

An Evaluation of the Behavioral Health/Juvenile Justice (BHJJ) Initiative: 2009-2015 Summit County Results

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EXECUTIVE SUMMARY: AN EVALUATION OF THE BEHAVIORAL HEALTH/JUVENILE JUSTICE INITIATIVE (BHJJ): 2009 – 2015 SUMMIT 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 Summit County, 223 youth have been enrolled in BHJJ (76.6% males, 62% African American). In the past two years, more non-whites (80%) than whites (20%) and males (75.3%) than females (24.7%) have been enrolled.
- ❖ Youth averaged 2.96 Axis I diagnoses. Females were significantly more likely to be diagnosed with Oppositional Defiant Disorder and Mood Disorder. Males were significantly more likely to be diagnosed with Conduct Disorder.
- ❖ Fifty-one percent of females and 52.9% of males were diagnosed with both a mental health and substance use diagnosis.
- ❖ Caregivers reported that 21.7% of the females had a history of sexual abuse, 40% talked about suicide, and nearly 9.8% had attempted suicide. Fifty-nine percent of females and 41.8% of males had family members who were diagnosed with or showed signs of depression.
- ❖ According to the OYAS, 60.8% of the youth served in BHJJ were moderate or high risk.
- ❖ In the 12 months prior to enrollment, 93.9% of youth were charged with a felony.

Educational Information

- ❖ Over 70% of the youth were suspended or expelled from school in the year prior to their enrollment. At termination, 77.5% of youth were attending school.
- ❖ At termination, workers reported that 90.7% 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 in Anxiety and Posttraumatic Stress.
- ❖ Results from the Ohio Scales indicated significant improvement in problem severity from intake to termination as reported by caregivers, workers, and youth.
- ❖ Summit County youth reported a decrease in past 30 day use of alcohol and marijuana from intake to termination.
- ❖ Almost 34 percent of successful completers and 71.2% of unsuccessful completers were at risk for out of home placement at termination.
- ❖ Ninety percent of caregivers agreed that they were satisfied with the services their child received through BHJJ and 91.9% agreed that the services received were culturally and ethnically sensitive.

Termination and Recidivism Information

- ❖ Sixty-seven percent of the youth terminated from the BHJJ program were identified locally as successful treatment completers. Nearly 70% of youth enrolled in the past biennium were identified as successful treatment completers. The average length of stay in the program was approximately 5.7 months (5.7 months for youth enrolled during previous biennium).
- ❖ Successful treatment completion in BHJJ produced lower percentages of subsequent felonies twelve months after termination than unsuccessful completion.
- ❖ Of the youth entering BHJJ with at least one felony charge, 52.3% were charged with a new felony in the 12 months following BHJJ termination.
- ❖ Twenty-six of the 212 youth (12.3%) 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: 2009-2015 SUMMIT 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 Summit County Juvenile Court collaborates with the County of Summit Alcohol, Drug Addiction and Mental Health Services Board, The Village Network, Child Guidance and Family Solutions (CGFS), The Center for Innovative Practices of Case Western Reserve University (CIP), Greenleaf Family Center and East Akron YMCA to provide Integrated Co-occurring Treatment (ICT) through CGFS with CIP oversight and Trauma—Focused Cognitive Behavioral Therapy (TF-CBT) through the Village Network with further support for both interventions through the use of Greenleaf Family Center Parent Advocates for caregivers and mentors for youth as provided by East Akron YMCA and court supervision and case management.

Additional supports have been added since 2011 to further promote program engagement and success, including opportunities for youth to work directly with Sylvan Learning Center staff individually and in small group settings. Sylvan staff often works with the local public schools in IEP development for the program youth with whom they work. Approximately 55 - 60 youth can be referred to the program annually. Since 2009, 67% of the roughly 140 youth referred were African American, 28% White and 5% Bi-racial. Nearly all of the youth were charged with one or more felonies and scored moderate to high-risk on the OYAS. Approximately 80% of the referrals were males and the general age range was between 14 and 18 years old.

Generally, males and females from 12 to 18 years old who commit a felony offense and who are known to have serious substance abuse/mental health issues can be referred to the program. Typically, BHJJ services are targeted to youth between 14 to 18 years old, as these services, while flexible, tend to be designed to be effective with this age-range. All youth under consideration for referral to BHJJ services must first be staffed, (a meeting held among various experienced court staff from probation, felony disposition, and partnering agency professionals) post-adjudication (after admitting to their offense in court) for appropriateness (mental health and/or substance abuse issues, serious offenders, etc.).

These youth have been placed on probation or intensive probation, some of whom are on suspended ODYS commitments. Once the youth has been admitted into the program and assigned to a provider agency treatment program, the Probation Officer, Probation Supervisor, Felony Disposition Supervisor and the program Case Manager, along with any other contributing agency/organization member (i.e. mental health professional, chemical dependency counselor, school personnel, etc.) will meet to develop case plan and provide further disposition recommendations to the judiciary. All available assessments (SASSI, OYAS, Screen Pediatric Psychosocial Influences or SPPI, etc.) are reviewed and discussed to help inform these decisions. These assessments have been administered by court staff when the youth is first brought into detention. In many cases, these youth have been previously involved with the court and some or all of these tests may have been administered at that/those time(s). New assessments are administered each time a youth becomes re-involved with the court.

If the youth and family are ordered to participate and cooperate with the behavioral health service provider, a referral will be made to the provider by the probation officer assigned to the case. Once the youth/family has engaged, monthly reviews will be scheduled to gauge progress, service gaps and any non-compliance issues. A Behavioral Health Court Docket (BHCD) was implemented during FY2011 BHJJ programming to bolster judicial oversight and provide structure to the application of incentives and sanctions to both youth and their caregivers.

Once an initial recommendation has been made as to which of the two provider services is more appropriate and ordered by judicial process, The Village Network or Child Guidance and Family Solutions begins delivering services and applying further assessments as needed. One of the key components of the treatments offered by both of these organizations is the flexibility built into both models to ensure that services are delivered in a culturally competent manner and that youth and families referred to them are not rejected or that when difficulties arise, they are not ejected from the program, with the exception of incidents that may cause serious concerns over public safety issues.

Successful treatment completion is determined by the service provider based on number of sessions completed, compliance with court orders, probation and the individual and family case plan as set forth by the program case manager. In order to successfully complete the Village Network's TFCBT, therapists attempt to assure the overall level of functioning has improved and a decrease in risk factors, an increase in school engagement (more days present at school), no additional felony charges, no commitments to DYS, an increase in grade point average, 40 or more successful engagements with the counselor (face to face contacts), and consistent compliance with medication orders. At the end of the program they continue to maintain in the community, and avoid substitute care.

Child Guidance and Family Solutions deems someone as "successful" in the ICT program (as part of the BHJJ grant) on the basis of two overarching factors: 1) Whether the youth attended for the entirety of the program and 2) Whether they remained in the home, i.e., whether we avoided a placement at ODYS.

In addition to the two main criteria, successful ICT completion also includes:

- Improved stability at home.
- Stabilization of mental health symptoms that would warrant less intensive mental health treatment.
- Reduction in use that would warrant less intensive alcohol/drug treatment.
- Improved functioning at school and in the community.
- Connected to other treatment provider(s) or supports at the end of treatment.

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.

SUMMIT COUNTY

DEMOGRAPHICS

Summit County has enrolled 223 youth in the BHJJ program since 2009. Of the 223 youth enrolled, 23.4% (n = 52) were female and 76.6% (n = 170) were male (data were missing for one youth). Since July 2013, 75.3% (n = 64) of new enrollees have been male (see Table 3).

The majority of the overall sample of youth were either African American (62.0%, n = 132) or Caucasian (24.4%, n = 52). The remainder racial composition of the population was classified as “other” (13.6%, n = 52). A similar pattern was found for youth enrolled since July 2013, although a slightly lower proportion of African Americans (61.2%, n = 119) and Caucasians (20.0%, n = 17) was observed. The average age of the youth at intake into BHJJ was 15.76 years old (SD = 1.28) with a range between 10.3 and 18.1 years.

Table 3. Demographic Information for BHJJ Youth in Summit County

	All Youth Enrolled (2009 - 2015)	Youth Enrolled between July 2013 – June 2015
Gender	Female = 23.4% (n = 52) Male = 76.6% (n = 170)	Female = 24.7% (n = 21) Male = 75.3% (n = 64)
Race	African American = 62.0% (n = 132) Caucasian = 24.4% (n = 52) Other = 13.6% (n = 29)	African American = 61.2% (n = 52) Caucasian = 20.0% (n = 17) Other = 18.9% (n = 16)
Age at Intake	15.76 years (SD = 1.28)	15.83 years (SD = 1.18)

CUSTODY ARRANGEMENT AND HOUSEHOLD INFORMATION

At intake, the majority of youth lived with the biological mother (63.3%, n = 131) (see Table 4). At time of enrollment, 87.0% (n = 180) of the BHJJ youth lived with at least one biological parent.

Over 80% of the BHJJ caregivers (84.5%, n = 111) had at least a high school diploma or GED, and 8.5% (n = 17) had a bachelor’s degree or higher (see Table 5). Thirty one caregivers (15.5%) reported that they did not graduate from high school.

Caregivers reported their annual household income. The median household income for BHJJ families was between \$15,000 - \$19,999 (see Table 6). Nearly 90% of caregivers (86.6%, n = 154) reported annual household incomes below \$35,000 and 58.5% (n = 154) reported an annual household income below \$20,000. Over 30% of BHJJ families (31.5%, n = 56) reported an annual household income below \$10,000.

Table 4. Custody Arrangement for BHJJ Youth in Summit County

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	15.5% (n=32)
Biological Mother Only	63.3% (n=131)
Biological Father Only	8.2% (n=17)
Adoptive Parent(s)	1.9% (n=4)
Sibling	0.0% (n=0)
Aunt/Uncle	0.0% (n=0)
Grandparents	8.2% (n=17)
Friend	0.0% (n=0)
Ward of the State	0.0% (n=0)
Other	1.0% (n=2)

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

Number of School Years Completed	Number of Caregivers
Less than High School	15.5% (n=31)
High School Graduate or G.E.D.	40.2% (n=80)
Some College or Associate Degree	35.7% (n=71)
Bachelor's Degree	3.5% (n=7)
More than a Bachelor's Degree	5.0% (n=10)

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

Annual Household Income	BHJJ Families
Less than \$5,000	25.3% (n=45)
\$5,000 - \$9,999	6.2% (n=11)
\$10,000 - \$14,999	16.9% (n=30)
\$15,000 - \$19,999	10.1% (n=18)
\$20,000 - \$24,999	15.7% (n=28)
\$25,000 - \$34,999	12.4% (n=22)
\$35,000 - \$49,999	8.4% (n=15)
\$50,000 - \$74,999	2.8% (n=5)
\$75,000 - \$99,999	1.1% (n=2)
\$100,000 and over	1.1% (n=2)

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 had a history of sexual abuse, running away, and talking about suicide.

Caregivers reported that 14.6% (n = 7) of females and 9.1% (n = 14) of males had a history of being physically abused while 21.7% (n = 10) of females and 2.6% (n = 4) of males had a history of being sexually abused. Caregivers of 40.0% (n = 20) of females and 21.1% (n = 32) of males reported hearing the child talking about committing suicide and 9.8% (n = 5) of females and 8.6% (n = 13) of males had attempted suicide at least once. Over half of the caregivers of females (59.1%, n = 26) and males (52.8%, n = 75) reported a family history of depression.

Table 7. Youth and Family History in Summit County

Question	Females	Males
Has the child ever been physically abused?	14.6% (n=7)	9.1% (n=14)
Has the child ever been sexually abused?	21.7% (n=10) ^{***}	2.6% (n=4)
Has the child ever run away?	69.6% (n=32) [*]	51.0% (n=74)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	54.9% (n=28)	65.6% (n=99)
Has the child ever talked about committing suicide?	40.0% (n=20) ^{**}	21.1% (n=32)
Has the child ever attempted suicide?	9.8% (n=5)	8.6% (n=13)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	46.9% (n=23)	35.7% (n=55)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	59.1% (n=26)	52.8% (n=75)
Has anyone in the child's biological family had a mental illness, other than depression?	51.2% (n=22)	41.8% (n=56)
Has the child ever lived in a household in which someone was convicted of a crime?	38.8% (n=19)	43.0% (n=64)
Has anyone in the child's biological family had a drinking or drug problem?	50.0% (n=22)	53.1% (n=76)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	31.0% (n=13)	28.3% (n=36)

^{*}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 6.0% (n = 3) of females had been pregnant but none were currently expecting a child. Caregivers reported that 9.7% (n = 12) of males had impregnated a female and 8.9% (n = 5) were currently expecting a child. Over 8% of females (8.3%, n = 2) and (12.7%, n = 9) of males currently had children. Of those who had children, none of the females and one of the males (11.1%) 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 Summit County youth

based on the OYAS risk categories by gender and race are presented in Table 8. Ohio Youth Assessment System data were available for 223 youth in Summit County. Chi-square analyses revealed significant group differences in the OYAS categories based on gender ($p = .02$) but not for race. A higher proportion of males (36.0%; $n = 58$) were identified as moderate risk to reoffend than females (15.7%; $n = 8$). While race was not significant, nearly twice the percentage of Nonwhite youth (33.3%; $n = 17$) was identified as high risk compared to White youth (17.6% $n = 9$).

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

	OYAS Low	OYAS Moderate	OYAS High
Female*	51.0% ($n = 26$)	15.7% ($n = 8$)	33.3% ($n = 17$)
Male	35.4% ($n = 57$)	36.0% ($n = 58$)	28.6% ($n = 46$)
White	43.1% ($n = 22$)	39.2% ($n = 20$)	17.6% ($n = 9$)
Nonwhite	37.3% ($n = 57$)	29.4% ($n = 45$)	33.3% ($n = 51$)

* $p < .05$

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 females was Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder (40.4%, $n = 21$) and Conduct Disorder for males (56.1%, $n = 88$; see Table 9).

A total of 619 Axis I diagnoses were identified for 209 youth with diagnostic information (2.96 diagnoses per youth). Females reported 155 Axis I diagnoses (2.98 diagnoses per female) and males reported 464 Axis I diagnoses (2.95 diagnoses per male). Chi-square analysis indicated that a significantly higher proportion of females were diagnosed with Oppositional Defiant Disorder and Mood Disorder while a significantly higher proportion of males were diagnosed with Conduct Disorder. Of the youth who had available diagnostic information, 51.0% ($n = 25$) of females and 52.9% ($n = 81$) of males had a co-occurring substance use and mental health diagnosis.

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

DSM-IV Axis I Diagnosis	Females	Males
Alcohol-related Disorders	11.5% ($n=6$)	10.2% ($n=16$)
Attention Deficit Hyperactivity Disorder	40.4% ($n=21$)	43.9% ($n=69$)
Bipolar Disorder	3.8% ($n=2$)	2.5% ($n=4$)
Cannabis-related Disorders	38.5% ($n=20$)	45.2% ($n=71$)
Conduct Disorder	25.0% ($n=13$)	56.1% ($n=88$)***
Depressive Disorders	9.6% ($n=5$)	5.1% ($n=8$)
Mood Disorder	32.7% ($n=17$)*	19.1% ($n=30$)
Oppositional Defiant Disorder	40.4% ($n=21$)*	25.5% ($n=40$)
Post-traumatic Stress Disorder	15.4% ($n=8$)	10.2% ($n=16$)

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

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, 70.1% (n = 143) were either suspended or expelled from school. While in treatment with BHJJ, 51.5% (n = 87) 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, 77.3% (n = 140) of youth were currently attending school excluding those on summer break. At termination, 77.5% (n = 124) 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 Summit County from intake to termination based on completion status. At termination, 37.8% (n = 40) of successful completers received mostly A's, B's, and C's while 22.0% (n = 11) of unsuccessful completers received mostly A's, B's, and C's.

At termination, workers reported that 39.0% (n = 67) of youth were attending school more than before starting treatment and 51.7% (n = 89) of youth were attending school 'about the same' amount compared to before starting treatment. Workers reported 7.6% (n = 13) of youth were attending school less often than before treatment in BHJJ.

Table 10. Academic Performance in Summit County

Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	7.2% (n=14)	9.3% (n=15)
Mostly B's and C's	20.1% (n=39)	22.8% (n=37)
Mostly C's and D's	28.9% (n=56)	29.6% (n=48)
Mostly D's and F's	43.8% (n=85)	38.3% (n=62)

Table 11. Academic Performance in Summit 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	6.5% (n=3)	8.0% (n=4)	7.7% (n=8)	10.4% (n=11)
Mostly B's and C's	28.3% (n=13)	14.0% (n=7)	19.2% (n=20)	27.4% (n=29)
Mostly C's and D's	23.9% (n=11)	24.0% (n=12)	30.8% (n=32)	32.1% (n=34)
Mostly D's and F's	41.3% (n=19)	54.0% (n=27)	42.3% (n=44)	30.2% (n=32)

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

Figure 1. Problem Severity Scores across Time - Summit County

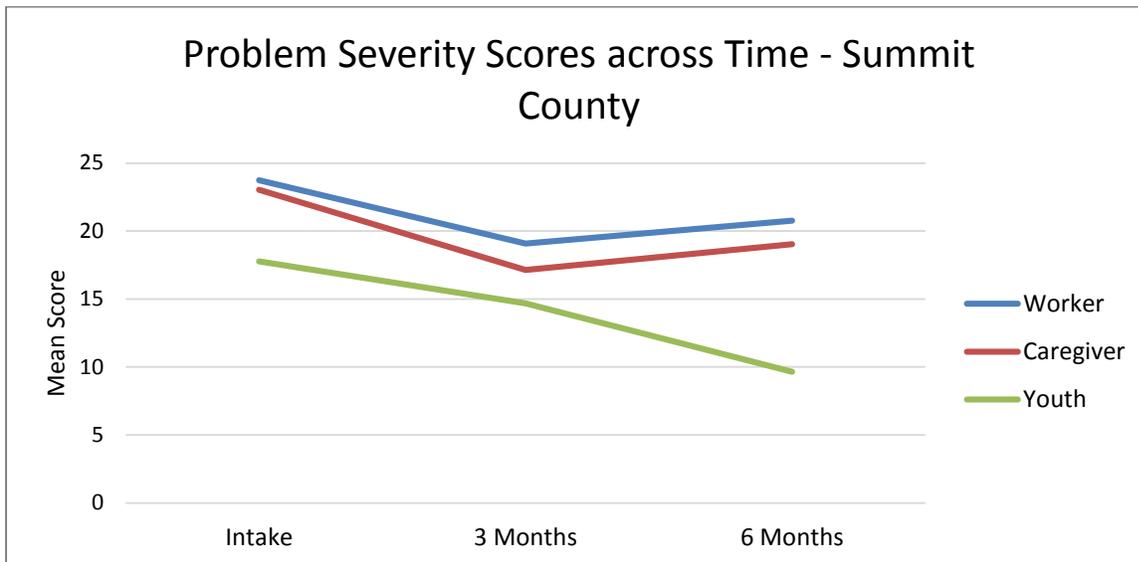
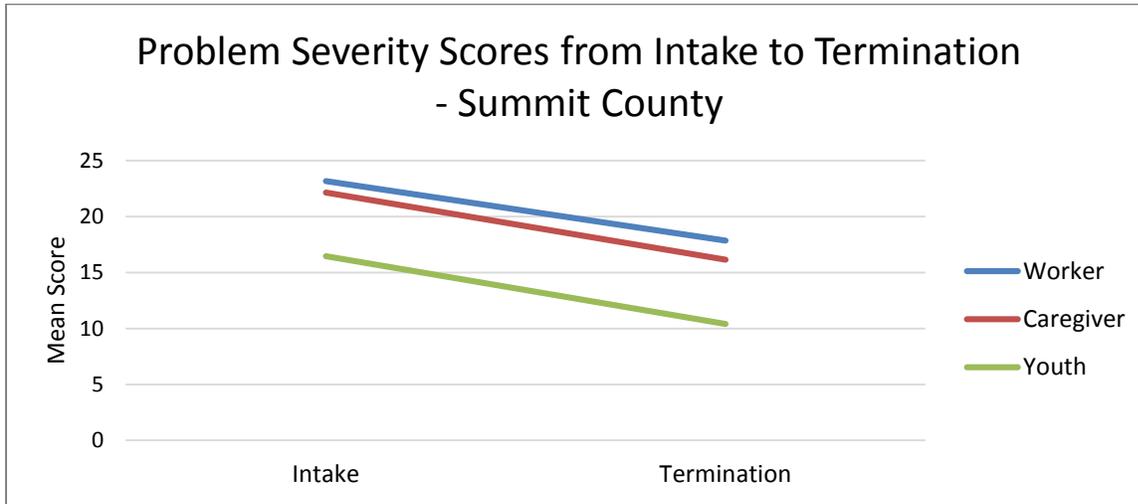


Figure 2. Problem Severity Scores from Intake to Termination - Summit County



*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 three months and termination (see Table 12) compared to intake. Significant improvements were noted at three months $t(320) = 11.28$, $p < .001$ and at termination: $t(487) = 16.10$, $p < .001$. Small effect sizes were found for each of these measurement intervals.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	22.47 (SD=17.34; n=87)	17.16 (SD=14.24; n=87)	3.42**	.33
Intake to Six Months	21.92 (SD=19.17; n=12)	19.04 (SD=12.89; n=12)	0.70	.17
Intake to Termination	22.15 (SD=16.58; n=103)	16.15 (SD=14.64; n=103)	3.71***	.38

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

WORKER RATING

For workers, paired samples t-tests indicated significant improvement in Problem Severity at three months and termination (see Table 13) compared to intake. Significant improvements were noted at three months $t(134) = 3.82$, $p < .001$ and at termination: $t(150) = 5.43$, $p < .001$. Small effect sizes were observed for each time period.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	22.73 (SD=12.06; n=135)	19.02 (SD=9.47; n=135)	3.82***	.34
Intake to Six Months	25.67 (SD=12.79; n=21)	21.00 (SD=10.99; n=21)	1.45	.39
Intake to Termination	23.18 (SD=12.51; n=150)	17.87 (SD=9.78; n=150)	5.43***	.47

*** $p < .001$

YOUTH RATING

Scores on the Problem Severity scale as reported by youth showed significant improvement for six months and termination (see Table 14) compared to intake. Significant improvements were noted at six months: $t(18) = 1.41, p < .01$; and at termination: $t(140) = 5.54, p < .001$. A small effect size was observed for the intervals between intake and three months. Moderate effect sizes were observed for the intervals between intake to six months and intake to termination.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	16.08 (SD=12.74; n=131)	14.56 (SD=12.20; n=131)	1.41	.12
Intake to Six Months	17.11 (SD=13.07; n=19)	9.79 (SD=8.93; n=19)	3.53**	.65
Intake to Termination	16.47 (SD=14.36; n=141)	10.42 (SD=9.19; n=141)	5.54***	.50

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

FUNCTIONING

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

Figure 3. Functioning Scores across Time - Summit County

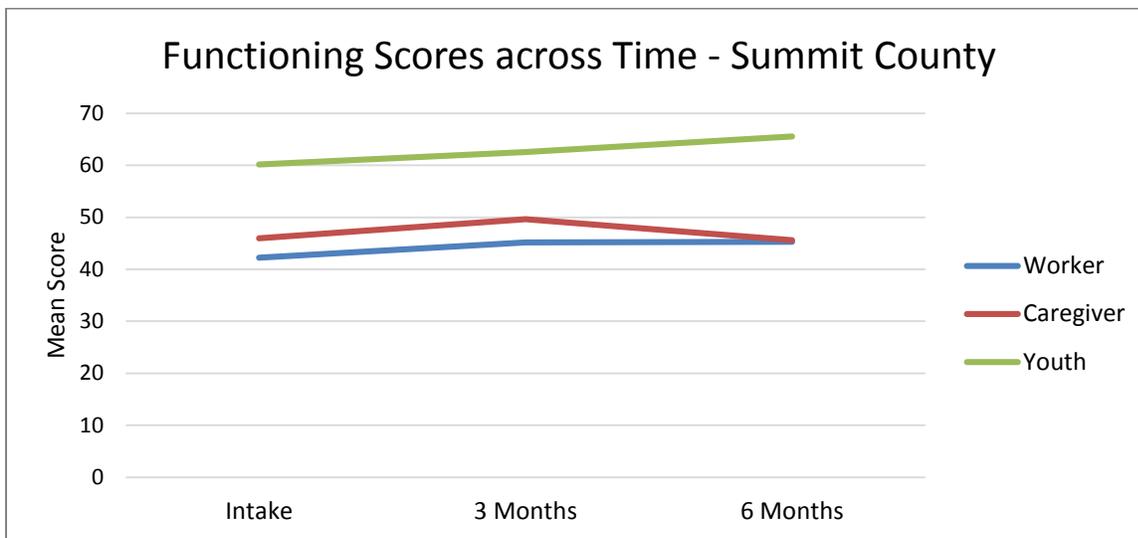
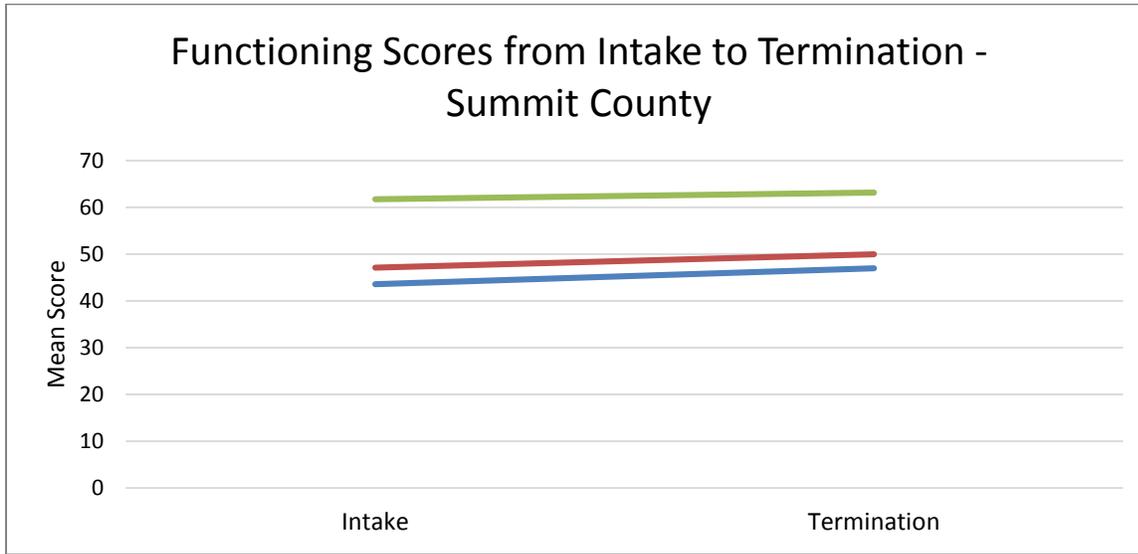


Figure 4. Functioning Scores from Intake to Termination - Summit County



CAREGIVER RATING

Paired samples t-tests revealed significant improvements in Functioning at the three month interval (see Table 15) compared to intake. Significant improvements were noted at three months: $t(87) = -2.53, p < .05$. Small effect sizes were noted for each time interval.

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

	Mean Time 1	Mean Time 2	t	d
Intake to Three Months	45.81 (SD=17.74; n=88)	50.07 (SD=16.86; n=88)	-2.53*	.25
Intake to Six Months	43.85 (SD=21.29; n=13)	45.62 (SD=18.44; n=13)	-0.29	.09
Intake to Termination	47.14 (SD=17.18; n=105)	49.98 (SD=19.38; n=105)	-1.54	.16

*p < .05

WORKER RATING

For workers, paired samples t-tests indicated significant improvement in the Functioning scale for 3 months and termination compared to intake (see Table 16). Significant improvements were noted at three months: $t(134) = -2.13, p < .05$; and termination: $t(150) = -3.52, p < .01$. Small effect sizes were noted for each measurement interval.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	43.36 (SD=11.83; n=135)	45.36 (SD=11.25; n=135)	-2.13*	.17
Intake to Six Months	43.52 (SD=10.12; n=21)	45.24 (SD=9.76; n=21)	-0.63	.17
Intake to Termination	43.63 (SD=12.12; n=151)	46.99 (SD=12.74; n=151)	-3.52**	.27

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

YOUTH RATING

While scores improved, youth-rated Functioning differences did not reach statistical significance (see Table 17). Small effect sizes were noted for each of the measurement intervals.

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

	Mean Time 1	Mean Time 2	<i>t</i>	<i>d</i>
Intake to Three Months	60.52 (SD=11.69; n=130)	62.68 (SD=11.50; n=130)	-1.90	.18
Intake to Six Months	62.11 (SD=12.62; n=19)	65.89 (SD=9.84; n=19)	-1.11	.33
Intake to Termination	61.79 (SD=11.86; n=141)	63.21 (SD=15.97; n=141)	-1.04	.11

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

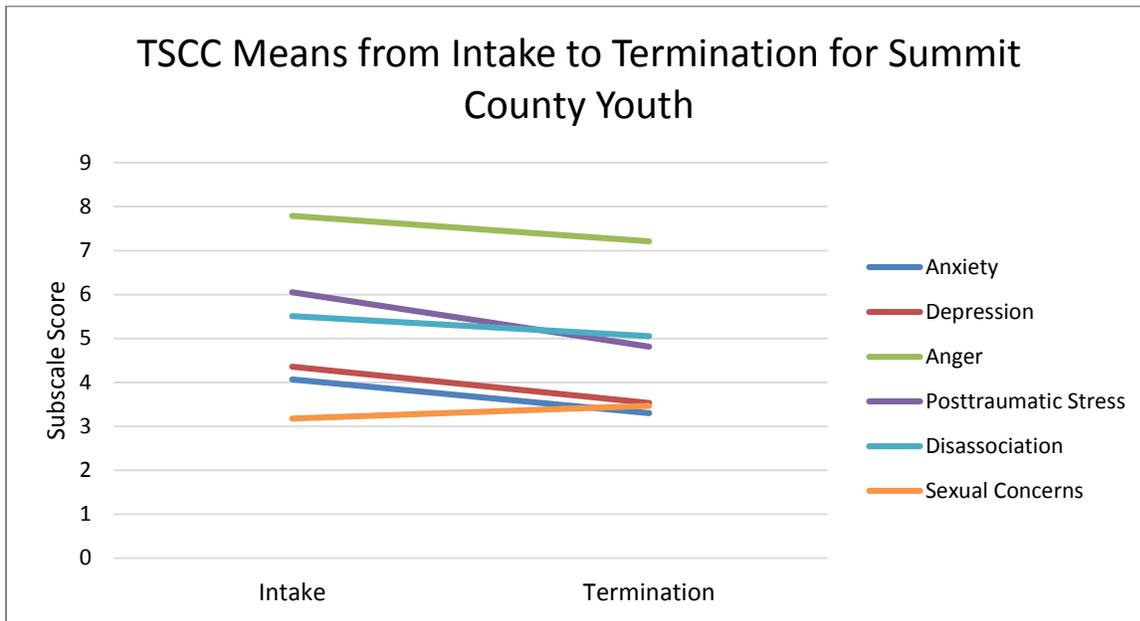
Paired samples t-tests were conducted on the six subscales for Summit County BHJJ youth who have subscale scores both at intake and at termination. Data were available for youth aged 8-17 who had completed the TSCC at both intake and termination, and youth who were not identified as either underresponders or hyperresponders. Statistically significant improvements were noted for Anxiety and Posttraumatic Stress: Anxiety ($t(72) = 2.03, p < .05$) and Posttraumatic Stress ($t(72) = 2.19, p < .05$). 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 Summit County Youth

	Intake	Termination	t	d
Anxiety	4.07 (SD=4.08; n=73)	3.30 (SD=3.16; n=73)	2.03*	.21
Depression	4.36 (SD=3.96; n=73)	3.53 (SD=3.07; n=73)	1.91	.23
Anger	7.79 (SD=5.49; n=72)	7.21 (SD=5.02; n=72)	1.08	.11
PTS	6.05 (SD=5.26; n=73)	4.81 (SD=4.22; n=73)	2.19*	.26
Dissociation	5.51 (SD=4.41; n=73)	5.06 (SD=4.34; n=73)	1.07	.10
Sexual Concerns	3.18 (SD=3.27; n=73)	3.47 (SD=3.64; n=73)	-0.75	.08

* $p < .05$

Figure 5. TSCC Means from Intake to Termination for Summit 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 did not reveal any significant differences between males and females for lifetime substance use.

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

	Males		Females	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	80.0% (n = 128)	13.71 (SD = 5.97)	76.5% (n = 39)	13.46 (SD = 1.54)
Cigarettes	56.6% (n = 90)	12.73 (SD = 2.37)	60.8% (n = 31)	12.94 (SD = 2.37)
Chewing Tobacco	9.9% (n = 16)	13.31 (SD = 2.02)	2.0% (n = 1)	16.00
Marijuana	87.5% (n = 140)	12.62 (SD = 2.10)	78.0% (n = 39)	12.97 (SD = 2.05)
Cocaine	3.7% (n = 6)	14.17 (SD = 1.47)	9.8% (n = 5)	15.00 (SD = 1.23)
Pain Killers (use inconsistent with prescription)	13.7% (n = 22)	14.00 (SD = 1.08)	18.0% (n = 9)	14.11 (SD = 1.54)
GHB	0.6% (n = 1)	14.00 ^a	0.0% (n = 0)	N/A
Inhalants	3.1% (n = 5)	13.60 (SD = 1.34)	0.0% (n = 0)	N/A
Heroin	0.6% (n = 1)	14.00	0.0% (n = 0)	N/A
Amphetamines	1.9% (n = 3)	14.33 (SD = 1.53)	2.0% (n = 1)	14.00
Ritalin (use inconsistent with prescription)	5.0% (n = 8)	14.14 (SD = 1.57)	10.0% (n = 5)	15.00 (SD = 1.41)
Barbiturates	4.3% (n = 7)	14.29 (SD = 1.11)	6.0% (n = 3)	14.33 (SD = 0.58)
Non-prescription Drugs	16.6% (n = 26)	14.37 (SD = 1.28)	12.0% (n = 6)	14.83 (SD = 1.17)
Hallucinogens	5.0% (n = 8)	14.25 (SD = 1.39)	2.0% (n = 1)	16.00
PCP	1.2% (n = 2)	14.50 (SD = 0.71)	0.0% (n = 0)	N/A
Ketamine	0.6% (n = 1)	14.00	0.0% (n = 0)	N/A
Ecstasy	11.8% (n = 19)	14.06 (SD = 0.90)	10.0% (n = 5)	14.20 (SD = 1.30)
Tranquilizers	11.9% (n = 19)	14.22 (SD = 1.35)	14.0% (n = 7)	14.14 (SD = 1.35)

^a 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. Previous six month marijuana use decreased from intake to termination for males, while use for all three substances decreased for females. Six month marijuana use among males decreased from 63.0% (n = 87) at intake to 61.1% (n = 55) at termination. Six month marijuana use among females decreased from 64.1% (n = 2%) at intake to

50.0% (n = 10) at termination. Because the average length of stay for youth in the BHJJ program in Summit County is less than six month, the time period measured at intake and termination may overlap. Substance use measures that examine use in the past 30 days may be a more accurate account of the substance use patterns for Summit County youth.

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

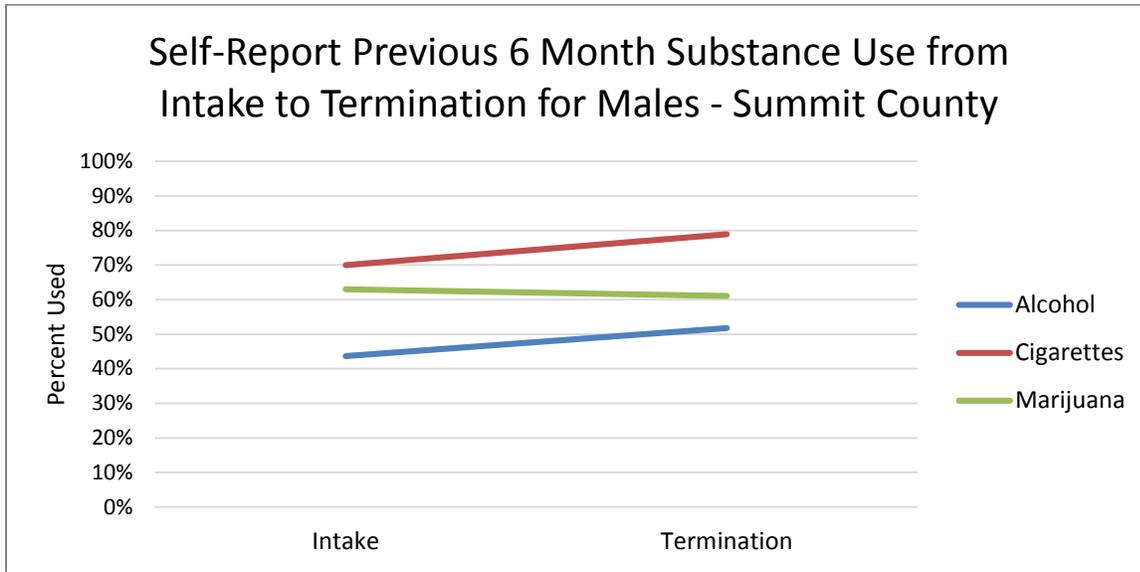
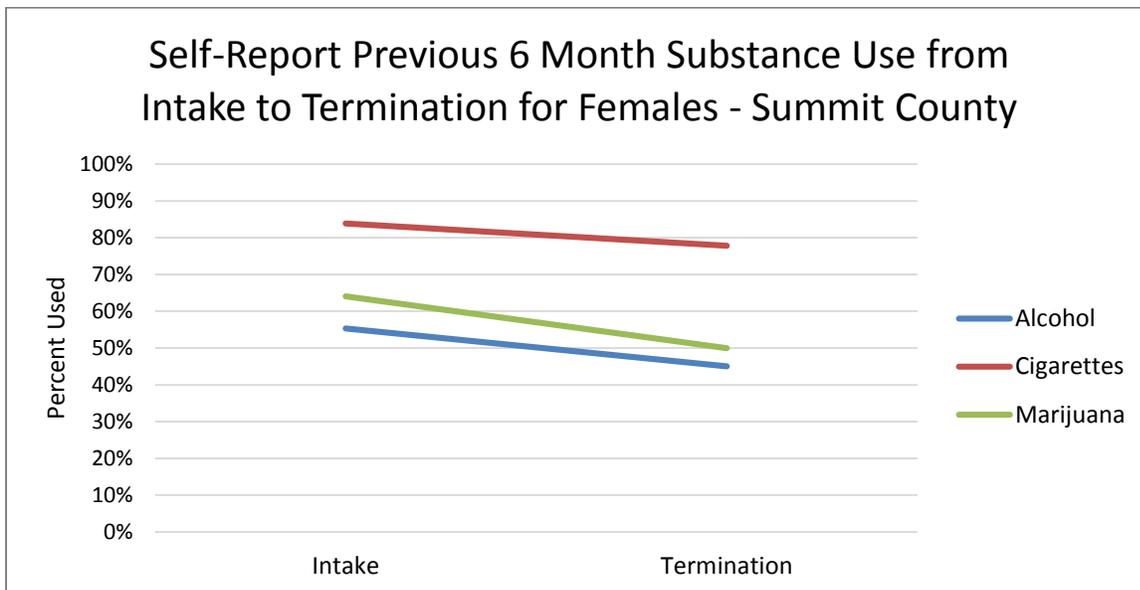


Figure 7. Self-Report Previous 6 Month Substance Use from Intake to Termination for Females – Summit County



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 females. Male-reported 30 day alcohol use decreased from 1.29 days (SD = 2.39; n = 42) at intake to 0.65 days of alcohol use (SD = 1.36; n = 37) at termination. Female-reported 30 day alcohol use decreased from 2.00 days (SD = 2.45; n = 14) at intake to 0.73 days (n = 156) at termination. Male-reported 30 day marijuana use decreased from 7.91 days (SD = 13.59; n = 65) at intake to 2.86 days (SD = 6.50; n = 47) at termination. Female-reported 30 day marijuana use decreased from 3.18 days (SD = 5.31; n = 17) intake to 2.00 days (SD = 5.72; n = 12) at termination.

Figure 8. Average Previous 30 Day Substance Use for Males from Intake to Termination – Summit County

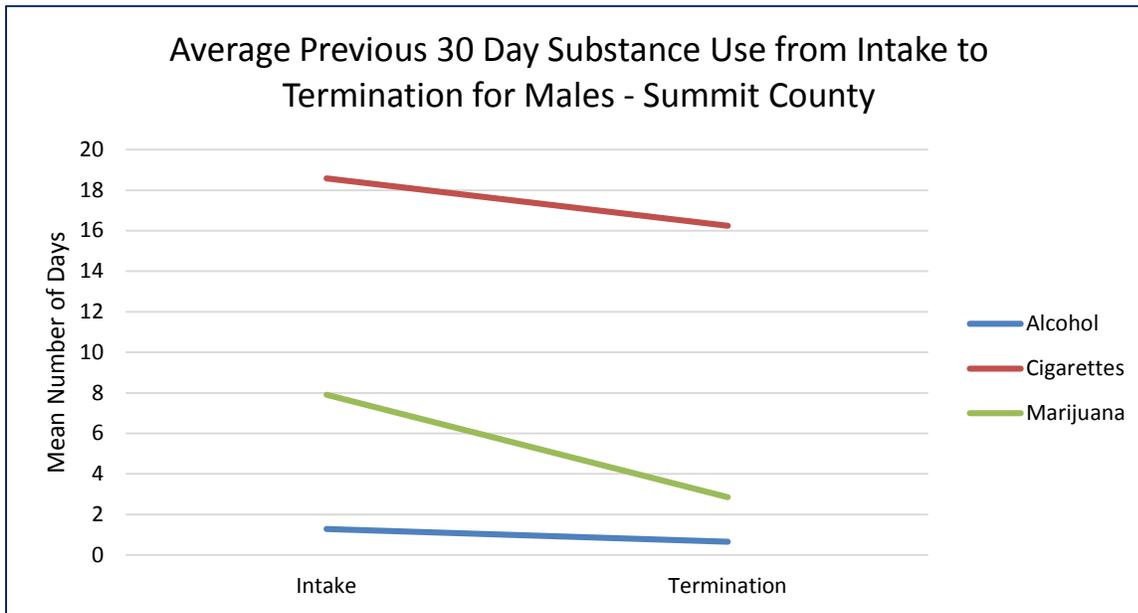
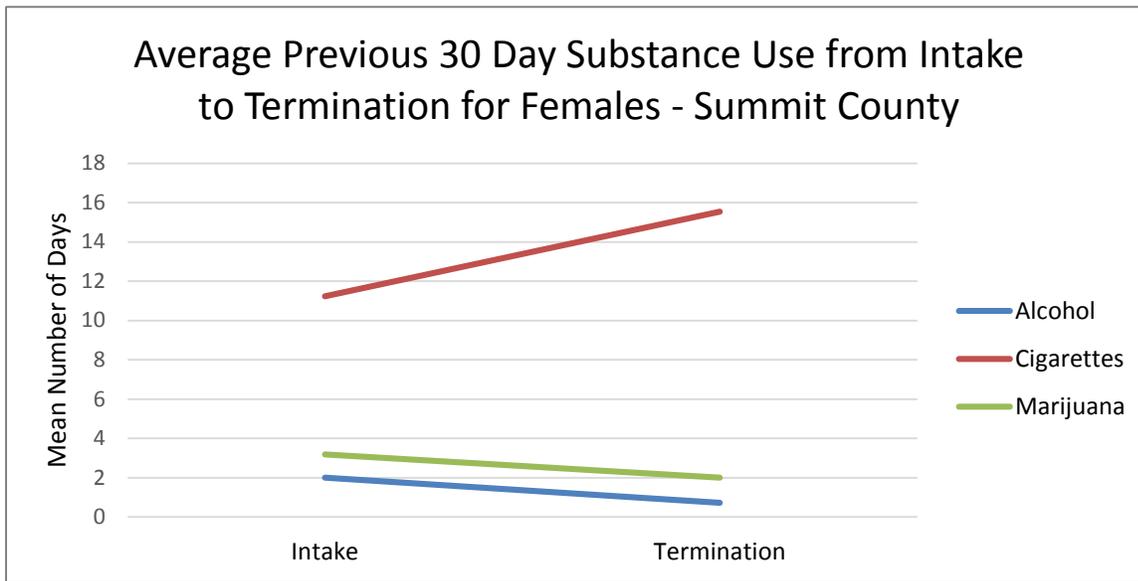


Figure 9. Self-Report Previous 30 Day Substance Use for Females – Summit County



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 50.5% (n = 98) of caregivers and 31.6% (n = 66) of workers reported no problems with drugs or alcohol in the past 30 days while 67.5% (n = 79) of caregivers and 56.7% (n = 89) of workers reported no problems at termination. Similarly, 56.3% (n = 117) of youth reported no problems in the past 30 days with drugs or alcohol at intake while 73.2% (n = 109) of youth reported no problems at termination.

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

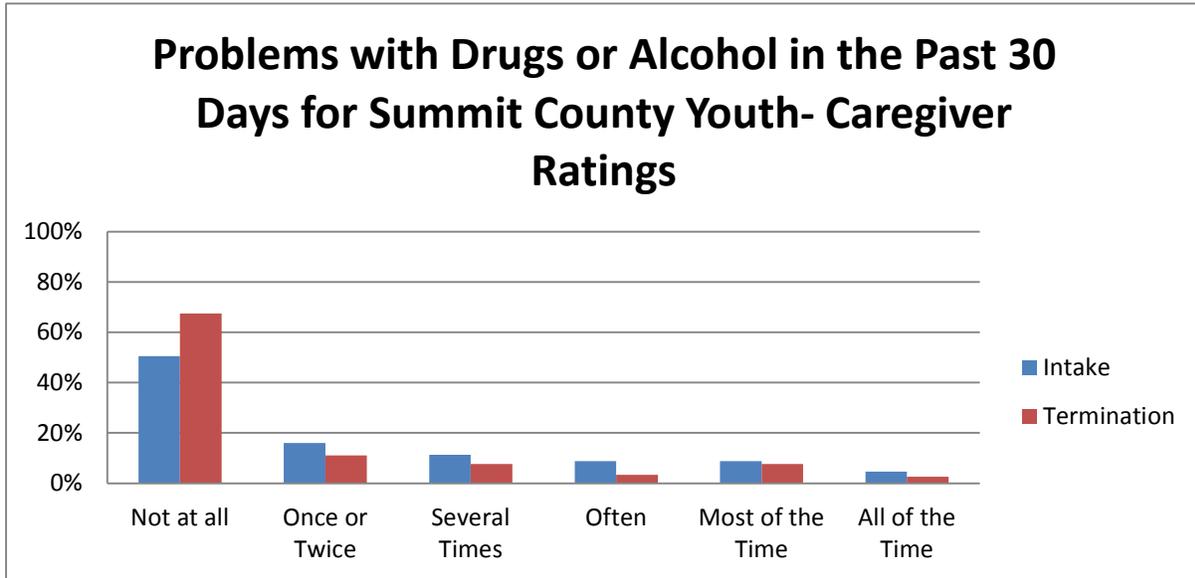


Figure 11. Problems with Drugs or Alcohol in the Past 30 Days for Summit County Youth - Worker Ratings

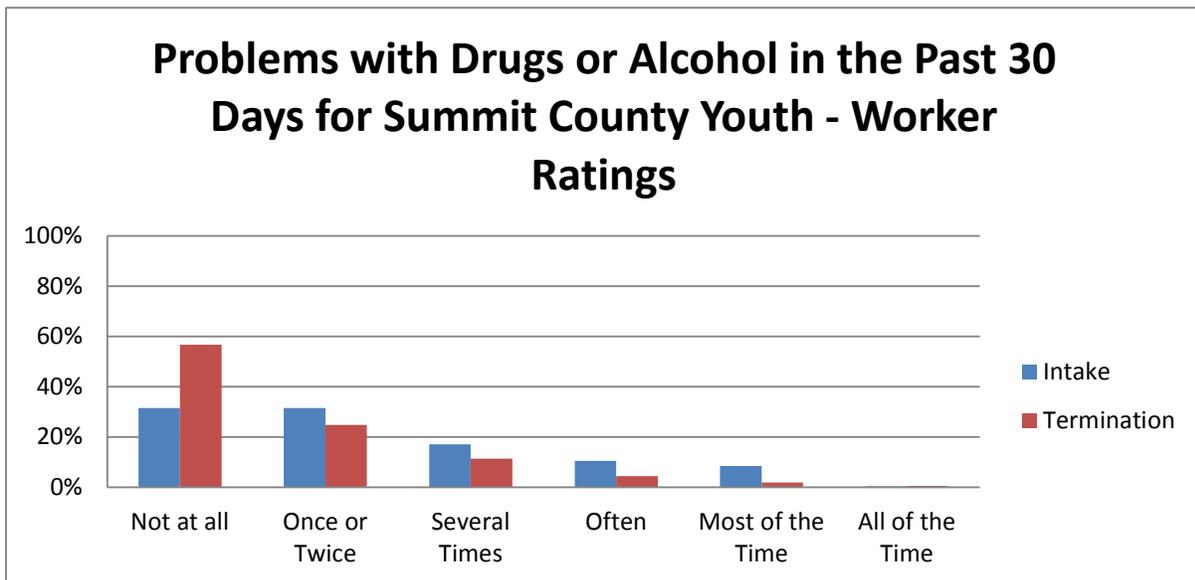
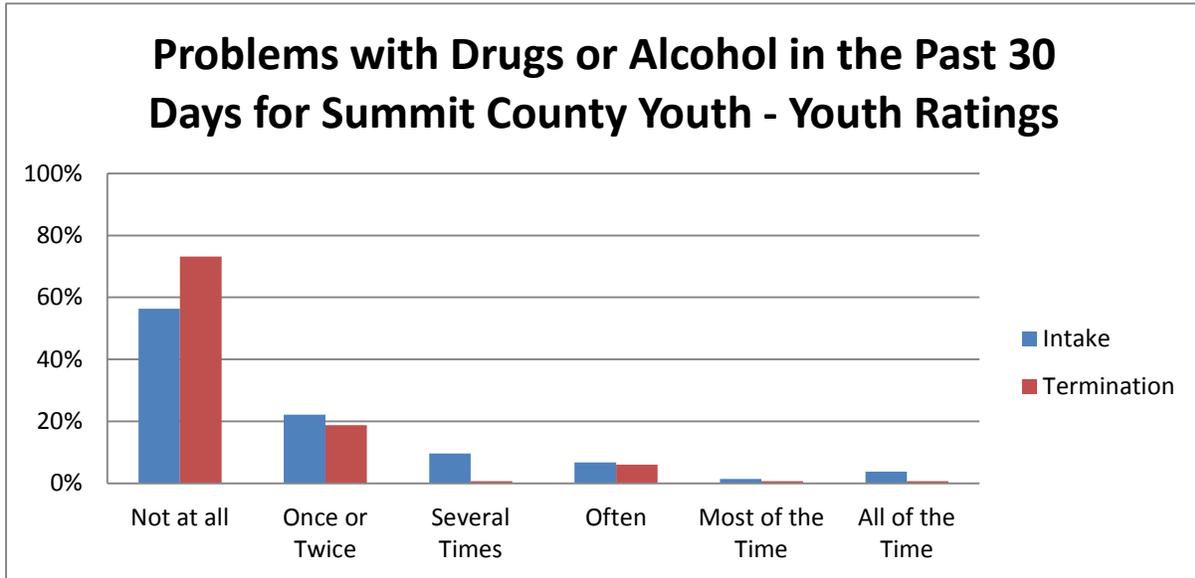


Figure 12. Problems with Drugs or Alcohol in the Past 30 Days for Summit County Youth - Youth Ratings



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 174 youth terminated from the BHJJ program in Summit County. **Over 67% (67.2%, n = 117) of the youth terminated from the BHJJ program were identified as successful treatment completers.** In Summit County 2.9% (n = 5) were withdrawn from the program and 8.6% (n = 15) 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, 69.5% (n = 41) of youth terminated successfully from the BHJJ program in Summit County.

Table 20. Reasons for Termination from BHJJ – Summit County

Termination Reason	All Youth	Youth Enrolled from July 2013 to June 2015
Successfully Completed Services	67.2% (n = 117)	69.5% (n = 41)
Client Did Not Return/Rejected Services	2.3% (n = 4)	3.4% (n = 2)
Out of Home Placement	8.6% (n = 15)	6.8% (n = 4)
Client/Family Moved	0.6% (n = 1)	1.7% (n = 1)
Client Withdrawn	2.9% (n = 5)	0.0% (n = 0)
Client AWOL	3.4% (n = 6)	6.8% (n = 4)
Client Incarcerated	6.9% (n = 12)	6.8% (n = 4)
Other	8.0% (n = 14)	5.1% (n = 3)

AVERAGE LENGTH OF STAY

The average length of stay for youth in the Summit County BHJJ program was 171 days. For youth identified as completing treatment successfully, the average length of stay was 191 days and for youth identified as unsuccessful treatment completers, the average length of stay was 133 days. For youth enrolled since July 1, 2013, the average length of stay in BHJJ was 167 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, 70.5% of the youth (n = 122) in Summit County were at risk for out of home placement. At termination, 46.5% (n = 80) of youth were at risk for out of home placement. Of those youth who successfully completed BHJJ treatment, 33.9% (n =

39) were at risk for out of home placement at termination while 71.2% (n = 37) 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 73.1% (n = 128) of the youth and had stayed the same for 22.3% (n = 39) of the youth. Police contacts increased for 3.4% (n = 6) of the youth and the worker was unable to estimate for 1.1% (n = 2).

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, 90% (n = 45) of caregivers either strongly agreed or agreed that they were satisfied with the services their child received and 80% (n = 40) either strongly agreed or agreed that the services their child and/or family received were right for them. A strong majority (94%, n = 47) of caregivers either strongly agreed or agreed that staff treated them with respect and 91.9% (n = 45) strongly agreed or agreed that they were satisfied with the cultural and ethnic sensitivity of BHJJ staff.

Table 21. Satisfaction with Services – Summit County

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Overall I am satisfied with the services my child received	52.0%	38.0%	8.0%	0.0%	2.0%
The services my child and/or family received were right for us	42.0%	38.0%	14.0%	4.0%	2.0%
Staff treated me with respect	68.0%	26.0%	4.0%	0.0%	2.0%
Staff were sensitive to my cultural/ethnic background	53.1%	38.8%	6.1%	0.0%	2.0%

RECIDIVISM

METHODOLOGY

Court data were provided by the Summit 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, 88.2% (n = 187) of the BHJJ youth had a misdemeanor charge, 93.9% (n = 199) had a felony charge, and 98.6% (n = 209) 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, 83.3% (n = 95) of successful completers and 98.1% (n = 53) of unsuccessful completers were charged with a misdemeanor.

Table 22. Charges Prior to BHJJ Enrollment – Summit County

	Overall			Successful			Unsuccessful		
	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent
3 months	43.4% (n = 92)	77.8% (n = 165)	83.5% (n = 177)	43.0% (n = 49)	74.6% (n = 85)	80.7% (n = 92)	44.4% (n = 24)	83.3% (n = 45)	87.0% (n = 47)
6 months	75.5% (n = 160)	92.5% (n = 196)	97.2% (n = 206)	70.2% (n = 80)	92.1% (n = 105)	97.4% (n = 111)	83.3% (n = 45)	94.4% (n = 51)	98.1% (n = 53)
12 months	88.2% (n = 187)	93.9% (n = 199)	98.6% (n = 209)	83.3% (n = 95)	94.7% (n = 108)	99.1% (n = 113)	98.1% (n = 53)	94.4% (n = 51)	100.0% (n = 54)
18 months	90.1% (n = 191)	94.8% (n = 201)	99.1% (n = 210)	86.0% (n = 98)	96.5% (n = 110)	99.1% (n = 113)	98.1% (n = 53)	94.4% (n = 51)	100.0% (n = 54)

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, 63.4% (n = 85) of youth were charged with at least one new misdemeanor and 39.6% (n = 53) were charged with at least one new felony. Sixty five percent (64.9%, n = 87) 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 59.5% (n = 44) of successful completers were charged with at least one new misdemeanor, 35.1% (n = 26) were charged with at least one new felony, and 58.1% (n = 43) were adjudicated delinquent. Of the youth who completed unsuccessfully, 67.6% (n = 25) were charged with at least one new misdemeanor, 45.9% (n = 17) were charged with at least one new felony, and 78.4% (n = 29) were adjudicated delinquent in the 12 months after their enrollment in BHJJ.

Table 23. Charge after BHJJ Enrollment – Summit County

	Overall			Successful			Unsuccessful		
	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent
3 months	34.6% (n = 65)	16.0% (n = 30)	37.8% (n = 71)	26.9% (n = 28)	11.5% (n = 12)	30.8% (n = 32)	46.9% (n = 23)	22.4% (n = 11)	53.1% (n = 26)
6 months	51.1% (n = 90)	25.0% (n = 44)	53.4% (n = 94)	42.4% (n = 42)	18.2% (n = 18)	45.5% (n = 45)	66.0% (n = 31)	38.3% (n = 18)	72.3% (n = 34)
12 months	63.4% (n = 85)	39.6% (n = 53)	64.9% (n = 87)	59.5% (n = 44)	35.1% (n = 26)	58.1% (n = 43)	67.6% (n = 25)	45.9% (n = 17)	78.4% (n = 29)
18 months	76.0% (n = 76)	48.0% (n = 47)	77.6% (n = 76)	77.4% (n = 41)	41.5% (n = 22)	75.5% (n = 40)	73.3% (n = 22)	57.1% (n = 16)	82.1% (n = 23)

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, 57.5% (n = 50) of youth were charged with at least one new misdemeanor, 34.5% (n = 30) were charged with at least one new felony, and 57.5% (n = 50) were adjudicated delinquent (see Table 24).

In the 12 months following their termination from BHJJ, 63.5% (n = 33) of successful completers were charged with at least one new misdemeanor, 36.5% (n = 19) were charged with at least one new felony, and 61.5% (n = 32) were adjudicated delinquent. Of the youth who completed unsuccessfully, 47.1% (n = 16) were charged with at least one new misdemeanor, 29.4% (n = 10) were charged with at least one new felony, and 50.0% (n = 17) were adjudicated delinquent in the 12 months after their termination from BHJJ.

Table 24. Charges after BHJJ Termination – Summit County

	Overall			Successful			Unsuccessful		
	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent	Misdemeanors	Felonies	Adjudicated Delinquent
3 months	22.0% (n = 28)	11.0% (n = 14)	21.3% (n = 27)	23.2% (n = 19)	11.0% (n = 9)	22.0% (n = 18)	20.5% (n = 9)	11.4% (n = 5)	20.5% (n = 9)
6 months	36.0% (n = 41)	20.2% (n = 23)	33.3% (n = 38)	38.4% (n = 28)	23.3% (n = 17)	32.9% (n = 24)	32.5% (n = 13)	15.0% (n = 6)	35.0% (n = 14)
12 months	57.5% (n = 50)	34.5% (n = 30)	57.5% (n = 50)	63.5% (n = 33)	36.5% (n = 19)	61.5% (n = 32)	47.1% (n = 16)	29.4% (n = 10)	50.0% (n = 17)
18 months	76.9% (n = 50)	50.8% (n = 33)	73.8% (n = 48)	73.8% (n = 31)	47.6% (n = 20)	71.4% (n = 30)	81.8% (n = 18)	54.5% (n = 12)	77.3% (n = 17)

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 107 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 107 youth, 52.3% (n = 56) were charged with a new felony in the 12 months after their termination from BHJJ.

Twenty-six of the 212 BHJJ youth (12.3%) from Summit County for whom we had recidivism data were committed to an ODYS facility at any time following their enrollment.

SUCCESS STORY

B is a 16 year old African American female. Despite her family's extensive criminal history, this is her first time being involved with the juvenile justice system. She admitted to experimenting with drugs/alcohol with her friends days before her offense (Robbery), as well as the day of the incident that brought her to us. She later reported that the trauma and consequences of the charge forced her to stop use and be ready to give a clean test each time she was tested by probation to keep from receiving a probation violation. She was used to seeing her mother and father use drugs and alcohol as both had been to jail for drug-related incidents. Through services provided by the Village Network, B was able to process what she had seen her parents do and how it related to her starting a pattern of social drug use. Her treatment plan put together by Village Network helped her focus on making better choices, reducing illegal activity, and managing anger, as she suffered from Adjustment Disorder with Anxiety, and some anger issues.

She tends to feel that she was in the wrong place at the wrong time but instead of trying to avoid taking responsibility and refusing to engage in BHJJ programming, she chose to use this as a learning experience. Weekly sessions with Village Network gave her the regular support needed to help her make better choices and not lose focus with her treatment plan goals.

As B's case manager this has been the way I have seen her deal with most negative situations. She is the kind of client BHJJ was made for because she embraces positive change and redirection. During her time in the program she has made sure she understood her responsibilities to the court and moved forward without mistakes to reach her individual plan objectives. The program promotes the ability to discuss issues that may be important to changing behavior. B is able to take what she has learned from therapy and positive pro-social activities and use it in her daily life. She is happy to dig deeper within herself and practice newly learned skills, be a leader and recreate situations that need to be adjusted for better outcome.

B wants to be a doctor one day so she takes full advantage of the tutoring that Sylvan Learning Centers provides through BHJJ funding. After a long school day she makes herself available to be picked up for two hours of tutoring all in an effort to become better at math and reading. The tutors have explained to her that these skills have to be well tuned in order for her to become a good doctor so she works diligently to complete what is required time after time. B was a good student when she came to us, but engagement with Sylvan Learning Center taught her how to be even better and plan for the future. She has been able to improve her study habits, complete her work more efficiently and not become angry or frustrated with difficult tasks. She was also able to attend a college visit which helped her learn to plan for college. She has brought her GPA up to a solid B average and is now starting to contact colleges for program information on her own. She now knows that going to college is not only a reality, but becoming a doctor can be as well. Since B has been in the program one of the things I am most impressed about is that she has learned how to care about her community. She has taken all of the lessons she has learned from the services and turned them into lifestyle changes that she knows makes her a better person.

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