

An Evaluation of the Behavioral Health/Juvenile Justice (BHJJ) Initiative: 2008-2015 Hamilton County Results

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EXECUTIVE SUMMARY: AN EVALUATION OF THE BEHAVIORAL HEALTH/JUVENILE JUSTICE (BHJJ) INITIATIVE: 2008 – 2015 HAMILTON 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 Hamilton County, 225 youth have been enrolled in BHJJ (70.7% males, 51.7% African American). In the past two years, more African Americans (60.4%) than Whites (39.6%) and males (75%) than females (25%) have been enrolled.
- ❖ Youth averaged 1.9 Axis I diagnoses. Males were significantly more likely to be diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). Females were significantly more likely to be diagnosed with Depressive Disorders and Post-traumatic Stress Disorder.
- ❖ Over 34% of males and 26% of females were diagnosed with both a mental health and substance use diagnosis.
- ❖ Caregivers reported that 16.1% of the females had a history of sexual abuse, over 41% talked about suicide, and over 23% had attempted suicide. Over 65% of males and 67% of females had family members who were diagnosed with or showed signs of depression.
- ❖ According to the OYAS, 44.8% of the youth served in BHJJ were moderate or high risk.
- ❖ Nearly 29% of youth had felony charges in the 12 months prior to enrollment.

Educational Information

- ❖ Over 56% of the youth were suspended or expelled from school in the year prior to their enrollment. At termination, 93.7% of youth were attending school. At intake, 16.1% of youth earned mostly A's or B's, while at termination, 26.4% of youth earned mostly A's or B's.
- ❖ At termination, workers reported that 91.8% of youth were attending school more or than or about the same as they were before starting treatment.

Mental/Behavioral Health Outcomes

- ❖ BHJJ youth reported a significant decrease in trauma symptoms of Anger, Posttraumatic Stress, and Dissociation 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.
- ❖ Both males and females reported decreased 6 month alcohol and marijuana use.
- ❖ At termination, 100% of caregivers reported that they were satisfied with the services their child received and that they were satisfied with the cultural and ethnic sensitivity of BHJJ staff.

Termination and Recidivism Information

- ❖ Over 75% 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 7 months (6.9 months for youth enrolled during previous biennium).
- ❖ Prior to the BHJJ program, 18.3% of youth were at risk for out of home placement. At termination, 16.7% were at risk for out of home placement.
- ❖ Successful treatment completion in BHJJ produced lower percentages of subsequent juvenile court charges, felonies, misdemeanors, and delinquent adjudications than unsuccessful completion, although both groups demonstrated decreased juvenile court involvement after termination from BHJJ compared to before enrollment.
- ❖ One year after termination, 15.7% of successful treatment completers and 25.0% of unsuccessful treatment completers had a new felony charge. Of the youth entering BHJJ with at least one felony charge, 29.6% were charged with a new felony in the 12 months following BHJJ termination.
- ❖ Four of the 217 youth (1.8%) 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: 2008-2015 HAMILTON 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 BHJJ project in Hamilton County consists of a collaborative effort between Hamilton County Juvenile Court (HCJC), Hamilton County Mental Health and Recovery Services Board (HCMHRSB) and Lighthouse Youth Services (LYS). Together these entities provide services for the Juvenile Mental Health Court, enhancing the coordination of care for youth and families through the use of evidence based clinical practice. The Lighthouse Individualized Docket Services (LIDS) program reflects the values of Ohio Family and Children First Council's County Comprehensive Family Services Coordination Plan. Lighthouse Youth Services (LYS) is a certified provider of the Ohio Mental Health and Addiction Services (OhioMHAS) to provide "Other" Mental Health Services, Community Psychiatric Support Treatment (CPST), Behavioral Health Counseling and Therapy, Mental Health Assessment, Pharmacological Management, and Alcohol or Other Drug (AOD) Treatment and Prevention services. The agency is also accredited through CARF International.

BHJJ funding has provided the opportunity for the program to identify and implement a model of screening, assessment and evaluation protocols that provide for a comprehensive service delivery system. Referrals are received by court personnel or within the community. Initial screening for the program can be completed by Mental Health Access Point (MHAP), the front door to community mental health services, regardless if the youth is in the community or in detention. The initial screening consists of a set of eligibility criteria including age, mental health diagnosis, caregiver availability, and degree of criminal charges. Youth are further reviewed at weekly staff meetings to determine appropriateness for the program and to identify the treatment modality, Functional Family Therapy (FFT), which is primary, Adolescent Community Reinforcement Approach (A-CRA), Teen Intervene, or other varied models of intervention within LYS based on needs of the youth and family. The staff meeting consists of representatives from the Juvenile Court, MHAP, and LYS.

The eligibility criteria include:

- Hamilton County resident,
- Males and females,
- Age 12-17 years (with the ability to consult with the review team on eligibility for youth under age 12 years),
- Pre-adjudication for first time offenders and/or youth who have no more than 5 prior contacts with juvenile court (PDD only),
- Adjudication of delinquency (IDD only),
- As defined by DSM-IV TR, and DSM V once operational, serious emotional disorders/neurobiological disorders (including but not limited to the following): affective disorders (e.g. bi-polar and major depressive episode); anxiety disorders (e.g. phobias and post-traumatic stress disorder) ; psychotic disorders (e.g. schizophrenia and schizoaffective disorder); severe attention deficit hyperactivity disorder; with or without co-occurring serious emotional disorders and substance abuse disorders;
- As defined by DSM-IV TR, and DSM V once operational behavioral disorders normally diagnosed in childhood (e.g. oppositional-defiant, disruptive behavior, and conduct disorders) with co-occurring mental health or substance abuse disorders;
- Identified caregiver willing to engage in treatment with the youth; and
- Voluntary admission with the consent of the parent/custodian

Prior to admission all youth are assessed using the Ohio Youth Assessment System (OYAS), the HCMHRSB Diagnostic Assessment Form (DAF) or the HCJC Multidimensional Assessment Form. These

instruments provide an extensive overview of the family's functioning level in multiple domains as well as identifying the youth's mental health diagnosis. Further assessment occurs after admission using several instruments from FFT Outcome Questionnaire (OQ) Measures and the Child and Adolescent Needs and Strengths scale (CANS).

Through BHJJ funding, the Hamilton County Juvenile Mental Health Court is able to deliver evidence based services in a cross system model with MHAP, Hamilton County Mental Health Recovery Services Board, Juvenile Court and LYS. All services provided to the youth/family are reported to the Magistrates on the Individualized Disposition Docket (IDD) and the Pretrial Diversion Docket (PDD) through the use of dedicated probation staff and the LYS Court Liaison. The Magistrates are then able to utilize this information in their decision making. This intensive, cross system model enhances the ability to provide appropriate individualized services for the local target population.

Lighthouse Youth Services has implemented the following evidence based practices in several programs: Positive Behavioral Intervention Services (PBIS), Girls' Circle, Parents As Teachers, Work Appreciation for Youth (WAY), a proprietary evidence based practice replicated in consultation with Children's Village, New York, Multidimensional Treatment Foster Care , Trauma Focused Treatment (L.I.T.E. group- Learning to Integrate Trauma with Expression), Structured Sensory Interventions for Traumatized Children, Adolescents, and Parents (SITCAP), and Assertive Community Treatment (ACT). Each of these programs offers quality interventions for children and families in a least restrictive setting, and has contributed to a clear reduction in out-of-home placements. Youth and families participating in the LIDS program have access to all programs within Lighthouse. The primary interventions offered in the LIDS program is Functional Family Therapy (FFT) as well as two evidence-based substance abuse programs: Adolescent Community Reinforcement Approach (A-CRA) and Teen Intervene.

The LIDS program is a model of successful community intersystem collaboration. HCJC and HCMHRB have worked through a period of extensive planning and careful implementation to develop these systems. As a result of this work, HCMHRB makes available funding for "Other" mental health services for LIDS intervention services such as the Court Liaison's activities (i.e., completing court reports, attending docket sessions, etc.). Monthly Infrastructure meetings with LYS, HCJC, MHAP, and HCMHRB, enable ongoing program review and development as well as ongoing process improvement. The LIDS Advisory Committee also provides oversight and coordination of care between systems. The Committee meets quarterly, is chaired by the HCMHRB and includes partners from LYS, HCJC, MHAP and NAMI. Youth and families that have graduated from the LIDS program are invited to share their story to the LIDS Advisory Committee, that aide in the identification of strengths and areas for improvement.

Typical length of stay in the program is about 6-8 months to complete Functional Family Therapy and meet probation requirements. Although admission to the program is voluntary, discharge from the program is not voluntary and requires court approval. Youth who are successfully discharged from IDD have completed all phases of FFT. Youth and their families are connected to on-going traditional and non-traditional services and supports as needed.

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.

HAMILTON COUNTY

DEMOGRAPHICS

Hamilton County has enrolled 225 youth in the BHJJ program since 2008. Of the 225 youth enrolled, 29.3% (n = 66) were female and 70.7% (n = 159) were male. Since July 2013, 75.0% (n = 36) of new enrollees have been male (see Table 3).

The majority of the overall sample of youth were either Caucasian (41.1%, n = 85) or African American (51.7%, n = 107). A similar pattern was found for youth enrolled since July 2013, with a slightly lower proportion of Caucasians (39.6%, n = 19) and a slightly higher proportion of African Americans (60.4%, n = 29). The average age of the youth at intake into BHJJ was 15.16 years old (SD = 1.41) with a range between 11.1 and 17.6 years.

Table 3. Demographic Information for BHJJ Youth in Hamilton County

	All Youth Enrolled (2008 - 2015)	Youth Enrolled between July 2013 – June 2015
Gender	Female = 29.3% (n = 66) Male = 70.7% (n = 159)	Female = 25.0% (n = 12) Male = 75.0% (n = 36)
Race	African American = 51.7% (n = 107) Caucasian = 41.1% (n = 85) Other = 7.3% (n = 15)	African American = 60.4% (n = 29) Caucasian = 39.6% (n = 19) Other = 0.0% (n = 0)
Age at Intake	15.16 years (SD = 1.41)	15.36 years (SD = 1.15)

CUSTODY ARRANGEMENT AND HOUSEHOLD INFORMATION

At intake, nearly two-thirds of youth lived with the biological mother (66.0%, n = 524) (see Table 4). At time of enrollment, 85.3% (n = 168) of the BHJJ youth lived with at least one biological parent.

Over 81% of the BHJJ caregivers (81.8%, n = 159) had at least a high school diploma or GED, and 13.8% (n = 27) had a bachelor's degree or higher (see Table 5). Nearly one in five caregivers (18.0%, n = 35) 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). More than 75.0% of caregivers (76.7%, n = 145) reported annual household incomes below \$35,000 and 45.0% (n = 85) reported an annual household income below \$20,000. Nearly 30% of BHJJ families (29.1%, n = 55) reported an annual household income below \$10,000.

Table 4. Custody Arrangement for BHJJ Youth in Hamilton County

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	17.3% (n=34)
Biological Mother Only	66.0% (n=130)
Biological Father Only	2.0% (n=4)
Adoptive Parent(s)	5.1% (n=10)
Sibling	0.0% (n=0)
Aunt/Uncle	2.5% (n=5)
Grandparents	6.6% (n=13)
Friend	0.0% (n=0)
Ward of the State	0.0% (n=0)
Other	0.5% (n=1)

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

Number of School Years Completed	Number of Caregivers
Less than High School	18.0% (n=35)
High School Graduate or G.E.D.	37.6% (n=73)
Some College or Associate Degree	30.4% (n=59)
Bachelor's Degree	4.6% (n=9)
More than a Bachelor's Degree	9.2% (n=18)

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

Annual Household Income	BHJJ Families
Less than \$5,000	18.5% (n=35)
\$5,000 - \$9,999	10.6% (n=20)
\$10,000 - \$14,999	7.4% (n=14)
\$15,000 - \$19,999	8.5% (n=16)
\$20,000 - \$24,999	13.8% (n=26)
\$25,000 - \$34,999	18.0% (n=34)
\$35,000 - \$49,999	11.6% (n=22)
\$50,000 - \$74,999	5.8% (n=11)
\$75,000 - \$99,999	1.6% (n=3)
\$100,000 and over	4.2% (n=8)

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. Caregivers reported that a significantly larger proportion of females than males had a lifetime history of sexual abuse and suicide attempts. A significantly larger proportion of males reported a history of living in a household with someone convicted of a crime.

Table 7. Youth and Family History in Hamilton County

Question	Females	Males
Has the child ever been physically abused?	12.9% (n=8)	7.4% (n=10)
Has the child ever been sexually abused?	16.1% (n=10)**	4.7% (n=6)
Has the child ever run away?	66.1% (n=41)	49.6% (n=65)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	41.7% (n=25)	53.7% (n=72)
Has the child ever talked about committing suicide?	41.7% (n=25)	34.4% (n=45)
Has the child ever attempted suicide?	23.3% (n=14)*	9.9% (n=13)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	28.6% (n=18)	29.1% (n=39)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	67.8% (n=40)	65.1% (n=84)
Has anyone in the child's biological family had a mental illness, other than depression?	33.3% (n=19)	41.6% (n=52)
Has the child ever lived in a household in which someone was convicted of a crime?	14.0% (n=8)	41.5% (n=51)***
Has anyone in the child's biological family had a drinking or drug problem?	41.0% (n=25)	49.6% (n=66)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms	50.8% (n=32)	50.8% (n=64)

*p < .05, ** p < .01, ***p < .001

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 8.3% (n = 5) of females had been pregnant and of those youth, 40.0% (n = 2) were currently expecting a child. Caregivers reported that 2.7% (n = 3) of males had impregnated a female, none were currently expecting a child. Over less than 3% of females (2.8%, n = 1) and (2.7%, n = 2) of males currently had children. Of those who had children, 100% of females (n = 1) but none of the males currently lived with the 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 Hamilton County youth based on the OYAS risk categories by gender and race are presented in Table 8. Chi-square analyses revealed significant group differences in the OYAS categories based on gender (p = .003) but

not for race. A larger percentage of females (74.5%) than males (47.5%) were identified as low risk for reoffending.

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

	OYAS Low	OYAS Moderate	OYAS High
Female*	74.5% (n = 41)	21.8% (n = 12)	3.6% (n = 2)
Male	47.5% (n = 66)	46.8% (n = 65)	5.8% (n = 8)
White	57.7% (n = 41)	36.6% (n = 26)	5.6% (n = 4)
Nonwhite	51.4% (n = 54)	42.9% (n = 45)	5.7% (n = 6)

*p < .05

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. As shown in Table 9, the most common Axis I diagnosis for females was Oppositional Defiant Disorder (29.0%) and Attention Deficit Hyperactivity Disorder for males (56.8%).

A total of 396 Axis I diagnoses were identified for 201 youth with diagnostic information (1.97 diagnoses per youth). Females reported 114 Axis I diagnoses (1.84 diagnoses per female) and males reported 282 Axis I diagnoses (2.03 diagnoses per male). Chi-square analysis indicated that a significantly higher proportion of females were diagnosed with Depressive Disorders and Post-traumatic Stress Disorder while a significantly higher proportion of males were diagnosed with Attention Deficit Hyperactivity Disorder. Of the youth who had available diagnostic information, 26.4% (n = 14) of females and 34.2% (n = 41) of males had a co-occurring substance use and mental health diagnosis.

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

DSM-IV Axis I Diagnosis	Females	Males
Alcohol-related Disorders	6.5% (n = 4)	2.9% (n = 4)
Attention Deficit Hyperactivity Disorder	24.2% (n = 15)	56.8% (n = 79)***
Bipolar Disorder	8.1% (n = 5)	11.5% (n = 16)
Cannabis-related Disorders	17.7% (n = 11)	27.3% (n = 38)
Conduct Disorder	6.5% (n = 4)	12.9% (n = 18)
Depressive Disorders	24.2% (n = 15)*	12.2% (n = 17)
Mood Disorder	8.1% (n = 5)	10.8% (n = 15)
Oppositional Defiant Disorder	29.0% (n = 18)	28.1% (n = 39)
Post-traumatic Stress Disorder	14.5% (n = 9)*	5.0% (n = 7)

*p < .05, ***p < .001

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, 56.3% (n = 81) were either suspended or expelled from school. While in treatment with BHJJ, 40.9% (n = 38) 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, 87.3% (n = 131) of youth were currently attending school excluding those on summer break. At termination, 93.7% (n = 89) 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 Hamilton County from intake to termination based on completion status. At termination, 31.9% (n = 22) of successful completers received mostly A's and B's while none of the unsuccessful completers had received mostly A's and B's.

At termination, workers reported that 52.0% (n = 51) of youth were attending school more than before starting treatment and 39.8% (n = 39) of youth were attending school 'about the same' amount compared to before starting treatment. Workers reported 6.1% (n = 6) of youth were attending school less often than before treatment in BHJJ.

Table 10. Academic Performance in Hamilton County

Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	16.1% (n = 24)	26.4% (n = 23)
Mostly B's and C's	22.1% (n = 33)	36.8% (n = 32)
Mostly C's and D's	37.6% (n = 56)	27.6% (n = 24)
Mostly D's and F's	24.2% (n = 36)	9.2% (n = 8)

Table 11. Academic Performance in Hamilton 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	14.3% (n = 4)	0.0% (n = 0)	20.3% (n = 15)	31.9% (n = 22)
Mostly B's and C's	21.4% (n = 6)	20.0% (n = 3)	24.3% (n = 18)	39.1% (n = 27)
Mostly C's and D's	35.7% (n = 10)	60.0% (n = 9)	37.8% (n = 28)	21.7% (n = 15)
Mostly D's and F's	28.6% (n = 8)	20.0% (n = 3)	17.6% (n = 13)	7.2% (n = 5)

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 3 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 Hamilton 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 - Hamilton County

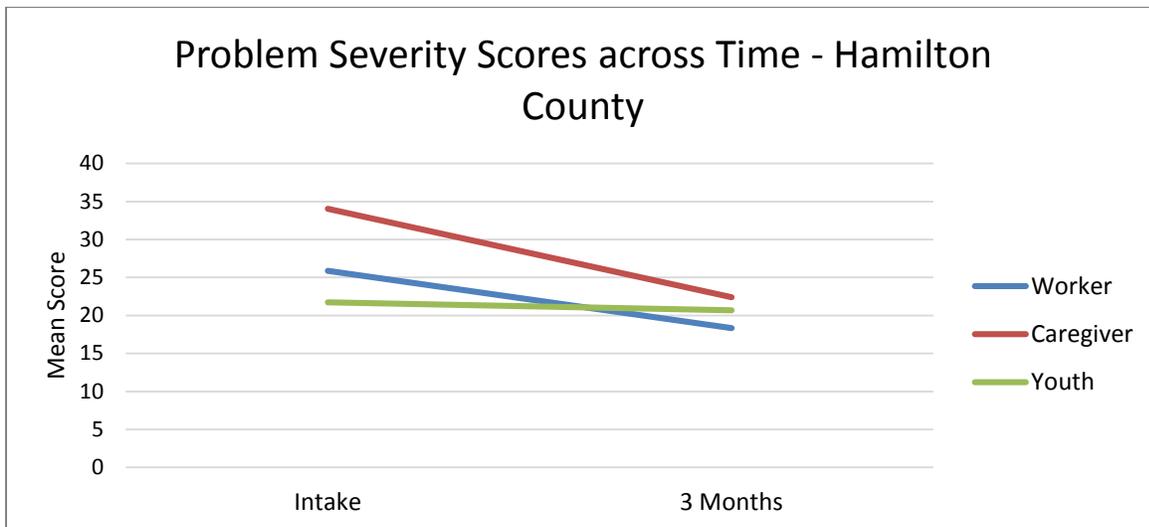
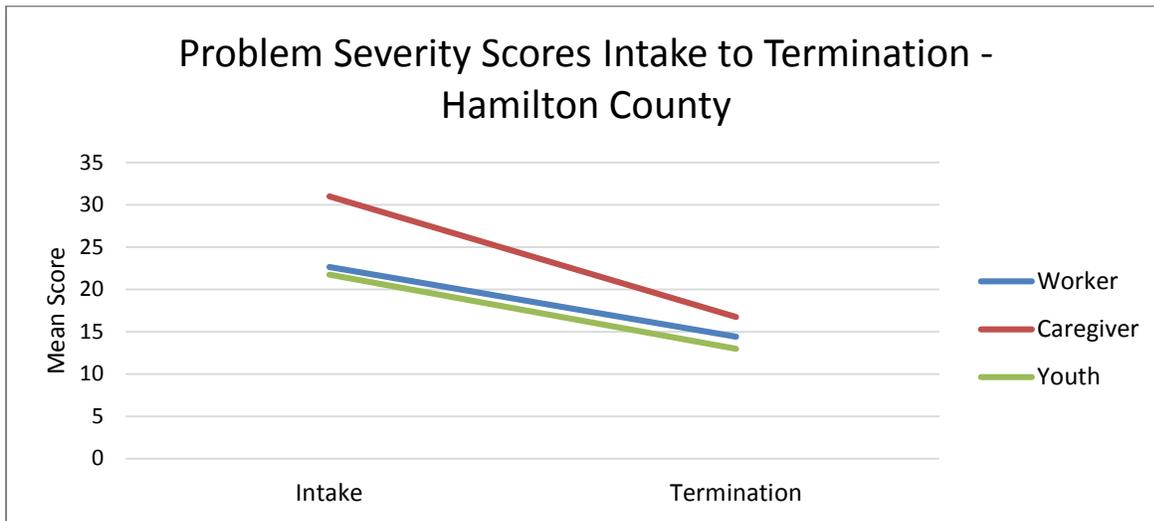


Figure 2. Problem Severity Scores from Intake to Termination - Hamilton County



*all comparisons from intake to termination are significant at the $p < .001$ level

CAREGIVER RATING

Paired samples t-tests revealed significant improvements in Problem Severity at both measurement intervals (see Table 12) compared to intake. Significant improvements were noted at termination: $t(33) = 5.04$, $p < .001$. A moderate effect size was found for intake to three months. A large effect size was found for intake to termination.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	31.67 (SD=15.33; n=6)	22.00 (SD=16.43; n=6)	1.63	.61
Intake to Termination	31.01 (SD=14.55; n=34)	16.74 (SD=11.84; n=34)	5.04***	1.08

*** $p < .001$

WORKER RATING

For workers, paired samples t-tests indicated significant improvement in Problem Severity at every data collection point (see Table 13). Significant improvements were noted at three months $t(5) = 6.58$, $p < .01$; and at termination: $t(67) = 5.74$, $p < .001$. Large effect sizes were noted for each time point.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	33.00 (SD=8.25; n=6)	13.83 (SD=8.86; n=6)	6.58**	2.27
Intake to Termination	22.64 (SD=11.07; n=68)	14.40 (SD=9.25; n=68)	5.74***	.81

** $p < .01$, *** $p < .001$

YOUTH RATING

Scores on the Problem Severity scale as reported by youth showed significant improvement at termination (see Table 14). Significant improvements were noted termination: $t(64) = 5.52, p < .001$. A moderate effect size was noted for intake to termination and a large effect size was noted for intake to three months.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	36.70 (SD=8.79; n=6)	23.33 (SD=10.98; n=6)	2.53	1.34
Intake to Termination	21.74 (SD=14.85; n=65)	12.98 (SD=12.75; n=65)	5.52***	.63

*** $p < .001$

FUNCTIONING

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

Figure 3. Functioning Scores across Time - Hamilton County

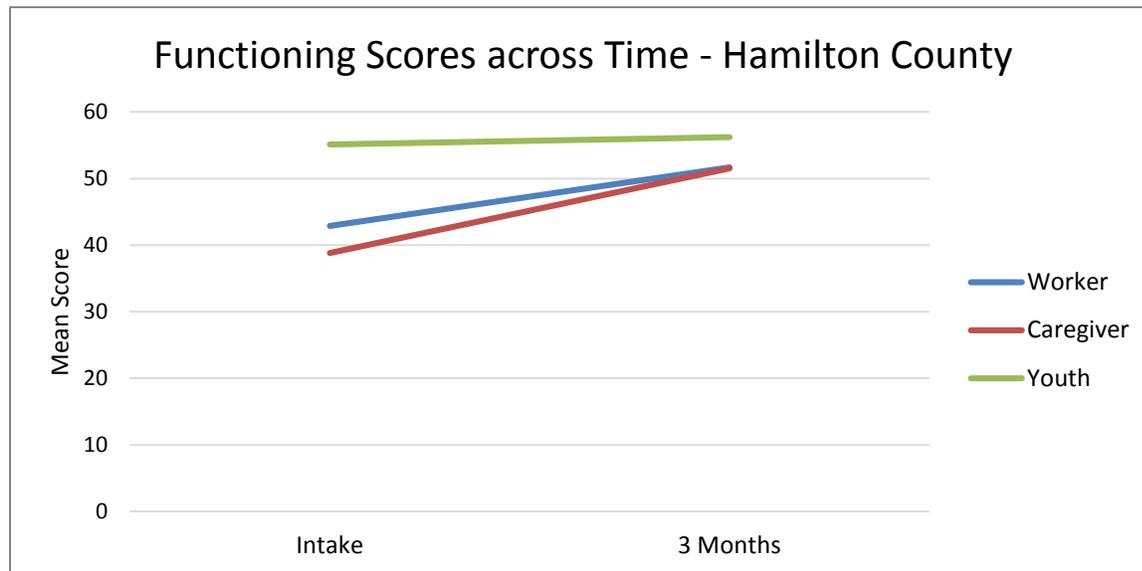
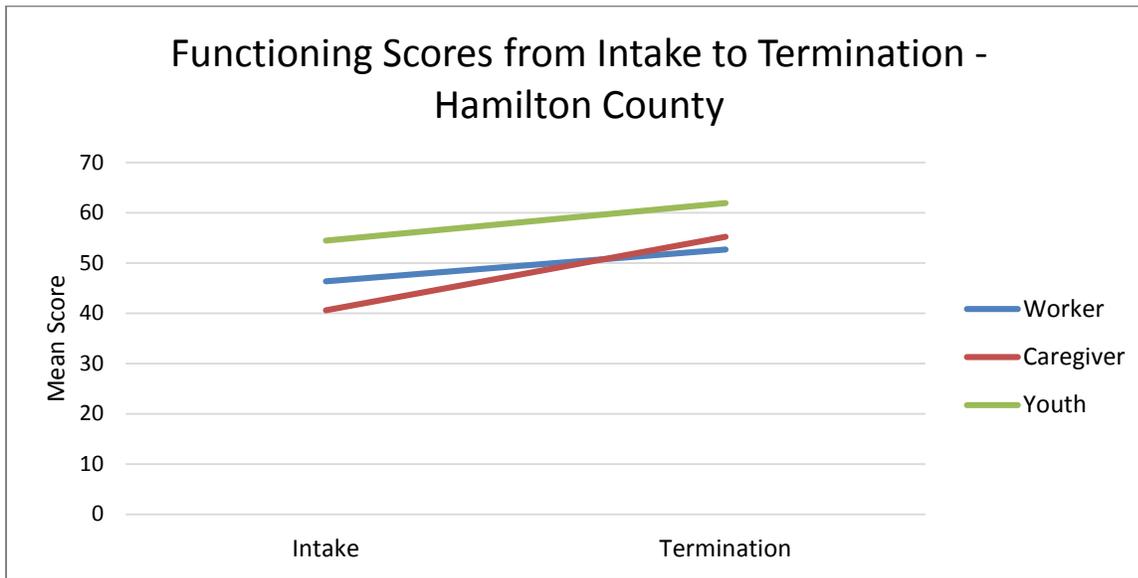


Figure 4. Functioning Scores from Intake to Termination - Hamilton County



*all comparisons from intake to termination are significant at least at the $p < .01$ level

CAREGIVER RATING

Paired samples t-tests revealed significant improvements in Functioning at both measurement intervals (see Table 15) compared to intake. Significant improvements were noted at three months: $t(6) = -2.61, p < .05$; and termination: $t(34) = -5.37, p < .001$. Large effect sizes were noted for both time points.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	43.42(SD=8.06; n=7)	53.17 (SD=15.01; n=7)	-2.61*	.81
Intake to Termination	40.59 (SD=15.56; n=34)	55.24 (SD=14.46; n=34)	-5.37***	.98

* $p < .05$, *** $p < .001$

WORKER RATING

For workers, paired samples t-tests indicated significant improvement in the Functioning scale for both of the measurement intervals (see Table 16). Significant improvements were noted at three months: $t(5) = -4.60, p < .01$; and termination: $t(67) = -2.98, p < .01$. A moderate effect size was noted for intake to termination while a large effect size was noted for intake to three months.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	43.67 (SD=11.43; n=6)	59.83 (SD=10.34; n=6)	-5.00**	1.48
Intake to Termination	46.38 (SD=11.25; n=68)	52.72 (SD=13.96; n=68)	-2.98**	.50

** $p < .01$

YOUTH RATING

Paired samples t-tests conducted on the youth ratings of Functioning indicated significant improvement from intake to termination (see Table 17). Significant improvements were observed at termination: $t(59) = -7.38$, $p < .01$. Moderate effect sizes were noted for both time points.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	48.00 (SD=11.19; n=6)	55.33 (SD=14.79; n=6)	-1.56	.56
Intake to Termination	54.45 (SD=14.91; n=60)	61.98 (SD=12.34; n=60)	-3.56**	.55

** $p < .01$

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

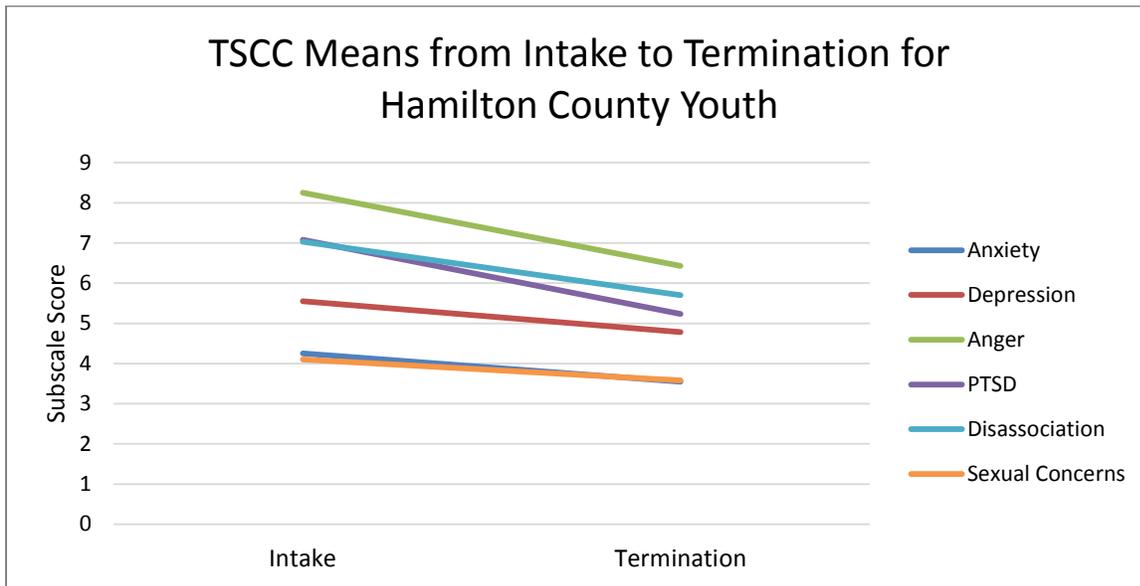
Statistically significant improvements were noted for the Anger, PTS, and Dissociation Subscales: Anger ($t(39) = 3.31, p < .01$), Posttraumatic Stress ($t(39) = 3.35, p < .01$), Dissociation ($t(39) = 2.73, p < .01$). The data indicated small effect sizes for all subscales. Means reported in Table 18 are represented graphically in Figure 5.

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

	Intake	Termination	t	d
Anxiety	4.25 (SD=2.99; n=40)	3.55 (SD=2.35; n=40)	1.78	.26
Depression	5.55 (SD=3.78; n=40)	4.48 (SD=2.99; n=40)	1.79	.31
Anger	8.25 (SD=4.06; n=40)	6.43 (SD=3.62; n=40)	3.31**	.47
PTS	7.08 (SD=4.97; n=40)	5.22 (SD=3.78; n=40)	3.35**	.42
Dissociation	7.03 (SD=4.25; n=40)	5.70 (SD=3.62; n=40)	2.73**	.34
Sexual Concerns	4.10 (SD=4.24; n=40)	3.58 (SD=3.29; n=40)	1.00	.14

**p < .01

Figure 5. TSCC Means from Intake to Termination for Hamilton 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. Chi-square analyses revealed that a significantly higher proportion of males reported lifetime use of chewing tobacco than females.

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

	Males		Females	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	44.9% (n = 57)	13.36 (SD = 1.72)	44.1% (n = 26)	13.18 (SD = 1.53)
Cigarettes	46.5% (n = 59)	12.61 (SD = 2.75)	40.0% (n = 24)	13.43 (SD = 1.21)
Chewing Tobacco	13.3% (n = 17)*	14.15 (SD = 1.68)	3.4% (n = 2)	14.00 (SD = 0.00)
Marijuana	61.7% (n = 82)	13.00 (SD = 1.67)	52.5% (n = 31)	13.60 (SD = 1.32)
Cocaine	3.1% (n = 4)	14.75 (SD = 1.26)	5.0% (n = 3)	14.67 (SD = 1.56)
Pain Killers (use inconsistent with prescription)	10.3% (n = 13)	14.82 (SD = 1.08)	7.1% (n = 4)	13.25 (SD = 1.26)
GHB	0.8% (n = 1)	N/A	0.0% (n = 0)	N/A
Inhalants	0.8% (n = 1)	13.00 ^a	1.8% (n = 1)	12.00
Heroin	0.0% (n = 0)	N/A	0.0% (n = 0)	N/A
Amphetamines	1.6% (n = 2)	15.00	1.7% (n = 1)	16.00
Ritalin (use inconsistent with prescription)	5.3% (n = 7)	12.17 (SD = 3.31)	10.2% (n = 6)	14.40 (SD = 1.34)
Barbiturates	0.8% (n = 1)	15.00	1.7% (n = 1)	14.00
Non-prescription Drugs	8.7% (n = 11)	14.30 (SD = 1.95)	8.6% (n = 5)	13.60 (SD = 1.52)
Hallucinogens	4.7% (n = 6)	15.40 (SD = 0.89)	3.3% (n = 2)	14.50 (SD = 0.71)
PCP	0.0% (n = 0)	N/A	1.8% (n = 1)	16.00
Ketamine	0.8% (n = 1)	17.00	1.7% (n = 1)	14.00
Ecstasy	6.3% (n = 8)	15.38 (SD = 1.06)	5.2% (n = 3)	14.00 (SD = 1.73)
Tranquilizers	4.7% (n = 6)	14.83 (SD = 0.98)	3.4% (n = 2)	14.50 (SD = 0.71)

*p < .05

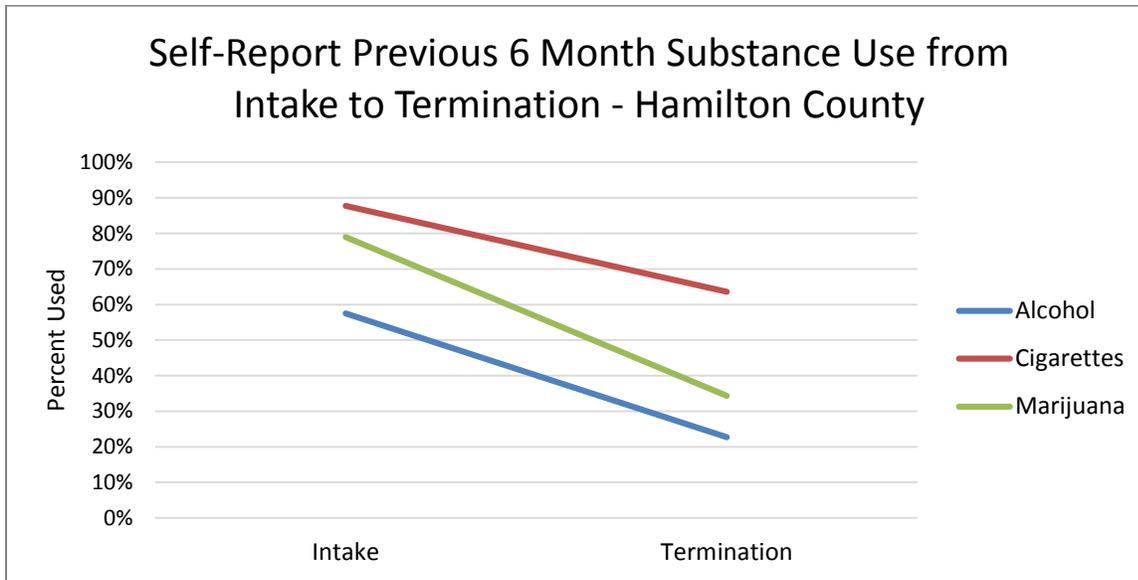
^aStandard Deviations are not calculated when only one respondent reported using a substance.

SIX MONTH SUBSTANCE USE

Youth were also asked to report whether they had used each substance in the past six months. Figure 6 and Figure 7 present past six month use for the most commonly reported substances for males and females respectively among those who reported lifetime use. The percentage of those using

substances decreased for youth among the most commonly reported substances. Six month alcohol use decreased from 57.5% (n = 46) at intake to 22.7% (n = 5) at termination, cigarette use decreased from 87.7% (n = 71) at intake to 63.6% (n = 14) at termination, and marijuana use decreased from 79.0% (n = 83) at intake to 34.3% (n = 12) at termination. McNemar’s test revealed a significant decrease in the proportion of youth using marijuana from intake to termination.

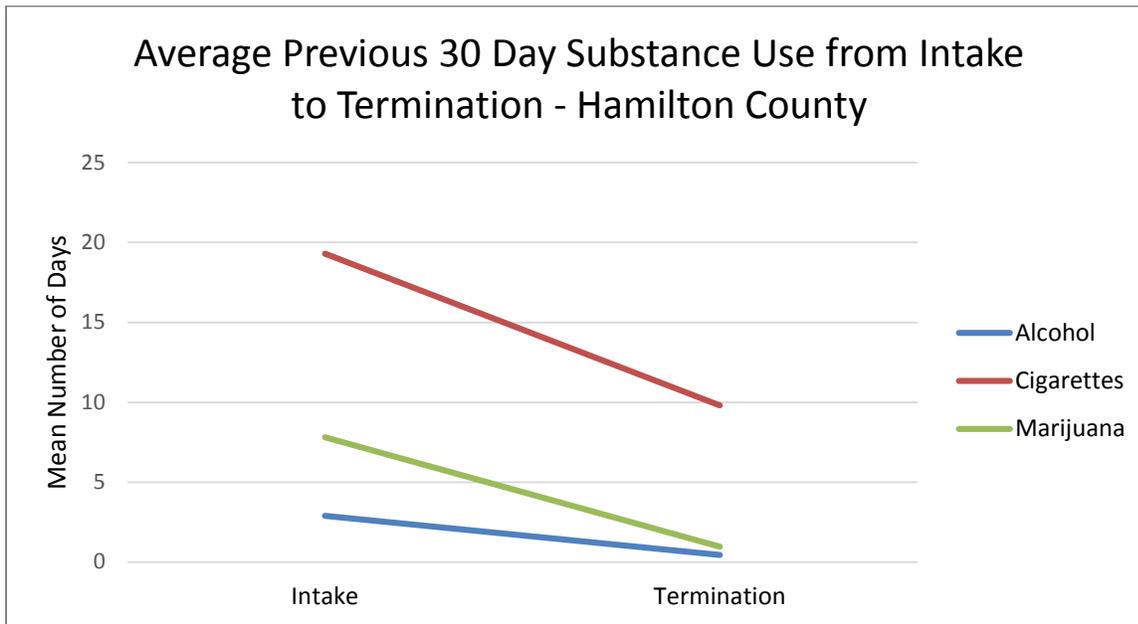
Figure 6. Self-Report Previous 6 Month Substance Use from Intake to Termination - Hamilton County



30 DAY SUBSTANCE USE

If youth had reported any lifetime use and if they had reported use in the past six months, youth were asked how many days they had used each substance in the past 30 days. Figure 7 shows the average number of days used in the previous 30 days for the three most commonly reported substances. Thirty day use declined from intake to termination for all three substances. Thirty day alcohol use decreased from 2.89 days (SD = 5.03; n = 37) at intake to 0.44 days (n = 9) at termination. Thirty day cigarette use decreased from 19.3 days (SD = 14.7; n = 63) at intake to 9.81 days (SD = 10.82; n = 16) at termination. Thirty day marijuana use decreased from 7.81 days (SD = 13.41; n = 62) at intake to 0.96 days (SD = 2.25; n = 28) at termination. Paired t-tests revealed a statistically significant difference from intake to termination for all three substances.

Figure 7. Average Previous 30 Day Substance Use from Intake to Termination – Hamilton 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 8, Figure 9, and Figure 10). At intake 50.5% (n = 49) of caregivers and 50.0% (n = 91) of workers reported no problems with drugs or alcohol in the past 30 days while 78.9% (n = 45) of caregivers and 73.9% (n = 68) of workers reported no problems at termination. Similarly, 58.2% (n = 107) of youth reported no problems in the past 30 days with drugs or alcohol at intake while 78.7% (n = 70) of youth reported no problems at termination.

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

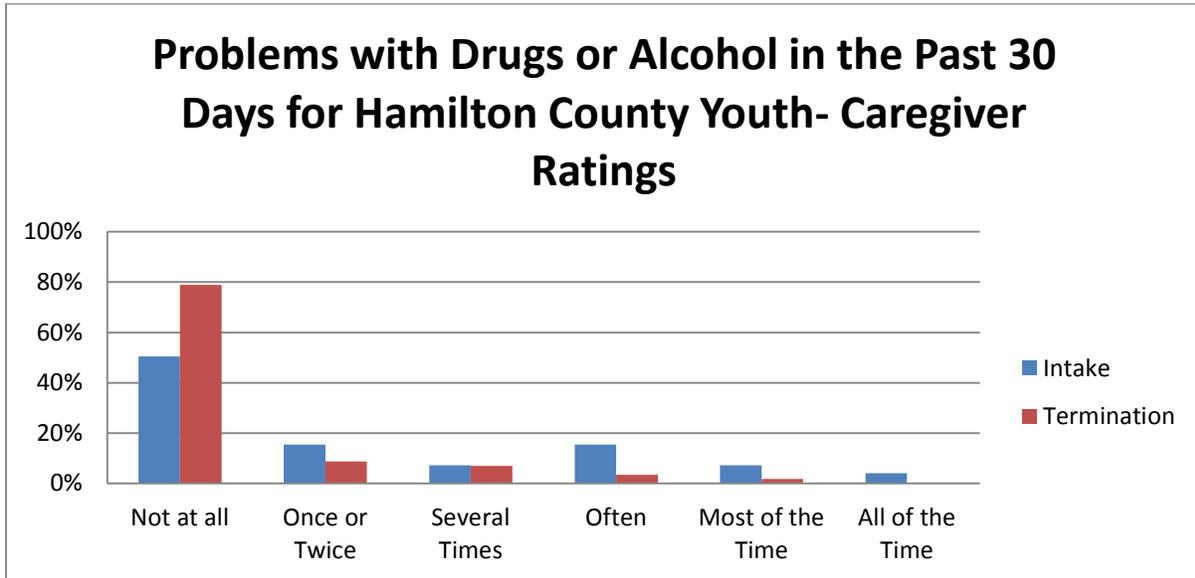


Figure 9. Problems with Drugs or Alcohol in the Past 30 Days for Hamilton County Youth - Worker Ratings

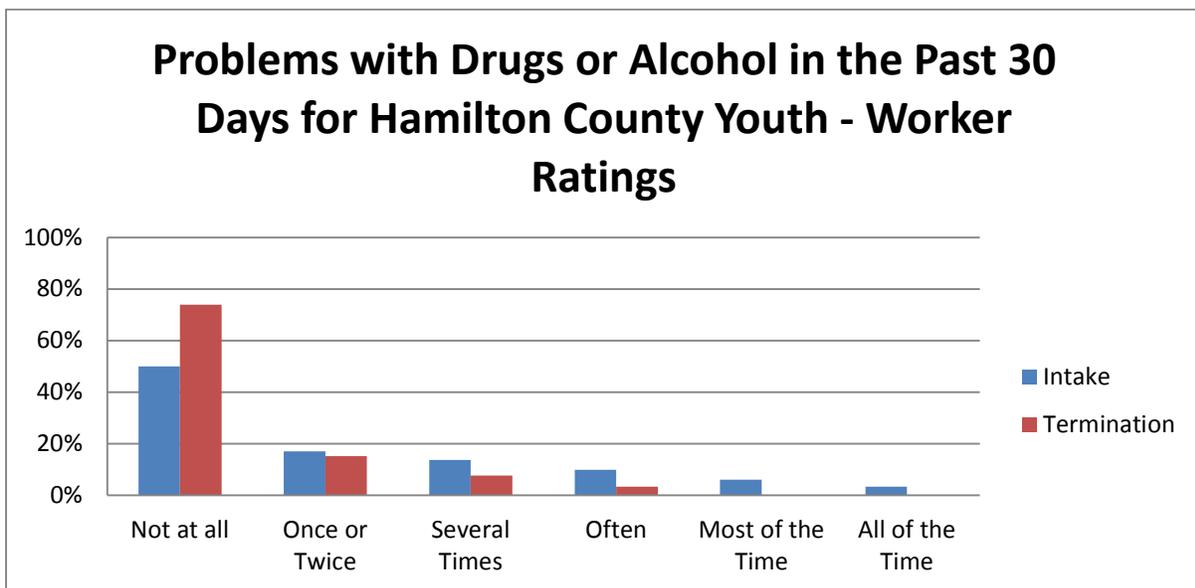
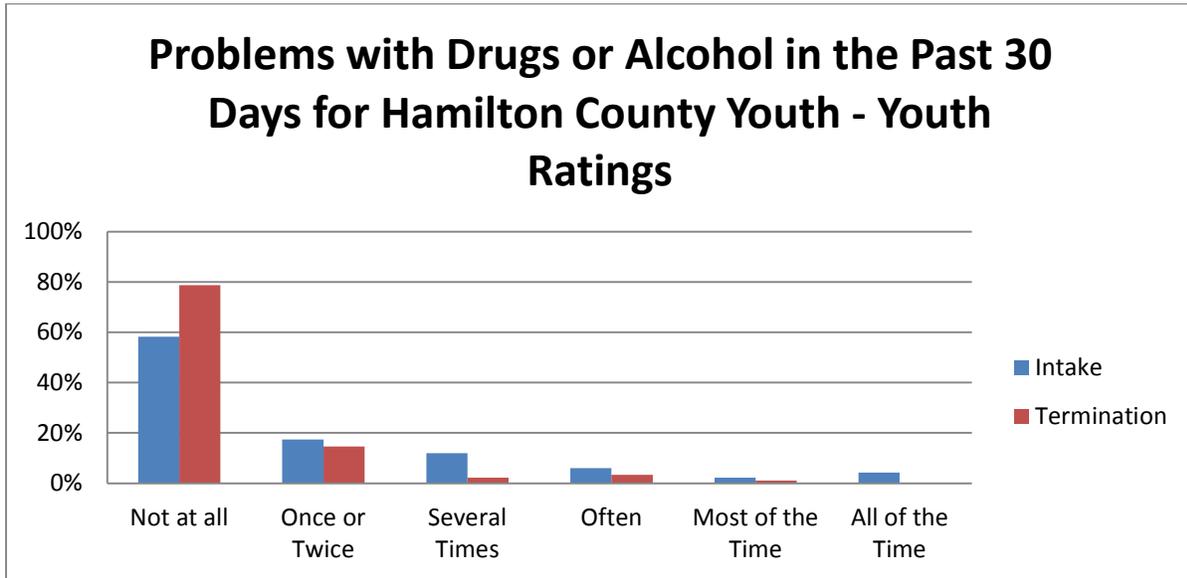


Figure 10. Problems with Drugs or Alcohol in the Past 30 Days for Hamilton County Youth - Youth Ratings



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 161 youth terminated from the BHJJ program in Hamilton County. **Over 75% (75.2%, n = 121) of the youth terminated from the BHJJ program were identified as successful treatment completers.** In Hamilton County 3.7% (n = 6) were withdrawn from the program and 4.3% (n = 7) were terminated from the program due to an out of home placement. Table 20 presents all of the reasons for termination from BHJJ.

In the latest evaluation period that began July 2013 and ended in June 2015, 60% (n = 21) of youth terminated successfully from the BHJJ program in Hamilton County. For this biennium, reasons for unsuccessful termination (i.e. client did not return, out of home placement, etc.) are not available at this time for Hamilton County. Forty percent (n = 14) terminated unsuccessfully in this biennium.

Table 20. Reasons for Termination from BHJJ – Hamilton County

Termination Reason	All Youth	Youth Enrolled from July 2013 to June 2015
Successfully Completed Services	75.2% (n = 121)	60% (n = 21)
Client Did Not Return/Rejected Services	0.1% (n = 1)	a
Out of Home Placement	4.3% (n = 7)	a
Client/Family Moved	0.0% (n = 0)	a
Client Withdrawn	3.7% (n = 6)	a
Client AWOL	0.0% (n = 0)	a
Client Incarcerated	2.5% (n = 4)	a
Other	1.9% (n = 3)	a

^aReason not available at this time for Hamilton County

AVERAGE LENGTH OF STAY

The average length of stay for youth in the Hamilton County BHJJ program was 209 days. For youth identified as completing treatment successfully, the average length of stay was 211 days and for youth identified as unsuccessful treatment completers, the average length of stay was 195 days. For youth enrolled since July 1, 2013, the average length of stay in BHJJ was 208 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, 18.3% of the youth (n = 28) in Hamilton County were at risk for out of home placement. At termination, 16.7% (n = 17) of youth were at risk for out of home placement. Of those youth who successfully completed BHJJ treatment, 5.6% (n = 5) were at risk for out of home placement at termination while 60% (n = 12) 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 77.1% (n = 74) of the youth and had stayed the same for 19.8% (n = 19) of the youth. Police contacts increased for 3.1% (n = 3) 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, 100% (n = 36) of caregivers either strongly agreed or agreed that they were satisfied with the services their child received and 100% (n = 36) either strongly agreed or agreed that the services their child and/or family received were right for them. All (100%, n = 37) of caregivers either strongly agreed or agreed that staff treated them with respect and 100% (n = 36) strongly agreed or agreed that they were satisfied with the cultural and ethnic sensitivity of BHJJ staff.

Table 21. Satisfaction with Services – Hamilton County

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Overall I am satisfied with the services my child received	61.1%	38.9%	0.0%	0.0%	0.0%
The services my child and/or family received were right for us	63.9%	36.1%	0.0%	0.0%	0.0%
Staff treated me with respect	48.6%	51.4%	0.0%	0.0%	0.0%
Staff were sensitive to my cultural/ethnic background	55.6%	44.4%	0.0%	0.0%	0.0%

RECIDIVISM

METHODOLOGY

Court data were provided by the Hamilton 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.

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, 18 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, 69.6% (n = 151) of the BHJJ youth had a misdemeanor charge, 28.9% (n = 65) had a felony charge, and 65.0% were adjudicated delinquent (see Table 22).

Previous juvenile court information is presented for youth based on BHJJ treatment completion status (successful vs. unsuccessful). In the 12 months prior to enrollment, 57.4% (n = 54) of successful completers and 84.2% (n = 16) of unsuccessful completers were adjudicated delinquent. A lower percentage of successful completers had a felony charge in the 12 months prior to intake (26.6%, n = 25) than unsuccessful completers (36.8%, n = 7).

Table 22. Charges Prior to BHJJ Enrollment – Hamilton County

	Overall			Successful			Unsuccessful		
	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent
3 months	39.6% (n = 86)	12.0% (n = 26)	34.6% (n = 75)	42.6% (n = 40)	10.6% (n = 10)	33.0% (n = 31)	42.1% (n = 8)	15.8% (n = 3)	42.1% (n = 8)
6 months	62.7% (n = 136)	25.8% (n = 56)	57.6% (n = 125)	60.6% (n = 57)	25.5% (n = 24)	53.2% (n = 50)	57.9% (n = 11)	31.6% (n = 6)	63.2% (n = 12)
12 months	69.6% (n = 151)	28.9% (n = 65)	65.0% (n = 141)	68.1% (n = 64)	26.6% (n = 25)	57.4% (n = 54)	84.2% (n = 16)	36.8% (n = 7)	84.2% (n = 16)
18 months	73.3% (n = 159)	31.8% (n = 69)	68.2% (n = 148)	73.4% (n = 69)	27.7% (n = 26)	61.7% (n = 58)	84.2% (n = 16)	36.8% (n = 7)	84.2% (n = 16)

RECIDIVISM AFTER ENROLLMENT

We defined recidivism after enrollment as receiving a new charge or adjudication at 3, 6, 12, and 18 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, 53.7% (n = 80) of youth were charged with at least one new misdemeanor and 16.8% (n = 25) were charged with at least one new felony. Fifty percent (50.3%, n = 75) of the youth were adjudicated delinquent in the 12 months after their enrollment in BHJJ (see Table 23).

In the 12 months after enrollment in BHJJ 51.4% (n = 36) of successful completers were charged with at least one new misdemeanor, 12.9% (n = 9) were charged with at least one new felony, and 45.7% (n = 32) were adjudicated delinquent. Of the youth who completed unsuccessfully, 50.0% (n = 9) were charged with at least one new misdemeanor, 33.3% (n = 6) were charged with at least one new felony, and 66.7% (n = 12) were adjudicated delinquent in the 12 months after their enrollment in BHJJ.

Table 23. Chargers after BHJJ Enrollment – Hamilton County

	Overall			Successful			Unsuccessful		
	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent
3 months	24.6% (n = 45)	6.0% (n = 11)	22.7% (n = 42)	20.0% (n = 16)	2.5% (n = 2)	15.0% (n = 12)	27.8% (n = 5)	22.0% (n = 4)	38.9% (n = 7)
6 months	38.2% (n = 68)	9.6% (n = 17)	34.3% (n = 61)	32.5% (n = 25)	3.9% (n = 3)	26.0% (n = 20)	44.4% (n = 8)	33.3% (n = 6)	61.1% (n = 11)
12 months	53.7% (n = 80)	16.8% (n = 25)	50.3% (n = 75)	51.4% (n = 36)	12.9% (n = 9)	45.7% (n = 32)	50.0% (n = 9)	33.3% (n = 6)	66.7% (n = 12)
18 months	62.5% (n = 75)	26.7% (n = 32)	63.3% (n = 76)	60.0% (n = 36)	20.0% (n = 12)	58.3% (n = 35)	55.6% (n = 10)	44.4% (n = 8)	66.7% (n = 12)

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, 50.0% (n = 48) of youth were charged with at least one new misdemeanor, 18.8% (n = 18) were charged with at least one new felony, and 49.0% (n = 47) were adjudicated delinquent (see Table 24).

In the 12 months following their termination from BHJJ, 50.0% (n = 35) of successful completers were charged with at least one new misdemeanor, 15.7% (n = 11) were charged with at least one new felony, and 45.7% (n = 32) were adjudicated delinquent. Of the youth who completed unsuccessfully, 45.8% (n = 11) were charged with at least one new misdemeanor, 25.0% (n = 6) were charged with at least one new felony, and 54.2% (n = 13) were adjudicated delinquent in the 12 months after their termination from BHJJ.

Table 24. Charges after BHJJ Termination – Hamilton County

	Overall			Successful			Unsuccessful		
	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent
3 months	21.3% (n = 30)	7.8% (n = 11)	18.4% (n = 26)	22.4% (n = 24)	6.5% (n = 7)	16.5% (n = 14)	12.5% (n = 4)	12.5% (n = 4)	16.7% (n = 3)
6 months	35.2% (n = 43)	10.7% (n = 13)	35.2% (n = 43)	36.3% (n = 33)	8.8% (n = 8)	34.1% (n = 31)	27.6% (n = 8)	13.8% (n = 4)	34.5% (n = 10)
12 months	50.0% (n = 48)	18.8% (n = 18)	49.0% (n = 47)	50.0% (n = 35)	15.7% (n = 11)	45.7% (n = 32)	45.8% (n = 11)	25.0% (n = 6)	54.2% (n = 13)
18 months	62.0% (n = 44)	25.4% (n = 18)	54.9% (n = 39)	63.0% (n = 34)	22.2% (n = 12)	51.9% (n = 28)	56.3% (n = 9)	31.3% (n = 5)	62.5% (n = 10)

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. A total of 24 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. Of the 27 youth, 29.6% (n = 8) were charged with a new felony in the 12 months after their termination from BHJJ.

Four of the 217 BHJJ youth (1.8%) from Hamilton County for whom we had recidivism data were committed to an ODYS facility at any time following their enrollment.

SUCCESS STORY

J is currently in the top of her class, in her junior year, she is taking several college credit courses and on track to graduate a year early from high school. She is musically inclined, able to play five instruments. J is also artistically talented with paintings and other crafts. Looking at where J is now, no one would be able to guess the dark places she has been.

In early January, I stepped into a house with a mother who greeted me and a client that did not. As we sat in the living room, it was apparent to me that J was not going to be cooperative in therapy. While her mother discussed with me all the different therapies that they have tried, J laid her head down on the chair and closed her eyes. Engaging J was going to be a challenge. Mother explained to me, with little help from J, the reasons they were in court; J had a few runaway charges with a false alarm stating that she was kidnapped. At this point in time, J was also skipping a majority of her classes and failing several of them.

For a few months, we met for family therapy every week. At the beginning, we discussed many issues with Dad's inattention and Mom's overprotectiveness. With Mom's cooperation, we were able to help J gain independence and self-worth. J was given freedoms and responsibilities around the house. At the same time, we explored the relationship she had with Dad and Dad's girlfriend. Dad's girlfriend was threatened by J's natural abilities and intelligence. This was having a huge effect on J's self-esteem. Dad was also only involved in J's life when negative situations were occurring. To get Dad's attention, she would simply have to do something that would get her in trouble. In therapy, we worked on building J's self-worth and she came to the realization that she did not need this negative attention. J was put into the I-Space program to help give her activities and make friends. Slowly, J found value in her abilities and relationship with Mom.

J is a very intelligent girl. When talking to her, we found that she was skipping classes because she was bored. She would attend on testing days and get straight A's without even trying. Looking at this situation we found that she could apply to be part of a college credit course load, which would challenge her. Family therapy was the perfect match for J because it allowed for all different aspects of her life to be addressed. She always had the potential for greatness, but we were able to guide her in putting the pieces in place.

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