different occasions: at intake for the past 6 months and at two 6-month intervals. Thus, the OMHRC may be used as a repeated measure for an 18-month period. Additionally, each time-version of the instrument is produced on reproduction paper which provides an ongoing record of the earlier observation. This allows copies to be sent between agencies for referral and follow-up communication.

How to use the OMHRC: The OMHRC is designed as both a rating checklist and a self-report instrument. Respondents simply check the **O** mark for each symptom or problem that is present or suspected. The staff version may be administered as a semi-structured interview, and one is printed on the front cover. Once familiar with the OMHRC, it takes about 3-4 minutes to complete. In a sense, each item is an instrument, and the presence of the problem may be sufficient for a mental health referral. The instrument can also be scaled by counting the number of symptoms/problems endorsed in the first 31 items. Scores range from 0 to 31 with higher scores reflecting greater magnitude of the referral need. The OMHRC also comes with a broadband assessment of problems, which is printed on the back of the staff version. This assessment is arranged to reflect the results of the concept mapping procedures discussed below. It is useful to compare your broadband assessment with the observations made on individual OMHRC items.

Reliability, validity, and utility: The OMHRC was developed from a list of 86 problems/symptoms identified by a panel of providers and administrators in mental health and juvenile justice. This prototype was field tested on a sample of 146 adjudicated and court-bound youth with the staff version and 52 youth with the parent version. The research participants were from urban and rural settings, and averaged 15 years old (sd = 1.5). Most were males (79%). This prototype had internal consistency coefficients of .88 for the staff and .83 for the parent versions. Others were revised or collapsed to develop a 31-item prototype, which had an internal consistency of approximately .7. Total scores on the parent version of this revision correlated with internalized and externalized scores, and scores distinguished between those youth who reported having seen a mental health professional from those who had not, and between those youth who report that a trusted person has suggested they have a mental or emotional problem from those who had not.

The OMHRC was also developed with concept mapping, a procedure using multidimensional scaling and cluster analysis. The results are displayed in Figure 1 for a 5-point triage rating. The average correlation between the triage ratings for a child psychiatrist and the other members of the panel was .95, suggesting there was 90% common variance. Items were then selected for inclusion based on high triage ratings and clustering. Those items surviving are numbered in descending order from 1 to 31 on the OMHRC and are identified in the figure.

The plane displaying the clusters is conceptually divisible along two intersecting continua: problems more characteristic of a youth in the mental health system and those more characteristic of the juvenile justice system; and secondly, problems that are internalized and those that are externalized. Symptoms/problems in the upper left section reflect those chiefly the focus of the mental health system, while those in the lower right section are more the focus of the juvenile justice system. The other two sections reflect problems that likely require a multi-inter-agency, collaborative intervention, such as juvenile justice, mental health, schools, physical health care systems, and family/children services.

Availability: Kevin Corcoran, Ph.D., J.D., Graduate School of Social Work, Portland State University, POB 751, Portland, OR 97207-0751. The OMHRC was developed with funding from the Center for the Study of Mental Health Policy & Services, PSU and OR Commission on Children and Families. The parent and youth versions are available in Spanish. In public domain and may be copied ad libitum.

