

# Executive Summary: An Evaluation of the Behavioral Health/Juvenile Justice (BHJJ) Initiative: 2006-2015 Montgomery County Results

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## EXECUTIVE SUMMARY: AN EVALUATION OF THE BEHAVIORAL HEALTH/JUVENILE JUSTICE (BHJJ) INITIATIVE: 2006 – 2015 MONTGOMERY 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**

- ❖ 1,410 youth have been enrolled in BHJJ (52.1% males, 49.5% Caucasian). In the past two years, youth enrolled in Montgomery County were comprised of more males (60.8%) than females (39.2%) and more non-whites (51.3%) than whites (48.7%).
- ❖ Youth averaged 2.5 Axis I diagnoses. Females were significantly more likely to be diagnosed with Alcohol-related Disorders, Post-traumatic Stress Disorder, and Depressive Disorders. Males were significantly more likely to be diagnosed with Cannabis Disorder, Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder.
- ❖ Over 40% of males and 32% of females were diagnosed with both a mental health and substance use diagnosis.
- ❖ Caregivers reported that 25% of the females had a history of sexual abuse, over 48% talked about suicide, and over 23% had attempted suicide. Over 65% of males and 69% of females had family members who were diagnosed with or showed signs of depression.
- ❖ According to the OYAS, 56.6% of the youth served in Montgomery County were either moderate or high risk.

- ❖ Of the youth enrolled in Montgomery County, 22.7% had a felony charge in the 12 months prior to enrollment.

### **Educational Information**

- ❖ Nearly 66% of the youth were suspended or expelled from school in the year prior to their enrollment. At termination, 86.5% of youth were attending school. At termination, 27.2% of successful completers and 9.2% of unsuccessful completers received mostly A's and B's.
- ❖ At termination, workers reported that 90.8% 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 trauma symptoms from intake to termination.
- ❖ Results from the Ohio Scales indicated the caregiver, worker, and youth all reported increased youth functioning and decreased problem severity while in BHJJ treatment.
- ❖ Both males and females reported decreased six month and 30 day substance use with respect to most of the commonly used substances, including alcohol and marijuana.
- ❖ There was a 44% reduction in risk for out of home placement from intake to termination. About six percent of successful completers and 57% of unsuccessful completers were at risk for out of home placement at termination.
- ❖ Over 95% of caregivers agreed that they were satisfied with the services their child received through BHJJ and 97.4% agreed that the services received were culturally and ethnically sensitive.

### **Termination and Recidivism Information**

- ❖ Over 60% (60.8%) of the youth terminated from the BHJJ program were identified locally as successful treatment completers. Over 57% (57.1%) of youth enrolled in the past biennium were identified as successful treatment completers. The average length of stay in the program was approximately 5 months (5.2 months for youth enrolled during previous biennium).
- ❖ Successful treatment completion in BHJJ produced lower percentages of subsequent 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, 15.6% of successful treatment completers and 22.6% of unsuccessful treatment completers had a new felony charge. Of the youth entering BHJJ with at least one felony charge, 30.2% were charged with a new felony in the 12 months following BHJJ termination.
- ❖ Twenty-five of the 1392 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: 2006-2015 MONTGOMERY 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](mailto: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.

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### 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.

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### 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”.

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### 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.

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## 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.

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## 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.

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## 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.

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## 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.

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## 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.

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## 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.

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## 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**

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

**Table 2. Optional BHJJ Questionnaires**

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

## PROJECT DESCRIPTION

In Montgomery County, the BHJJ program is referred to as the LIFE Program (Learning Independence and Family Empowerment), and is a county-wide collaborative that has been in existence since 2006. The LIFE Program is made possible through the ongoing collaboration with the following organizations: Montgomery County Juvenile Court; South Community, Inc.; Ohio Department of Mental Health and Addiction Services (OhioMHAS) and the Ohio Department of Youth Services – Dayton Regional Office. The program serves females and males between the ages of 10 and 18 who are involved with Montgomery County Juvenile Court; who have a DSM-IV diagnosis and meet at least one of the following criteria:

- Substantial mental status impairment in behavioral, cognitive and/or affective domains
- Co-occurring Substance Abuse
- Violent and/or pattern of criminal behavior
- Threat to public safety, community, self, and/or others
- Substantial impairment in daily living skills and limited success in major life domains
- Exposed to and/or victim of trauma and/or domestic violence
- History of multi-system involvement

Youth and families involved in the LIFE Program are referred by Juvenile Court personnel. The youth is assessed by the Caring for Kids Program, which provides 24-hours screening and assessment services for youth involved in the Montgomery County Juvenile Court (MCJC). A MCJC Judge, Magistrate, Probation Officer or Intervention Specialist could also identify an adolescent who meets program criteria and refer the youth directly to the LIFE Program. In other instances, a youth could be paroled from the Ohio Department of Youth Services (ODYS) or released from one of the local MCJC secure facilities and referred directly in to the LIFE Program as a plan for re-entry. When the referral is complete, the youth and family may be referred to three separate therapeutic interventions, Functional Family Therapy (FFT), Functional Family Therapy-Contingency Management (FFT-CM) and/or Seven Challenges.

Functional Family Therapy is an elite evidenced based practice model supported by Blueprints for Healthy Youth Development. FFT has over 40 years of research demonstrating its effectiveness with juvenile-justice involved youth and has shown to reduce recidivism. FFT-CM is an enhancement to the FFT intervention to include protocols for treatment of co-occurring mental health and substance abuse problems. When the youth and family are referred to FFT or FFT-CM, the case is assigned to a therapist who contacts the family within 48 hours. The therapist meets with the family for family therapy sessions. Sessions are determined based on client and family need, but on average, the FFT intervention ranges from 8 to 16 sessions. A youth and family successfully complete the intervention when they have completed all phases of the FFT Model; have decreased recidivism and have increased overall youth and family functioning. If the family experiences difficulty after completing treatment, the family is offered booster sessions if needed.

Montgomery County has continued to address adolescent substance abuse treatment service gaps in the community by enhancing LIFE Program services to include the Seven Challenges Model. The expansion has allowed the LIFE Program to service youth and families who did not engage in the FFT services; allowed youth to remain in treatment once FFT ended; or allowed youth who needed more intense intervention to receive group and individual at the same time FFT is provided. The Seven Challenges is designed specifically for adolescents with drug problems, to motivate a decision and commitment to change, and supports success in implementing the desired changes. The Seven

Challenges has been used nationally and internationally, and is listed on SAMHSA's National Registry of Evidence-based Programs and Practices. The program is supported by many Juvenile Justice systems and by Reclaiming Futures. The Seven Challenges Program has shown substantial reduction in substance abuse and impressive mental health improvements with adolescents.

Two Life Program Care Specialists operate the Seven Challenges Program, providing youth and families for an average of 8 to 20 group, individual and/or family sessions. All primary LIFE Program therapeutic services are located in the home environment and in the community to alleviate transportation barriers for families

In addition to services from the FFT Therapist and Care Specialist, a LIFE Probation Officer or Intervention Specialist is assigned to the youth to provide intense intervention or probation services. The youth also has access to a South Community psychiatrist, as needed and a Natural Helper (a family mentor) through MCJC Reclaiming Futures Natural Helper Program. The family also meets in their home with the Outcomes Support Specialist at specified intervals during treatment to complete outcome measures, which are submitted to the BHJJ Project Evaluator at Case Western Reserve University.

The Therapists, Program Managers, Probation Officers, Intervention Specialists, Care Specialists, and Psychiatrist attend bi-weekly interdisciplinary team meetings. Other providers who are involved with LIFE clients are invited to attend as needed. Juvenile Court personnel then will report progress on treatment or make any recommendations to treatment to the court Judges/Magistrates. The FFT Therapists in the LIFE Program also meet for weekly group clinical consultation and individual supervision with the FFT Site Lead/LIFE Program Managers. Global Therapist Ratings are completed by the FFT Site Lead/Program Manager, and families complete surveys periodically throughout the course of treatment to assure fidelity of the FFT model. The Care Specialists meet bi-weekly with the Seven Challenges site lead. Fidelity reviews are completed quarterly on each staff.

The LIFE Program also embraces suggestions and feedback from the Advisory Board. The LIFE Advisory Board oversees the overall functioning of the program. The Advisory Board includes: South Community, Montgomery County Alcohol Drug Addiction and Mental Health Services Board, Montgomery County Juvenile Court, Ohio Department of Youth Services, Reclaiming Futures Mentoring Program, and a parent. The Advisory Board meets quarterly. Reports are distributed, and successes and barriers are discussed.

As the therapeutic intervention ends, the therapists, care specialists and probation officer continue to collaborate and to link the youth and family with community resources as needed to help sustain the changes made during treatment. The youth could also be linked with other services provided within South Community's continuum of care. If the family experiences difficulty after treatment has ended, they are able to contact South Community directly and indicate their previous involvement with the LIFE Program. A determination is made as to whether the family could benefit from FFT "booster sessions" or whether another intervention is more appropriate.

## 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<sup>1</sup>.

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

## MONTGOMERY COUNTY

### DEMOGRAPHICS

Montgomery County has enrolled 1,410 youth in the BHJJ program since 2006. Of the 1,410 youth enrolled, 47.9% (n = 676) were female and 52.1% (n = 734) were male. Since July 2013, 60.8% (n = 256) of new enrollees have been male (see Table 3).

The majority of the overall sample of youth were either Caucasian (49.5%, n = 675) or African American (40.7%, n = 556). A similar pattern was found for youth enrolled since July 2013, although a slightly lower proportion of African Americans (38.7%, n = 163) and Caucasians (48.7%, n = 205) was observed. A higher proportion of the population fell into the “Other” race category (12.6%, n = 53). The average age of the youth at intake into BHJJ was 15.5 years old (SD = 1.63) with a range between 9.6 and 18.76 years.

**Table 3. Demographic Information for BHJJ Youth in Montgomery County**

	All Youth Enrolled (2006 - 2015)	Youth Enrolled between July 2013 – June 2015
<b>Gender</b>	Female = 47.9% (n = 676) Male = 52.1% (n = 734)	Female = 39.2% (n = 165) Male = 60.8% (n = 256)
<b>Race</b>	African American = 40.7% (n = 556) Caucasian = 49.5% (n = 675) Other = 9.7% (n = 134)	African American = 38.7% (n = 163) Caucasian = 48.7% (n = 205) Other = 12.6% (n = 53)
<b>Age at Intake</b>	15.54 years (SD = 1.63)	15.35 years (SD = 1.83)

### CUSTODY ARRANGEMENT AND HOUSEHOLD INFORMATION

At intake, the majority of youth lived with the biological mother (57.8%, n = 744) (see Table 4). At time of enrollment, 84.5% (n = 1,087) of the BHJJ youth lived with at least one biological parent.

Over 75% of the BHJJ caregivers (78.6%, n = 993) had at least a high school diploma or GED, and 8.9% (n = 113) had a bachelor’s degree or higher (see Table 5). Over one in five caregivers (21.4%, n = 271) 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). Three out of four caregivers (75.1%, n = 916) reported annual household incomes below \$35,000 and 50.4% (n = 614) reported an annual household income below \$20,000. Over 20% of BHJJ families (22.6%, n = 275) reported an annual household income below \$10,000.

**Table 4. Custody Arrangement for BHJJ Youth in Montgomery County**

<b>Custody</b>	<b>BHJJ Youth</b>
<b>Two Biological Parents or One Biological and One Step or Adoptive Parent</b>	20.7% (n=266)
<b>Biological Mother Only</b>	57.8% (n=744)
<b>Biological Father Only</b>	6.0% (n=77)
<b>Adoptive Parent(s)</b>	3.7% (n=48)
<b>Sibling</b>	0.2% (n=2)
<b>Aunt/Uncle</b>	1.9% (n=24)
<b>Grandparents</b>	8.0% (n=103)
<b>Friend</b>	0.0% (n=0)
<b>Ward of the State</b>	0.3% (n=4)
<b>Other</b>	1.5% (n=19)

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

<b>Number of School Years Completed</b>	<b>Number of Caregivers</b>
<b>Less than High School</b>	21.4% (n=271)
<b>High School Graduate or G.E.D.</b>	28.2% (n=357)
<b>Some College or Associate Degree</b>	41.4% (n=523)
<b>Bachelor’s Degree</b>	4.8% (n=61)
<b>More than a Bachelor’s Degree</b>	4.1% (n=52)

**Table 6. Annual Household Income for BHJJ Families in Montgomery County**

<b>Annual Household Income</b>	<b>BHJJ Families</b>
<b>Less than \$5,000</b>	14.7% (n=179)
<b>\$5,000 - \$9,999</b>	7.9% (n=96)
<b>\$10,000 - \$14,999</b>	18.2% (n=222)
<b>\$15,000 - \$19,999</b>	9.6% (n=117)
<b>\$20,000 - \$24,999</b>	13.6% (n=166)
<b>\$25,000 - \$34,999</b>	11.1% (n=136)
<b>\$35,000 - \$49,999</b>	12.1% (n=148)
<b>\$50,000 - \$74,999</b>	8.4% (n=102)
<b>\$75,000 - \$99,999</b>	2.4% (n=29)
<b>\$100,000 and over</b>	2.0% (n=25)

## 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 higher percentage of females than males had a history of sexual abuse, running away, talking about suicide, attempting suicide, and a family history of mental illness. A significantly larger proportion of males than females had a history of substance abuse and that the child was currently taking emotional or behavioral medication.

Caregivers reported that 17.9% (n = 108) of females and 14.6% (n = 100) of males had a history of being physically abused while 25.0% (n = 148) of females and 9.6% (n = 65) of males had a history of being sexually abused. Caregivers of 48.0% (n = 289) of females and 31.9% (n = 219) of males reported hearing the child talking about committing suicide and 23.9% (n = 142) of females and 10.6% (n = 72) of males had attempted suicide at least once. Nearly seventy percent of caregivers of females (69.0%, n = 408) and 65.2% (n = 432) of males reported a family history of depression.

**Table 7. Youth and Family History in Montgomery County**

Question	Females	Males
Has the child ever been physically abused?	17.9% (n=108)	14.6% (n=100)
Has the child ever been sexually abused?	25.0% (n=148)***	9.6% (n=65)
Has the child ever run away?	58.6% (n=350)**	49.2% (n=331)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	40.2% (n=241)	51.0% (n=346)***
Has the child ever talked about committing suicide?	48.0% (n=289)***	31.9% (n=219)
Has the child ever attempted suicide?	23.9% (n=142)***	10.6% (n=72)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	40.8% (n=247)	39.4% (n=268)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	69.0% (n=408)	65.2% (n=432)
Has anyone in the child's biological family had a mental illness, other than depression?	50.3% (n=299)*	44.6% (n=292)
Has the child ever lived in a household in which someone was convicted of a crime?	38.4% (n=226)	40.3% (n=269)
Has anyone in the child's biological family had a drinking or drug problem?	63.3% (n=376)	61.4% (n=414)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms	26.3% (n=156)	36.3% (n=242)***

\*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 9.0% (n = 49) of females had been pregnant and 11.0% (n = 20) were currently expecting a child. Caregivers reported that 3.2% (n = 21) of males had impregnated a female and 4.7% (n = 5) were currently expecting a child. Over 10% of females (10.9%, n = 14) and 8.7% (n = 9) of males currently had children. Of those who had children, 100% of females (n = 9) and one of the males (16.7%) 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 Montgomery 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 ( $p = .004$ ), but not race. A larger percentage of males (46.7%) than females (27.1%) were identified as moderate risk.

**Table 8. OYAS Categories by Race and Gender for Montgomery County**

	OYAS Low	OYAS Moderate	OYAS High
<b>Female*</b>	55.2% (n = 53)	27.1% (n = 26)	17.7% (n = 17)
<b>Male</b>	36.7% (n = 62)	46.7% (n = 79)	16.6% (n = 28)
<b>White</b>	50.4% (n = 60)	35.3% (n = 42)	14.3% (n = 17)
<b>Nonwhite</b>	37.6% (n = 53)	43.3% (n = 61)	19.1% (n = 27)

\* $p < .05$

## 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. The most common Axis I diagnosis for both females (48.8%,  $n = 317$ ) and males (52.2%,  $n = 372$ ) was Oppositional Defiant Disorder (see Table 9).

A total of 3,352 Axis I diagnoses were identified for 1,361 youth with diagnostic information (2.46 diagnoses per youth). Females reported 1,538 Axis I diagnoses (2.37 diagnoses per female) and males reported 1,814 Axis I diagnoses (2.55 diagnoses per male). Chi-square analysis indicated that a significantly higher proportion of females were diagnosed with Alcohol-related Disorders and Depressive Disorders while a significantly higher proportion of males were diagnosed with Cannabis-related Disorders, Attention Deficit Hyperactivity Disorder, and Conduct Disorder. Of the youth who had available diagnostic information, 32.8% ( $n = 212$ ) of females and 40.7% ( $n = 289$ ) of males had a co-occurring substance use and mental health diagnosis.

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

DSM-IV Axis I Diagnosis	Females	Males
<b>Alcohol-related Disorders</b>	14.6% (n=95)**	9.0% (n=64)
<b>Attention Deficit Hyperactivity Disorder</b>	24.8% (n=161)	45.4% (n=323)***
<b>Bipolar Disorder</b>	9.9% (n=64)	8.3% (n=59)
<b>Cannabis-related Disorders</b>	24.5% (n=159)	31.0% (n=221)**
<b>Conduct Disorder</b>	11.7% (n=76)	22.8% (n=162)***
<b>Depressive Disorders</b>	23.7% (n=154)***	10.7% (n=76)
<b>Mood Disorder</b>	12.5% (n=81)	9.7% (n=69)
<b>Oppositional Defiant Disorder</b>	48.8% (n=317)	52.2% (n=372)
<b>Post-traumatic Stress Disorder</b>	6.3% (n=41)*	3.4% (n=24)

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

## 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, 65.6% (n = 706) were either suspended or expelled from school. While in treatment with BHJJ, 34.2% (n = 318) 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, 88.7% (n = 847) of youth were currently attending school excluding those on summer break. At termination, 86.5% (n = 728) 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 Montgomery County from intake to termination based on completion status. At termination, 27.2% (n = 141) of successful completers received mostly A's and B's while 9.2% (n = 48) of unsuccessful completers received mostly A's and B's.

At termination, workers reported that 30.9% (n = 289) of youth were attending school more than before starting treatment and 59.9% (n = 559) of youth were attending school 'about the same' amount compared to before starting treatment. Workers reported 4.0% (n = 37) of youth were attending school less often than before treatment in BHJJ.

**Table 10. Academic Performance in Montgomery County**

Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	21.9% (n=216)	20.3% (n=169)
Mostly B's and C's	25.8% (n=254)	31.0% (n=258)
Mostly C's and D's	22.9% (n=226)	29.7% (n=247)
Mostly D's and F's	29.4% (n=290)	19.1% (n=159)

**Table 11. Academic Performance in Montgomery 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	17.4% (n=48)	9.2% (n=27)	23.8% (n=125)	27.2% (n=141)
Mostly B's and C's	24.3% (n=67)	24.2% (n=71)	27.8% (n=146)	34.7% (n=180)
Mostly C's and D's	26.1% (n=72)	37.9% (n=111)	22.3% (n=117)	25.2% (n=131)
Mostly D's and F's	32.2% (n=89)	28.7% (n=84)	26.1% (n=137)	12.9% (n=67)

## OHIO SCALES

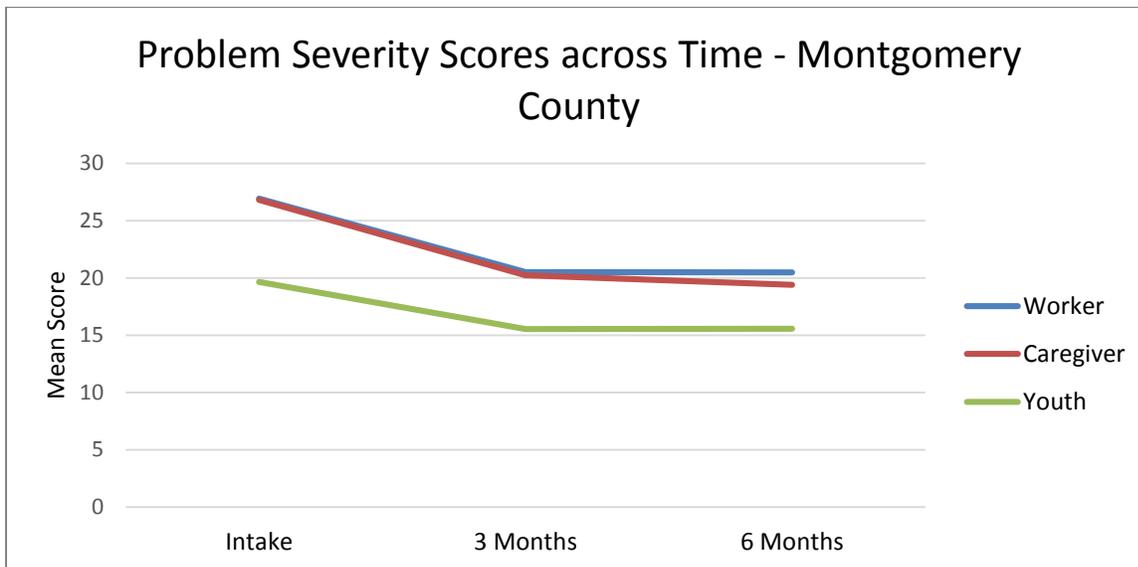
One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum 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

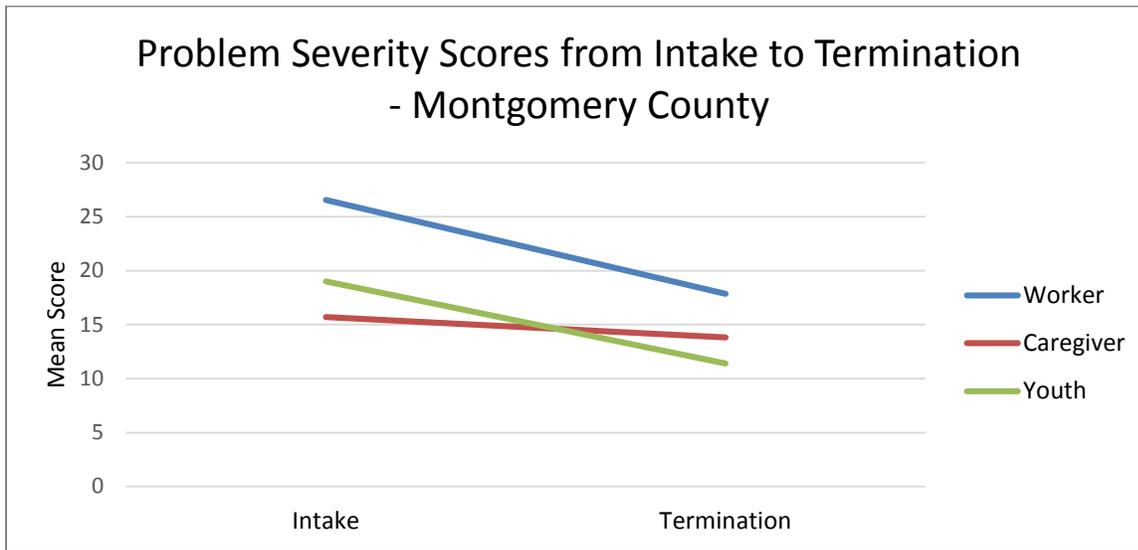
Overall means for the Problem Severity scale by rater and assessment period for Montgomery County youth are represented graphically in Figure 1. Means from intake to termination are presented in Figure 2.

**Figure 1. Problem Severity Scores across Time - Montgomery County**



\*all comparisons from intake to each successive time point are significant at the  $p < .001$  level

**Figure 2. Problem Severity Scores from Intake to Termination - Montgomery 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 each measurement interval (see Table 12) compared to intake. Significant improvements were noted at three months  $t(338) = 12.27, p < .001$ ; six months:  $t(48) = 5.88, p < .001$ ; and at termination:  $t(671) = 21.16, p < .001$ . Moderate effect sizes were found for intake to three months, while large effect sizes were noted for intake to six months and intake to termination.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	29.81 (SD=16.51; n=339)	20.43 (SD=13.61; n=339)	12.27***	.62
Intake to Six Months	33.89 (SD=19.85; n=49)	19.22 (SD=15.06; n=49)	5.88***	.83
Intake to Termination	25.71 (SD=16.40; n=672)	13.82 (SD=12.20; n=672)	21.16***	.82

\*\*\* $p < .001$

#### 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  $t(360) = 10.31, p < .001$ ; six months:  $t(54) = 5.47, p < .001$ ; and at termination:  $t(1010) = 17.71, p < .001$ . Moderate effect sizes were found for intake to three months and intake to termination. A large effect size was noted for intake to six months.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
<b>Intake to Three Months</b>	27.75 (SD=13.17; n=361)	20.57 (SD=12.37; n=361)	10.31***	.56
<b>Intake to Six Months</b>	32.56 (SD=14.40; n=55)	20.53 (SD=15.01; n=55)	5.47***	.82
<b>Intake to Termination</b>	26.55 (SD=13.33; n=1011)	17.86 (SD=13.36; n=1011)	17.71***	.65

\*\*\*p &lt; .001

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**YOUTH RATING**

**Scores on the Problem Severity scale as reported by youth showed significant improvement for all three measurement intervals (see Table 14).** Significant improvements were noted at three months  $t(347) = 7.05, p < .001$ ; six months:  $t(49) = 3.79, p < .001$ ; and at termination:  $t(657) = 15.69, p < .001$ . A small effect size was found for the time between intake and three months. Moderate effect sizes were noted for the time periods between intake and six months and intake and termination.

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

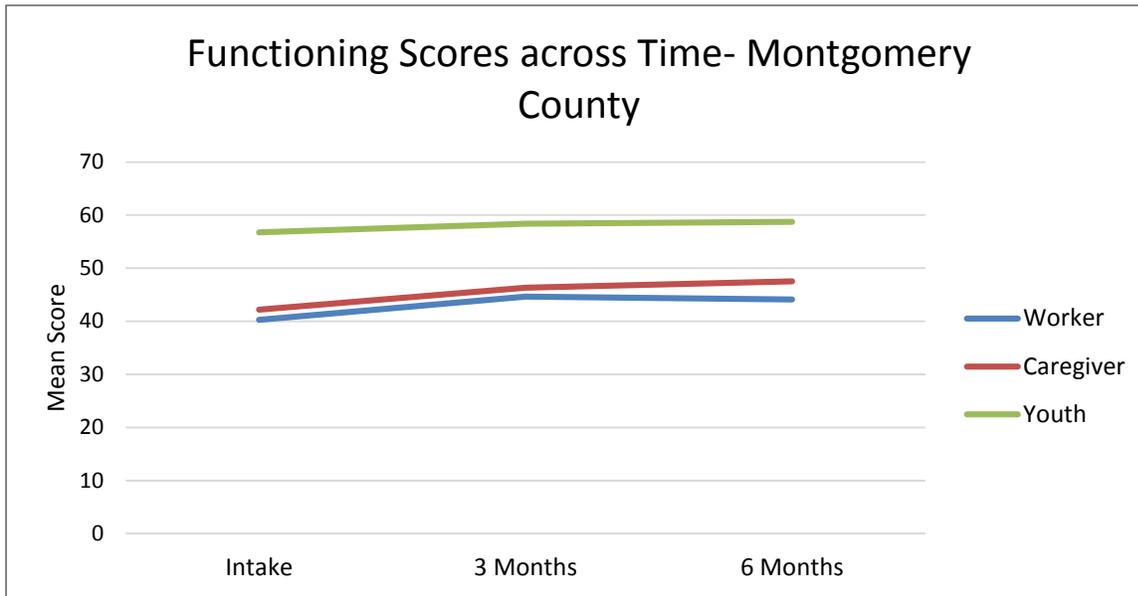
	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
<b>Intake to Three Months</b>	20.93 (SD=15.33; n=348)	15.67 (SD=12.64; n=348)	7.05***	.37
<b>Intake to Six Months</b>	25.11 (SD=20.01; n=50)	15.17 (SD=14.31; n=50)	3.79***	.57
<b>Intake to Termination</b>	19.01 (SD=14.20; n=658)	11.39 (SD=10.27; n=658)	15.69***	.61

\*\*\*p &lt; .001

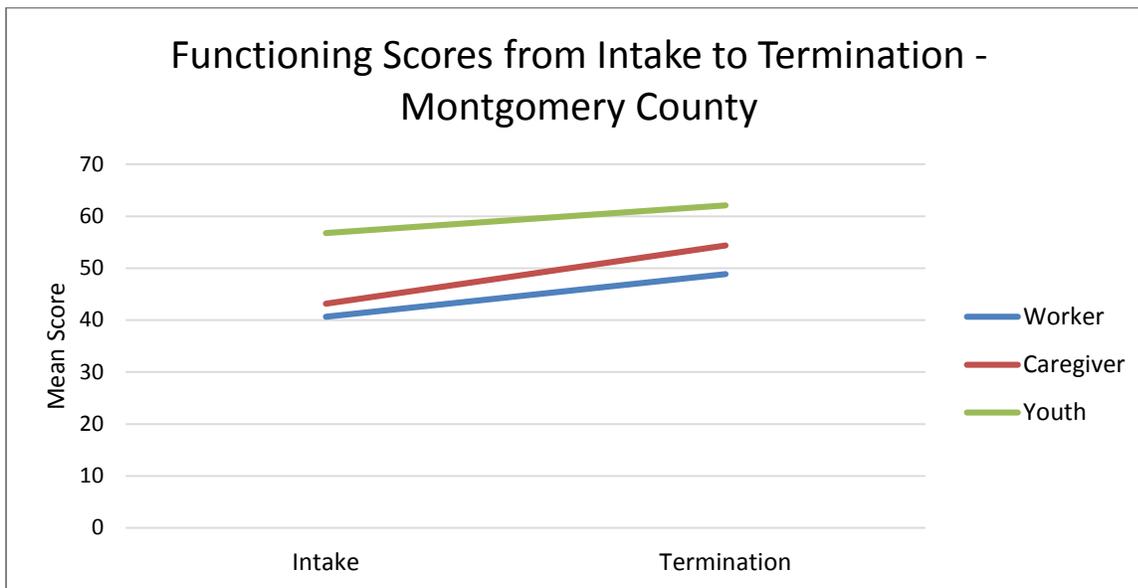
## FUNCTIONING

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

**Figure 3. Functioning Scores across Time - Montgomery County**



**Figure 4. Functioning Scores from Intake to Termination - Montgomery County**



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

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## CAREGIVER RATING

Paired samples t-tests revealed significant improvements in Functioning at each measurement interval (see Table 15) compared to intake. Significant improvements were noted at three months:  $t(334) = -8.49, p < .001$ ; six months:  $t(50) = -4.41, p < .001$ ; and termination:  $t(674) = -18.74, p < .001$ . Moderate effect sizes were noted between intake and six months and intake and termination, while a small effect size was observed between intake and three months.

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

---

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	39.53 (SD=15.77; n=335)	46.40 (SD=15.75; n=335)	-8.49***	.44
Intake to Six Months	36.59 (SD=18.37; n=51)	48.22 (SD=16.39; n=51)	-4.41***	.67
Intake to Termination	43.14 (SD=16.49; n=675)	54.35 (SD=16.05; n=675)	-18.74***	.69

\*\*\* $p < .001$

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## WORKER RATING

For workers, paired samples t-tests indicated significant improvement in the Functioning scale for each of the measurement intervals (see Table 16). Significant improvements were noted at three months:  $t(358) = -7.21, p < .001$ ; six months:  $t(54) = -3.77, p < .001$ ; and termination:  $t(1011) = -16.65, p < .001$ . Moderate effect sizes were noted between intake and six months and intake and termination, while a small effect size was observed between intake and three months.

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

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	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	39.89 (SD=11.66; n=359)	44.72 (SD=11.80; n=359)	-7.21***	.41
Intake to Six Months	36.09 (SD=12.07; n=55)	44.15 (SD=13.46; n=55)	-3.77***	.63
Intake to Termination	40.67 (SD=11.10; n=1012)	48.86 (SD=14.15; n=1012)	-16.65***	.64

\*\*\* $p < .001$

---

## YOUTH RATING

Paired samples t-tests conducted on the youth ratings of Functioning indicated significant improvement at three months and termination (see Table 17). Significant improvements were observed at three months:  $t(349) = -3.93, p < .001$ ; and termination:  $t(659) = -10.21, p < .001$ . Small effect sizes were noted for each of the measurement intervals.

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

---

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	55.99 (SD=12.02; n=350)	58.70 (SD=12.97; n=350)	-3.93***	.22
Intake to Six Months	54.76 (SD=13.56; n=51)	59.04 (SD=15.74; n=51)	-1.85	.29
Intake to Termination	56.78 (SD=12.79; n=660)	62.11 (SD=12.53; n=660)	-10.21***	.42

\*\*\* $p < .001$

The Trauma Symptom Checklist for Children (TSCC) was administered to youth in the BHJJ program in Montgomery 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 Montgomery County BHJJ youth who have subscale scores both at intake and at termination (see Table 18). Data were available for youth aged 8-17 who had completed the TSCC at both intake and termination, and youth who were not identified as either underresponders or hyperresponders. Effect sizes, represented by Cohen’s *d*, are also presented using the recommended criteria for its interpretation in Cohen’s (1988) seminal work. Interpretation of Cohen’s *d* is based on the criteria where 0.2 indicates a small effects size, 0.5 indicates a medium effect, and 0.8 indicates a large effect<sup>2</sup>. While statistical significance refers to whether the observed differences in the means are likely to have occurred by chance, effect sizes measure the magnitude of the observed differences.

Statistically significant improvements were noted for all subscales including: Anxiety ( $t(324) = 6.33, p < .001$ ), Depression ( $t(324) = 9.32, p < .001$ ), Anger ( $t(324) = 7.61, p < .001$ ), Posttraumatic Stress ( $t(324) = 8.18, p < .001$ ), Dissociation ( $t(324) = 8.09, p < .001$ ), and Sexual Concerns ( $t(324) = 3.72, p < .05$ ). The data indicated small effect sizes for all subscales. Means reported in Table 18 are represented graphically in Figure 5.

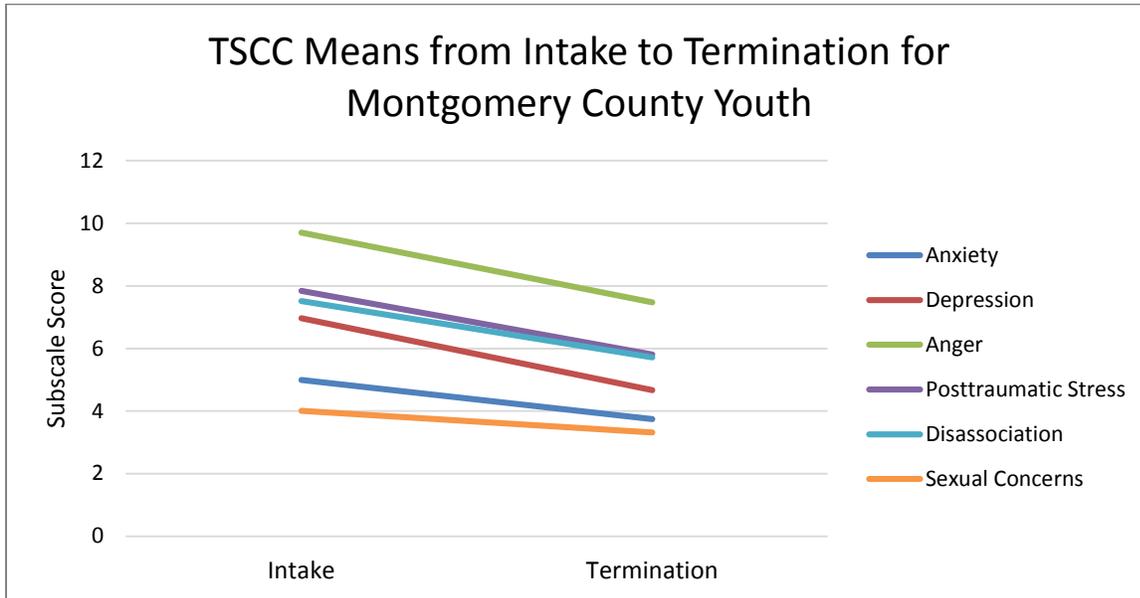
**Table 18. Paired Samples T Tests for TSCC Subscales for Montgomery County Youth**

	Intake	Termination	t	d
<b>Anxiety</b>	4.99 (SD=4.04; n=325)	3.74 (SD=3.36; n=325)	6.33 <sup>***</sup>	.34
<b>Depression</b>	6.97 (SD=5.13; n=325)	4.76 (SD=3.75; n=325)	9.32 <sup>***</sup>	.49
<b>Anger</b>	9.76 (SD=5.87; n=325)	7.47 (SD=4.59; n=325)	7.61 <sup>***</sup>	.43
<b>PTS</b>	7.84 (SD=5.23; n=325)	5.82 (SD=4.82; n=325)	8.18 <sup>***</sup>	.40
<b>Dissociation</b>	7.52 (SD=4.83; n=325)	5.72 (SD=4.18; n=325)	8.09 <sup>***</sup>	.40
<b>Sexual Concerns</b>	4.01 (SD=3.67; n=325)	3.32 (SD=3.60; n=325)	3.72 <sup>***</sup>	.19

\*\*\* $p < .001$

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

Figure 5. TSCC Means from Intake to Termination for Montgomery 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 marijuana and chewing tobacco than females.

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

	Males		Females	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
<b>Alcohol</b>	55.1% (n = 376)	13.21 (SD = 2.33)	57.8% (n = 340)	13.39 (SD = 1.90)
<b>Cigarettes</b>	56.0% (n = 380)	12.58 (SD = 2.59)	52.0% (n = 307)	12.55 (SD = 2.34)
<b>Chewing Tobacco</b>	18.2% (n = 123)**	13.58 (SD = 2.25)	4.8% (n = 28)	14.07 (SD = 1.57)
<b>Marijuana</b>	64.6% (n = 442)*	13.06 (SD = 2.00)	56.1% (n = 331)	13.24 (SD = 1.71)
<b>Cocaine</b>	5.1% (n = 35)	14.35 (SD = 1.32)	6.4% (n = 37)	14.54 (SD = 2.05)
<b>Pain Killers (use inconsistent with prescription)</b>	14.0% (n = 95)	14.08 (SD = 1.54)	14.7% (n = 86)	13.89 (SD = 1.60)
<b>GHB</b>	0.3% (n = 2)	15.00 (SD = 1.41)	0.2% (n = 1)	14.00 <sup>a</sup>
<b>Inhalants</b>	2.9% (n = 20)	13.42 (SD = 2.48)	2.7% (n = 16)	14.06 (SD = 1.61)
<b>Heroin</b>	1.8% (n = 12)	14.08 (SD = 1.38)	1.9% (n = 11)	14.64 (SD = 0.92)
<b>Amphetamines</b>	2.8% (n = 19)	16.89 (SD = 12.35)	2.2% (n = 13)	14.62 (SD = 1.39)
<b>Ritalin (use inconsistent with prescription)</b>	7.1% (n = 48)	13.63 (SD = 2.42)	5.5% (n = 32)	14.16 (SD = 1.46)
<b>Barbiturates</b>	2.1% (n = 14)	14.14 (SD = 1.46)	2.2% (n = 13)	14.08 (SD = 1.32)
<b>Non-prescription Drugs</b>	5.8% (n = 39)	13.68 (SD = 2.47)	5.3% (n = 31)	13.67 (SD = 1.99)
<b>Hallucinogens</b>	6.3% (n = 43)	14.36 (SD = 1.21)	4.6% (n = 27)	14.78 (SD = 1.22)
<b>PCP</b>	1.8% (n = 12)	15.08 (SD = 1.56)	1.5% (n = 9)	14.33 (SD = 0.50)
<b>Ketamine</b>	0.9% (n = 6)	15.83 (SD = 1.17)	0.3% (n = 2)	14.50 (SD = 0.71)
<b>Ecstasy</b>	4.7% (n = 32)	15.09 (SD = 1.33)	2.7% (n = 16)	14.37 (SD = 1.41)
<b>Tranquilizers</b>	13.5% (n = 92)	14.29 (SD = 1.77)	13.4% (n = 78)	14.42 (SD = 1.58)

\*p < .05; \*\* p < .01

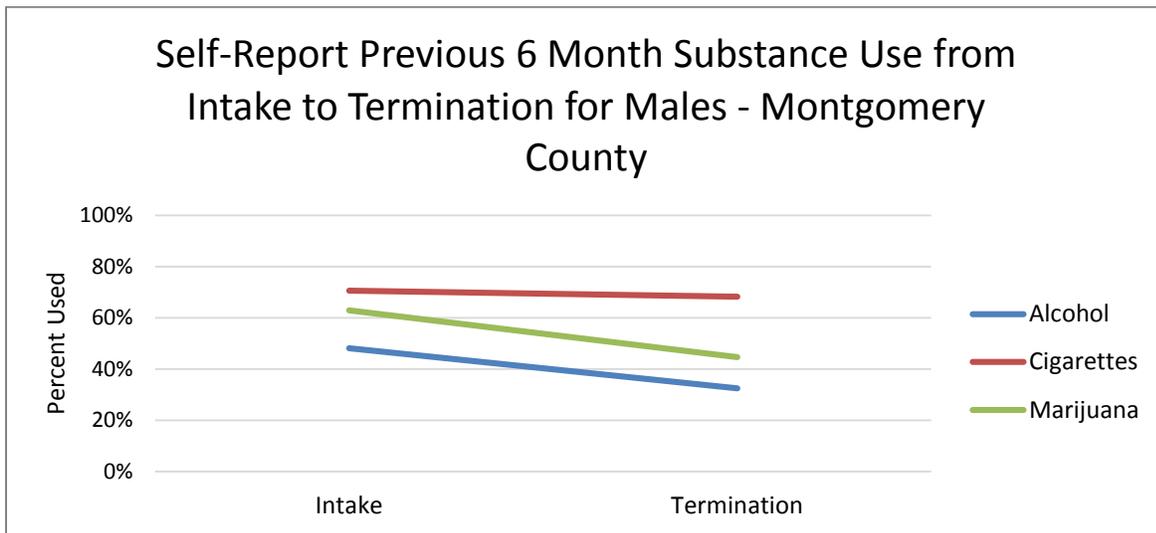
<sup>a</sup> Standard Deviations are not calculated when only one respondent reported using a substance.

## SIX MONTH SUBSTANCE USE

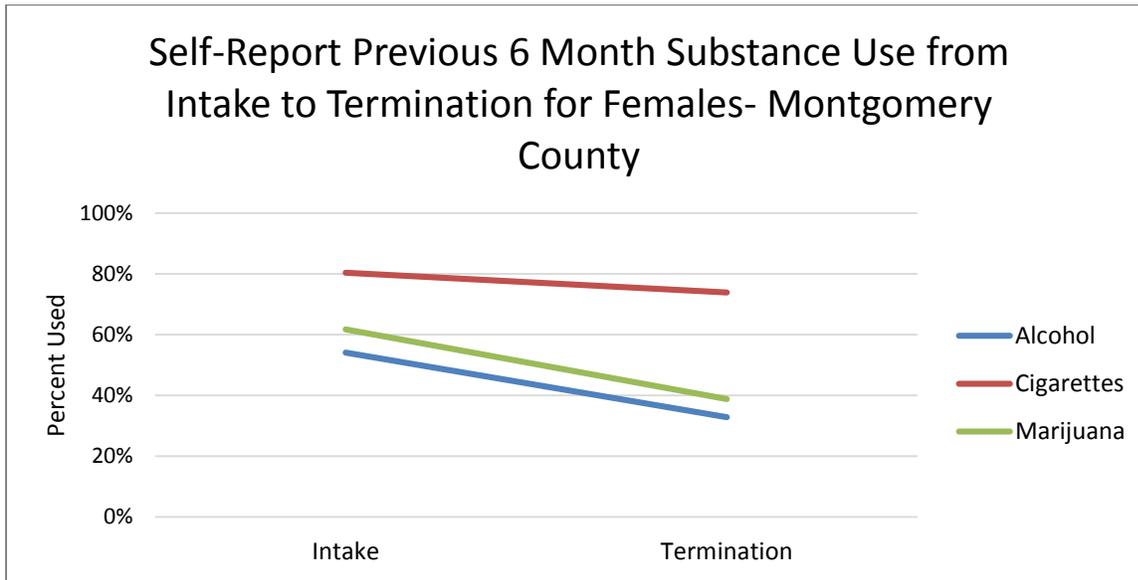
Youth were also asked to report whether they had used each substance in the past six months. Figure 6 and Figure 7 present past six month use for the most commonly reported substances for males and females respectively among those who reported lifetime use. The percentage of those using substances decreased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

month alcohol use among males decreased from 48.1% (n = 179) at intake to 32.5% (n = 54) at termination. Six month female alcohol use decreased from 54.1% (n = 172) at intake to 32.8% (n = 44) at termination. Six month cigarette use among males decreased from 70.6% (n = 264) at intake to 68.2% (n = 118) at termination. Six month cigarette use among females decreased from 80.4% (n = 242) at intake to 73.9% (n = 102) at termination. Six month marijuana use among males decreased from 62.9% (n = 271) at intake to 44.6% (n = 87) at termination. Six month marijuana use among females decreased from 61.7% (n = 198) at intake to 38.8% (n = 54) at termination. McNemar's tests revealed a significant decrease in the proportion of males and females using alcohol and marijuana from intake to termination.

**Figure 6. Self-Report Previous 6 Month Substance Use from Intake to Termination for Males – Montgomery County**



**Figure 7. Self-Report Previous 6 Month Substance Use from Intake to Termination for Females – Montgomery 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 8 and Figure 9 show the average number of days use in the previous 30 days for the three most commonly reported substances by gender. Thirty day use declined from intake to termination for the three most commonly reported substances with the exception of cigarette use among males. Thirty day alcohol use among males decreased from 2.84 days (SD = 7.00; n = 132) at intake to 0.81 days (SD = 2.97; n = 67) at termination. Thirty day alcohol use among females decreased from 2.44 days (SD = 5.32; n = 133) at intake to 0.21 days (n = 75) at termination. Thirty day marijuana use among males decreased from 7.77 days (SD = 11.90; n = 214) at intake to 2.67 days (SD = 6.96; n = 109) at termination. Thirty day marijuana use among females decreased from 5.71 days (SD = 9.41; n = 158) intake to 0.90 days (SD = 3.68; n = 92) at termination. Paired t-tests revealed a statistically significant difference from intake to termination for marijuana use among both males and females, and a significant difference for alcohol use among females.

Figure 8. Average 30 Day Substance Use for Males – Montgomery County

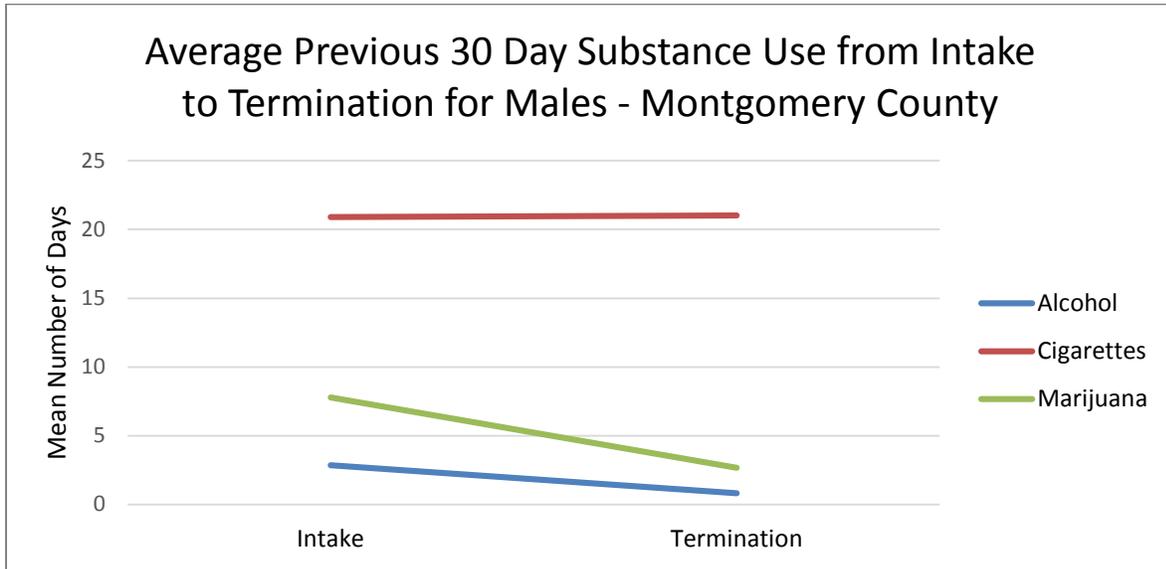
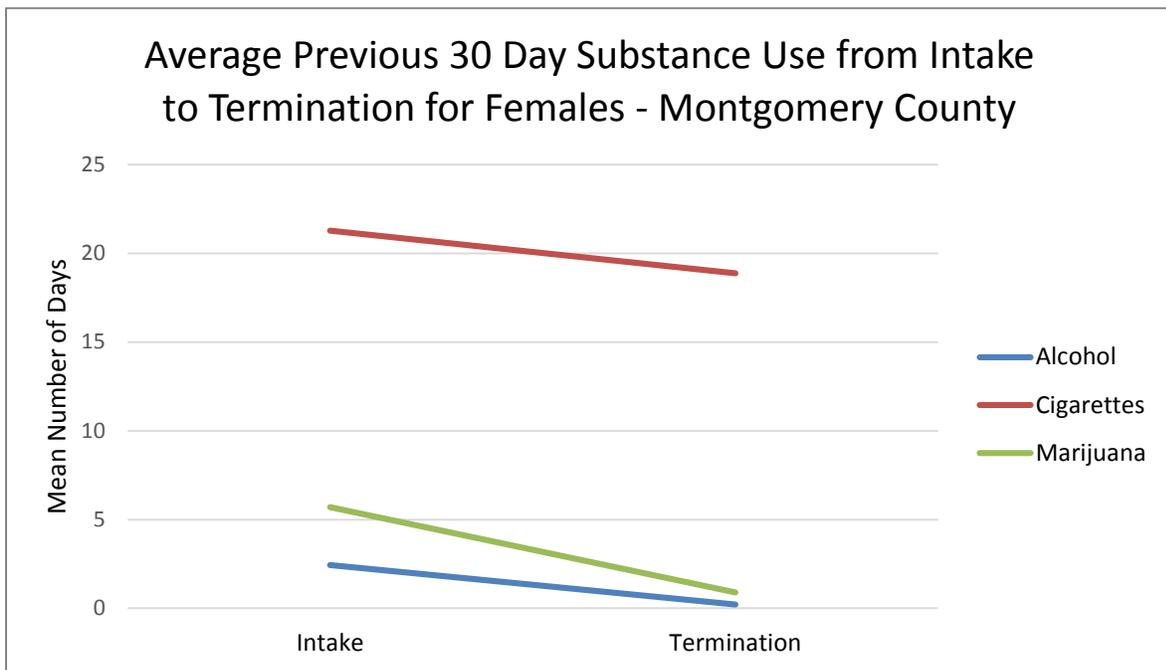


Figure 9. Average Previous 30 Day Substance Use for Females – Montgomery County



## 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 10, Figure 11, and Figure 12). At intake 62.2% (n = 787) of caregivers and 49.4% (n = 644) of workers reported no problems with drugs or alcohol in the past 30 days while 77.7% (n = 583) of caregivers and 63.9% (n = 695) of workers reported no problems at termination. Similarly, 68.9% (n = 888) of youth reported no problems in the past 30 days with drugs or alcohol at intake while 78.6% (n = 595) of youth reported no problems at termination.

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

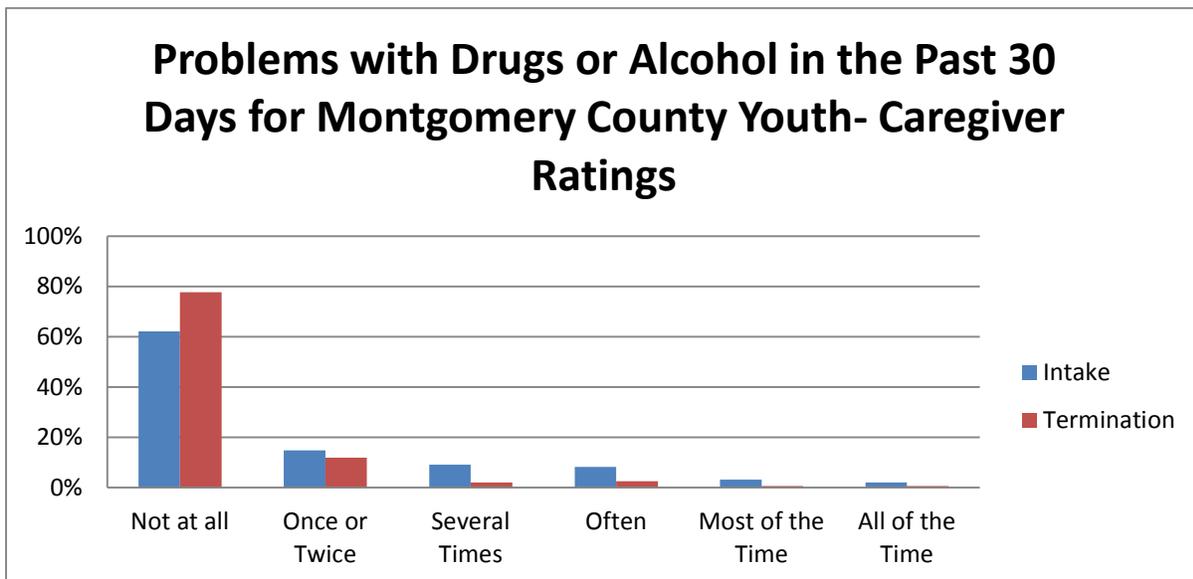


Figure 11. Problems with Drugs or Alcohol in the Past 30 Days for Montgomery County Youth - Worker Ratings

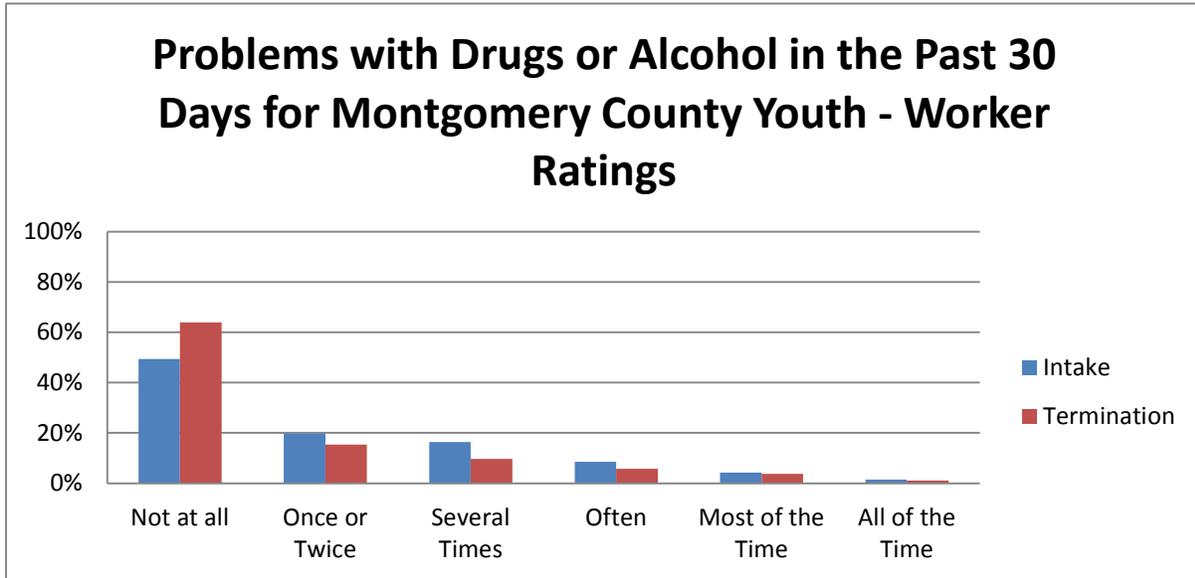
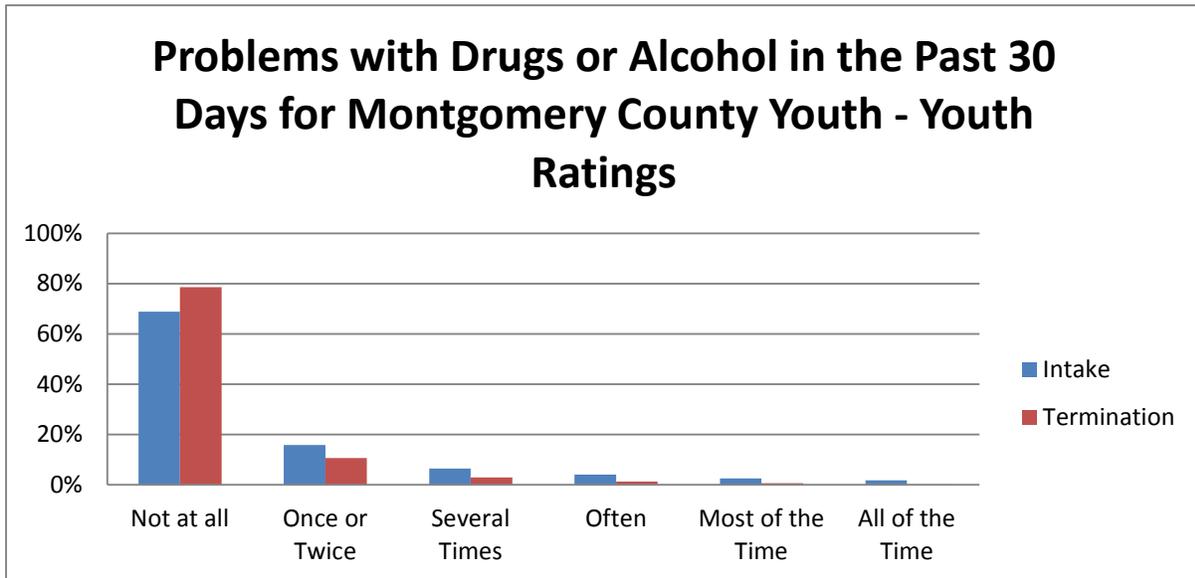


Figure 12. Problems with Drugs or Alcohol in the Past 30 Days for Montgomery County Youth - Youth Ratings



## 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 1,215 youth terminated from the BHJJ program in Montgomery County. **Over 60% (60.8%, n = 739) of the youth terminated from the BHJJ program were identified as successful treatment completers.** An additional 3.0% of youth (n = 37) were terminated from the program when the youth or family moved out of the county. Therefore, 63.8% (n = 776) of youth enrolled in BHJJ were terminated successfully or because the youth or family moved out of the county and were no longer able to receive BHJJ services. In Montgomery County, 12.1% (n = 147) of youth were withdrawn from the program and 7.5% (n = 91) 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, 57.1% (n = 182) of youth terminated successfully from the BHJJ program in Montgomery County.

**Table 20. Reasons for Termination from BHJJ – Montgomery County**

Termination Reason	All Youth	Youth Enrolled from July 2011 to June 2013
Successfully Completed Services	60.8% (n = 739)	57.1% (n = 182)
Client Did Not Return/Rejected Services	7.3% (n = 88)	9.7% (n = 31)
Out of Home Placement	7.5% (n = 91)	11.0% (n = 35)
Client/Family Moved	3.0% (n = 37)	5.3% (n = 17)
Client Withdrawn	12.1% (n = 147)	9.1% (n = 29)
Client AWOL	2.2% (n = 27)	1.6% (n = 5)
Client Incarcerated	2.6% (n = 31)	2.8% (n = 9)
Other	4.5% (n = 55)	3.4% (n = 11)

### AVERAGE LENGTH OF STAY

The average length of stay for youth in the Montgomery County BHJJ program was 153 days. For youth identified as completing treatment successfully, the average length of stay was 164 days and for youth identified as unsuccessful treatment completers, the average length of stay was 134 days. For youth enrolled since July 1, 2013, the average length of stay in BHJJ was 157 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, 46.9% of the youth (n = 622) in Montgomery County were at risk for out of home placement. At termination, 26.2% (n = 318) of youth were at risk for out of home placement. Of those youth who successfully completed BHJJ treatment, 6.3% (n = 46) were at risk for out of home placement at termination while 57.0% (n = 263) 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 58.7% (n = 555) of the youth and had stayed the same for 31% (n = 293) of the youth. Police contacts increased for 8.5% (n = 80) of the youth and worker was unable to estimate for 1.9% (n = 18).

## 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, 95.5% (n = 562) of caregivers either strongly agreed or agreed that they were satisfied with the services their child received and 91.3% (n = 535) either strongly agreed or agreed that the services their child and/or family received were right for them. A strong majority (99%, n = 580) of caregivers either strongly agreed or agreed that staff treated them with respect and 97.4% (n = 569) strongly agreed or agreed that they were satisfied with the cultural and ethnic sensitivity of BHJJ staff.

**Table 21. Satisfaction with Services – Montgomery County**

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Undecided</b>	<b>Disagree</b>	<b>Strongly Disagree</b>
<b>Overall I am satisfied with the services my child received</b>	65.6%	29.9%	3.4%	0.5%	0.5%
<b>The services my child and/or family received were right for us</b>	59.4%	31.9%	6.8%	1.4%	0.5%
<b>Staff treated me with respect</b>	80.2%	18.8%	0.7%	0.2%	0.2%
<b>Staff were sensitive to my cultural/ethnic background</b>	72.4%	25.0%	2.2%	0.2%	0.2%

## RECIDIVISM

### METHODOLOGY

Court data were provided by the Montgomery 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, 69.2% (n = 963) of the BHJJ youth had a misdemeanor charge, 22.7% (n = 316) had a felony charge, and 64.1% (n = 892) were adjudicated delinquent (see Table 22).

Previous juvenile court information is presented for youth based on BHJJ treatment completion status (successful vs. unsuccessful) (see Table 22). In the 12 months prior to enrollment, 63.7% (n = 469) of successful completers and 67.4% (n = 308) of unsuccessful completers were adjudicated delinquent. A slightly lower percentage of successful completers had a felony charge in the 12 months prior to intake (22.4%, n = 165) than unsuccessful completers (23.0%, n = 105).

**Table 22. Charges Prior to BHJJ Enrollment – Montgomery County**

	Overall			Successful			Unsuccessful		
	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent
<b>3 months</b>	44.8% (n = 624)	10.4% (n = 145)	39.0% (n = 543)	45.0% (n = 331)	9.9% (n = 73)	39.9% (n = 294)	46.6% (n = 213)	10.1% (n = 46)	41.6% (n = 190)
<b>6 months</b>	60.7% (n = 845)	17.2% (n = 240)	55.2% (n = 769)	60.2% (n = 443)	16.8% (n = 124)	55.7% (n = 410)	61.7% (n = 282)	17.3% (n = 79)	57.1% (n = 261)
<b>12 months</b>	69.2% (n = 963)	22.7% (n = 316)	64.1% (n = 892)	67.5% (n = 497)	22.4% (n = 165)	63.7% (n = 469)	72.0% (n = 329)	23.0% (n = 105)	67.4% (n = 308)
<b>18 months</b>	72.4% (n = 1,008)	23.9% (n = 332)	66.2% (n = 922)	71.5% (n = 526)	23.2% (n = 171)	65.6% (n = 483)	74.6% (n = 341)	24.3% (n = 111)	69.6% (n = 318)

## 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, 54.0% (n = 503) of youth were charged with at least one new misdemeanor and 20.9% (n = 195) were charged with at least one new felony. Fifty two percent (52.1%, n = 485) 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 50.7% (n = 267) of successful completers were charged with at least one new misdemeanor, 15.0% (n = 79) were charged with at least one new felony, and 47.8% (n = 252) were adjudicated delinquent. Of the youth who completed unsuccessfully, 59.6% (n = 187) were charged with at least one new misdemeanor, 29.6% (n = 93) were charged with at least one new felony, and 60.5% (n = 190) were adjudicated delinquent in the 12 months after their enrollment in BHJJ.

**Table 23. Charges after BHJJ Enrollment – Montgomery County**

	Overall			Successful			Unsuccessful		
	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent
<b>3 months</b>	28.4% (n = 359)	9.7% (n = 123)	29.3% (n = 371)	22.5% (n = 156)	5.5% (n = 38)	22.3% (n = 154)	38.1% (n = 161)	14.9% (n = 63)	40.7% (n = 172)
<b>6 months</b>	42.8% (n = 499)	16.4% (n = 191)	42.7% (n = 498)	36.9% (n = 240)	11.1% (n = 72)	35.9% (n = 234)	50.9% (n = 201)	23.0% (n = 91)	52.7% (n = 208)
<b>12 months</b>	54.0% (n = 503)	20.9% (n = 195)	52.1% (n = 485)	50.7% (n = 267)	15.0% (n = 79)	47.8% (n = 252)	59.6% (n = 187)	29.6% (n = 93)	60.5% (n = 190)
<b>18 months</b>	60.1% (n = 413)	22.9% (n = 157)	56.8% (n = 390)	59.4% (n = 236)	18.4% (n = 73)	54.9% (n = 218)	62.7% (n = 141)	28.9% (n = 65)	61.8% (n = 139)

## 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, 42.7% (n = 359) of youth were charged with at least one new misdemeanor, 18.3% (n = 154) were charged with at least one new felony, and 39.6% (n = 333) were adjudicated delinquent (see Table 24).

In the 12 months following their termination from BHJJ, 41.2% (n = 209) of successful completers were charged with at least one new misdemeanor, 15.6% (n = 79) were charged with at least one new felony, and 36.9% (n = 187) were adjudicated delinquent. Of the youth who completed unsuccessfully, 46.1% (n = 147) were charged with at least one new misdemeanor, 22.6% (n = 72) were charged with at least one new felony, and 44.8% (n = 143) were adjudicated delinquent in the 12 months after their termination from BHJJ.

**Table 24. Charges after BHJJ Termination – Montgomery County**

	Overall			Successful			Unsuccessful		
	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent
<b>3 months</b>	21.2% (n = 214)	8.4% (n = 85)	21.9% (n = 221)	19.6% (n = 120)	6.4% (n = 39)	19.3% (n = 118)	24.2% (n = 93)	11.2% (n = 43)	26.0% (n = 100)
<b>6 months</b>	32.1% (n = 294)	12.6% (n = 115)	31.8% (n = 291)	29.5% (n = 163)	10.0% (n = 55)	27.9% (n = 154)	36.5% (n = 127)	16.1% (n = 56)	38.2% (n = 133)
<b>12 months</b>	42.7% (n = 359)	18.3% (n = 154)	39.6% (n = 333)	41.2% (n = 209)	15.6% (n = 79)	36.9% (n = 187)	46.1% (n = 147)	22.6% (n = 72)	44.8% (n = 143)
<b>18 months</b>	53.2% (n = 268)	23.2% (n = 117)	50.0% (n = 252)	51.1% (n = 162)	18.9% (n = 60)	47.6% (n = 151)	57.0% (n = 102)	30.2% (n = 54)	54.7% (n = 98)

## 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 179 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 179 youth, 30.2% (n = 54) were charged with a new felony in the 12 months after their termination from BHJJ.

**Twenty-five of the 1,392 BHJJ youth (1.8%) from Montgomery County for whom we had recidivism data were committed to an ODYS facility at any time following their enrollment.**

## SUCCESS STORY

This youth has been involved in a number of different services since 2012. He has a long history of behavioral issues which led to his involvement in Montgomery County Juvenile Court. He has been on probation since he was 11 years old and has picked up multiple charges over the years including domestic violence, unauthorized use of a vehicle, truancy, possession of drugs, assault, and complicity to robbery. The youth was placed at Nicholas Residential Facility in 2012 and has been in and out of treatment for the last several years with little success because of his resistance to treatment.

He is one of six children and his parents both have history of drug and alcohol abuse in addition to being in the criminal justice system themselves. He has lived with his mother most of his life until he was placed into foster care at 10 years old. He then went to live with his father and began using marijuana and alcohol at age 14 as this seemed like a "normal" lifestyle to him because he saw it every day.

He immediately began violating his probation by testing positive for marijuana. However, after he witnessed his best friend shot and killed in front of him, he relapsed, became hopeless and suicidal. At the age of 17 years old, he was hospitalized for the first time for hearing voices, experiencing hallucinations, having delusions, paranoia and communicated to his pregnant girlfriend, thoughts about killing himself.

The youth was referred to the LIFE Program, where the family engaged in Functional Family Therapy and the youth also engaged in the Seven Challenges Program. Through the hard work and dedication of the youth and family, they have successfully completed treatment and the youth is stable. He is currently employed full time at a local grocery store in which he shows commitment and dedication to his job. He is maintaining his own apartment and he participates in treatment, utilizes supports, and completed his probation successfully. His mother has stated "Without the LIFE Program and all the support from his probation officer, I am not sure where he would be."

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