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

Trumbull County Results

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EXECUTIVE SUMMARY: AN EVALUATION OF THE BEHAVIORAL HEALTH/JUVENILE JUSTICE (BHJJ) INITIATIVE: 2013–2015 TRUMBULL 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 Trumbull County, 21 youth have been enrolled in BHJJ (61.9% male, 50% Caucasian). Average age of intake is about 15 years.

- Youth averaged 1.65 Axis I diagnoses. Over 61% of males and 57% of females were diagnosed with Oppositional Defiant Disorder and over 38% of males and 42% of females were diagnosed with Conduct Disorder.

- Caregivers reported that 42.9% of the females had a history of sexual abuse, over 66% talked about suicide, 50% had attempted suicide. Over 69% of males and 66% of females had family members who were diagnosed with or showed signs of depression.

- According to the OYAS, 94.4% of the youth served in Trumbull County were either moderate or high risk.

- Of the youth enrolled in Trumbull County, 11% had a felony charge in the 12 months prior to enrollment.

Educational Information

- Nearly 75% of the youth were suspended or expelled from school in the year prior to their enrollment. At termination, 100% of youth were attending school. At intake, 30.6% of youth

were receiving A's, B's, and C's in school, and at termination 72.7% were receiving A's, B's and C's.

- At termination, workers reported that 100% 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 significant decrease in Anxiety trauma symptoms from intake to termination.

- Results from the Ohio Scales indicated the caregivers and workers all reported increased youth functioning and decreased problem severity while in BHJJ treatment.

- Youth reported decreased six month alcohol and marijuana use from intake to termination.

- Risk for out of home placement decreased by 58% from intake to termination. Thirty percent of successful completers and 100% of unsuccessful completers were at risk for out of home placement at termination.

Termination and Recidivism Information

- Over 91% (91.7%) 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.

- Youth demonstrated decreased misdemeanor and delinquent adjudication involvement after termination from BHJJ compared to before enrollment.

- One year after termination, 11% of completers had a new felony charge.

- One of the 18 youth (5.5%) enrolled in BHJJ for whom we had recidivism data were sent to an ODYS facility at any time following their enrollment in BHJJ.

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, Kanary, & 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 BHJJ program serving Trumbull County is called the Mahoning Valley (MV) BHJJ Collaborative Project. Homes For Kids provides the services, (MST and TIP Informed High Fidelity Wraparound) for the project and the program serves male and female youth ages 12 to 17. The defined target population is multi-system involved youth who are at risk for out of home placement or incarceration or returning from an out of home placement. All youth entering the program will be designated SED and many will have a co-occurring substance abuse diagnosis. Our program implemented two evidence-based practices, Multisystemic Therapy (MST) and the Transition to Independence Process (TIP), as well as the evidenced-informed High Fidelity Wraparound. Our primary goals are to: reduce out of home placements, divert youth from Mahoning and Trumbull County Juvenile Court Programs or ODYS institutions to evidence-based, family-focused programming in the community, maintain or reduce Mahoning and Trumbull Counties commitments to ODYS, improve intersystem communication and collaboration, and share outcomes (successes and failures) across two contiguous counties that have many similarities.

Due to the projects focus on Multi System Involved Youth (Cross Over), youth can and do enter the program from various channels that include juvenile court, children services boards, or county family and children first councils. Prior to referral, each juvenile court ideally administers the OYAS to determine the risk of recidivism. Homes For Kids provides MST services to each youth identified as appropriate for the program. Upon completion of the MST Program, youth and families who are inclined and willing will be transferred to Wraparound Facilitation within each System of Care. Wraparound Facilitators will incorporate the TIP treatment model in engaging youth and empowering families to lead healthier lives.

Trauma Informed Care is heavily embedded in the MST Collaborative through the use of trauma informed protocols. Cultural Competence is also embedded through the entire project as it is a core component of the MST, TIP, and High-Fidelity Wraparound models. Youth entering the MV BHJJ Collaborative Program are screened and assessed (at intake and discharge) for trauma using the Trauma Symptom Checklist for Children (TSCC) and for substance abuse utilizing the Substance Use Survey (SUS) at intake, bi-annually, and discharge.

The MV BHJJ Collaborative project provides the region with 4 MST Therapists, capable of serving approximately 60 youth annually. MST is an effective evidence based tool that has been proven to work with the toughest offenders ages 12-17 who have a long history of arrests. All four MST Therapists are employed by Homes For Kids of Ohio.

Youth referred to the program are assessed by an MST Therapist and if appropriate and a good fit for the program, the case is opened and an initial session is scheduled with the family within 48 hours. The therapist meets with the family in their home to conduct family therapy sessions utilizing the MST model of treatment. MST therapists meet with families at minimum three times a week in their home working on getting the parent back in the driver seat of their family. MST clinicians go to where the child is and are on call 24 hours a day, seven days a week. They work intensively with parents and caregivers to put them in control. The therapist works with the caregivers to keep the adolescent focused on school, creating positive peer relationships, and gaining job skills. The therapist and caregivers introduce the youth to sports and recreational activities as an alternative to hanging out. The therapist and caregiver work intensively to improve family functioning and cohesiveness.

As with all evidence based programs, model adherence is a central theme. All client families complete TAM's (Therapist Adherence Measure) two weeks into treatment and every 30 days after on their assigned therapist to ensure the therapist is adhering to the MST model. These TAM's are entered by the MST supervisor onto the MST services secure website. To date adherence to the model falls within the expected targets.

The four therapists on the MST team and the MST supervisor attend weekly MST group supervision for two hours followed by one hour of case consultation with an MST consultant employed at the Center for Innovative Practices at Case Western Reserve University. In addition to weekly 3 hour supervision and consultation, MST therapists attend treatment staffings at juvenile court and children services as scheduled. The MST team also has quarterly Booster trainings with the MST consultant on topics picked by the MST team, supervisor and consultant aimed at increasing adherence to the model and increasing successful case outcomes.

As the MST treatment episode ends, the therapist, probation officer, and child welfare staff continue to collaborate and link the youth and family with community resources as needed, to help sustain the changes made during treatment. The families are offered the option of a step down into High-Fidelity Wraparound services and this is coordinated with the family by the MST therapist for a smooth transition from MST to wraparound. The MST therapist schedules with the wraparound facilitator to accompany them to the family's home to meet them and step the family down into wraparound services. A client and family is deemed to be successfully terminated from MST if they have: completed the 3-5 months of the program, learned new skills for sustainability in regards to utilizing informal supports as respite, improved their cohesion level as a family, decreased all referral behaviors, the youth is living in the home or community at time of discharge, attending work or school and has no new charges since entering the program.

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 effect[1].

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

TRUMBULL COUNTY

DEMOGRAPHICS

Trumbull County has enrolled 21 youth in the BHJJ program since 2013. Of the 21 youth enrolled, 38.1% (n = 8) were female and 61.9% (n = 13) were male (see Table 3). The majority of the overall sample of youth were either or Caucasian (50.0%, n = 10) or African American (30.0%, n = 6). The remainder of the population was composed of the "Other" racial category (20.0%, n = 10). The average age of the youth at intake into BHJJ was 15.2 years old (SD = 1.69) with a range between 11.9 and 17.6 years.

Table 3. Demographic Information for BHJJ Youth in Trumbull County

	All Youth Enrolled (2013 - 2015)
Gender	Female = 38.1% (n = 8)
	Male = 61.9% (n = 13)
Race	African American = 30.0% (n = 6)
	Caucasian = 50.0% (n = 10)
	Other = 20.0% (n = 4)
Age at Intake	15.20 years (SD = 1.69)

CUSTODY ARRANGEMENT AND HOUSEHOLD INFORMATION

At intake, 40.0% (n = 8) of BHJJ youth lived with the biological mother (see Table 4). At time of enrollment, 65.0% (n = 13) of the BHJJ youth lived with at least one biological parent.

Over 75% of the BHJJ caregivers (78.8%, n = 15) had at least a high school diploma or GED, and 15.8% (n = 3) had a bachelor's degree or higher (see Table 5). Over one in five caregivers (21.2%, n = 4) 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). Over three in four caregivers (76.5%, n = 13) reported annual household incomes below $35,000 and 47.1% (n = 8) reported an annual household income below $20,000. Over seventeen percent (17.7%, n = 3) reported an annual household income below $10,000.

Table 4. Custody Arrangement for BHJJ Youth in Trumbull County

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	15.0% (n=3)
Biological Mother Only	40.0% (n=8)
Biological Father Only	10.0% (n=2)
Adoptive Parent(s)	15.0% (n=3)
Sibling	0.0% (n=0)
Aunt/Uncle	0.0% (n=0)
Grandparents	10.0% (n=2)
Friend	0.0% (n=0)
Ward of the State	0.0% (n=0)
Other	10.0% (n=2)

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

Number of School Years Completed	Number of Caregivers
Less than High School	21.2% (n=4)
High School Graduate or G.E.D.	36.8% (n=7)
Some College or Associate Degree	26.3% (n=5)
Bachelor's Degree	0.0% (n=0)
More than a Bachelor's Degree	15.8% (n=3)

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

Annual Household Income	BHJJ Families
Less than $5,000	11.8% (n=2)
$5,000 - $9,999	5.9% (n=1)
$10,000 - $14,999	23.5% (n=4)
$15,000 - $19,999	5.9% (n=1)
$20,000 - $24,999	29.4% (n=5)
$25,000 - $34,999	0.0% (n=0)
$35,000 - $49,999	11.8% (n=2)
$50,000 - $74,999	5.9% (n=1)
$75,000 - $99,999	0.0% (n=0)
$100,000 and over	5.9% (n=1)

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). Due to sample size restrictions, we were not able to conduct tests for statistical significance.

Caregivers reported that 28.6% (n = 2) of females and 30.8% (n = 4) of males had a history of being physically abused while 42.9% (n = 3) of females and 15.4% (n = 2) of males had a history of being sexually abused. Caregivers of 66.7% (n = 4) of females and 61.5% (n = 8) of males reported hearing the child talking about committing suicide and 50.0% (n = 3) of females and 41.7% (n = 5) of males had attempted suicide at least once. Two out of three caregivers of females (66.7%, n = 4) and half of the caregivers of males (50.0%, n = 6) reported a family history of depression.

Table 7. Youth and Family History in Trumbull County

Question	Females	Males
Has the child ever been physically abused?	28.6% (n=2)	30.8% (n=4)
Has the child ever been sexually abused?	42.9% (n=3)	15.4% (n=2)
Has the child ever run away?	42.9% (n=3)	76.9% (n=10)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	28.6% (n=2)	38.5% (n=5)
Has the child ever talked about committing suicide?	66.7% (n=4)	61.5% (n=8)
Has the child ever attempted suicide?	50.0% (n=3)	41.7% (n=5)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	28.6% (n=2)	30.8% (n=4)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	66.7% (n=4)	69.2% (n=9)
Has anyone in the child's biological family had a mental illness, other than depression?	66.7% (n=4)	50.0% (n=6)
Has the child ever lived in a household in which someone was convicted of a crime?	14.3% (n=1)	38.5% (n=5)
Has anyone in the child's biological family had a drinking or drug problem?	57.1% (n=4)	38.5% (n=5)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	42.9% (n=3)	23.1% (n=3)

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 none of the females had ever been pregnant and no male impregnated a female.

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 Trumbull County youth based on the OYAS risk categories by gender and race are presented in Table 8. While these data are preliminary, as there are low numbers in each category, a greater proportion of Nonwhite youth (62.5%; n = 5) than White youth (30.0%; n = 3) were identified as high risk to reoffend.

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

	OYAS Low	OYAS Moderate	OYAS High
Female	14.3% (n = 1)	28.6 % (n = 2)	57.1% (n = 4)
Male	0.0% (n = 0)	63.6% (n = 7)	36.4% (n = 4)
White	0.0% (n = 0)	70.0% (n = 7)	30.0% (n = 3)
Nonwhite	12.5% (n = 1)	25.0% (n = 2)	62.5% (n = 5)

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. The most common Axis I diagnosis for both females (57.1%, n = 4) and males (61.5%, n = 8) was Oppositional Defiant Disorder (see Table 9).

A total of 33 Axis I diagnoses were identified for 20 youth with diagnostic information (1.65 diagnoses per youth). Females reported 12 Axis I diagnoses (1.71 diagnoses per female) and males reported 21 Axis I diagnoses (1.61 diagnoses per male). Of the youth who had available diagnostic information, 28.6% (n = 2) of females and 15.4% (n = 2) of males had a co-occurring substance use and mental health diagnosis.

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

DSM-IV Axis I Diagnosis	Females	Males
Alcohol-related Disorders	0.0% (n=0)	0.0% (n=0)
Attention Deficit Hyperactivity Disorder	0.0% (n=0)	23.1% (n=3)
Bipolar Disorder	14.3% (n=1)	0.0% (n=0)
Cannabis-related Disorders	28.6% (n=2)	15.4% (n=2)
Conduct Disorder	42.9% (n=3)	38.5% (n=5)
Depressive Disorders	0.0% (n=0)	7.7% (n=1)
Mood Disorder	0.0% (n=0)	7.7% (n=1)
Oppositional Defiant Disorder	57.1% (n=4)	61.5% (n=8)
Post-traumatic Stress Disorder	28.6% (n=2)	7.7% (n=1)

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, 75.0% (n = 15) were either suspended or expelled from school. While in treatment with BHJJ, 16.7% (n = 2) 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, 100.0% (n = 17) of youth were currently attending school excluding those on summer break. At termination, 91.7% (n = 11) 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). While at intake, 30.6% (n = 6) received mostly A's, B's, and C's, 72.7% (n = 8) received mostly A's, B's, and C's at termination.

At termination, workers reported that 70.0% (n = 7) of youth were attending school more than before starting treatment and 30.0% (n = 3) of youth were attending school 'about the same' amount compared to before starting treatment.

Table 10. Academic Performance in Trumbull County

Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	5.6% (n=1)	18.2% (n=2)
Mostly B's and C's	25.0% (n=5)	54.5% (n=6)
Mostly C's and D's	35.0% (n=7)	18.2% (n=2)
Mostly D's and F's	35.0% (n=7)	9.1% (n=1)

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 Trumbull County youth are represented graphically in Figure 1. Means from intake to termination are presented in Figure 2.

Figure 1. Problem Severity Scores across Time - Trumbull County

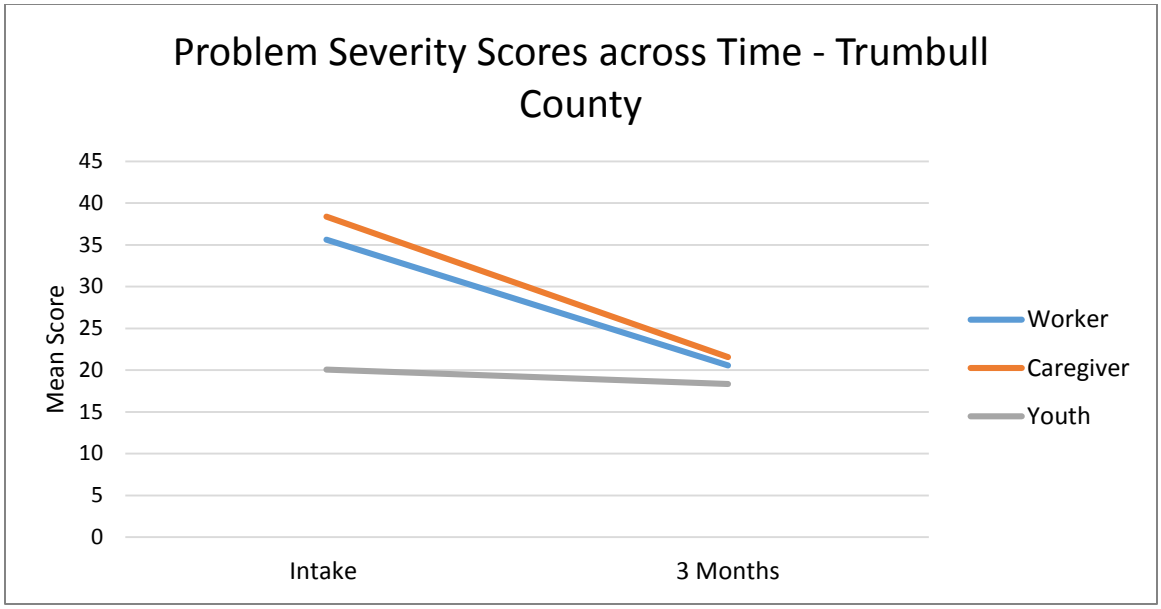
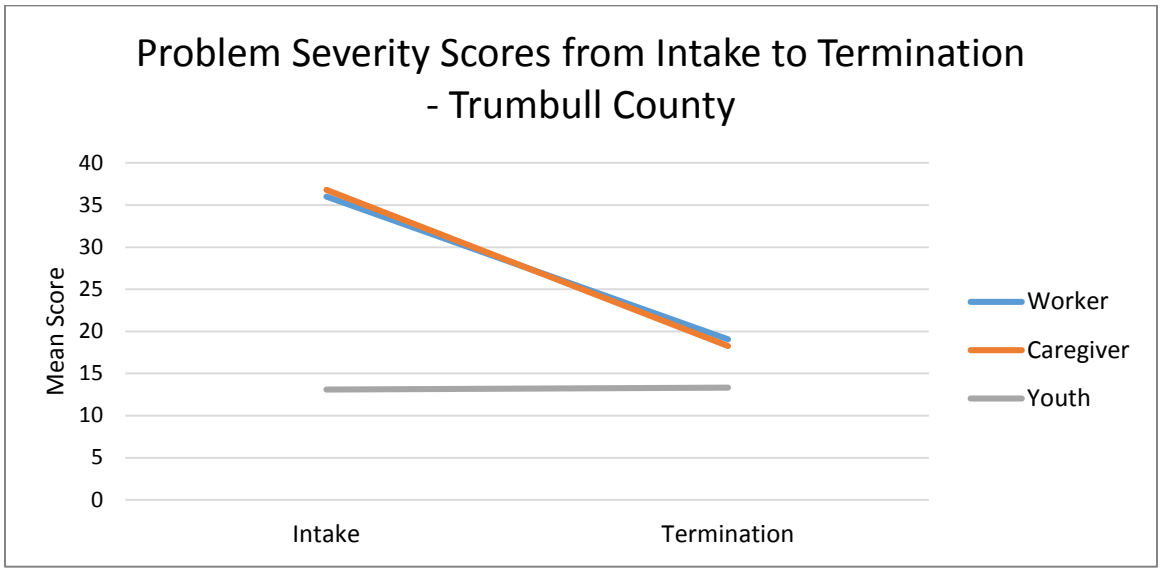


Figure 2. Problem Severity Scores from Intake to Termination - Trumbull County



CAREGIVER RATING

Paired samples t-tests revealed significant improvements in Problem Severity at termination (see Table 11) compared to intake. Significant improvements were noted at termination: $t(10) = 3.60$, $p < .01$. Large effect sizes were found for both of these measurement intervals.

Table 11. Paired Samples T-Tests for Caregiver Report Problem Severity Scores for Trumbull County

	Mean Time 1	Mean Time 2	*t*	*d*
Intake to Three Months	38.24 (SD=18.62; n=8)	22.13 (SD=15.34; n=8)	2.06	.94
Intake to Termination	36.81 (SD=17.05; n=11)	18.27 (SD=11.91; n=11)	3.60**	1.26

**p < .01

WORKER RATING

For workers, paired samples t-tests indicated significant improvement in Problem Severity termination (see Table 12). Significant improvements were noted at termination: $t(12) = 4.77$, $p < .001$. Large effect sizes were observed for both time periods.

Table 12. Paired Samples T-Tests for Worker Report Problem Severity Scores for Trumbull County

	Mean Time 1	Mean Time 2	*t*	*d*
Intake to Three Months	38.13 (SD=15.82; n=8)	20.63 (SD=9.93; n=8)	2.30	1.32
Intake to Termination	36.00 (SD=14.97; n=13)	19.08 (SD=9.50; n=13)	4.77***	1.35

***p < .001

YOUTH RATING

While Problem Severity scores for youth decreased from intake to three months (see Table 13), these differences did not reach statistical significance. Small effect sizes were observed for the intervals between intake and three months and between intake and termination.

Table 13. Paired Samples T-Tests for Youth Report Problem Severity Scores for Trumbull County

	Mean Time 1	Mean Time 2	*t*	*d*
Intake to Three Months	17.57(SD=22.60; n=7)	17.04 (SD=9.59; n=7)	0.71	.03
Intake to Termination	13.10 (SD=9.81; n=10)	13.32 (SD=10.72; n=10)	-0.10	.02

FUNCTIONING

Overall means for the Functioning scale by rater and assessment period for Trumbull County youth are represented in Figure 3. Means from intake to termination are presented in Figure 4.

Figure 3. Functioning Scores across Time - Trumbull County

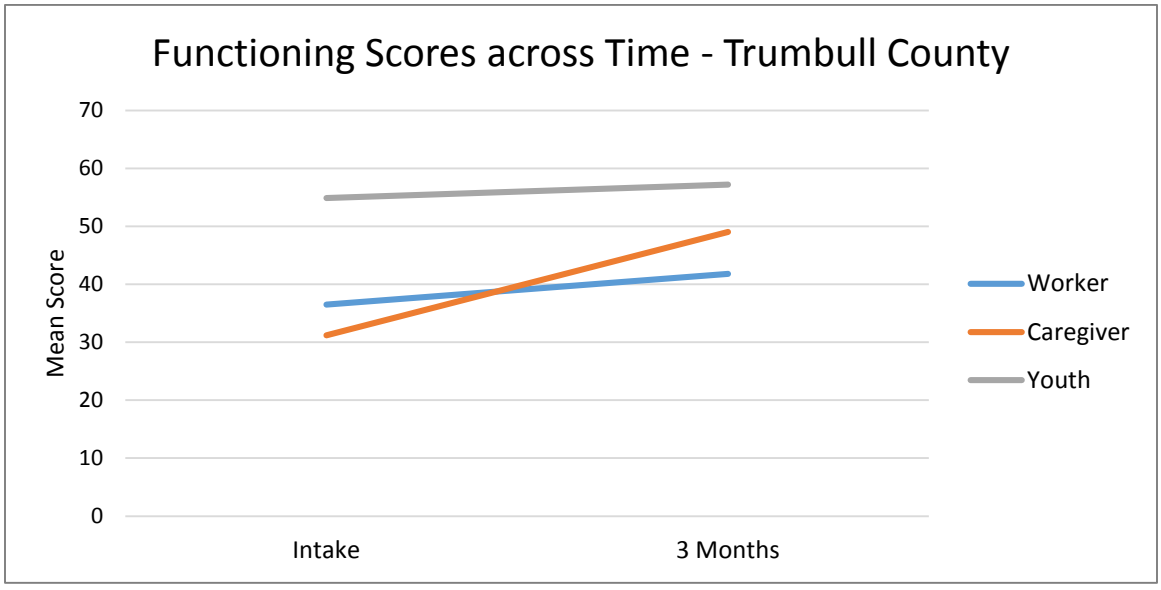
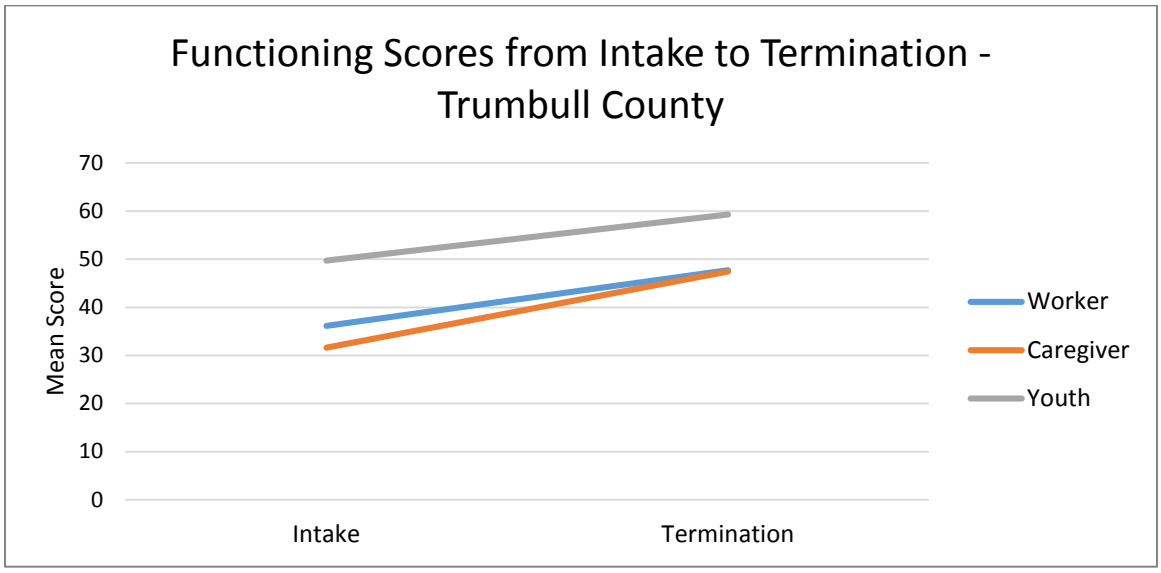


Figure 4. Functioning Scores from Intake to Termination - Trumbull County



CAREGIVER RATING

Paired samples t-tests revealed significant improvements in Functioning at both measurement intervals (see Table 14) compared to intake. Significant improvements were noted at three months: $t(7) = -4.16$, $p < .01$; and termination: $t(10) = -3.08$, $p < .05$. Large effect sizes were noted for both time periods.

Table 14. Paired Samples T-Tests for Caregiver Report Functioning Scores for Trumbull County

	Mean Time 1	Mean Time 2	*t*	*d*
Intake to Three Months	34.00 (SD=14.34; n=8)	51.38 (SD=13.84; n=8)	-4.16**	1.23
Intake to Termination	31.64 (SD=13.19; n=11)	47.45 (SD=11.60; n=11)	-3.08*	1.27

*p < .05, **p < .01

WORKER RATING

For workers, paired samples t-tests indicated significant improvement in the Functioning scale for intake to termination (see Table 15). Significant improvements were noted at termination: $t(12) = -5.32$, $p < .001$. A moderate effect size was found for intake to three months, while a large effect size was noted for intake to termination.

Table 15. Paired Samples T-Tests for Worker Report Functioning Scores for Trumbull County

	Mean Time 1	Mean Time 2	*t*	*d*
Intake to Three Months	36.62 (SD=10.01; n=8)	42.38 (SD=11.82; n=8)	-1.38	.52
Intake to Termination	36.15 (SD=7.96; n=13)	47.69 (SD=8.87; n=13)	-5.32***	1.37

***p < .001

YOUTH RATING

Although youth-rated Functioning increased compared to intake, these differences are not statistically significant (see Table 16). A small effect size was found for the measurement interval between intake and three months, and a moderate effect size was found for intake to termination.

Table 16. Paired Samples T-Tests for Youth Report Functioning Scores for Trumbull County

	Mean Time 1	Mean Time 2	*t*	*d*
Intake to Three Months	52.00 (SD=26.18; n=6)	62.33 (SD=15.55; n=6)	-0.72	.48
Intake to Termination	49.70 (SD=20.61; n=10)	59.30 (SD=16.09; n=10)	-1.61	.52

TSCC

The Trauma Symptom Checklist for Children (TSCC) was administered to youth in the BHJJ program in Trumbull 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 17 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.

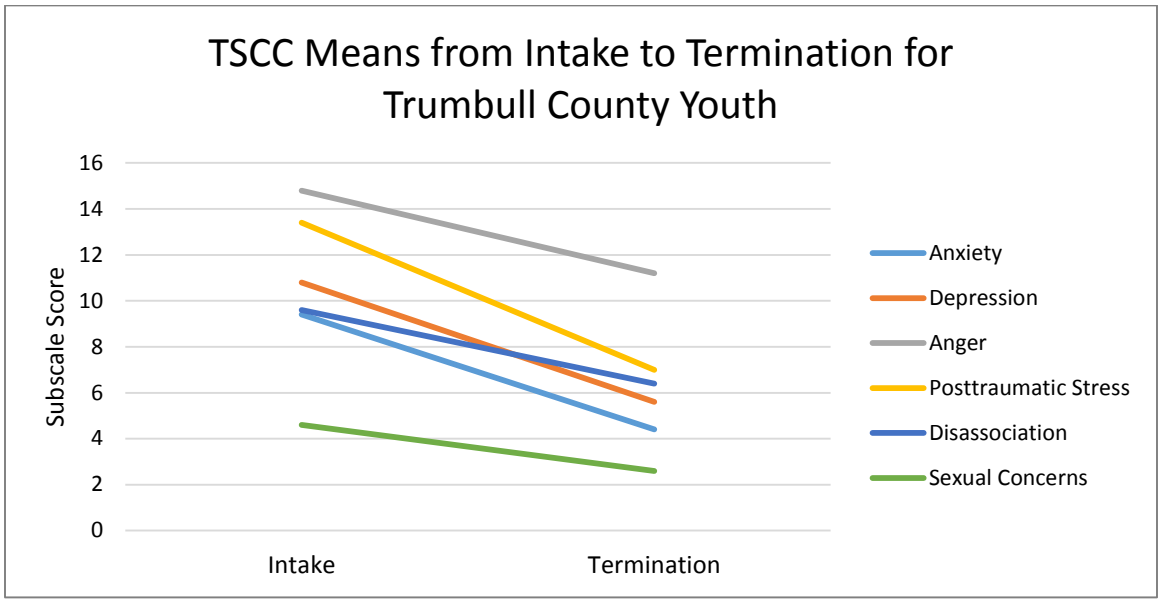
Paired samples t-tests were conducted on the six subscales for Trumbull County BHJJ youth who have subscale scores both at intake and at termination (see Table 17). Data were available for youth aged 8-17 who had completed the TSCC at both intake and termination, and youth who were not identified as either underresponders or hyperresponders. Statistically significant improvements were noted for Anxiety: ($t(4) = 3.04$, $p < .05$). The data indicated a small effect size for Dissociation, a moderate effect size for Anger and Sexual Concerns, and large effect sizes for Anxiety, Depression, and Posttraumatic Stress. Decreases were shown in every domain. Means reported in Table 17 are represented graphically in Figure 5.

Table 17. Paired Samples T Tests for TSCC Subscales for Trumbull County Youth

	Intake	Termination	t	d
Anxiety	9.40 (SD=4.72; n=5)	4.40 (SD=2.70; n=5)	3.04*	1.30
Depression	10.80 (SD=4.48; n=5)	5.60 (SD=4.04; n=5)	1.92	1.22
Anger	14.80 (SD=6.06; n=5)	11.20 (SD=7.60; n=5)	1.49	.52
PTS	13.40 (SD=6.73; n=5)	7.00 (SD=7.48; n=5)	1.88	.90
Dissociation	9.60 (SD=10.26; n=5)	6.40 (SD=4.56; n=5)	0.92	.40
Sexual Concerns	4.60 (SD=4.93; n=5)	2.60 (SD=2.07; n=5)	1.12	.53

*p < .05

Figure 5. TSCC Means from Intake to Termination for Trumbull 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 18 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.

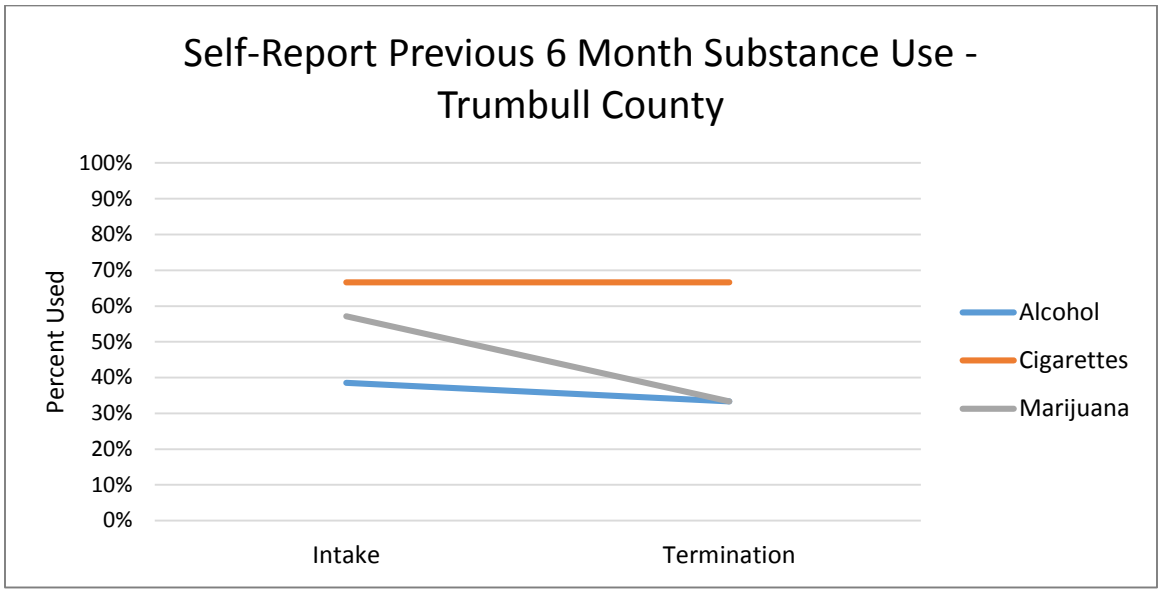
Youth were also asked to report whether they had used each substance in the past six months. Figure 6 presents past six month use for the most commonly reported substances among those who reported lifetime use. With the exception of cigarette use, the percentage of those using substances decreased among the most commonly reported substances. Six month alcohol use decreased from 38.5% (n = 5) to 33.3% (n = 2) at termination. Six month marijuana use decreased from 57.1% (n = 8) at intake to 33.3% (n = 2) at termination.

Table 18. Self-Report Substance Use at Intake for Trumbull County BHJJ Youth

	Males		Females	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	66.7% (n = 8)	11.75 (SD = 4.03)	71.4% (n = 5)	14.20 (SD = 1.79)
Cigarettes	66.7% (n = 8)	12.43 (SD = 2.23)	57.1% (n = 4)	13.50 (SD = 1.29)
Chewing Tobacco	41.7% (n = 5)	13.20 (SD = 1.64)	0.0% (n = 0)	N/A
Marijuana	75.0% (n = 9)	13.25 (SD = 2.32)	71.4% (n = 5)	13.40 (SD = 1.52)
Cocaine	0.0% (n = 0)	N/A	14.3% (n = 1)	16.00
Pain Killers (use inconsistent with prescription)	20.0% (n = 2)	13.00[a]	28.6% (n = 2)	14.50
GHB	0.0% (n = 0)	N/A	0.0% (n = 0)	N/A
Inhalants	16.7% (n = 2)	15.00 (SD = 0.0)	14.3% (n = 1)	14.00
Heroin	0.0% (n = 0)	N/A	0.0% (n = 0)	N/A
Amphetamines	0.0% (n = 0)	N/A	0.0% (n = 0)	N/A
Ritalin (use inconsistent with prescription)	9.1% (n = 1)	15.00	14.3% (n = 1)	14.00
Barbiturates	0.0% (n = 0)	N/A	0.0% (n = 0)	N/A
Non-prescription Drugs	0.0% (n = 0)	N/A	14.3% (n = 1)	14.00
Hallucinogens	0.0% (n = 0)	N/A	28.6% (n = 2)	16.00 (SD = 0.0)
PCP	0.0% (n = 0)	N/A	0.0% (n = 0)	N/A
Ketamine	0.0% (n = 0)	N/A	0.0% (n = 0)	N/A
Ecstasy	0.0% (n = 0)	N/A	14.3% (n = 1)	16.00
Tranquilizers	8.3% (n = 1)	16.00	0.0% (n = 0)	N/A

[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 - Trumbull 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. Caregiver and Worker raters reported fewer problems with drugs or alcohol at termination from BHJJ (see Figure 7, Figure 8, and Figure 9). At intake 38.9% (n = 7) of caregivers and 36.8% (n = 7) of workers reported no problems with drugs or alcohol in the past 30 days while 75% (n = 9) of caregivers and 64.3% (n = 9) of workers reported no problems at termination. About 84% (84.2%, n = 16) of youth reported no problems in the past 30 days with drugs or alcohol at intake while 81.8% (n = 2) of youth reported no problems at termination.

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

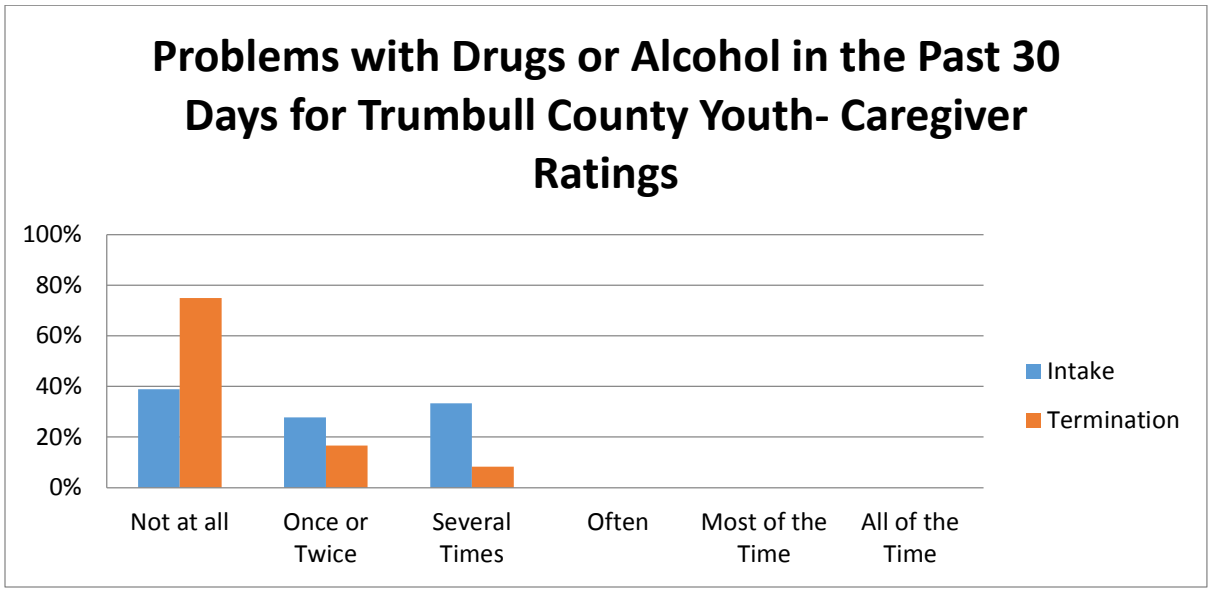


Figure 8. Problems with Drugs or Alcohol in the Past 30 Days for Trumbull County Youth - Worker Ratings

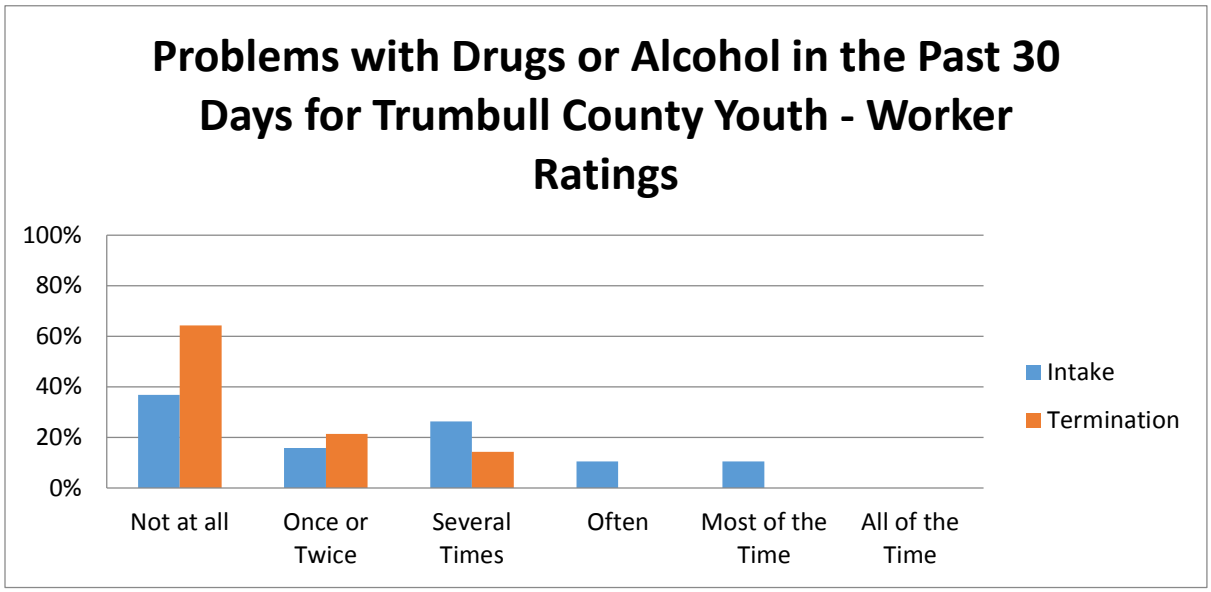
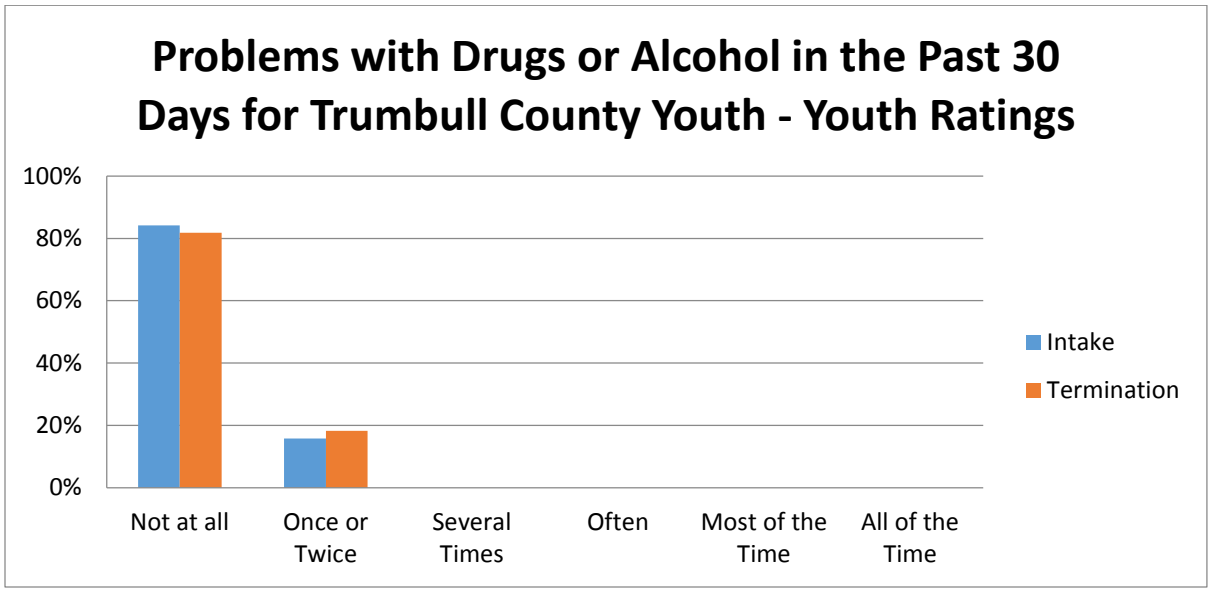


Figure 9. Problems with Drugs or Alcohol in the Past 30 Days for Trumbull County Youth - Youth Ratings



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 12 youth terminated from the BHJJ program in Trumbull County. **Over 91% (91.7%, n = 11) of the youth terminated from the BHJJ program were identified as successful treatment completers.** One youth (8.3%) was terminated from the BHJJ program due to incarceration.

AVERAGE LENGTH OF STAY

The average length of stay for youth in the Trumbull County BHJJ program was 147 days. For youth identified as completing treatment successfully, the average length of stay was 147 days and for youth identified as unsuccessful treatment completers, the average length of stay was 150 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, 87.5% of the youth (n = 14) in Trumbull County were at risk for out of home placement. At termination, 36.4% (n = 4) of youth were at risk for out of home placement. Of those youth who successfully completed BHJJ treatment, 30% (n = 3) were at risk for out of home placement at termination while 100% (n = 1) 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 had been receiving mental health services through BHJJ. Workers reported that police contacts has been reduced for 83.3% (n = 10) of the youth and had stayed the same for 8.3% (n = 1) of the youth. Police contacts increased for 8.3% (n = 1) of the youth.

RECIDIVISM

METHODOLOGY

Court data were provided by the Trumbull 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, 12, and 18 month intervals for prior to enrollment and 3, 6, 12, and 18 month intervals after enrollment and termination.

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, 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, 88.9% (n = 16) of the BHJJ youth had a misdemeanor charge, 11.1% (n = 2) had a felony charge, and 83.3% (n = 15) were adjudicated delinquent (see Table 19).

Table 19. Charges Prior to BHJJ Enrollment – Trumbull County

	Misdemeanors	Felonies	Adjudicated Delinquent
3 months	61.1% (n = 11)	5.6% (n = 1)	55.6% (n = 10)
6 months	72.2% (n = 13)	5.6% (n = 1)	66.7% (n = 12)
12 months	88.9% (n = 16)	11.1% (n = 2)	83.3% (n = 15)
18 months	88.9% (n = 16)	11.1% (n = 2)	83.3% (n = 15)

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. Eighteen month data is not yet available for this county.

In the 12 months after enrollment in BHJJ, 60.0% (n = 3) of youth were charged with at least one new misdemeanor and 40.0% (n = 2) were charged with at least one new felony. Sixty percent (n = 3) of the youth were adjudicated delinquent in the 12 months after their enrollment in BHJJ (see Table 20).

Table 20. Charges after BHJJ Enrollment – Trumbull County

	Misdemeanors	Felonies	Adjudicated Delinquent
3 months	21.4% (n = 3)	14.3% (n = 2)	21.4% (n = 3)
6 months	18.2% (n = 2)	9.1% (n = 1)	27.3% (n = 3)
12 months	60.0% (n = 3)	40.0% (n = 2)	60.0% (n = 3)

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, 55.6% (n = 5) of youth were charged with at least one new misdemeanor, 11.1% (n = 1) were charged with at least one new felony, and 44.4% (n = 4) were adjudicated delinquent (see Table 21).

Table 21. Charges after BHJJ Termination – Trumbull County

	Misdemeanors	Felonies	Adjudicated Delinquent
3 months	40.0% (n = 4)	10.0% (n = 1)	30.0% (n = 3)
6 months	42.9% (n = 3)	14.3% (n = 1)	28.6% (n = 2)
12 months	55.6% (n = 5)	11.1% (n = 1)	44.4% (n = 4)

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. Only one felony offender 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. This one case did not recidivate one year after BHJJ termination.

One of the 18 BHJJ youth (5.5%) from Trumbull County for whom we had recidivism data were committed to an ODYS facility at any time following their enrollment.

SUCCESS STORY

D became a part of the BHJJ project after being referred to MST treatment. D is a 17 yr male who was in and out of detention several times and living w/ grandparents. His referral behaviors were THC use, AWOL, Truancy and Physical Aggression and some mental health issues. D's grandparents reported that the defiant and disrespectful behaviors were out of control. D's grandparents also reported last year the police were called to the home about 15 times.

The family engaged in the assessment process to determine his needs. The MST therapist quickly linked and coordinated the family with some extra natural supports to help implement strategies emphasized in the MST program. The grandparents were engaged in frequent sessions and meetings with MST and the probation officer.

D and the family worked really hard over the several months to make changes and adjust to utilizing recommended strategies to reduce stressors and change the family structure. The family completed 5 months of MST treatment, the police and probation officer were only called 2 times during the 5 months of MST. The grandparents reported being extremely happy with the decrease in calls to formal supports. At discharge, D was negative for THC, truant from school only twice over 5 months and had no physical aggression or AWOL behavior. D's grandparents reported feeling confident in their ability to handle their grandson's behavior and displayed a clear improvement in their positive communication.

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