

An Evaluation of the Behavioral Health/Juvenile Justice (BHJJ) Initiative: 2013-2015 Lorain County Results

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EXECUTIVE SUMMARY: AN EVALUATION OF THE BEHAVIORAL HEALTH/JUVENILE JUSTICE (BHJJ) INITIATIVE: 2013–2015 LORAIN COUNTY RESULTS

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Juvenile justice-involved youth with serious behavioral health issues often have inadequate and limited access to care to address their complex and multiple needs. Ohio's Behavioral Health/Juvenile Justice (BHJJ) initiative was intended to transform and expand the local systems' options to better serve these youth. Recent emphasis was placed on decreasing the population of ODYS facilities while providing alternatives to incarceration. Twelve counties participated in BHJJ in the newest biennium: Cuyahoga, Franklin, Cuyahoga, Hamilton, Lucas, Summit, Wayne, Holmes, Trumbull, Mahoning, Lorain, and Wood. BHJJ was funded by a partnership between the Ohio Departments of Youth Services (ODYS) and Mental Health and Addiction Services (OhioMHAS). The Begun Center for Violence Prevention Research and Education at Case Western Reserve University provided research and evaluation services for the program.

The BHJJ program diverts youth from local and state detention centers into more comprehensive, community-based mental and behavioral health treatment. The BHJJ program enrolled juvenile justice-involved youth between 10-18 years of age who met several of the following criteria: a DSM IV Axis I diagnosis, substantial mental status impairment, a co-occurring substance use/abuse problem, a pattern of violent or criminal behavior, and a history of multi-system involvement.

Demographics and Youth Characteristics

- ❖ In Lorain County, 35 youth have been enrolled in BHJJ (68.6% male, 45.7% Caucasian). The average age at intake was 16.6 years old.
- ❖ Youth averaged 2.9 Axis I diagnoses. Females were significantly more likely to be diagnosed with Posttraumatic Stress Disorder (PTSD).
- ❖ One-hundred percent of males and females were diagnosed with both a mental health and substance use diagnosis.
- ❖ Caregivers reported that 33.3% of the females had a history of sexual abuse, over 72% talked about suicide, and over 45% had attempted suicide. Over 69% of males and 63% of females had family members who were diagnosed with or showed signs of depression.
- ❖ According to the OYAS, 73.5% of the youth served in Lorain County were either moderate or high risk.
- ❖ Of the youth enrolled in Lorain County, 22.9% had a felony charge in the 12 months prior to enrollment.

Educational Information

- ❖ Nearly 43% of the youth were suspended or expelled from school in the year prior to their enrollment. At termination, 68.4% of youth were attending school. At termination, 57.2% of successful completers and 20% of unsuccessful completers received mostly A's, B's, and C's.
- ❖ At termination, workers reported that 94.4% of youth were attending school more or about the same amount as they were before starting treatment.

Mental/Behavioral Health Outcomes

- ❖ BHJJ youth reported a decrease in trauma symptoms from intake to termination.
- ❖ Results from the Ohio Scales indicated the caregiver, worker, and youth all reported increased youth functioning and decreased problem severity while in BHJJ treatment.
- ❖ Youth reported decreased 6 month marijuana use from intake to termination.
- ❖ Over 12% of successful completers and 72% of unsuccessful completers were at risk for out of home placement at termination.
- ❖ Eighty-five percent of caregivers agreed that they were satisfied with the services their child received through BHJJ and 90.5% agreed that the services received were culturally and ethnically sensitive.

Termination and Recidivism Information

- ❖ Thirty-six percent of the youth terminated from the BHJJ program were identified locally as successful treatment completers. The average length of stay in the program was approximately 5 months.
- ❖ One year after termination, zero youth had a new felony charge.
- ❖ None of the 32 youth enrolled in BHJJ for whom we had recidivism data were sent to an ODYS facility at any time following their enrollment in BHJJ.

AN EVALUATION OF THE BEHAVIORAL HEALTH/JUVENILE JUSTICE (BHJJ) INITIATIVE: 2013-2015 LORAIN COUNTY RESULTS

JUVENILE JUSTICE AND MENTAL HEALTH

Youth involved in the juvenile justice system report significant behavioral health impairment. While estimates vary, most studies report that between 65-75% of juvenile justice-involved (JJI) youth have at least one mental health or substance abuse disorder and 20% to 30% report suffering from a serious mental disorder (Cocozza & Skowyra, 2000; Shufelt & Cocozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). Rates of similar mental health/substance use disorders among the general adolescent population are far lower (Cuellar, McReynolds, & Wasserman, 2006; Friedman, Katz-Levy, Manderscheid, & Sondheimer, 1996; Merikangas, et al., 2010; Otto, Greenstein, Johnson, & Friedman, 1992; U.S. Department of Health and Human Services, 1999).

Studies have found that JJI females are often more likely to suffer from mental health disorders than JJI males (Teplin et al., 2002; Nordess et al., 2002; Shufelt & Cocozza, 2006; Wasserman, McReynolds, Ko, Katz, & Carpenter, 2005). Driving this difference is the fact that Anxiety and Mood Disorders are far more common in JJI girls than JJI boys (Shufelt & Cocozza, 2006; Teplin et al., 2002; Wasserman et al., 2005). Not only are JJI girls more likely to report mental health disorders, they are also more likely to report co-occurring mental health and substance use disorders than JJI males (Abram, Teplin, McClelland, & Dulcan, 2003; Wasserman et al., 2005; Wasserman, McReynolds, Schwalbe, Keating, & Jones, 2010).

While it is clear that a significant percentage of JJI youth have mental health problems, many have not received help or treatment for these issues prior to entering the system. One study found that only 34% of juvenile detainees with Anxiety, Mood, or Disruptive Behavior Disorders had ever received prior mental health treatment (Novins, Duclos, Martin, Jewett, & Manson, 1999). In another study, only 17% of juvenile detainees reported previous mental health treatment by a psychiatrist or therapist (Feinstein et al., 1998). A SAMHSA-funded study reported that while 94% of juvenile justice facilities had some type of mental health services available to youth, the quality and comprehensiveness of these services varied greatly based on the facility (Goldstrom, Jaiquan, Henderson, Male, & Manderscheid, 1998). Goldstrom et al. (1998) reported that 71% of juvenile detention centers offer mental health screening while only 56% conduct full evaluations. In facilities where full evaluations are offered, screenings and assessments are often not standardized (Hoge, 2002; Soler, 2002).

JUVENILE JUSTICE/MENTAL HEALTH DIVERSION PROGRAMS

The prevalence of juvenile justice youth with mental health issues is cause for alarm. While the juvenile justice system is often the first time a youth is screened for mental health problems, the system is often ill-prepared to properly treat these youth (Cocozza & Skowyra, 2000; Skowyra & Powell, 2006; Teplin et al., 2002; U.S. Department of Justice, 2005). In response to the growing number of youth entering the juvenile justice system with mental health issues and the lack of proper care in these facilities, many communities have developed diversion programs or mental health courts as an alternative to detention or incarceration. These programs allow for more in-depth assessment and

evaluation and more comprehensive and evidence-based treatment and supervision services than are available in typical juvenile justice facilities.

OHIO'S BEHAVIORAL HEALTH/JUVENILE JUSTICE (BHJJ) INITIATIVE

Over 15 years ago, Ohio's juvenile court judges met with representatives from the Ohio Department of Mental Health (ODMH) and the Ohio Department of Youth Services (ODYS) to address a growing and serious concern. Many of the youth who appeared in court demonstrated serious mental health and/or substance use problems. Not only did these judges lack the resources and expertise to identify, assess, and serve these youth, but there were few alternative programs into which these youth could be placed in lieu of a detention facility.

The state recommended funding local pilot projects in an attempt to divert youth who demonstrated a need for behavioral health service from incarceration and into community-based treatment settings. The pilot program operated in three counties in Ohio. While small in scope, the pilot project was successful in reducing the number of youth with behavioral health issues committed to the ODYS.

In 2005, the state allocated new resources to the Behavioral Health/Juvenile Justice (BHJJ) project and funded several counties throughout Ohio to expand upon the work accomplished in the pilot phase. The intent of the BHJJ project was to transform the local systems' ability to identify, assess, evaluate, and treat multi-need, multi-system youth and their families and to identify effective programs, practices, and policies. As in the pilot, the initiative was designed to divert JJI youth with mental health or substance use issues from detention and into community and evidence-based treatment. The state identified criteria to be used by participating counties to determine if a youth was appropriate for inclusion in the BHJJ project, including: a DSM-IV diagnosis, aged 10 to 18, substantial mental status impairment, co-occurring substance abuse, a pattern of criminal behavior, charged and/or adjudicated delinquent, a threat to public safety, exposed to trauma or domestic violence, and a history of multi-system involvement. Each county was able to determine which and how many criteria the youth had to meet to be eligible for participation.

Since 2006, 17 counties have been selected to participate in the BHJJ program. Urban, suburban, and rural counties have been included in the project. These counties were required to use evidence-based or evidence-informed treatment models; however, the state allowed each county to select the model that best fit the needs of their youth and families. Examples of the types of treatment models provided through BHJJ include Multi-systemic Therapy (MST), Functional Family Therapy (FFT), Integrated Co-Occurring Treatment (ICT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Multidimensional Family Therapy (MDFT).

While each county employs slightly different protocols and procedures in the implementation of BHJJ, the juvenile court is the typical entry point into the program. Youth who have been charged with a crime are given a psychological assessment to determine if they meet criteria for inclusion in BHJJ. If the youth meets criteria and the youth and family agrees to participate, the youth is recommended for BHJJ participation. If the judge or magistrate accepts the recommendation, the youth is enrolled in the BHJJ program and referred or linked to the treatment agency responsible for providing the treatment services. In most cases the youth remains on probation supervision during their time in the BHJJ program. While residential placement is an option in some of the participating counties, a mission of

BHJJ is to provide treatment in the least restrictive setting possible and therefore the majority of the treatment is provided in-home or in outpatient settings.

A key component to the BHJJ program is the ongoing outcome evaluation provided by the Begun Center for Violence Prevention Research and Education at the Mandel School for Applied Social Sciences at Case Western Reserve University (Kretschmar, Butcher, & Flannery, 2016; Kretschmar, Butcher, Canary, & Devens, 2015). The current evaluation report includes data from 2006 through June 30, 2015. For information or copies of previous evaluation reports, please contact Dr. Jeff Kretschmar at jeff.kretschmar@case.edu or visit (<http://mha.ohio.gov/Default.aspx?tabid=136>).

MEASURES AND INSTRUMENTATION

All of the instruments collected as part of the BHJJ evaluation were in TeleForm© format. TeleForm© is a software program that allows for data transmission via fax machine, scanner, or .pdf file. Instruments are created using this software and once completed, can be faxed or scanned directly into a database.

OHIO YOUTH PROBLEM, FUNCTIONING, AND SATISFACTION SCALES (OHIO SCALES)

The Ohio Scales (Ogles, Melendez, Davis, & Lunnen, 2001) were designed to assess clinical outcomes for children with severe emotional and behavioral disorders, and were developed primarily to track service effectiveness. The measure assesses four primary domains of outcomes with four subscales: Problem Severity, Functioning, Hopefulness, and Satisfaction with services. In the Ohio Scales–Caregiver version, the caregiver rates his/her child’s problem severity and functioning, and the caregiver’s satisfaction with services and hopefulness about caring for his or her child. In the Ohio Scales–Youth version, the youth rates his/her own problem severity and functioning, and his/her satisfaction with services and hopefulness about life or overall well-being. The Worker version does not include the Satisfaction or Hopefulness scales. A score is generated for each of the four subscales, with a total score for the scale generated by summing the items.

TRAUMA SYMPTOM CHECKLIST FOR CHILDREN (TSCC)

The Trauma Symptom Checklist for Children (TSCC) is a 54-item Likert-type questionnaire containing six subscales designed to measure anxiety, anger, depression, posttraumatic stress, dissociation, and sexual concerns (Briere, 1996). Youth respond to a series of questions regarding the frequency of certain thoughts, events, or behaviors. Responses are made on a 4-point, 0-3 scale with “0” indicating “never” and “3” indicating “almost all the time”.

SUBSTANCE USE SURVEY – REVISED

This measure, adapted from the SAMHSA-funded Tapestry Project (a demonstration and research project that identifies, serves and follows youth and families from Cuyahoga County, Ohio, with significant behavioral and mental health needs), collects information reported by the youth about the frequency of his or her substance use, including tobacco, alcohol, marijuana, cocaine, painkillers, and several additional substances.

ENROLLMENT AND DEMOGRAPHICS FORM (ENROLLMENT FORM)

This form permits program staff to record several important pieces of information including date of enrollment, reasons for BHJJ services, DSM-IV diagnoses, Global Assessment of Functioning (GAF) scores, and agencies with which the youth is involved. In addition, out-of-home placement status, risk for placement, and educational and vocational data are collected.

CHILD INFORMATION UPDATE FORM (TERMINATION FORM)

This form is completed by the treatment staff at termination from the BHJJ program, and is used to record DSM-IV diagnoses, GAF score, date and reasons for termination from the program, and out-of-home placement risk. Educational and vocational data, as well as information related to contacts with the police are also captured.

RECENT EXPOSURE TO VIOLENCE

This 26-item optional scale measures several youth-reported violent acts: threats, beatings, hitting, knife attacks, sexual abuse, and shootings (adapted from Singer, Anglin, Song, & Lunghofer, 1995). Youths respond to a 4-point scale ranging from “0” (never) to “3” (almost every day). Subjects report separately on violence they have experienced directly and violence they have witnessed. For threats, slapping/hitting, and beatings, questions are specific to the setting in which the violence has occurred: at home, at school, or in the neighborhood. The remaining items do not specify the setting in which the violence occurred. This scale, which has an acceptable internal consistency (Cronbach’s alpha = .86), served as our measure of victimization.

CAREGIVER INFORMATION QUESTIONNAIRE (INTAKE AND TERMINATION)

The Caregiver Information Questionnaire, adapted from SAMHSA/Center for Mental Health Services (2005), permits staff to record information including demographics, risk factors, family composition, physical custody of the child, abuse history, family history of mental health issues, the child’s mental and physical health service use history, caregiver employment status, and child’s presenting problems.

YOUTH SERVICES SURVEY FOR FAMILIES

The Youth Services Survey for Families (YSSF) (SAMHSA) was designed to assess caregiver satisfaction with services the youth received, and if, as a result of those services, the youth is showing improved functioning. This measure was optional.

RECIDIVISM

Recidivism can be defined in many ways: a new offense, a violation of probation, new adjudication, or commitment to ODYS. Recidivism is a standard measure of program success, especially as an indicator of treatment outcomes over time. For this evaluation, recidivism was defined in three ways; a new misdemeanor or felony charge, a new adjudication, and a placement in an ODYS facility any time after enrollment in the BHJJ program. These data are provided to the evaluators by the juvenile court in each participating county. Recidivism data are presented for youth prior to and after enrollment and termination from BHJJ.

OHIO YOUTH ASSESSMENT SYSTEM (OYAS)

The OYAS is a criminogenic risk assessment tool designed to assist juvenile court staff with placement and treatment decisions based on a youth’s risk score. The OYAS contains five distinct

versions of the tool administered at different points in the juvenile justice process: Diversion, Detention, Disposition, Residential, and Reentry. Youth receive a total score and fall into three risk levels; low, moderate, or high. Each county’s juvenile court supplied OYAS data to the evaluators.

DATA COLLECTION SCHEDULE

The evaluation contains both mandatory and optional questionnaires (see Table 1 and Table 2).

Table 1. Required BHJJ Questionnaires

Measure	Who Completes	When Administered
Ohio Scales	Youth & Worker	Intake, every 3 months, Term
Trauma Symptom Checklist for Children (TSCC)	Youth	Intake, Term
Substance Use Survey – Revised (SUS)	Youth with Program Staff	Intake, every 6 months, Term
Enrollment and Demographics Information Form (EDIF)	Program Staff	Intake
Child Information Update Form (CIUF)	Program Staff	Term
Caregiver Information Questionnaire – Intake (CIQ-I)	Caregiver with Program Staff	Intake

Table 2. Optional BHJJ Questionnaires

Measure	Who Completes	When Administered
Ohio Scales	Caregiver	Intake, every 3 months, Term
Recent Exposure to Violence Scale (REVS)	Youth	Intake, Term
Caregiver Information Questionnaire – Term (CIQ-F)	Caregiver with Program Staff	Term
Youth Service Survey for Families (YSSF)	Caregiver	Term

PROJECT DESCRIPTION

The Lorain County Behavioral Health/Juvenile Justice (BHJJ) program is a collaboration of Bellefaire JCB, Lorain County Juvenile Court, and the Lorain County Board of Mental Health. Sponsored by the Ohio Department of Youth Services (ODYS) and the Ohio Department of Mental Health and Addiction Services (OhioMHAS), the BHJJ program is a diversion program for justice-involved youth who experience mental health and substance use disorders (co-occurring disorders). In lieu of detention, identified youth are diverted to the community, evidenced-based or promising treatment practices.

In Lorain County, youth identified as appropriate by the Lorain County Juvenile Court are referred to Bellefaire JCB's Integrated Co-Occurring Treatment (ICT) program. The ICT program provides a comprehensive mix of services to meet the mental health and substance use needs of the youth and their family. ICT utilizes an integrated treatment approach, embedded in an intensive home-based method of service delivery, to provide a set of core services to youth with co-occurring disorders of substance use and serious emotional disability. It addresses the reciprocal interaction of how each disorder affects the other, in context of the youth's family, culture, peers, school, and greater community. ICT Therapists work to prioritize saliency and immediacy of need which may fluctuate from session to session. The Lorain County BHJJ program consists of three full-time ICT Therapists in addition to one full time ICT Supervisor. All ICT staff complete a three day, comprehensive, core training provided by the ICT Consultant from the Center of Innovative Practices at Case Western Reserve University. A key aspect of providing quality services involves the collaboration of treatment providers and court staff. In efforts to enhance collaboration, and build positive working relationships, the ICT staff meets with the Lorain County Juvenile Court staff to review cases including both treatment and court recommendations. These collaborative meetings ensure that all providers are on the same page regarding the course of treatment.

The Lorain County Juvenile Court identifies appropriate candidates for ICT and notifies Bellefaire JCB's Intake Specialist and ICT Supervisor of these referrals. Once a youth has been referred to services they are scheduled to complete an intake - at the office, to obtain necessary financial information. When the intake is completed the youth is assigned to an ICT Therapist to begin services within the home. The ICT Therapist utilizes a variety of instruments to assess functioning and to assist with identifying key issues that will need to be addressed in treatment. The youth will either complete an integrated mental health/substance use assessment or a substance use assessment (a substance use assessment is implemented if a youth enters the program with a recently completed mental health evaluation). In addition to the comprehensive assessment the following measures are employed with the youth/family: The Childhood Trust Events Survey, CRAFFT screener (a mnemonic acronym of first letters of key words in the six screening questions), SASSI assessment (Substance Abuse Subtle Screening Inventory), Burns Depression Inventory, Burns Anxiety Inventory, and the Suicide Risk Assessment. The results of these instruments are incorporated into the diagnostic assessment and utilized to support treatment recommendations. Youth are provided services at a minimum of 3-5 hours per week, which averages 2-4 contacts on a weekly basis. Services are provided for a minimum of 3 months and youth are able to receive services for up to 6 months.

Prior to implementing specific interventions, the ICT staff focus on engagement with youth that are typically resistant to counseling services. Engagement often occurs through the employment of motivational interviewing strategies and responding with a non-confrontational approach. Once rapport has been established, and salient issues have been identified, the ICT Therapist may assist the family with developing a behavioral contract and will work towards crisis stabilization. Every family/client will work with their therapist to develop a safety plan, during their initial session, to reduce the frequency of

crises and to keep the youth safe when residing in the home environment. Additional interventions include: life skills building, job skills training, family therapy, crisis management, role play/practicing skills, advocacy for the youth at school, and collaboration with court staff to reduce reoffending behaviors.

After one month before expected ICT completion, planning is initiated with youth, family and the treatment team to determine appropriate referral recommendations. At the end of treatment, the goal is to be able to transition the youth to a lower level of care. This means the high intensity of home-based services would no longer be needed and the youth could successfully transition to weekly counseling services if appropriate. A successful completion of services can be defined by the level of engagement that has occurred throughout the course of therapy. Several facets are evaluated to determine whether a youth has successfully completed treatment. These include: maintaining the majority of counseling appointments, a reduction in reoffending behaviors, a reduction in substance use, increased school attendance, increased involvement in prosocial activities, and remaining in the home at the termination of services/avoiding an out of home placement. The ICT Therapist will assist the family with coordinating referral options and will help to connect the family to services prior to terminating services.

DESCRIPTION OF THE ANALYSES USED IN THE REPORT

Several types of inferential statistics are used throughout the report. Three types of bivariate analyses are discussed throughout both the overall report and the county specific reports. The chi-square analysis refers to a bivariate technique where a relationship between two variables is tested to determine if there are any significant differences. For example, if we are interested in whether males and females differ on whether they have ever used alcohol, a chi-square test is used. If there is a statistically significant result, this indicates that the difference between females and males is unlikely to have occurred by chance. Thus, we would describe the difference for the gender groups as a *real difference* rather than one that could have occurred by chance.

In instances where the bivariate relationship of interest is a measure that is both a yes/no measure and one that is repeated, a McNemar's test is used. For example, if we are interested in whether there is a statistically significant decrease in the proportion of youth using alcohol in the past six months from intake to termination, we would use a McNemar's test. A statistically significant result would indicate that the observed difference in six month use from intake to termination is a real difference and one that likely did not occur by chance.

The third type of bivariate analysis used throughout the report is the t-test. T-tests are similar to chi-square tests in that they test two variables to determine whether there are significant differences. For example, if we are interested in whether females and males differ on their levels of posttraumatic stress symptoms, a t-test is used. Since the variable posttraumatic stress lies on a continuous scale, we examine whether the corresponding means for the two gender groups significantly differ. Independent samples t-tests are used when there are two distinct groups (e.g. female and male) while paired samples t-tests are used when we are interested in whether means for the same group from different time points differ significantly (e.g. pre/post differences).

While statistical significance is an indication of how likely differences between groups or time points could occur by chance, effect sizes measure the magnitude of these observed differences. In other words, while statistical significance tells us whether a difference exists, effect sizes tell us how much of a difference exists. Effect sizes as represented by Cohen's *d* are also presented using the recommended criteria for its interpretation in Cohen's (1988) seminal work. Interpretation of Cohen's *d* is based on the criteria where 0.2 indicates a small effect size, 0.5 indicates a medium effect, and 0.8 indicates a large effect¹.

¹ For a more thorough review see Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

LORAIN COUNTY

DEMOGRAPHICS

Lorain County has enrolled 35 youth in the BHJJ program since 2013. Of the 35 youth enrolled, 31.4% (n = 11) were female and 68.6% (n = 24) were male (see Table 3).

The majority of the overall sample of youth were either or Caucasian (45.7%, n = 16) or categorized as “Other” (37.1%, n = 13). The average age of the youth at intake into BHJJ was 16.6 years old (SD = 0.99) with a range between 14.4 and 17.95 years old.

Table 3. Demographic Information for BHJJ Youth in Lorain County

	All Youth Enrolled (2013 - 2015)
Gender	Female = 31.4% (n = 11) Male = 68.6% (n = 24)
Race	African American = 17.1% (n = 6) Caucasian = 45.7% (n = 16) Other = 37.1% (n = 13)
Age at Intake	16.55 years (SD = 0.99)

CUSTODY ARRANGEMENT AND HOUSEHOLD INFORMATION

At intake, the majority of youth lived with at least one biological parent (73.5%, n = 524) (see Table 4). An additional 17.6% (n = 6) lived with a grandparent.

Eighty percent of the BHJJ caregivers (n = 28) had at least a high school diploma or GED, and 2.9% (n = 1) had more than a bachelor’s degree (see Table 5). One in five caregivers (20.0%, n = 7) reported that they did not graduate from high school.

Caregivers reported their annual household income. The median household income for BHJJ families was between \$20,000 - \$24,999 (see Table 6). Nearly 70% of caregivers (67.5%, n = 23) reported annual household incomes below \$35,000 and 61.7% (n = 21) reported an annual household income below \$20,000. Nearly 25% of BHJJ families (23.5%, n = 8) reported an annual household income below \$10,000.

Table 4. Custody Arrangement for BHJJ Youth in Lorain County

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	32.4% (n=11)
Biological Mother Only	38.2% (n=13)
Biological Father Only	2.9% (n=1)
Adoptive Parent(s)	0.0% (n=0)
Sibling	2.9% (n=1)
Aunt/Uncle	5.9% (n=2)
Grandparents	17.6% (n=6)
Friend	0.0% (n=0)
Ward of the State	0.0% (n=0)
Other	0.0% (n=0)

Table 5. Educational Outcomes for Caregivers of BHJJ Youth in Lorain County

Number of School Years Completed	Number of Caregivers
Less than High School	20.0% (n=7)
High School Graduate or G.E.D.	42.9% (n=15)
Some College or Associate Degree	34.3% (n=12)
Bachelor's Degree	0.0% (n=0)
More than a Bachelor's Degree	2.9% (n=1)

Table 6. Annual Household Income for BHJJ Families in Lorain County

Annual Household Income	BHJJ Families
Less than \$5,000	17.6% (n=6)
\$5,000 - \$9,999	5.9% (n=2)
\$10,000 - \$14,999	17.6% (n=6)
\$15,000 - \$19,999	20.6% (n=7)
\$20,000 - \$24,999	2.9% (n=1)
\$25,000 - \$34,999	2.9% (n=1)
\$35,000 - \$49,999	8.8% (n=3)
\$50,000 - \$74,999	14.7% (n=5)
\$75,000 - \$99,999	8.8% (n=3)
\$100,000 and over	0.0% (n=0)

YOUTH AND FAMILY HISTORY

Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history (see Table 7). Chi-square analysis was conducted on each item and significant differences are identified in Table 7. Partly due to sample size restrictions, no significant gender differences were found for any of the youth and family history questions.

Caregivers reported that 27.3% (n = 3) of females and 16.7% (n = 4) of males had a history of being physically abused while 33.3% (n = 3) of females and 20.8% (n = 5) of males had a history of being sexually abused. Caregivers of 72.7% (n = 8) of females and 54.2% (n = 13) of males reported hearing the child talking about committing suicide and 45.5% of females (n = 5) and 16.7% of males (n = 4) had attempted suicide at least once. A majority of the caregivers of females (63.6%, n = 7) and males (69.6%, n = 16) reported a family history of depression.

Table 7. Youth and Family History in Lorain County

Question	Females	Males
Has the child ever been physically abused?	27.3% (n=3)	16.7% (n=4)
Has the child ever been sexually abused?	33.3% (n=3)	20.8% (n=5)
Has the child ever run away?	72.7% (n=8)	41.7% (n=10)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	100.0% (n=11)	95.8% (n=23)
Has the child ever talked about committing suicide?	72.7% (n=8)	54.2% (n=13)
Has the child ever attempted suicide?	45.5% (n=5)	16.7% (n=4)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	45.5% (n=5)	41.7% (n=10)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	63.6% (n=7)	69.6% (n=16)
Has anyone in the child's biological family had a mental illness, other than depression?	63.6% (n=7)	33.3% (n=7)
Has the child ever lived in a household in which someone was convicted of a crime?	20.0% (n=2)	39.1% (n=9)
Has anyone in the child's biological family had a drinking or drug problem?	63.6% (n=7)	79.2% (n=19)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms	45.5% (n=5)	54.2% (n=13)

At intake, caregivers were asked if the youth had ever been pregnant (or if male, had ever impregnated a female) and if they were currently expecting a child. Caregivers reported that one female (10.0%) had been pregnant but none were currently expecting a child. Caregivers reported that one male (4.8%) had impregnated a female but none were currently expecting a child.

OHIO YOUTH ASSESSMENT SYSTEM

The OYAS is a criminogenic risk assessment tool designed to assist juvenile court staff with placement and treatment decisions based on a youth's risk score. Distribution of Lorain County youth based on the OYAS risk categories by gender and race are presented in Table 8. While the data are preliminary as there are fairly low numbers for each of the categories, a larger percentage of males (73.9%; n = 17) are identified as moderate risk to reoffend to than females (45.5%; n = 5).

Table 8. OYAS Categories by Race and Gender for Lorain County

	OYAS Low	OYAS Moderate	OYAS High
Female	45.5% (n = 5)	45.5% (n = 5)	9.1% (n = 1)
Male	17.4% (n = 4)	73.9% (n = 17)	8.7% (n = 2)
White	25.0% (n = 4)	62.5% (n = 10)	12.5% (n = 2)
Nonwhite	27.8% (n = 5)	66.7% (n = 12)	5.6% (n = 1)

DSM-IV DIAGNOSES

Workers were asked to report any DSM-IV Axis I diagnoses at intake into the BHJJ program. These diagnoses were either identified through a psychological assessment given as part of the enrollment process or in some cases, from psychological assessments given in close proximity to a youth's enrollment in BHJJ. All youth in Lorain County were diagnosed with a Cannabis-related Disorder. Other than Cannabis-related Disorders, the most common Axis I diagnosis for females was Post-traumatic Stress Disorder (45.5%, n = 5), while the most common Axis I diagnosis for males was Mood Disorder (45.8%, n = 11; see Table 9).

A total of 101 Axis I diagnoses were identified for 35 youth with diagnostic information (2.88 diagnoses per youth). Females reported 37 Axis I diagnoses (3.36 diagnoses per female) and males reported 64 Axis I diagnoses (2.67 diagnoses per male). Chi-square analysis indicated that a significantly higher proportion of females were diagnosed with Post-traumatic Stress Disorder. Of the youth who had available diagnostic information, 100.0% (n = 11) of females and 100.0% (n = 24) of males had a co-occurring substance use and mental health diagnosis.

Table 9. Most Common DSM-IV Axis I Diagnoses in Lorain County

DSM-IV Axis I Diagnosis	Females	Males
Alcohol-related Disorders	27.3% (n = 3)	20.8% (n = 5)
Attention Deficit Hyperactivity Disorder	18.2% (n = 2)	33.3% (n = 8)
Bipolar Disorder	0.0% (n = 0)	0.0% (n = 0)
Cannabis-related Disorders	100.0% (n = 11)	100.0% (n = 24)
Conduct Disorder	0.0% (n = 0)	8.3% (n = 2)
Depressive Disorders	18.2% (n = 2)	8.3% (n = 2)
Mood Disorder	27.3% (n = 3)	45.8% (n = 11)
Oppositional Defiant Disorder	9.1% (n = 1)	8.3% (n = 2)
Post-traumatic Stress Disorder	45.5% (n = 5)*	8.3% (n = 2)

*p < .05

EDUCATIONAL AND VOCATIONAL INFORMATION

EDUCATIONAL DATA

Several items that focused on educational and vocational information were included in the evaluation packet at both intake and termination from the BHJJ program. The items were completed by the worker with help from the youth and caregiver. In the 12 months prior to intake, 42.4% (n = 14) were either suspended or expelled from school. While in treatment with BHJJ, 21.1% (n = 4) of BHJJ youth were either suspended or expelled from school.

Educational data were analyzed for youth who were eligible for inclusion (youth on summer break or who had graduated at the time of the survey were not included in the analyses). At intake, 84.8% (n = 28) of youth were currently attending school excluding those on summer break. At termination, 68.4% (n = 13) of youth were attending school. Again, this does not include youth out of school due to summer break. If the youth was attending school, the worker was asked to identify the types of grades the youth typically received (see Table 10). Table 11 presents the academic performance of BHJJ youth in Lorain County from intake to termination based on completion status. At termination, 57.2% (n = 4) of successful completers received mostly A's, B's, and C's while 20.0% (n = 2) of unsuccessful completers received mostly A's, B's, and C's.

At termination, workers reported that 33.3% (n = 6) of youth were attending school more than before starting treatment and 61.1% (n = 11) of youth were attending school 'about the same' amount compared to before starting treatment. Workers reported 5.5% (n = 1) of youth were attending school less often than before treatment in BHJJ.

Table 10. Academic Performance in Lorain County

Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	3.0% (n = 1)	11.1% (n = 2)
Mostly B's and C's	33.3% (n = 11)	22.2% (n = 4)
Mostly C's and D's	27.3% (n = 9)	16.7% (n = 3)
Mostly D's and F's	36.4% (n = 12)	50.0% (n = 9)

Table 11. Academic Performance in Lorain County by Completion Status

Typical Grades	Unsuccessful Completers		Successful Completers	
	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	0.0% (n = 0)	0.0% (n = 0)	0.0% (n = 0)	28.6% (n = 2)
Mostly B's and C's	18.2% (n = 2)	20.0% (n = 2)	37.5% (n = 3)	28.6% (n = 2)
Mostly C's and D's	54.5% (n = 6)	10.0% (n = 1)	0.0% (n = 0)	14.3% (n = 1)
Mostly D's and F's	27.3% (n = 3)	70.0% (n = 7)	62.5% (n = 5)	28.6% (n = 2)

OHIO SCALES

One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum of service, separate charts are included that display the means from intake to termination. Decreases in Problem Severity and increases in Functioning correspond to positive change.

All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Paired samples t-tests were used to compare Problem Severity scores at intake to Problem Severity scores at the other assessment periods. A paired samples t-test compares the means of two variables by computing the difference between the two variables for each case and testing to see if the average difference is significantly different from zero. In order for a case to be included in the analyses, the rater must have scores for both assessment periods. For example, a caregiver must supply scores for both the intake and three month assessment period to be included in the paired samples t-test for that time point. If the caregiver only has an intake score, his or her data is not included in the analysis.

PROBLEM SEVERITY

Overall means for the Problem Severity scale by rater and assessment period for Lorain County youth are represented graphically in Figure 1. Means from intake to termination are presented in Figure 2. While the paired samples t-tests did not reveal significant improvements at this time, Problem Severity improved at every measurement interval for every rater.

Figure 1. Problem Severity Scores across Time - Lorain County

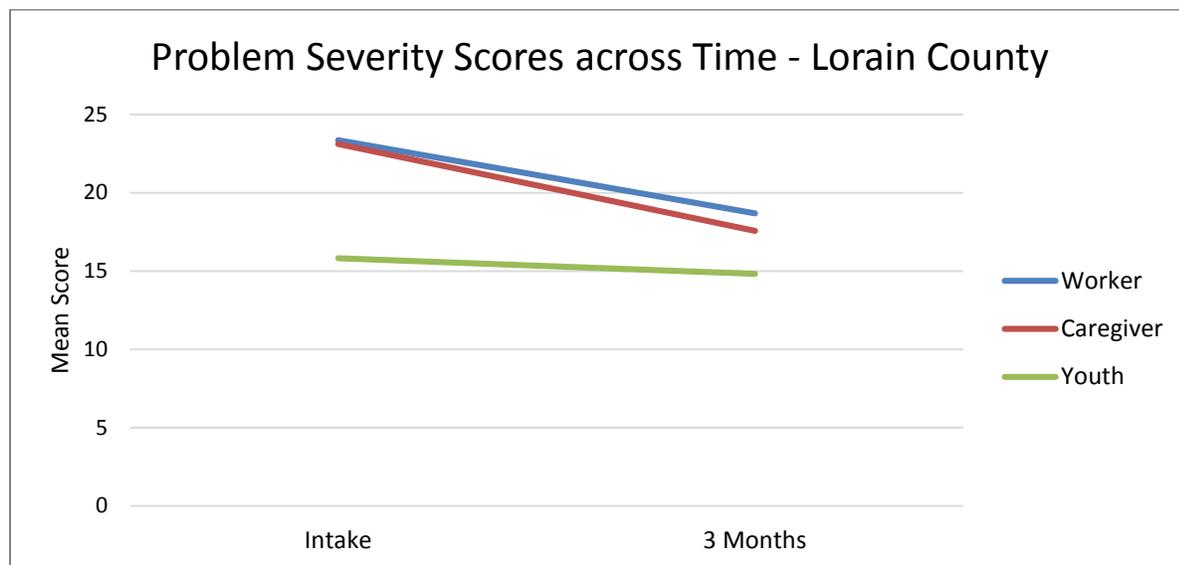
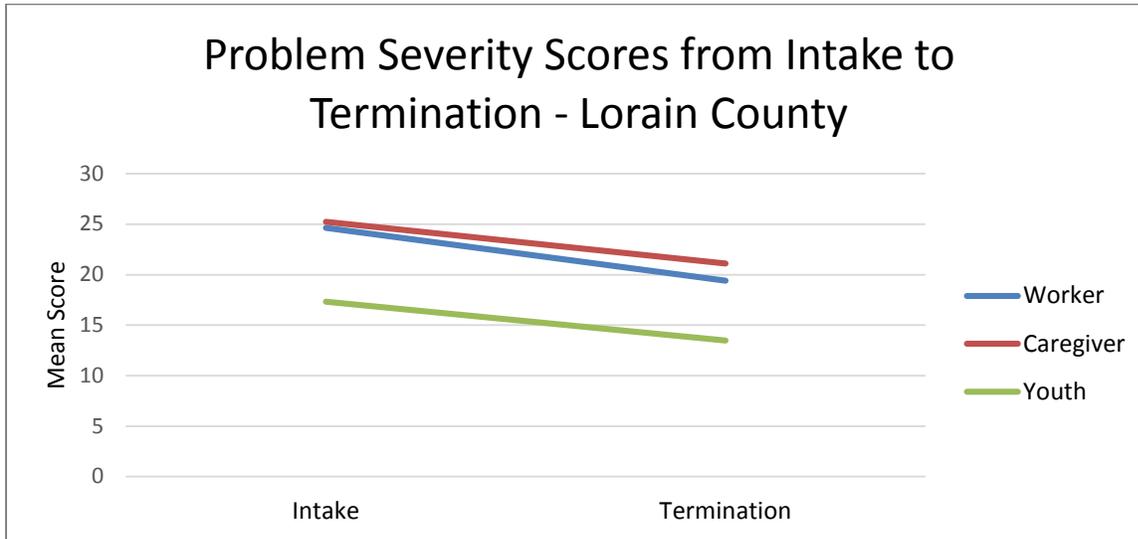


Figure 2. Problem Severity Scores from Intake to Termination - Lorain County



CAREGIVER RATING

While Problem Severity decreased at both measurement intervals (see Table 12) compared to intake, these differences were not statistically significant. Small effect sizes were found for each of these measurement intervals.

Table 12. Paired Samples T-Tests for Caregiver Report Problem Severity Scores for Lorain County

	Mean Time 1	Mean Time 2	t	d
Intake to Three Months	23.88 (SD=19.45; n=16)	17.56 (SD=11.99; n=16)	-1.47	.39
Intake to Termination	25.24 (SD=18.90; n=21)	21.11 (SD=12.88; n=21)	0.57	.25

WORKER RATING

For workers, although Problem Severity decreased at both measurement intervals (see Table 13), the differences are not statistically significant. A small effect size was observed for intake to termination. A moderate effect size was noted for intake to three months.

Table 13. Paired Samples T-Tests for Worker Report Problem Severity Scores for Lorain County

	Mean Time 1	Mean Time 2	t	d
Intake to Three Months	24.44 (SD=11.49; n=16)	18.69 (SD=11.48; n=16)	-1.34	.50
Intake to Termination	24.64 (SD=12.37; n=22)	19.41 (SD=12.70; n=22)	-1.56	.42

YOUTH RATING

Scores on the Problem Severity scale as reported by youth decreased (see Table 14), although these decreases are not statistically significant. Small effect sizes were observed for both measurement intervals.

Table 14. Paired Samples T-Tests for Youth Report Problem Severity Scores for Lorain County

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	19.40 (SD=11.27; n=15)	15.68 (SD=14.99; n=15)	-0.89	.28
Intake to Termination	17.33 (SD=13.07; n=21)	13.48 (SD=13.22; n=21)	-1.17	.29

FUNCTIONING

Overall means for the Functioning scale by rater and assessment period for Lorain County youth are represented graphically in Figure 3. Means from intake to termination are presented in Figure 4. While paired samples t-tests did not reveal statistically significant results, improvements in Functioning occurred in every rater.

Figure 3. Functioning Scores across Time - Lorain County

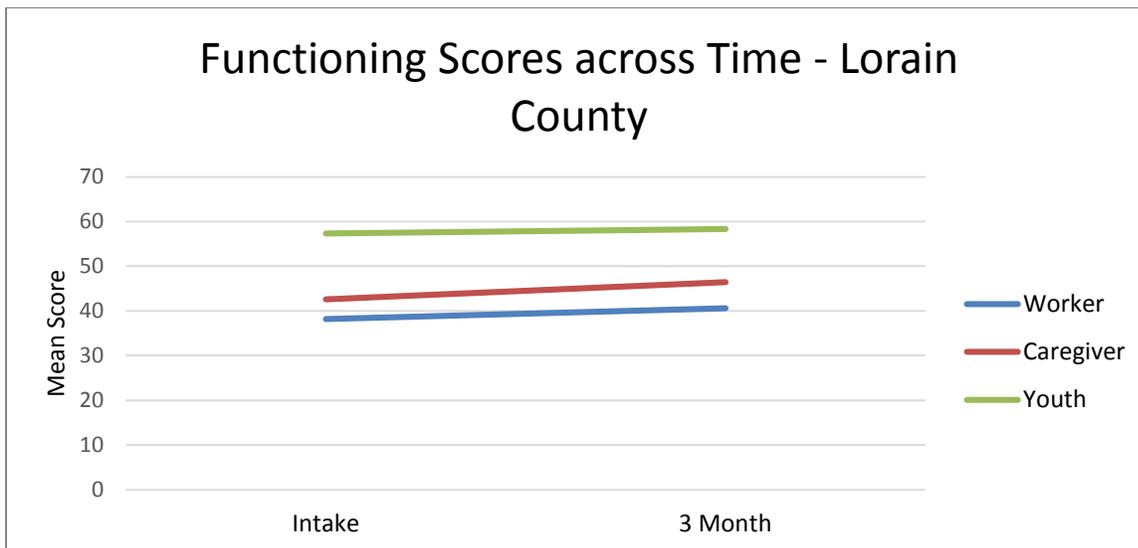
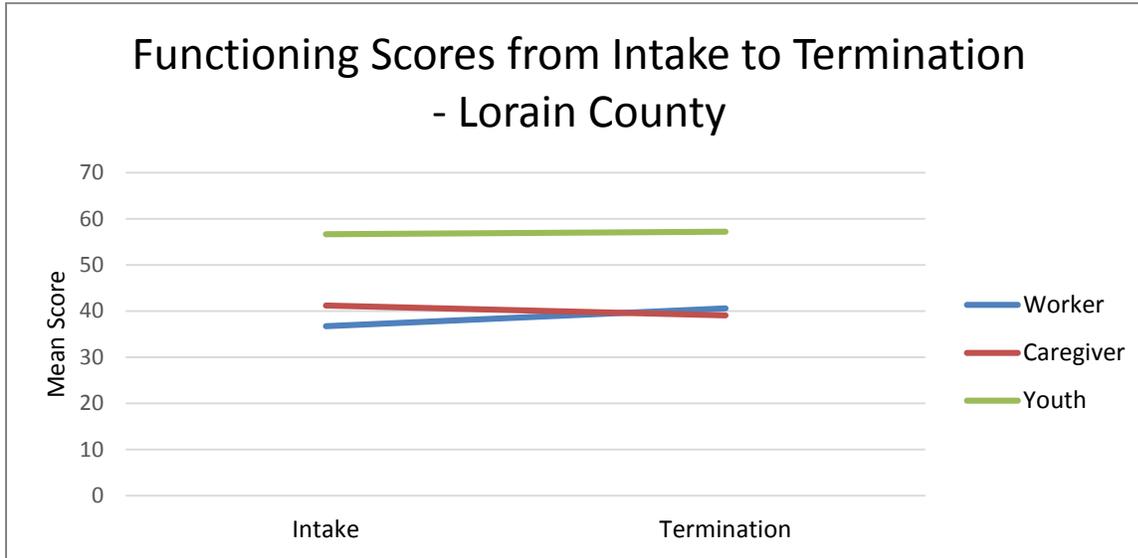


Figure 4. Functioning Scores from Intake to Termination - Lorain County



CAREGIVER RATING

While Functioning increased at both measurement intervals (see Table 15) compared to intake, these increases are not statistically significant. Small effect sizes were observed for both measurement intervals.

Table 15. Paired Samples T-Tests for Caregiver Report Functioning Scores for Lorain County

	Mean Time 1	Mean Time 2	t	d
Intake to Three Months	41.63 (SD=14.29; n=16)	46.44 (SD=13.17; n=16)	-1.47	.35
Intake to Termination	41.25 (SD=13.61; n=20)	39.05 (SD=13.44; n=20)	0.57	.16

WORKER RATING

For workers, Functioning increased at both measurement intervals (see Table 16). However, these increases were not statistically significant. Small effect sizes were observed for both measurement intervals.

Table 16. Paired Samples T-Tests for Worker Report Functioning Scores for Lorain County

	Mean Time 1	Mean Time 2	t	d
Intake to Three Months	35.06 (SD=11.52; n=16)	40.63 (SD=14.68; n=16)	-1.34	.42
Intake to Termination	35.77 (SD=11.25; n=22)	40.59 (SD=12.20; n=22)	-1.56	.41

YOUTH RATING

Although Functioning increased from intake to both measurement intervals (see Table 17), these increases were not statistically significant. Small effect sizes were noted for each of the measurement intervals.

Table 17. Paired Samples T-Tests for Youth Report Functioning Scores for Lorain County

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	55.36 (SD=11.52; n=14)	58.21 (SD=13.22; n=14)	-0.80	.23
Intake to Termination	56.70 (SD=10.90; n=20)	57.25 (SD=12.73; n=20)	-0.22	.04

The Trauma Symptom Checklist for Children (TSCC) was administered to youth in the BHJJ program in Lorain County at both intake and termination. The TSCC is made up of six subscales: Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, and Sexual Concerns. Higher scores on each of the subscales indicate higher levels of trauma symptoms. Table 18 shows the mean TSCC scores at intake and at termination. As described in the TSCC section in the overall BHJJ report, TSCC subscale scores are reported for youth ages 13-17 and those who were not identified as either underresponders or hyperresponders. The removal of such a large number of youth who were identified as “Underresponders” had a significant impact on the paired samples t-test results and the effect sizes. We are currently examining the practicality of removing these youth from the analyses.

Paired samples t-tests were conducted on the six subscales for Lorain County BHJJ youth who have subscale scores both at intake and at termination (see Table 18). Data were available for youth aged 8-17 who had completed the TSCC at both intake and termination, and youth who were not identified as either underresponders or hyperresponders. Effect sizes, represented by Cohen’s *d*, are also presented using the recommended criteria for its interpretation in Cohen’s (1988) seminal work. Interpretation of Cohen’s *d* is based on the criteria where 0.2 indicates a small effects size, 0.5 indicates a medium effect, and 0.8 indicates a large effect². While statistical significance refers to whether the observed differences in the means are likely to have occurred by chance, effect sizes measure the magnitude of the observed differences.

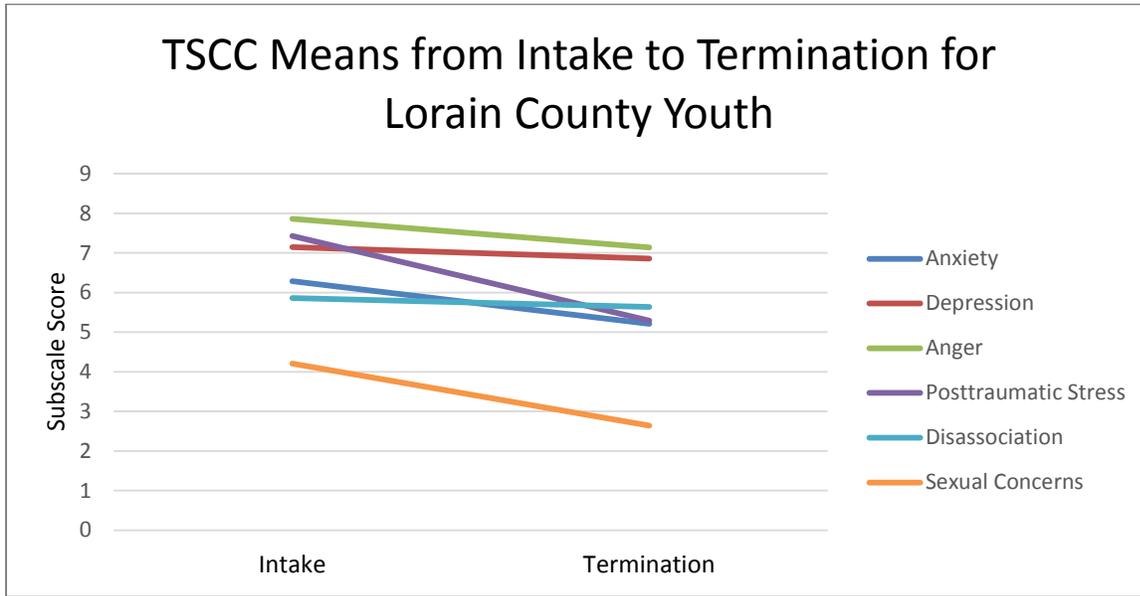
While statistically significant improvements were not noted for any of the subscales, trauma symptoms decreased from intake to termination for every TSCC domain. Means reported in Table 18 are represented graphically in Figure 5.

Table 18. Paired Samples T Tests for TSCC Subscales for Lorain County Youth

	Intake	Termination	t	d
Anxiety	6.29 (SD=5.17; n=14)	5.21 (SD=4.41; n=14)	0.72	.22
Depression	7.14 (SD=6.30; n=14)	6.86 (SD=5.27; n=14)	0.19	.05
Anger	7.86 (SD=4.96; n=14)	7.14 (SD=6.10; n=14)	0.38	.13
PTS	7.43 (SD=6.78; n=14)	5.29 (SD=5.46; n=14)	1.28	.35
Dissociation	5.86 (SD=5.53; n=14)	5.64 (SD=4.86; n=14)	0.11	.04
Sexual Concerns	4.21 (SD=3.77; n=14)	2.64 (SD=3.18; n=14)	1.11	.45

² For a more thorough review see Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

Figure 5. TSCC Means from Intake to Termination for Lorain County Youth



SUBSTANCE USE

Every six months the youth completed a self-report measure of substance use. The survey was designed to measure any lifetime use of each drug as well as patterns of current use. Table 19 presents the percentages of BHJJ youth who reported ever using alcohol or drugs and the average age of first use. Alcohol, cigarettes, and marijuana were the three most commonly used substances for both males and females. Due to small sample sizes, chi-square analyses detecting gender differences for substance use were not possible.

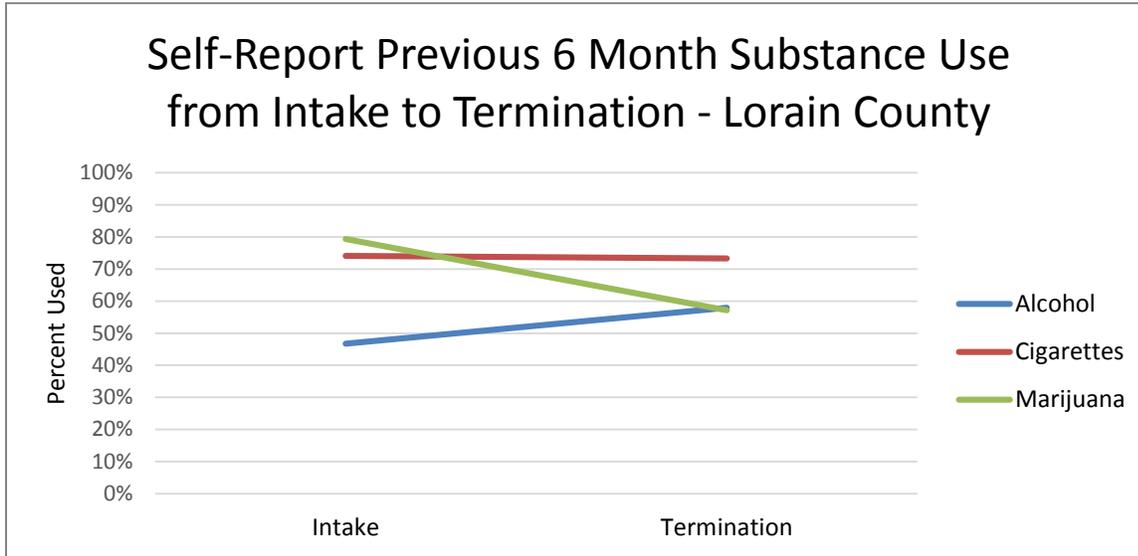
Youth were also asked to report whether they had used each substance in the past six months. Figure 6 presents past six month use for the most commonly reported substances among those who reported lifetime use. The percentage of those using cigarettes or marijuana decreased from intake to termination. Six month cigarette use decreased from 74.1% (n = 20) to 73.3% (n= 11) at termination. Six month marijuana use decreased from 79.4% (n = 27) intake to 57.1% (n = 12) at termination.

Table 19. Self-Report Substance Use at Intake for Lorain County BHJJ Youth

	Males		Females	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	87.5% (n = 21)	13.86 (SD = 1.24)	90.0% (n = 9)	12.56 (SD = 1.94)
Cigarettes	75.0% (n = 18)	13.18 (SD = 1.13)	90.0% (n = 9)	10.78 (SD = 2.44)
Chewing Tobacco	20.8% (n = 5)	14.20 (SD = 1.30)	10.0% (n = 1)	16.00
Marijuana	100% (n = 24)	13.12 (SD = 2.05)	100% (n = 10)	11.90 (SD = 1.97)
Cocaine	12.5% (n = 3)	15.33 (SD = 0.58)	30.0% (n = 3)	14.00 (SD = 1.73)
Pain Killers (use inconsistent with prescription)	39.1% (n = 9)	14.25 (SD = 0.71)	40.0% (n = 4)	13.33 (SD = 1.16)
GHB	0.0% (n = 0)	N/A	0.0% (n = 0)	N/A
Inhalants	13.0% (n = 3)	14.50 (SD = 0.71)	20.0% (n = 2)	13.00 (SD = 0.0)
Heroin	8.7% (n = 2)	16.00 (SD = 0.0)	20.0% (n = 2)	13.50 (SD = 2.12)
Amphetamines	4.5% (n = 1)	13.00 ^a	30.0% (n = 3)	13.00 (SD = 1.00)
Ritalin (use inconsistent with prescription)	17.4% (n = 4)	14.25 (SD = 0.96)	40.0% (n = 4)	12.50 (SD = 0.58)
Barbiturates	4.5% (n = 1)	15.00	10.0% (n = 1)	12.00
Non-prescription Drugs	22.7% (n = 5)	14.20 (SD = 1.10)	20.0% (n = 2)	14.50 (SD = 2.12)
Hallucinogens	16.7% (n = 4)	14.33 (SD = 2.08)	0.0% (n = 0)	N/A
PCP	4.2% (n = 1)	13.00	0.0% (n = 0)	N/A
Ketamine	0.0% (n = 0)	N/A	0.0% (n = 0)	N/A
Ecstasy	16.7% (n = 4)	14.75 (SD = 0.50)	30.0% (n = 3)	14.67 (SD = 1.53)
Tranquilizers	21.7% (n = 5)	14.40 (SD = 1.34)	30.0% (n = 3)	14.00 (SD = 0.0)

^a Standard Deviations are not calculated when only one respondent reported using a substance.

Figure 6. Self-Report Previous 6 Month Substance Use from Intake to Termination - Lorain County



OHIO SCALES AND SUBSTANCE USE

The Ohio Scales contain one Likert-scale item about the youth's problems with alcohol and drugs during the past 30 days. This question appears on all three versions of the Ohio Scales (Caregiver, Worker, and Youth). The responses range from zero to five, with zero indicating no problems at all with drugs or alcohol in the past 30 days and five indicating problems with drugs or alcohol all of the time. Scores on this item were examined at intake and termination for the three raters. All raters reported fewer problems with drugs or alcohol at termination from BHJJ (see Figure 7, Figure 8, and Figure 9). At intake 25.7% (n = 9) of caregivers and 38.2% (n = 13) of workers reported no problems with drugs or alcohol in the past 30 days while 36.4% (n = 8) of caregivers and 40.9% (n = 9) of workers reported no problems at termination. Similarly, 41.2% (n = 14) of youth reported no problems in the past 30 days with drugs or alcohol at intake while 45.5% (n = 10) of youth reported no problems at termination.

Figure 7. Problems with Drugs or Alcohol in the Past 30 Days for Lorain County Youth - Caregiver Ratings

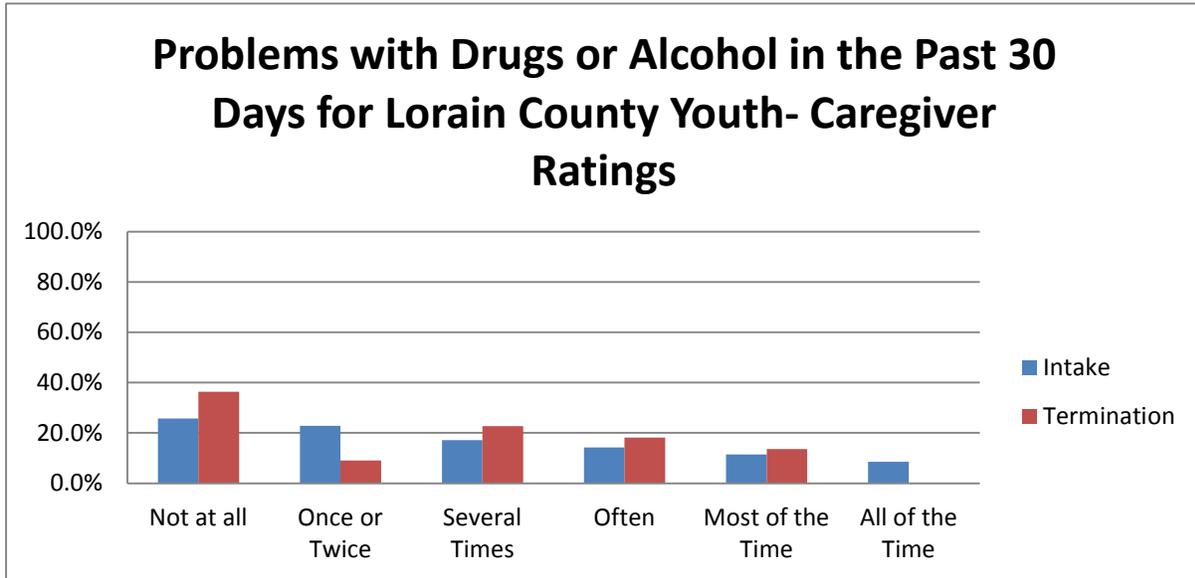


Figure 8. Problems with Drugs or Alcohol in the Past 30 Days for Lorain County Youth - Worker Ratings

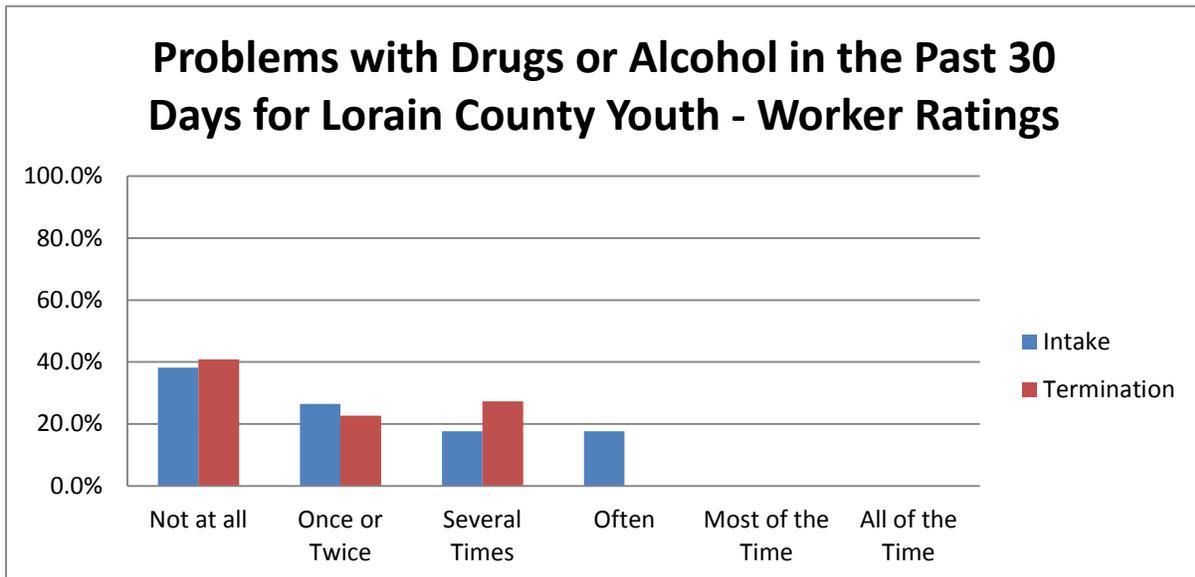
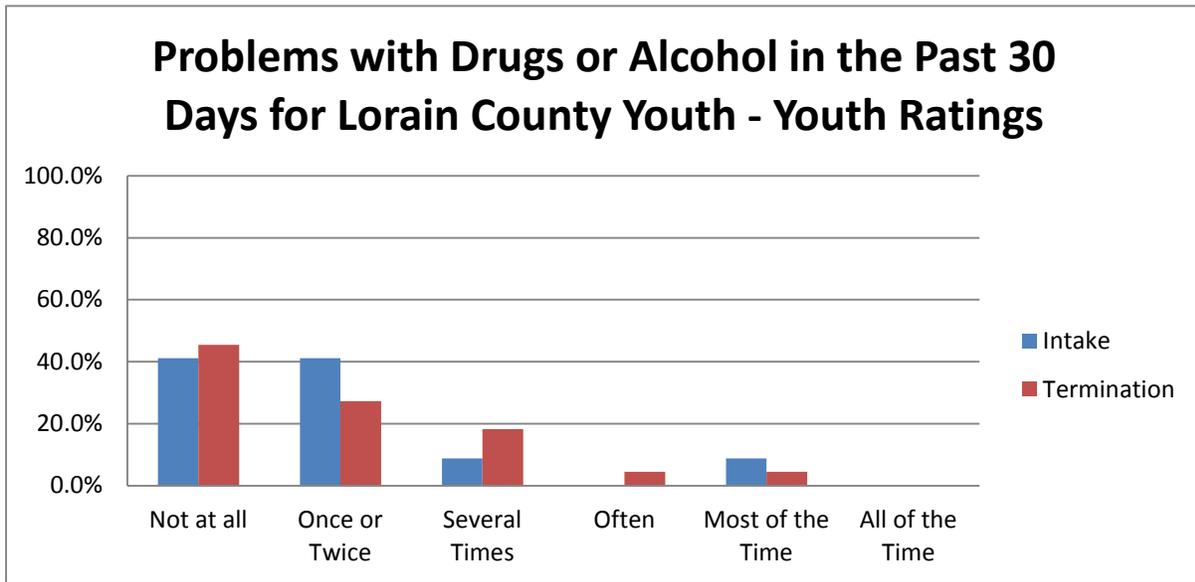


Figure 9. Problems with Drugs or Alcohol in the Past 30 Days for Lorain County Youth - Youth Ratings



TERMINATION INFORMATION

REASONS FOR TERMINATION

Upon termination of treatment from BHJJ, the case worker is asked to identify the reason for the youth's termination from the program. This information is typically focused on treatment outcomes and driven by local definitions of success, not necessarily whether the youth received new court charges or adjudications (recidivism), although youth may be terminated from the BHJJ program due to new involvement with the court. Typically, successful treatment completion is tied to attendance at meetings, progress in therapy, compliance with terms of the treatment plan, etc. County-specific definitions of successful termination are described in detail in the Project Descriptions section.

To date, there have been 22 youth terminated from the BHJJ program in Lorain County. **Thirty-six percent (36.4%, n = 8) of the youth terminated from the BHJJ program were identified as successful treatment completers.** In Lorain County 4.5% (n = 1) were withdrawn from the program and 22.7% (n = 5) were terminated from the program due to an out of home placement. Table 20 presents all of the reasons for termination from BHJJ.

Table 20. Reasons for Termination from BHJJ – Lorain County

Termination Reason	All Youth
Successfully Completed Services	36.4% (n = 8)
Client Did Not Return/Rejected Services	13.6% (n = 4)
Out of Home Placement	22.7% (n = 5)
Client/Family Moved	0.0% (n = 0)
Client Withdrawn	4.5% (n = 1)
Client AWOL	4.5% (n = 1)
Client Incarcerated	9.1% (n = 2)
Other	9.1% (n = 2)

AVERAGE LENGTH OF STAY

The average length of stay for youth in the Lorain County BHJJ program was 157 days. For youth identified as completing treatment successfully, the average length of stay was 173 days and for youth identified as unsuccessful treatment completers, the average length of stay was 122 days.

RISK FOR OUT OF HOME PLACEMENT

At intake into and termination from the BHJJ program, workers were asked whether the youth was at risk for out of home placement. Upon entering the program, 62.5% of the youth (n = 20) in Lorain County were at risk for out of home placement. At termination, 47.6% (n = 10) of youth were at risk for out of home placement. Of those youth who successfully completed BHJJ treatment, 12.5% (n = 1) were at risk for out of home placement at termination while 72.7% (n = 8) of youth who terminated unsuccessfully from the program were at risk for out of home placement.

POLICE CONTACTS

With help from the caregiver and youth, the worker was asked to estimate the frequency of police contacts since the youth has been receiving mental health services through BHJJ. Workers reported that police contacts had been reduced for 63.6% (n = 14) of the youth and had stayed the same for 36.4% (n = 8) of the youth.

SATISFACTION WITH SERVICES

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the BHJJ program (see Table 21). At termination from the BHJJ program, 85% (n = 17) of caregivers either strongly agreed or agreed that they were satisfied with the services their child received and 80% (n = 16) either strongly agreed or agreed that the services their child and/or family received were right for them. A strong majority (90.5%, n = 19) of caregivers either strongly agreed or agreed that staff treated them with respect and 90.5% (n = 19) strongly agreed or agreed that they were satisfied with the cultural and ethnic sensitivity of BHJJ staff.

Table 21. Satisfaction with Services – Lorain County

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Overall I am satisfied with the services my child received	20.0%	65.0%	5.0%	5.0%	5.0%
The services my child and/or family received were right for us	25.0%	55.5%	5.0%	10.0%	5.0%
Staff treated me with respect	23.8%	66.7%	0.0%	4.8%	4.8%
Staff were sensitive to my cultural/ethnic background	23.8%	66.7%	9.5%	0.0%	0.0%

RECIDIVISM

METHODOLOGY

Court data were provided by the Lorain County Juvenile Court, and consisted of charges, adjudications, and commitments to ODYS (at any time after their BHJJ enrollment, including after termination from BHJJ). Data were divided into charges prior to enrollment, charges after enrollment, and charges after termination from BHJJ. We also present the data by treatment completion status (successful vs. unsuccessful). Technical or probation violations were not considered to be new charges and thus were not included in the analyses. Data specific to charges for misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 3, 6, and 12 month intervals.

Several criteria for inclusion in the analysis were considered based on the time period of interest. While all youth 18 years of age and under are included in the analyses prior to enrollment, not all youth are included in each assessment period after enrollment and after termination. Any charges for youth over 18 years of age would likely be filed in adult court, and therefore would not appear in juvenile court records. A youth over 18 at the time of termination may show no future juvenile court involvement; however the individual may have charges in the adult system. Because we did not have access to adult records, youth 18 years of age or older at termination were eliminated from all analyses that examined charges after termination. Also, youth who turned 18 years old during the measurement interval in question (3, 6, or 12 months after enrollment or termination) were eliminated from the analysis because we lacked a complete picture of their possible court involvement.

Enrollment and termination dates were also used to identify youth for the analyses. For example, when examining recidivism data three months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least three months prior to the end of the data collection period, June 30, 2015. If the youth was terminated one month prior to the end of the data collection, that youth only had one month to recidivate. Therefore, the full extent of their recidivism is not known. For example, in order to be included in the three month after termination analyses, a youth had to have been 17.75 years old or younger at the time of termination and must have been terminated at least three months prior to the end of the data collection period. To be included in the 6 month analysis, youth had to have been 17.50 years old or younger at termination and have been terminated 6 months prior to June 30, 2015. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within three months after intake, youth must be 17.75 years old or younger at the time of enrollment and the enrollment date must be at least three months prior to the end of the data collection period for inclusion in the analysis.

RESULTS

JUVENILE COURT INVOLVEMENT PRIOR TO INTAKE

In the 12 months prior to their BHJJ enrollment, 74.3% (n = 26) of the BHJJ youth had a misdemeanor charge, 22.9% (n = 8) had a felony charge, and 77.1% (n = 27) were adjudicated delinquent (see Table 22).

Table 22. Charges Prior to BHJJ Enrollment – Lorain County

	Misdemeanors	Felonies	Adjudicated Delinquent
3 months	0.0% (n = 0)	0.0% (n = 0)	0.0% (n = 0)
6 months	57.1% (n = 20)	11.4% (n = 4)	54.3% (n = 19)
12 months	74.3% (n = 26)	22.9% (n = 8)	77.1% (n = 27)

RECIDIVISM AFTER ENROLLMENT

We defined recidivism after enrollment as receiving a new charge or adjudication at 3, 6, and 12 months after a youth's BHJJ enrollment date. Once again even if a charge was eventually dismissed, it was included in the 'Misdemeanors' and 'Felonies' columns of the associated tables but would not be included in the calculations of delinquent adjudications.

In the 12 months after enrollment in BHJJ, 42.9% (n = 3) of youth were charged with at least one new misdemeanor and zero were charged with at least one new felony. Twenty eight percent (28.6%, n = 2) of the youth were adjudicated delinquent in the 12 months after their enrollment in BHJJ (see Table 23).

Table 23. Charges after BHJJ Enrollment – Lorain County

	Misdemeanors	Felonies	Adjudicated Delinquent
3 months	29.6% (n = 8)	3.7% (n = 1)	29.6% (n = 8)
6 months	47.4% (n = 9)	10.5% (n = 2)	42.1% (n = 8)
12 months	42.9% (n = 3)	0.0% (n = 0)	28.6% (n = 2)

RECIDIVISM AFTER TERMINATION

We defined recidivism after termination as receiving a new charge or adjudication any time after a youth's BHJJ termination date. If a charge was eventually dismissed, it was still included in the 'Misdemeanors' and 'Felonies' column of the associated tables but would not be included in the calculations of delinquent adjudications.

In the 12 months after termination from BHJJ, 37.5% (n = 3) of youth were charged with at least one new misdemeanor, zero were charged with at least one new felony, and 25.0% (n = 2) were adjudicated delinquent (see Table 24).

Table 24. Charges after BHJJ Termination – Lorain County

	Misdemeanors	Felonies	Adjudicated Delinquent
3 months	14.3% (n = 2)	0.0% (n = 0)	7.1% (n = 1)
6 months	25.0% (n = 2)	0.0% (n = 0)	25.0% (n = 2)
12 months	37.5% (n = 3)	0.0% (n = 0)	25.0% (n = 2)

FELONY OFFENDERS AND ODYS COMMITMENTS

We examined data for those youth who committed felony offenses in the 12 months prior to their BHJJ enrollment to determine if they had new felony charges after their BHJJ termination. No felony offenders remained in the analysis after the data were restricted to youth 17 years old or younger, who had one full year to recidivate and for whom we had both recidivism and termination data.

None of the 32 BHJJ youth from Lorain County for whom we had recidivism data were committed to an ODYS facility at any time following their enrollment.

SUCCESS STORY

Mary* was referred to the Integrated Co-Occurring Treatment program through the Lorain County Juvenile Court and was eligible for services through the Behavioral Health and Juvenile Justice Grant. Mary was placed on probation due to receiving a domestic violence charge against her older brother. Mother reported that the police were contacted because Mary was trying to leave the house without permission. Mother shared that Mary's older brother stepped in to assist and client became aggressive with him (kicking and biting him). During this time, when client became physically aggressive towards her brother, she was using both alcohol and marijuana on a fairly consistent basis. Due to problematic substance use client was not permitted to leave the home with peers.

Mary was assessed by Emergency Stabilization Services through the Nord Center, prior to her admission into the ICT program, after experiencing feelings of suicidal ideation. Mary disclosed that a family member touched her inappropriately and took pictures of her naked. Mother confirmed that this information was disclosed to Lorain County Children Services who completed an investigation. When Mary was admitted into the ICT program she endorsed symptoms of suicidal ideation, self-injury, substance use, conflict with parents/siblings, truancy, and aggressiveness towards others. Mary and her Mother had a conflictual relationship due to allegations against a family member. Mary was temporarily living with her biological father when services began. Mary had some difficulty adjusting to living with her father, but with the support of individual/family counseling Mary began to repair her relationship with her father.

Over the course of six months Mary improved her school performance as evidenced by increased school attendance and better grades. Mary received drug tests through the Lorain County Juvenile Court which returned all negative results. Mary remained adamant that her goal was to not use alcohol or drugs during treatment and she was able to maintain sobriety over the course of six months of intensive counseling. Over time Mary began to develop hopefulness for her future which in turn reduced engagement in self-injury and suicidal ideation. Prior to beginning services Mary was cutting her arms/legs on a regular basis with a razor. Mary was frequently having thoughts of wanting to die and had developed a plan on how she wanted to follow through with killing herself.

While in treatment, family members began to report that Mary was getting along better with others by listening to rules at home and helping with chores around the house. A couple months into treatment Mary had a smooth transition back into living with her Mother. During family therapy sessions Mother would share concerns that client would return to old behaviors (using drugs, being defiant within the household), but as time progressed Mother began to see a change in Mary's behaviors. Mary completed a psychiatric evaluation through Bellefaire JCB and was placed on psychotropic medications to assist with mood stabilization. Mary began to replace old negative behaviors with new positive coping skills. Mary would spend time with peers engaging in prosocial activities and exhibited the ability to participate in social situations without using drugs or alcohol.

Mary has been able to develop goals for her future which includes moving out when she is 18, attending college with the support of close family friends, and becoming a veterinarian technician. On several occasions Mother would mention that client does not 'like many therapists' and that client 'has difficulty getting along with females', however Mother/client consistently reported having a different experience with this ICT Therapist. At the end of treatment, Mary and her Mother expressed gratitude and satisfaction with the services they received through Bellefaire JCB's ICT program.

*Name changed to protect client's confidentiality.

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