

An Evaluation of the Behavioral Health/Juvenile Justice (BHJJ) Initiative: 2006-2015 Results from a Ten-Year Outcome Evaluation

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RESULTS FROM A TEN-YEAR OUTCOME EVALUATION

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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 designed to provide these youth evidence and community-based behavioral health treatment in lieu of detention. Twelve counties participated in BHJJ during the most recent biennium: Cuyahoga, Franklin, Hamilton, Holmes, Lorain, Lucas, Mahoning, Montgomery, Summit, Trumbull, Wayne, and Wood. BHJJ was funded through a partnership between the Ohio Department of Youth Services (ODYS) and Ohio Mental Health and Addiction Services (OhioMHAS). The Begun Center for Violence Prevention Research and Education at Case Western Reserve University provided evaluation services for the program.

Demographics and Youth Characteristics

- ❖ 3,495 youth have been enrolled in BHJJ (61.4% males, 51.9% non-white). In the past two years, more non-whites (58.6%) than whites (41.4%) and males (66.5%) than females (33.5%) have been enrolled.
- ❖ Youth averaged 2.3 Axis I diagnoses. Females were significantly more likely to be diagnosed with Depressive Disorders, Alcohol-related Disorders, Bipolar Disorder, and Post-traumatic Stress Disorder (PTSD), Mood Disorder and Adjustment Disorders. Males were significantly more likely to be diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), Cannabis-Related Disorders, and Conduct Disorder.
- ❖ Over 43% of males and 38% of females were diagnosed with both a mental health and substance use diagnosis.
- ❖ Caregivers reported that 27% of the females had a history of sexual abuse, nearly 50% talked about suicide, and over 23% had attempted suicide. Over 60% of males and 68% of females had family members who were diagnosed with or showed signs of depression.
- ❖ According to the OYAS, 77.2% of the BHJJ youth were moderate or high risk to reoffend.
- ❖ In the current BHJJ counties, 35.4% of youth had felony charges in the 12 months prior to enrollment, ranging from 11.1% in Holmes and Trumbull Counties to 93.9% in Summit County.

Educational Information

- ❖ About 68% of the youth were suspended or expelled from school in the year prior to their BHJJ enrollment. During treatment, 36% were suspended or expelled. At intake, 38.2% of youth earned mostly A's, B's, or C's while at termination, almost 50% of youth earned mostly A's, B's, or C's. At termination, 83.5% of youth were attending school.
- ❖ At termination, workers reported that 89.2% 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 substance use with respect to most of the commonly used substances, including alcohol and marijuana.
- ❖ Youth demonstrated more than a 50% reduction in the risk for out of home placement at the time of termination. Eight percent of successful completers and 55.4% of unsuccessful completers were at risk for out of home placement at termination.
- ❖ Ninety-three percent of caregivers agreed that they were satisfied with the BHJJ services their child received and 96% agreed that the services received were culturally and ethnically sensitive.

Termination and Recidivism Information

- ❖ Nearly 66% percent of the youth terminated from the BHJJ program completed treatment successfully. Nearly 64% of youth enrolled in the past biennium were identified as successful treatment completers. The average length of stay in the program was approximately 7 months (5.6 months for youth enrolled during previous biennium).
- ❖ Successful treatment completion in BHJJ produced lower percentages of subsequent juvenile court charges, felonies, misdemeanors, and delinquent adjudications than unsuccessful completion, although both groups demonstrated decreased juvenile court involvement after termination from BHJJ compared to before enrollment.
- ❖ One year after termination, 16.2% of successful treatment completers and 22.1% of unsuccessful treatment completers had a new felony charge. Of the youth entering BHJJ with a felony charge, 27.2% of successful treatment completers and 34.2% of unsuccessful treatment completers were charged with a new felony in the 12 months following BHJJ termination.
- ❖ One hundred and eight of the 2,906 youth (3.7%) enrolled in BHJJ for whom we had recidivism data were sent to an ODYS facility at any time following their enrollment in BHJJ.
- ❖ Using only the direct State contribution to BHJJ of \$17.6 million since 2006, the average cost per youth enrolled in BHJJ was \$5,035. The FY15 per diem to house a youth at an ODYS institution was \$541 and the average length of stay was 12.6 months. Based on these numbers, the estimated cost of housing the average youth at an ODYS facility in FY15 was approximately \$205,580.

RESULTS FROM A TEN-YEAR OUTCOME EVALUATION

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 JJJ 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, in press; 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

DATE OF BHJJ PARTICIPATION

To date, 17 counties throughout Ohio have participated in the BHJJ program (see Table 3). The aggregate report includes data from all 17 counties. Currently, there are 12 BHJJ counties. In addition to the aggregate report, individual county reports are included for each of these current counties.

Table 3. Dates of BHJJ Participation

County	BHJJ Participation Dates
Butler	2008 – 2009
Champaign	2006 - 2009
Cuyahoga	2006 – present
Fairfield	2006 - 2009
Franklin	2006 - present
Hamilton	2008 – present
Holmes	2013 - present
Logan	2006 - 2009
Lorain	2013 – present
Lucas	2009 – present
Mahoning	2013 – present
Montgomery	2006 - present
Summit	2009 - present
Trumbull	2013 – present
Union	2006 - 2009
Wayne	2013 - present
Wood	2013 - 2015

PROJECT DESCRIPTIONS

Each county was asked to provide a description of their BHJJ project for inclusion in this report. Descriptions of the twelve counties that participated in BHJJ during the last biennium and their associated models are found below.

CUYAHOGA COUNTY

Cuyahoga County’s BHJJ model has evolved as a highly intensive structured program delivering effective, evidence-based treatment and culturally-appropriate services for serious juvenile offenders, ages 12 to 18, who exhibit serious behavioral health needs. These youth are juvenile justice-involved, residents of Cuyahoga County, adjudicated for misdemeanors or felonies, and have a history of multi-system involvement. Data provided by Ohio Department of Youth Services (ODYS) reflect that of all commitments from Cuyahoga County, nearly 95% are non-white and 94% male. Many of the youth enrolled in the BHJJ project are residents of the City of Cleveland, English speaking and indigent.

The BHJJ program within Cuyahoga County entails specialized Juvenile Court services, Care Coordination and a continuum of evidenced based treatment modalities which are the primary elements of the program. These include Juvenile Court’s model After-Care program, Care Coordination, and intensive use of wraparound services. Access is also available to the evidenced based practices of Multi-Systemic Therapy & Integrated Co-occurring Treatment. To further align with the design intent of

the BHJJ program, the provision of services are delivered within a youth's respective community in their natural environment.

The BHJJ model shifted upon the 2013-2015 grant period, as all BHJJ –funded positions were employed directly through the court. This made immediate improvement in communication and coordination regarding both a youth's legal status and treatment needs. A more cohesive team was formed, providing accurate and rapid responses to each family's needs. Additionally, the BHJJ team has access to a dedicated crisis stabilization bed. Services include crisis intervention, stabilization, comprehensive diagnostic assessment, psychiatric consultations, evaluation, and medication management. The aforementioned allows a crisis to be managed by providing a short term solution and ultimately avoiding the need for an out of home residential placement. Overall, since 2011, the BHJJ Project has seen its residential placements reduced by 70%.

Project Referral Process: BHJJ participants are identified by Probation Officers, Jurists, Alternative Case Planning (ACP) Review Committee or the ODYS Review Committee who suspect a youth has mental health concerns or has an identified substance abuse problem. The Probation Officer upon the referral conducts the OYAS, and refers the case to the BHJJ Probation Manager or Assessor. The BHJJ Assessor completes additional assessments. Once all assessments are complete, the BHJJ Manager assigns the case to a Probation Aftercare Coordinator and a Care Coordinator. The Care Coordinator organizes a team meeting with the family to discuss the results of the assessments and a strengths based plan to meet the individualized needs of each youth and family. If a case is pending within Juvenile Court system, the case is presented at a Court Hearing that includes a judge, public defender, probation staff and treatment staff. At the hearing, the case is funneled to the BHJJ Assessor to determine if the case appropriate for BHJJ programming.

Assessment Package: The BHJJ Assessor completes the former Ohio Department of Mental Health's Solutions for Ohio's Quality Improvement and Compliance (SOQIC) instrument and the initial Ohio Youth Problem and Satisfaction Scales. These along with the *Ohio Youth Assessment System (OYAS)* completed by the Court, yield a complete picture of the needs of the youth and families based on a comprehensive bio-psychosocial assessment. As such the BHJJ Assessor is then able to determine the most appropriate evidenced based practice model.

Care Coordination/Community Wraparound: The Care Coordinator develops the plan based on the youth's individualized needs, strengths and goals in a range of life domains, and creates a team including the participation of supportive others identified by the family. There are two main evidence based models inherent in the BHJJ project to which Care Coordinators plan with, ICT and MST. They also have the ability to develop or locate non-traditional services that fits the youth's needs. Both the Assessor and Care Coordinator are charged with accessing least restrictive options, which include the utilization of crisis beds, respite services, and evidence based treatment prior to residential treatment placements.

As mentioned above, ancillary services are necessary to support youth and families in the community. Therefore, wraparound services remain fundamental within the project. Care Coordination includes contracting for non-traditional Wraparound services such as respite, mentoring, art/music therapy, and pro-social activities including recreation and community involvement opportunities. This enables the development of individualized intervention plans and provides the flexibility necessary to tailor services and supports in response to changing needs and circumstances. This is achieved, in part, by leveraging local Community Wraparound and Family-Centered Services and Supports (FCSS) funds allocated by Cuyahoga County's Family & Children First Council (FCFC).

Treatment/Evidence Based Practices: The treatment component of the BHJJ project uses community-based resources and promising practices to support and extend treatment gains for youth and families. The OYAS measures criminogenic needs and, when used as a post-test, can indicate whether or not these needs were addressed in BHJJ treatment. Treatment Services include:

- Integrated Co-Occurring Treatment (ICT) Model: ICT is an integrated treatment approach embedded in an intensive home based method of service delivery, which provides a set of core services to youth with co-occurring disorders of substance use and Serious Emotional Disability.
- *Multi-Systemic Therapy (MST)*: MST focuses on understanding the “fit” of the child’s/family’s issues and how to best resolve them. In addition, MST focusses on assisting parents in building support systems and social networks within their community and empowers them to address their family’s needs more effectively. Particular emphasis is placed on ensuring the family’s ability to sustain positive changes and avoid recidivism once therapy has ended.

Additional services are available as warranted through existing funding at the Court and through the ADAMHS Board, and include the crisis stabilization bed and short-term residential treatment.

Placement Aftercare Coordinator (PAC): Placement Aftercare Coordinator provides not only the legal aspect of case management, but also helps to coordinate the range of program components accessed through the Court system. During the early part of aftercare, the youth and family have weekly contact with a Placement Aftercare Coordinator and are also involved with specialized counseling specific to the needs of the youth and family. By the end of aftercare, contact with Court and system representatives is monthly and the family and youth have built community supports and resources outside of the system.

The Cuyahoga County BHJJ project has been highly successful addition to the array of juvenile justice and behavioral health services available in Cuyahoga County. The county’s commitments of youth to ODYS facilities has declined by 69% since 2005. Additionally and as mentioned, since 2011 out of home placements have significantly reduced due to an effective service model that is intensive and cohesive contributing to successful outcomes for project participants.

FRANKLIN COUNTY

The Franklin County BHJJ Initiative was developed to meet the treatment and support needs of youth who, at a minimum, are seriously emotionally disturbed, substance abusing, serious juvenile offenders and may be involved in the child welfare system. This model has improved intersystem communication and shared outcomes among the behavioral health, juvenile justice, and child welfare systems.

This project is supported by the Cross System Initiative Committee (CSI), a local partnership that includes ADAMH, Franklin County Children Services (FCCS), Franklin County Common Pleas Court, Division of Domestic Relations and Juvenile Branch (Juvenile Court), and Franklin County Family and Children First Council. The model moves a youth from the Franklin County Juvenile Court Pre-Sentence Investigation through a screening and assessment process that involves a care manager who coordinates and facilitates the service delivery team throughout the program. The service delivery team includes the youth and family, probation officer, school, family-defined support, treatment providers, and other system representatives as necessary.

The assessors, who are independently-licensed behavioral health clinicians housed at the court, complete a comprehensive, evidence-based diagnostic assessment that covers all youth/family domains, is family-focused and strengths-based, includes criminogenic risk factors, and provides evidence-based recommendations. The clinicians are co-located at Juvenile Court to expedite the assessment process and enhance the collaboration between the two systems. The assessors are also available to present the identified treatment recommendations to the judges/magistrates.

The Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2) is used by court staff on all youth coming through Pre-Sentence Investigation, as well as with youth involved with Intake, Probation, and Juvenile Detention Center. The court's care coordinators work closely with the BHJJ clinicians to arrange BHJJ assessments of youth referred by the court. These youth include not only probation-involved youth but also youth for which the care coordinators are performing a case management function for adjudicated and non-adjudicated youth in an effort to prevent further penetration into the juvenile justice system. Additional eligibility criteria can include:

- Male or female ages 12 to 17
- DSM IV diagnosis
- Substantial mental status impairment in behavioral, cognitive, or affective functioning
- Co-occurring substance abuse disorders
- Adjudicated delinquent
- Learning disabilities and developmental disabilities
- Violent or pattern of criminal behavior

Treatment recommendations are individualized, based on the youth and family's particular mental health and/or substance abuse needs, with consideration also being given to location/transportation, individual preferences, level of urgency, current custody arrangements (e.g., youth in shelter care, group homes, or other out of home placements) as well as the age of the youth. Treatment recommendations are for evidence-based and evidence-informed programs that have been successful in addressing the needs of this diverse population. The following table captures the services available in Franklin County:

Treatment Model	Funding
MST (Multisystemic Therapy)	ADAMH Board of Franklin County, Franklin County Children Services & Franklin County Family and Children First Council
FFT (Functional Family Therapy)	ADAMH Board of Franklin County, Franklin County Children Services & Franklin County Juvenile Court
MDFT (Multidimensional Family Therapy)	Franklin County Children Services & Franklin County Juvenile Court
ICT (Integrated Co-occurring Treatment)	ADAMH Board of Franklin County, Department of Justice Re-Entry grant

Successful completion of the Franklin County BHJJ programs is defined as successful completion of the individualized treatment plan created by the youth, family and ongoing treatment provider.

HAMILTON COUNTY

The BHJJ project in Hamilton County consists of a collaborative effort between Hamilton County Juvenile Court (HCJC), Hamilton County Mental Health and Recovery Services Board (HCMHRSB) and Lighthouse Youth Services (LYS). Together these entities provide services for the Juvenile Mental Health Court, enhancing the coordination of care for youth and families through the use of evidence based clinical practice. The Lighthouse Individualized Docket Services (LIDS) program reflects the values of Ohio Family and Children First Council's County Comprehensive Family Services Coordination Plan. Lighthouse Youth Services (LYS) is a certified provider of the Ohio Mental Health and Addiction Services (OhioMHAS) to provide "Other" Mental Health Services, Community Psychiatric Support Treatment (CPST), Behavioral Health Counseling and Therapy, Mental Health Assessment, Pharmacological Management, and Alcohol or Other Drug (AOD) Treatment and Prevention services. The agency is also accredited through CARF International.

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

The eligibility criteria include:

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

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

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

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

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

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

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

HOLMES COUNTY (JOINT PROJECT WITH WAYNE COUNTY)

Holmes County's BHJJ program is known as the MST Program (Multisystemic Therapy) and serves females and males between the ages of 10 and 17 who are involved with Holmes County Juvenile Court. The youth and families are referred by personnel of the Holmes County Juvenile Court.

The Probation Officers identify youth and their families as candidates for the MST program based on:

- Risk of an out-of-home placement or returning from an out-of-home placement
- Multiple system involvement (legal, PCSA, behavioral health, education)
- Parent(s) or legal guardian(s) is/are willing and committed to participating in the MST program
- Previous failed attempts at treatment
- Significant history of involvement with the juvenile justice system
- Parental and youth dysfunction effecting the family's functioning in positive choices, education, employment and compliance to the law and probation terms.

The MST program is either ordered by the court through the juvenile's court case or agreed upon by the Diversion Officer, youth and parent/guardian in an informal Diversion contract. Once a youth is identified as a possible candidate for the MST program, a member of the probation department makes an initial contact with the family to verify eligibility, discuss the program, and gauge the family's willingness and commitment to participate. If the family is determined to be appropriate, a referral is submitted to the Crisis Intervention and Recovery Center (CIRC) MST supervisor, who will then conduct a thorough screening call with the family.

When the referral is complete, the case is assigned to the Holmes County therapist who contacts the family within 48 hours. The therapist meets with the family in their home to conduct family therapy sessions. The MST process usually lasts 5-7 months and with 3-5 weekly sessions depending on intensity of behaviors and availability of caregiver(s) to meet.

The MST theory of change is that the adolescent antisocial behavior (i.e. criminal activity, substance use, conduct problems) is driven by the interplay of risk factors associated with the multiple systems that youth are involved with, such as the individual (themselves), the family, peers, school, and the community. MST interventions focuses on empowering caregivers to gain the resources and skills needed to be more effective with their children. The family is viewed as critical to achieving and sustaining decreased adolescent antisocial behavior and improved functioning.

The design of MST interventions is based on nine treatment principles.

- 1) Finding the fit - The primary purpose of assessment is to understand the "fit" between the identified problems and their broader systemic context.
- 2) Positive and strength focused - Therapeutic contacts should emphasize the positive and should use systemic strengths as levers for change.
- 3) Increasing responsibility - Interventions should be designed to promote responsible behavior and decrease irresponsible behaviors among family members.
- 4) Present focused, action oriented, and well defined - Interventions should be present focused and action oriented, targeting specific well-defined problems.
- 5) Targeting sequences - Interventions should target sequences of behavior within and between multiple systems that maintain identified problems.

- 6) Developmentally appropriate - Interventions should be developmentally appropriate and fit the developmental needs of the youth.
- 7) Continuous effort - Interventions should be designed to require daily or weekly effort by family members.
- 8) Evaluation and accountability - Intervention efficacy is evaluated continuously from multiple perspectives, with providers assuming accountability for overcoming barriers to successful outcomes.
- 9) Generalization - Interventions should be designed to promote treatment generalization and long term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

The success of the MST process includes:

- Engaging families and mobilizing their strengths
- Promoting positive family relationships and parenting practices
- Steering teens away from deviant peers and toward prosocial friendships and activities
- Improving school performance and preventing dropout
- Helping caregivers develop strong social support networks

Throughout the duration of participation in the MST program, the MST therapist stays in close constant communication with the youth's probation officer, and/or other key participants, through regular phone calls and in person meetings. Determining when the youth has successfully completed the MST program is a collaborative decision between the MST provider, MST consultant, probation officer, youth, parents and other support systems that may be involved with the youth. The ultimate outcomes are to ensure the youth remains in the home, in school, and have no new legal charges at discharge from the program. MST success is determined by the family and youth consistently achieving the identified therapeutic goals for at least a month after termination and the youth does not have a new criminal charge(s) a month after MST has terminated their services with the identified youth.

LORAIN COUNTY

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

In Lorain County, youth identified as appropriate by the Lorain County Juvenile Court are referred to Bellefaire JCB's Integrated Co-Occurring Treatment (ICT) program. The ICT program provides a comprehensive mix of services to meet the mental health and substance use needs of the youth and their family. ICT utilizes an integrated treatment approach, embedded in an intensive home-based method of service delivery, to provide a set of core services to youth with co-occurring disorders of substance use and serious emotional disability. It addresses the reciprocal interaction of how each disorder affects the other, in context of the youth's family, culture, peers, school, and greater community. ICT Therapists work to prioritize saliency and immediacy of need which may fluctuate from session to session. The Lorain County BHJJ program consists of three full-time ICT Therapists in addition

to one full time ICT Supervisor. All ICT staff complete a three day, comprehensive, core training provided by the ICT Consultant from the Center of Innovative Practices at Case Western Reserve University. A key aspect of providing quality services involves the collaboration of treatment providers and court staff. In efforts to enhance collaboration, and build positive working relationships, the ICT staff meets with the Lorain County Juvenile Court staff to review cases including both treatment and court recommendations. These collaborative meetings ensure that all providers are on the same page regarding the course of treatment.

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

Prior to implementing specific interventions, the ICT staff focus on engagement with youth that are typically resistant to counseling services. Engagement often occurs through the employment of motivational interviewing strategies and responding with a non-confrontational approach. Once rapport has been established, and salient issues have been identified, the ICT Therapist may assist the family with developing a behavioral contract and will work towards crisis stabilization. Every family/client will work with their therapist to develop a safety plan, during their initial session, to reduce the frequency of crises and to keep the youth safe when residing in the home environment. Additional interventions include: life skills building, job skills training, family therapy, crisis management, role play/practicing skills, advocacy for the youth at school, and collaboration with court staff to reduce reoffending behaviors.

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

LUCAS COUNTY

Since SFY 2010, the Lucas County Behavioral Health and Juvenile Justice (LCBHJJ) Initiative has provided the opportunity to develop, sustain, and enhance two evidence-based approaches designed to serve serious juvenile offenders who have behavioral health care needs. The initiative's goals are to treat youth in the community with the least restrictive care that ensures safety for the youth and community, and divert them from commitment into the Ohio Department of Youth Services (ODYS). The evidence-based approaches are 1) Multi-systemic Therapy (MST) which includes supportive services, such as mentoring, pro-social activities, and an individualized service plan and, 2) High Fidelity Wraparound designed to support planning for targeted youth, their parents/caregivers, and families.

The gateway into MST and Wraparound comes through three points of entry within the Juvenile Court. The primary avenue has been through the Juvenile Probation department. Youth at high risk for ODYS commitment are identified by the Probation Officer or through the Courts resource staffing process. The resource staffing process is made up of a team within the Probation Department that reviews cases being referred for out of home placement. During SFY 2013 and subsequently in SFY 2014 Lucas County incorporated two additional portals into the LCBHJJ initiative.

One portal is by way of Rescue Incorporated which is housed at the Juvenile Detention Center. Rescue provides crisis counseling and intervention for youth incarcerated in the Juvenile Detention Center who may be experiencing a psychological/emotional crisis. The other additional portal is through the Lucas County Assessment Center, established in October 2013, located within the Lucas County Juvenile Justice Center. The Assessment Center staff screens low level offenders, minor misdemeanants, and status offenders at the time of arrest, as an alternative to detention for those youth that do not meet criteria to be detained. Both Rescue and the Assessment Center identify potential candidates for both MST and Wraparound through screening and assessment. When identified, youth are referred to MST or Wraparound through the juvenile probation resource staffing process. At the point of referral, the OYAS is completed. The decision for referral is based on the issues surrounding the youth and their family and specific program criteria.

For those youth who have participated in the BHJJ initiative successful completion is defined differently for the MST program and the Wraparound process. Successful completion of the MST program is based upon the mutual agreement of the primary caregiver(s) and the MST team. The primary outcomes for the program are: the youth is currently living at home, the youth is attending school (is not truant) or vocational training or, if of the legally appropriate age to not attend school, has a paying job (≥ 20 hours/week), and the youth has not been arrested since the beginning of MST treatment. Other factors taken into consideration for discharge readiness include evidence of improved family relations, improved network of informal social supports, demonstrated success in an educational or vocational setting, demonstrated changes in the youth's behavior, pro-social peers and activities. In addition, the team is looking for an indication that the primary caregiver(s) have improved their parenting skills necessary for handling subsequent problems.

For youth involved in Wraparound, successful completion is when the families' self-identified goals are met. The primary concerns that are addressed are safety and family relations.

MAHONING COUNTY (JOINT PROJECT WITH TRUMBULL COUNTY)

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

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

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

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

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

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

The four therapists on the MST team and the MST supervisor attend weekly MST group supervision for two hours followed by one hour of case consultation with an MST consultant employed at the Center for Innovative Practices at Case Western Reserve University. In addition to weekly 3 hour supervision and consultation, MST therapists attend treatment staffings at juvenile court and children services as scheduled. At the Mahoning County Juvenile Justice Center (MCJJC), they have several specialty dockets- Drug Treatment Court, Mental Health Court and Family Dependency court. These three dockets have weekly team staff meetings and court. The MST team sit on each of these teams and attend court to support their families and also for outreach and referrals for the program at HFK. The MST team also has quarterly Booster trainings with the MST consultant on topics picked by the MST team, supervisor and consultant aimed at increasing adherence to the model and increasing successful case outcomes.

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

MONTGOMERY COUNTY

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.

SUMMIT COUNTY

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.

TRUMBULL COUNTY (JOINT PROJECT WITH MAHONING COUNTY)

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

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

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

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

Youth referred to the program are assessed by an MST Therapist and if appropriate and a good fit for the program, the case is opened and an initial session is scheduled with the family within 48 hours. The therapist meets with the family in their home to conduct family therapy sessions utilizing the MST model of treatment. MST therapists meet with families at minimum three times a week in their home working on getting the parent back in the driver seat of their family. MST clinicians go to where the child is and are on call 24 hours a day, seven days a week. They work intensively with parents and

caregivers to put them in control. The therapist works with the caregivers to keep the adolescent focused on school, creating positive peer relationships, and gaining job skills. The therapist and caregivers introduce the youth to sports and recreational activities as an alternative to hanging out. The therapist and caregiver work intensively to improve family functioning and cohesiveness.

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

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

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

WAYNE COUNTY (JOINT PROJECT WITH HOLMES COUNTY)

The Wayne County Juvenile Court through a partnership with the Mental Health and Recovery Board of Wayne and Holmes Counties implemented Multi systemic Therapy (MST) utilizing the Behavioral Health and Juvenile Justice (BHJJ) grant. MST is a voluntary program that serves male and female youth between the ages of 10 and 17.5 who are involved with the Wayne County Juvenile Court. Participating youth have an Axis I diagnosis which is creating significant behavioral problems, which could include a co-occurring mental health and substance abuse diagnosis, and meet some if not all of the following criteria:

- At risk of an out-of-home placement or returning from an out-of-home placement
- Multiple system involvement
- Parent(s) or legal guardian(s) is/are willing and committed to participating in the MST program
- Previous failed attempts at treatment
- Significant history of involvement with the juvenile justice system

Once a youth is identified as a possible candidate for the MST program, a member of the probation department makes an initial screening contact with the family to verify eligibility, discuss the program, and gauge the family's willingness and commitment to participate. If the family is determined to be appropriate, a referral is submitted to the Crisis Intervention and Recovery Center (CIRC) MST supervisor, who will then conduct a thorough screening call with the family.

Upon completion of the referral process, the case is given to the MST therapist to conduct a comprehensive clinical assessment prior to beginning work with the family. The MST therapist meets with the family approximately three times per week, or whatever is deemed clinically appropriate, for approximately three to five months depending on the family's needs. These meetings occur in the families natural environment (home, school, community), and include the families' support system (relatives, friends, neighbors, etc.). Families have access to an MST therapist 24 hours a day, 7 days a week for crisis situations. The therapist's low case load of four to six families at a time allows for increased availability.

The goal of MST is to empower the caregivers with the skills to manage the youth's current behaviors, as well as to be able to generalize the skills to other youth in the home, and any new behaviors that might arise. This "multisystemic" approach views individuals as being surrounded by a network of interconnected systems that encompass individual, family, and extra familial (peer, school) factors, and recognizes that interventions may be necessary in any one or combination of these systems to bring about a desired behavior change. Therapists have a never ending focus on engagement and alignment with the primary caregiver and key stakeholders. The therapist utilizes the nine MST Treatment Principles and the MST Analytic Process to guide their treatment. There is an ongoing process of finding the fit between identified problems, and their broader systemic context. Then, this leads to individualized interventions for each family. Examples of interventions often used are the following: home behavior contracts, safety plans, supervision and monitoring plans, prevention and retrieval plans for leaving without permission/runaway behaviors, daily report cards for school behaviors – including improving home-school link, peer approval checklists, involvement in pro social activities, and home drug/alcohol screening plans.

Throughout the duration of participation in the MST program, the MST therapist stays in close constant communication with the youth's probation officer, and/or other key participants, through regular phone calls and in person meetings. In addition, numerous quality assurance methods are used to guarantee the families are receiving the best treatment possible in adherence with the MST model as outlined below:

- Through the license by MST Services, the MST provider (CIRC) utilizes a standardized and comprehensive system including weekly team supervision, consultation and quarterly training. In addition, the Therapist Adherence Measure (TAM), Supervisor Adherence Measure (SAM) and Consultant Adherence Measure (CAM) are also completed
- The project's community partners/stakeholders meet on a quarterly basis to discuss the program
- Program staff complete numerous screening tools and questionnaires with the participants throughout the program to aid in program evaluation by Case Western Reserve University, including: Ohio Youth Assessment System (OYAS), Caregiver Information Questionnaire (CIQ-I), Enrollment and Demographics Information Form (EDIF), Ohio Scales, Recent Exposure to Violence (REVS), Substance Use Survey (SUS) and Trauma Symptoms Checklist for Children (TSCC)

Determining when the youth has successfully completed the MST program is a collaborative decision between the MST provider, MST consultant, probation officer, youth, parents and other support systems that may be involved with the youth. In making the decision the team determines if the treatment goals (i.e., referral behaviors) have been achieved for at least three to four weeks, and if the family is able to effectively manage any future problems with success. The ultimate outcomes are to ensure the youth remains in the home, in school, and have no new legal charges at discharge from the program.

WOOD COUNTY

Wood County's BHJJ program is known as Project Assess, Address, and Achieve (A³) and is a systemic framework that serves adolescents ages of 10 and 18 and their families who have multi-system involvement, particularly with Wood 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

In order to better understand how youth with behavioral health issues flowed through the juvenile justice system, Wood County hosted and participated in a cross-systems mapping workshop, based on the Sequential Intercept Model (SIM). Additional objectives of the workshop included identifying the resources, gaps, and barriers in the existing juvenile justice system and developing a strategic plan to promote progress in addressing the juvenile justice diversion and treatment needs of youth with mental illness in contact with the juvenile justice system.

Youth and families involved in Project A³ are referred by Juvenile Court personnel. The youth is assessed by a therapist from Children's Resource Center, who through contract provides 24 hour crisis services and also completes Mental Health and Substance Abuse screening assessments for Wood County Juvenile Court. A Wood County Juvenile Court Probation Officer or Juvenile Court Mental Health Liaison could also identify an adolescent who met program criteria and refer the youth directly to Project A³, who, if not already receiving services, will complete the full diagnostic assessment at the first visit.

When the referral is complete, the case is assigned to a therapist who contacts the family within 48 hours. The therapist meets with the family in their home, at the Children's Resource Center agency, and/or another pre-determined location to conduct family therapy sessions utilizing the Functional Family Therapy (FFT) model, with the frequency of sessions determined by client need. On average the FFT intervention ranges from 12-18 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. Families may be offered additional "booster" sessions after treatment has ended if needed.

In addition to services from the therapist, an A³ Probation Officer and/or Juvenile Court Mental Health Liaison is assigned to the youth to provide more frequent probation and intervention services. The youth and family also complete outcome measures at specified intervals throughout the FFT process, which are distributed by the therapist, collected by the A³ graduate counseling intern and submitted to the BHJJ Project Evaluator at Case Western Reserve University.

The Therapists, Program Managers, Probation Officers, and Juvenile Court Mental Health Liaison communicate through meetings and phone conferences. This is a collaborative process and when applicable involves other providers who are involved with A³ clients. Juvenile Court reports on progress in treatment or makes recommendations to treatment to the court Judge or Magistrate. The Therapists in the A³ program also meet for weekly group clinical and individual supervision with the FFT Consultant, agency Chief Clinical Officer and Program Manager/Supervisor. Families complete surveys periodically throughout the course of treatment to assure fidelity on the FFT model. Additionally, The FFT Site Program Manager/Supervisor, agency Chief Clinical Officer, Program Director, Probation Officers, and Juvenile Court Mental Health Liaison communicate as needed to address any issues with the referral process. Specific referrals and appropriateness of the referrals are discussed, as well as any changes that need to be made in the process.

Project A³ also embraces suggestions and feedback from the BHJJ Grant Committee, which serves in an Advisory capacity. The BHJJ Grant Committee oversees the overall functioning of the program. The BHJJ Grant Committee includes: Wood County Juvenile Court, Children's Resource Center, Wood County Alcohol Drug Addiction and Mental Health Services Board, Bowling Green State University, Wood County Department of Job and Family Services, Wood County Educational Service Center, Family and Children First Council, and a parent. The BHJJ Grant Committee meets monthly. Reports are distributed and successes and barriers are discussed.

As the FFT intervention ends, the Therapist, Probation Officer, and Juvenile Court Mental Health Liaison continue to collaborate and to link the youth and family with community resources as needed to help support the changes made during treatment. The youth could also be linked with other services provided throughout agencies in Wood County including mental health, substance abuse, and/or sex offender programs, school based clinical therapy, community agency parent and prevention programs, as well as transition services. If the family experiences difficulty after treatment has ended, they are able to contact the youth's Probation Officer, Juvenile Court Mental Health Liaison, or FFT therapist directly to indicate their previous involvement with A³ and communicate concerns. A decision is made as to whether the family could benefit from continued FFT "booster" sessions or whether another intervention is appropriate. A client and family is regarded to be successfully terminated if they have completed all three phases of the FFT model and have learned new skills to reduce the risk factors associated with referral.

DATA ANALYSIS PLAN

The report is divided into two main sections. The first is an aggregate report using data from all the BHJJ counties. This includes data collected from the beginning of the BHJJ program in 2005 through June 30, 2015 and includes data from all counties who have participated, regardless of their current participation status. After the aggregate report are individual county reports highlighting data from each current BHJJ county since they have been participating in the BHJJ program. Because of limited sample size, no individual county report for Wood County could be generated.

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.

One-way ANOVAs are used when we are interested in whether mean differences on a dependent variable are significant along a categorical independent variable. For instance, one-way ANOVAs are conducted when we are interested in whether caregivers, youth, and workers differ significantly on mean Ohio Scales Functioning scores. The question of interest here is whether there are *real differences* between mean scores for the three different reporters.

Logistic regression is a multivariate statistical technique where the question to be answered is whether or not a variable predicts group membership. The use of the term multivariate here indicates that there is more than one independent variable included in the analysis. Each of the variables in the model contributes to the prediction of group membership and therefore, the effects of each variable in the analysis are controlled. Consider the question of whether recidivism can be predicted by risk assessment scores, age, race, and gender. Group membership in this case refers to whether or not an individual recidivated (yes/no). Results of the logistic regression will indicate the probability of recidivism for a male youth compared to a female, while controlling for, or holding constant, risk assessment scores, age, and race.

RESULTS

DEMOGRAPHICS

As of June 30, 2015, 3,495 youth have been enrolled in the BHJJ program (see Table 4). The average age at enrollment was 15.61 years (SD=1.54). More males (61.4%, n = 2,136) than females (38.6%, n = 1,341) have been enrolled. Caucasians (48.1%, n = 1,619) and African Americans (40.7%, n = 1,372) comprised the majority of the total sample.

Since the previous reporting period which ended on June 30, 2013, there have been 904 youth enrolled in the program. From July 1, 2013 through June 30, 2015 nearly two thirds (66.5%, n = 601) of BHJJ enrollees have been male and more than half (58.6%, n = 530) have been non-Caucasian.

Table 4. Enrollment by County

County	Total Number of Youth Enrolled
Butler	28
Champaign	97
Cuyahoga*	371
Fairfield	32
Franklin*	470
Hamilton*	225
Holmes*	11
Logan	269
Lorain*	35
Lucas*	218
Mahoning*	23
Montgomery*	1,420
Summit*	223
Trumbull*	21
Union	31
Wayne*	17
Wood*	4
Total	3,495

* Current BHJJ Counties

CUSTODY ARRANGEMENT AND HOUSEHOLD INFORMATION

At intake, the majority of youth lived with the biological mother (58.4%, n = 1,885) (see Table 5). More than 84.4% (n = 2,727) of BHJJ youth lived with at least one parent at enrollment.

Over 79% (79.4%; n = 2,498) of the BHJJ caregivers had at least a high school diploma or GED, and over 8% (8.4%; n = 262) had a bachelor's degree or higher. Slightly over one-fifth of caregivers (20.7%; n = 651) reported they did not graduate from high school (see Table 6).

Caregivers were asked to report their annual household income. The average household income was between \$15,000 and \$19,999. Three-quarters of caregivers (75.5%; n = 2,334) reported an annual household income below \$35,000 and 50.5% (n = 1,561) reported an annual household income less than \$20,000. More than one out of every four BHJJ families (26.6%; n = 821) reported an annual household income below \$10,000 (see Table 7).

Table 5. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	19.1% (n=618)
Biological Mother Only	58.4% (n=1,885)
Biological Father Only	6.9% (n=224)
Adoptive Parent(s)	4.0% (n=129)
Sibling	0.3% (n=10)
Aunt/Uncle	2.0% (n=66)
Grandparents	7.3% (n=235)
Friend	0.1% (n=3)
Ward of the State	0.5% (n=16)
Other	1.3% (n=43)

Table 6. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	20.7% (n=651)
High School Graduate or G.E.D.	36.0% (n=1,134)
Some College or Associate Degree	35.0% (n=1,102)
Bachelor's Degree	4.3% (n=135)
More than a Bachelor's Degree	4.1% (n=127)

Table 7. Annual Household Income for BHJJ Families

Annual Household Income	BHJJ Families
Less than \$5,000	18.1% (n=559)
\$5,000 - \$9,999	8.5% (n=262)
\$10,000 - \$14,999	14.7% (n=456)
\$15,000 - \$19,999	9.2% (n=284)
\$20,000 - \$24,999	13.2% (n=408)
\$25,000 - \$34,999	11.8% (n=365)
\$35,000 - \$49,999	12.4% (n=383)
\$50,000 - \$74,999	7.4% (n=228)
\$75,000 - \$99,999	2.8% (n=87)
\$100,000 and over	2.0% (n=61)

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 8). Chi-square analysis to test for gender differences was conducted on each item and significant differences are identified in Table 8. Overall, caregivers reported that BHJJ females had significantly higher levels of physical abuse, sexual abuse, running away, talking about suicide, attempting suicide, exposure to domestic violence, and family histories of substance use, depression, and mental illness than males. Caregivers reported BHJJ males had significantly higher levels of substance abuse than female participants.

At intake, caregivers were asked if the youth had ever been pregnant (or if male, had ever impregnated a female) or were currently expecting a child. Caregivers reported that 9.5% (n = 97) of females had been pregnant and of those youth, 40.7% (n = 37) were currently expecting a child. Caregivers reported that 5.5% (n = 86) of males had impregnated a female and of those youth, 31.6% (n = 24) were currently expecting a child at the time of enrollment in the program. Nearly 7% of females (6.8%, n = 23) and 6.2% (n = 39) of males currently had children. Of those who had children, 81.3% (n = 13) of females and 8.6% males (n = 3) currently lived with the child.

Table 8. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	18.7% (n=229) ^{***}	14.0% (n=278)
Has the child ever been sexually abused?	27.0% (n=324) ^{***}	7.4% (n=145)
Has the child ever run away?	58.9% (n=714) ^{***}	44.7% (n=863)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	46.3% (n=564)	54.1% (n=1,060) ^{***}
Has the child ever talked about committing suicide?	49.5% (n=604) ^{***}	30.4% (n=602)
Has the child ever attempted suicide?	23.6% (n=285) ^{***}	9.4% (n=183)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	41.7% (n=512) [*]	37.9% (n=752)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	68.1% (n=810) ^{***}	60.8% (n=1,164)
Has anyone in the child's biological family had a mental illness, other than depression?	48.3% (n=573) ^{***}	40.3% (n=780)
Has the child ever lived in a household in which someone was convicted of a crime?	38.8% (n=459)	40.8% (n=785)
Has anyone in the child's biological family had a drinking or drug problem?	61.8% (n=741) [*]	57.7% (n=1,118)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	32.1% (n=387)	32.7% (n=624)

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

PROBLEMS LEADING TO BHJJ SERVICES

The case worker or staff member assigned to the family typically completed a diagnostic assessment as part of the intake process. The workers were asked to identify the problems leading to the youth being referred for BHJJ services. For both females and males, the most common problem leading to BHJJ services was conduct/delinquency problems (90.1% and 91.5% respectively) (see Table 9). Chi-square analysis indicated females had significantly higher rates of problems related to suicide, depression, anxiety, adjustment, and eating disorders than males. Males had significantly higher rates of hyperactive and attention-related problems as well as problems related substance use and learning disabilities.

Table 9. Problems Leading to Services

Problems Leading to Services	Females	Males
Adjustment-related problems	12.6% (n=164) ^{***}	7.3% (n=150)
Anxiety-related problems	20.8% (n=270) ^{***}	15.0% (n=307)
Conduct/delinquency-related problems	90.1% (n=1,168)	91.5% (n=1,871)
Depression-related problems	48.7% (n=631) ^{***}	28.5% (n=582)
Eating disorders	1.8% (n=23) ^{***}	0.5% (n=10)
Hyperactive and attention-related problems	24.5% (n=318)	39.6% (n=809) ^{***}
Learning disabilities	4.2% (n=55)	8.5% (n=173) ^{***}
Pervasive development disabilities	0.6% (n=8)	1.4% (n=28)
Psychotic behaviors	2.1% (n=27)	2.2% (n=44)
School performance problems not related to learning disabilities	34.6% (n=449)	33.6% (n=687)
Specific developmental disabilities	0.7% (n=9)	1.5% (n=31) [*]
Substance use, abuse, dependence-related problems	41.4% (n=537)	49.6% (n=1,014) ^{***}
Suicide-related problems	12.0% (n=155) ^{***}	5.6% (n=115)

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

OHIO YOUTH ASSESSMENT SYSTEM

Ohio Youth Assessment System (OYAS) (criminogenic risk) data were collected at the time point closest to their respective enrollment dates were used for those enrolled since 2009. Table 10 shows the distribution of OYAS categories for BHJJ youth by gender and race. Chi-square tests revealed significant group differences in the OYAS categories based on both gender and race. A greater proportion of females were in the low risk category than males while a greater proportion of White youth were in the low risk category than Nonwhite youth. Further, 26.3% of Nonwhite youth were identified as high risk while 14.6% of White youth were identified as high risk.

Table 10. OYAS Risk Categories by Gender and Race

	OYAS Low	OYAS Moderate	OYAS High
Female	44.3% (n = 193)	35.3% (n = 154)	20.4% (n = 89)
Male^{***}	28.6% (n = 303)	48.9% (n = 518)	22.5% (n = 238)
White	40.8% (n = 212)	44.5% (n = 231)	14.6% (n = 76)
Nonwhite^{***}	28.5% (n = 264)	45.1% (n = 418)	26.3% (n = 244)

***p < .001

DSM-IV DIAGNOSES

Workers were asked to report any DSM-IV Axis I diagnoses at intake in 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 Oppositional Defiant Disorder (ODD) while the most common Axis I diagnosis for males was Attention Deficit Hyperactivity Disorder (ADHD) (see Table 11).

A total of 7,599 Axis I diagnoses were identified for 3,342 youth with diagnostic information (2.27 diagnoses per youth). Data related to diagnoses per youth vary greatly by county (see county reports for additional information). Females reported 2,889 Axis I diagnoses (2.28 diagnoses per female) and males reported 4,710 Axis I diagnoses (2.30 diagnoses per male). Chi-square analysis indicated females were significantly more likely to be diagnosed with Depressive Disorders, Alcohol-related Disorders, Bipolar Disorder, Post-traumatic Stress Disorder (PTSD), Adjustment Disorder, and Mood Disorder. Males were significantly more likely to be diagnosed with Cannabis-related Disorders, ADHD, and Conduct Disorder. Over 43% of males (43.9%, n = 849) and over one third of females (35.2%, n = 431) were identified as having both a DSM-IV Axis I mental health diagnosis and a substance use diagnosis. Of youth enrolled since July 2013, 48.3% (n = 289) of males and 38.2% of females (n = 115) were diagnosed with both a mental health and substance use diagnosis.

Table 11. Most Common DSM-IV Diagnoses

DSM-IV Axis I Diagnosis	Females	Males
Adjustment Disorder	6.6% (n = 86) [*]	4.9% (n = 101)
Alcohol-related Disorders	13.4% (n = 174) ^{**}	9.3% (n = 191)
Attention Deficit Hyperactivity Disorder	25.8% (n = 334)	40.5% (n = 828)^{***}
Bipolar Disorder	7.9% (n = 103) ^{**}	5.6% (n = 114)
Cannabis-related Disorders	27.8% (n = 360)	37.3% (n = 763) ^{***}
Conduct Disorder	11.2% (n = 145)	22.1% (n = 451) ^{***}
Depressive Disorders	21.8% (n = 283) ^{***}	12.1% (n = 248)
Disruptive Behavior Disorder	5.6% (n = 72)	6.6% (n = 135)
Mood Disorder	12.0% (n = 155) [*]	9.6% (n = 197)
Oppositional Defiant Disorder	40.1% (n = 520)	39.9% (n = 815)
Post-traumatic Stress Disorder	9.5% (n = 123) ^{***}	4.9% (n = 101)

*p < .05, ** 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 into and termination from the BHJJ program. The items were completed by the worker with help from the youth and caregiver. Just under 70% of the youth (68.1%, n = 1,572) were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in treatment with BHJJ, 36.4% (n = 698) of the youth were expelled or suspended from school.

Educational data were analyzed for youth who were eligible for inclusion (youth on summer break or who had graduated at the time of the survey were not included in the analyses). At intake, 84.3% (n = 1,779) of youth were currently attending school while at termination, 83.5% (n = 1,473) of BHJJ youth were attending school. If the youth was attending school, the worker was asked to identify the types of grades the youth typically received. Table 12 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 13 displays this information based on completion status.

At intake, 38.2% of youth were earning mostly A's, B's, or C's and 34.6% were earning mostly D's and F's. At termination from BHJJ, 49.9% of youth were earning mostly A's, B's, or C's, and 20.4% were earning mostly D's and F's. Academic improvement was largely dependent upon BHJJ completion status (see Table 13). While academic performance varied little at intake for youth regardless of future BHJJ completion status, youth who completed successfully reported significant academic performance improvement at termination. For example, at intake, 35.5% of unsuccessful completers and 39.7% of successful completers received mostly A's, B's, or C's. At termination, 31.8% of unsuccessful completers and 58.9% of successful completers received mostly A's, B's, or C's.

At termination, workers reported that 40.5% (n = 784) of youth were attending school more than before starting treatment and 48.7% (n = 943) of youth were attending school 'about the same' amount compared to before starting treatment. Workers reported that 6.1% (n = 118) were attending school less often than before treatment in BHJJ. At termination, 37.5% (n = 526) of the youth attending school had Individual Educational Plans (IEPs).

Table 12. Academic Performance

Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	15.2% (n = 329)	17.5% (n = 306)
Mostly B's and C's	23.0% (n = 498)	32.4% (n = 566)
Mostly C's and D's	27.2% (n = 591)	29.7% (n = 520)
Mostly D's and F's	34.6% (n = 751)	20.4% (n = 356)

Table 13. Academic Performance for Youth 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	13.3% (n = 67)	8.6% (n = 45)	16.1% (n = 185)	22.0% (n = 258)
Mostly B's and C's	22.2% (n = 112)	23.2% (n = 121)	23.6% (n = 272)	36.9% (n = 433)
Mostly C's and D's	28.6% (n = 144)	34.9% (n = 182)	26.2% (n = 302)	27.3% (n = 320)
Mostly D's and F's	35.9% (n = 181)	33.3% (n = 174)	34.1% (n = 393)	13.7% (n = 161)

VOCATIONAL DATA

At intake into BHJJ, workers reported that 7.2% (n = 168) of youth were employed, with the vast majority (96.3%, n = 155) of those youth working part-time. At termination, 12.1% (n = 239) of the youth were employed and 87.0% (n = 200) were employed part-time. In the 12 months prior to their enrollment in BHJJ 8.7% of youth (n = 240) received employment counseling or vocational training and 21.0% (n = 489) of youth planned to pursue employment counseling or vocational training in the next 12 months. **At termination, 12.3% (n = 240) of youth received employment counseling or vocational training in the past 12 months and 23.3% (n = 454) planned to pursue employment counseling or vocational training in the next 12 months.**

OHIO SCALES

One of the main measures in the data collection packet is 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 intake, three month, six month, nine month, and termination data. While additional assessment periods did exist, the number of assessments in these groups was less than ideal for analysis and these assessment periods are not reported here. 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.

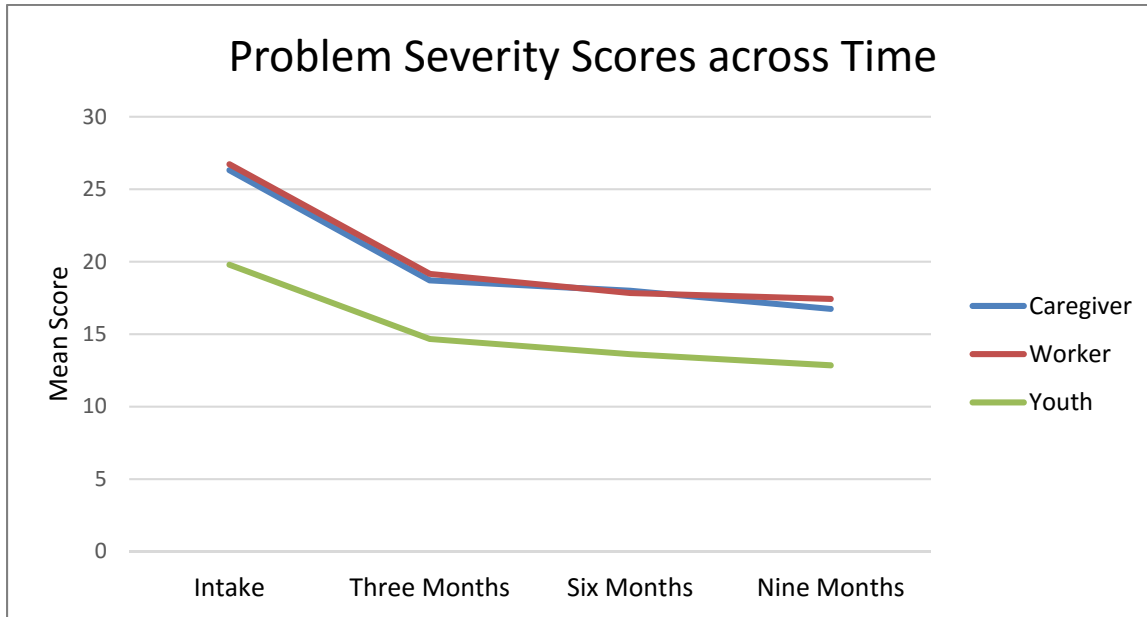
PROBLEM SEVERITY

Means for the Problem Severity scale by rater and assessment period can be found in Table 14 and also in Figure 1 and Figure 2. One-way ANOVAs were performed on the data to examine the effect county of enrollment had on intake Problem Severity scores. Results of the One-Way ANOVAs revealed significant differences on the Problem Severity scale at intake for caregivers $F(16, 2751) = 9.10, p < .001$; for workers: $F(16, 3212) = 6.50, p < .001$; and for youth $F(16, 1389) = 5.76, p < .001$. Post hoc comparisons revealed that Franklin County reported significantly lower Problem Severity scores than most other counties for the youth and caregiver ratings. Additional county-level information can be found in the individual county reports.

Table 14. Problem Severity Scores over Time

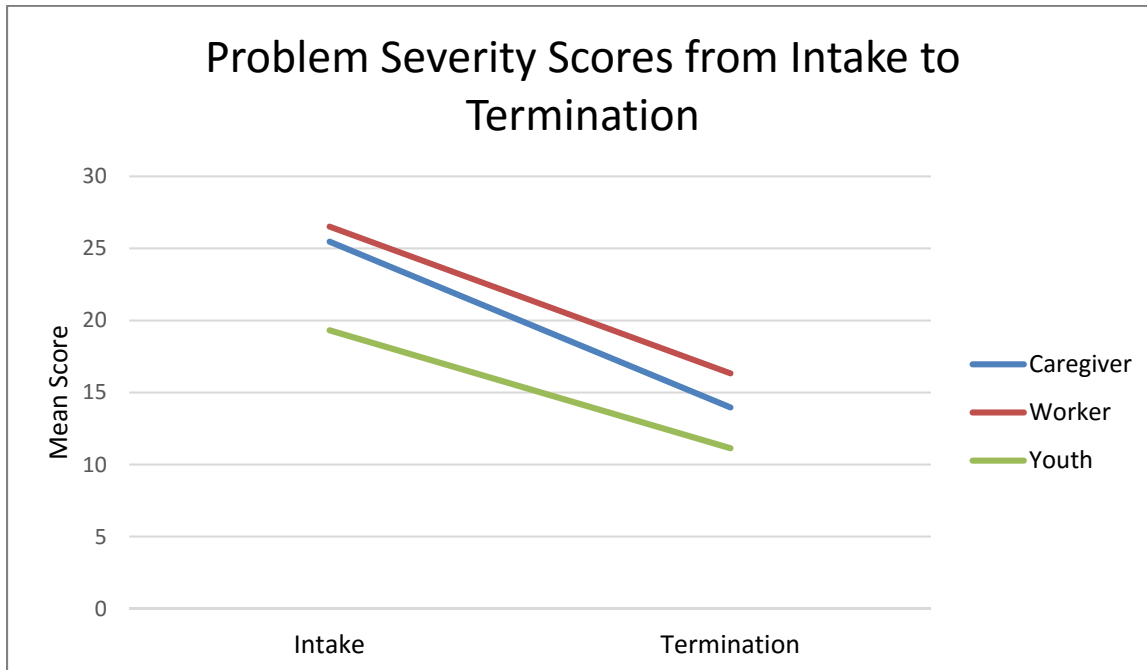
	Caregiver	Worker	Youth
Intake	26.32 (SD=17.15; n=2,768)	26.73 (SD=13.40; n=3,229)	19.80 (SD=14.76; n=3,189)
Three Months	18.71 (SD=14.03; n=1,255)	19.16 (SD=12.10; n=1,611)	14.67 (SD=12.36; n=1,541)
Six Months	18.00 (SD=14.56; n=531)	17.84 (SD=11.85; n=678)	13.62 (SD=12.18; n=637)
Nine Months	16.75 (SD=13.43; n=279)	17.43 (SD=11.36; n=312)	12.85 (SD=11.33; n=307)
Termination	14.11 (SD=14.11; n=1,469)	16.43 (SD=12.78; n=1,236)	11.21 (SD=10.73; n=1,739)

Figure 1. Problem Severity Scores across Time



*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



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

CAREGIVER RATINGS

Paired samples t-tests revealed significant improvements in Problem Severity at each measurement interval (see Table 15) compared to intake. Significant improvements were noted at three months: $t(1177) = 17.15$, $p < .001$; six months: $t(506) = 10.60$, $p < .001$; nine months: $t(266) = 9.56$, $p < .001$; and at termination $t(1353) = 25.40$, $p < .001$. Large effect sizes were noted for the periods between intake and nine months and intake and termination. Moderate effect sizes were noted for the periods between intake and three months and between intake and six months.

Table 15. Paired Samples T-Tests for Problem Severity - Caregiver

	Mean Time 1	Mean Time 2	t	d
Intake to Three Months	26.47 (SD=17.04; n=1178)	18.71 (SD=14.07; n=1178)	17.15***	.50
Intake to Six Months	26.50 (SD=18.07; n=507)	17.88 (SD=14.68; n=507)	10.60***	.52
Intake to Nine Months	27.64 (SD=18.77; n=267)	16.47 (SD=13.39; n=267)	9.56***	.69
Intake to Termination	25.48 (SD=16.88; n=1354)	13.97 (SD=13.05; n=1354)	25.40***	.76

*** $p < .001$

WORKER RATINGS

For workers, paired samples t-tests indicated significant improvement in Problem Severity from intake to each successive data collection point (see Table 16). Improvements were noted at three months: $t(1186) = 21.44$, $p < .001$; six months: $t(511) = 17.25$, $p < .001$; nine months: $t(242) = 11.16$, $p < .001$; and at termination $t(1398) = 30.32$, $p < .001$. Large effect sizes were found for all time periods except for intake to three months, which was a medium effect size.

Table 16. Paired Samples T-Tests for Problem Severity - Worker

	Mean Time 1	Mean Time 2	t	d
Intake to Three Months	26.63 (SD=13.09; n=1544)	19.11 (SD=12.08; n=1544)	21.44***	.59
Intake to Six Months	27.99 (SD=13.83; n=649)	17.68 (SD=11.78; n=649)	17.25***	.80
Intake to Nine Months	27.66 (SD=13.24; n=302)	17.54 (SD=11.45; n=302)	11.16***	.82
Intake to Termination	26.52 (SD=13.17; n=2095)	16.34 (SD=12.67; n=2095)	30.32***	.79

*** $p < .001$

YOUTH RATINGS

Paired samples t-tests conducted on the youth ratings indicated significant improvement at each data collection point (see Table 17). Improvements were noted at three months: $t(1476) = 14.59$, $p < .001$; six months: $t(613) = 12.03$, $p < .001$; nine months: $t(299) = 9.58$, $p < .001$; and at termination $t(1629) = 24.08$, $p < .001$. Moderate effect sizes were observed between intake and six, nine, and termination. A small effect size was noted for the time period between intake and three months.

Table 17. Paired Samples T-Tests for Problem Severity - Youth

	Mean Time 1	Mean Time 2	t	d
Intake to Three Months	19.93 (SD=14.89; n=1477)	14.67 (SD=12.48; n=1477)	14.59***	.38
Intake to Six Months	20.81 (SD=15.56; n=614)	13.55 (SD=12.07; n=614)	12.03***	.52
Intake to Nine Months	21.05 (SD=14.81; n=300)	12.80 (SD=11.37; n=300)	9.58***	.64
Intake to Termination	19.32 (SD=14.44; n=1629)	11.14 (SD=10.75; n=1629)	24.08***	.64

*** $p < .001$

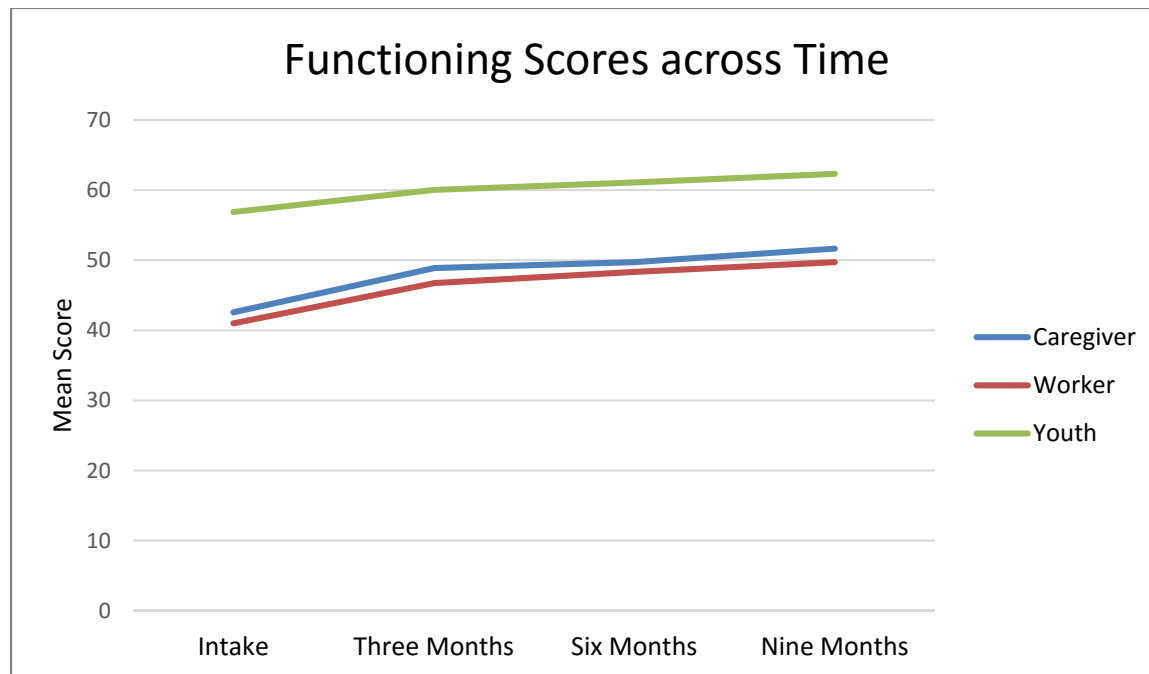
FUNCTIONING SCORES

Means for the Functioning scale by rater and assessment period can be found in Table 18 and Figure 3 and Figure 4. One-way ANOVAs were performed to examine the effect county of enrollment had on intake Functioning scores. Results revealed significant differences on the Functioning scale at intake for caregivers: $F(16, 2754) = 8.99, p < .001$; workers: $F(16, 3197) = 17.863, p < .001$; and youth: $F(16, 3175) = 4.44, p < .001$. Post hoc comparisons revealed that caregivers in Franklin County consistently reported higher Functioning scores for youth compared to all other BHJJ counties. Additional county-level information can be found in the individual county reports.

Table 18. Functioning Scores across Time

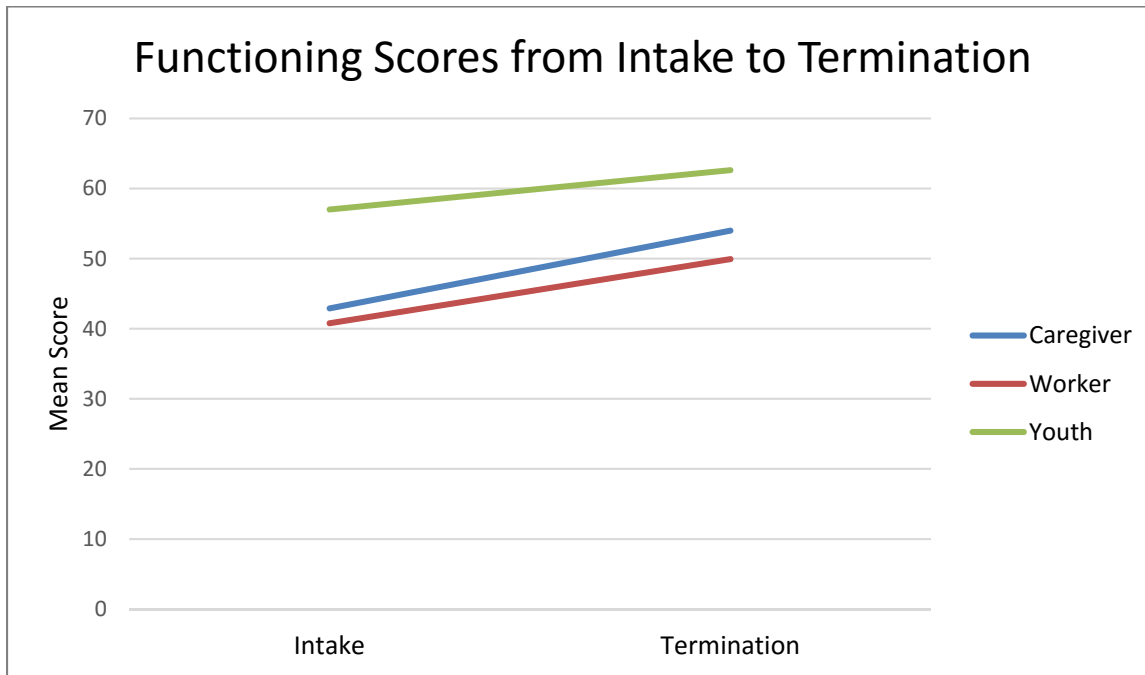
	Caregiver	Worker	Youth
Intake	42.59 (SD=16.74; n=2,771)	41.01 (SD=11.77; n=3,214)	56.88 (SD=13.07; n=3,176)
Three Months	48.88 (SD=16.44; n=1,254)	46.74 (SD=13.35; n=1,601)	60.03 (SD=13.30; n=1,546)
Six Months	49.73 (SD=16.49; n=533)	48.34 (SD=13.69; n=676)	61.08 (SD=12.97; n=636)
Nine Months	51.67 (SD=14.95; n=276)	49.73 (SD=13.45; n=313)	62.32 (SD=12.95; n=309)
Termination	53.83 (SD=16.68; n=1,479)	49.93 (SD=14.57; n=2,244)	62.53 (SD=13.31; n=1,746)

Figure 3. Functioning Scores across Time



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

Figure 4. Functioning Scores from Intake to Termination



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

CAREGIVER RATINGS

Paired samples t-tests revealed significant improvements in Functioning at each measurement interval (see Table 19) compared to intake. Significant improvements were noted at three months: $t(1188) = -15.06, p < .001$; six months: $t(516) = -10.33, p < .001$; nine months: $t(268) = -9.31, p < .001$; and termination: $t(1357) = -24.01, p < .001$. Moderate effect sizes were found for the periods between intake and six months, intake and nine months and intake and termination. A small effect size observed between intake and three months.

Table 19. Paired Samples T-Tests for Functioning Scores - Caregiver

	Mean Time 1	Mean Time 2	t	d
Intake to Three Months	42.10 (SD=16.61; n=1189)	49.11 (SD=16.34; n=1189)	-15.06***	.42
Intake to Six Months	41.47 (SD=17.22; n=517)	49.97 (SD=16.46; n=517)	-10.33***	.50
Intake to Nine Months	41.00 (SD=17.62; n=269)	51.57 (SD=15.90; n=269)	-9.31***	.53
Intake to Termination	42.91 (SD=16.76; n=1358)	54.01 (SD=16.51; n=1358)	-24.01***	.67

*** $p < .001$

WORKER RATINGS

Paired samples t-tests indicated significant improvement in functioning at each data collection point (see Table 20). Significant improvements were observed at three months: $t(1523) = -15.63, p < .001$; six months: $t(642) = -12.56, p < .001$; nine months: $t(299) = -8.38, p < .001$; and termination: $t(2092) = -26.39, p < .001$. Moderate effect sizes were observed for the intervals of intake and six months, intake and nine months, and intake and termination. A small effect size was noted for intake to three months.

Table 20. Paired Samples T-Tests for Functioning Scores - Worker

	Mean Time 1	Mean Time 2	t	d
Intake to Three Months	41.47 (SD=12.20; n=1524)	46.82 (SD=13.37; n=1524)	-15.63***	.41
Intake to Six Months	40.97 (SD=12.32; n=643)	48.41 (SD=13.79; n=643)	-12.56***	.57
Intake to Nine Months	41.78 (SD=12.42 n=300)	49.52 (SD=13.44; n=300)	-8.38***	.60
Intake to Termination	40.79 (SD=11.64; n=2093)	49.94 (SD=14.57; n=2093)	-26.39***	.69

***p < .001

YOUTH RATING

Paired samples t-tests conducted on the youth ratings indicated significant improvement at each data collection point (see Table 21). Significant improvements were observed at three months: $t(1481) = -.876$, $p < .001$; six months: $t(612) = -.876$, $p < .001$; nine months: $t(298) = -.812$, $p < .001$; and termination: $t(1626) = -15.64$, $p < .001$. A moderate effect size was noted for the time period between intake and nine months while small effect sizes were observed for intake and three months, intake and six months, and intake and termination.

Table 21. Paired Samples T-Tests for Functioning Scores - Youth

	Mean Time 1	Mean Time 2	t	d
Intake to Three Months	57.04 (SD=12.88; n=1482)	60.17 (SD=13.14; n=1482)	-8.76***	.24
Intake to Six Months	55.77 (SD=13.45; n=613)	61.22 (SD=13.01; n=613)	-8.76***	.41
Intake to Nine Months	55.51 (SD=12.72; n=299)	62.37 (SD=12.92; n=299)	-8.12***	.54
Intake to Termination	57.02 (SD=13.02; n=1627)	62.63 (SD=13.37; n=1627)	-15.64***	.43

***p < .001

TRAUMA SYMPTOM CHECKLIST FOR CHILDREN (TSCC)

The Trauma Symptom Checklist for Children (TSCC) is a 54-item Likert-type survey composed of six subscales: anger, anxiety, depression, dissociation, post-traumatic stress disorder, and sexual concerns. The TSCC was administered at intake and termination from BHJJ. The TSCC contains an Underresponse and Hyperresponse scale. The Underresponse scale “reflects a tendency toward denial, a general under-endorsement response set, or a need to appear unusually symptom-free” (Briere, 1996). According to the professional manual, any child who has a t-score above 70 on the Underresponse scale should be eliminated from further data analysis. The Hyperresponse scale “indicates a general overresponse to TSCC items, a specific need to appear especially symptomatic, or a state of being overwhelmed by traumatic stress” (Briere, 1996). The TSCC professional manual recommends eliminating any child with a Hyperresponse t-score above 90 from further data analysis.

An examination of the Underresponse scale indicated that of the 3,219 complete intake TSCC surveys, 19.4% (n = 625) contained t-scores at 70 or higher while of the 1,818 complete termination TSCC surveys, 29.2% (n = 531) contained t-scores at 70 or higher. A similar examination of the Hyperresponse scale revealed that 1.1% (n = 37) scored 90 or above on the intake TSCC while 0.5% (n = 9) scored 90 or above on the termination TSCC. These youth were eliminated from all further data analyses conducted on the TSCC.

Mean subscale scores at intake and termination can be found in Figure 5 and Table 23. Differences in mean subscale scores are presented using two indices (see Table 24). Paired-samples t-tests were conducted to show whether means at intake and termination on each TSCC subscale differed significantly. 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 underreporters or hyperresponders.

Results from paired samples t-tests indicated that there were significant symptom reductions on all subscales from intake to termination (see Table 24). Statistically significant improvements were found on the Anxiety scale; $t(779) = 8.59, p < .001$, the Depression scale; $t(779) = 10.92, p < .001$, the Anger scale; $t(779) = 10.67, p < .001$, the Posttraumatic Stress scale; $t(778) = 10.21, p < .001$, the Dissociation scale; $t(777) = 9.65, p < .001$, and the Sexual Concerns scale; $t(778) = 6.11, p < .001$. Considering Cohen’s (1988) established cutoffs, small effects were found for all subscales. 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.

Table 22. Means and Standard Deviations for TSCC Subscales at Intake and Termination for Males in the BHJJ Program

	Intake			Termination		
	M	SD	n	M	SD	n
Anxiety	3.48	3.26	1,474	3.00	2.81	614
Depression	4.42	3.73	1,474	3.49	3.13	614
Anger	8.23	5.28	1,476	6.60	4.52	613
Posttraumatic Stress	5.81	4.79	1,474	4.82	4.10	614
Dissociation	5.88	4.84	1,469	4.87	3.89	614
Sexual Concerns	3.59	3.42	1,473	3.18	3.27	614

Table 23. Means and Standard Deviations for TSCC Subscales at Intake and Termination for Females in the BHJJ Program

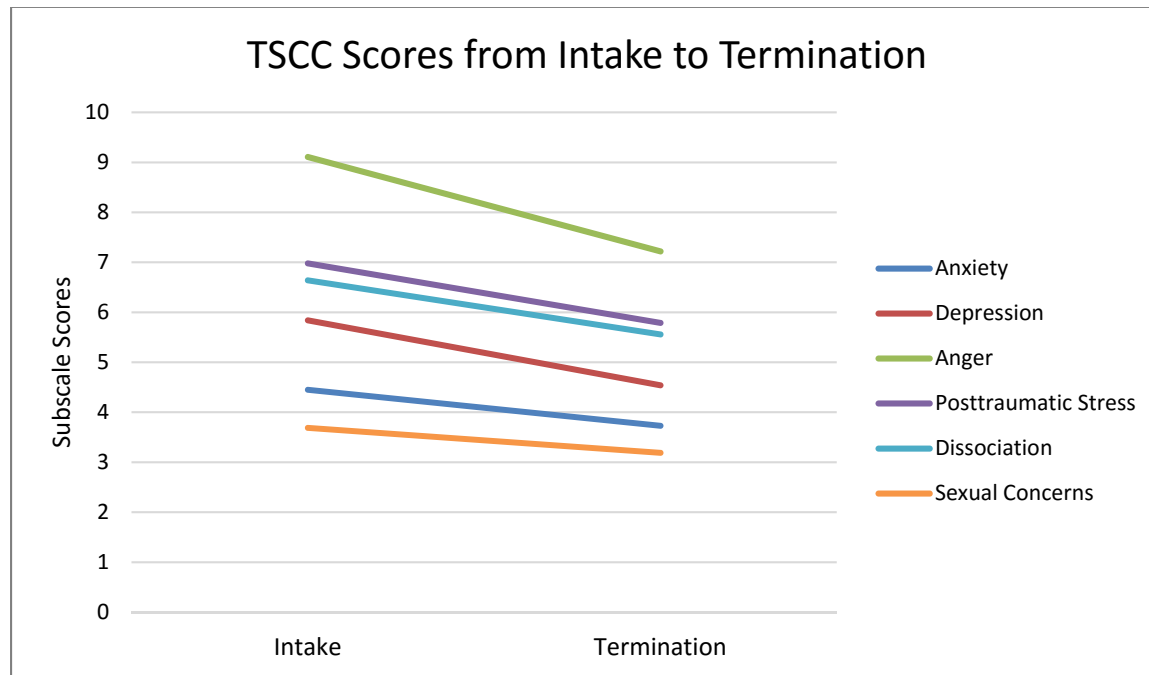
	Intake			Termination		
	M	SD	n	M	SD	n
Anxiety	6.01	4.27	937	4.62	3.67	353
Depression	8.07	5.02	937	6.05	3.87	353
Anger	10.52	5.78	937	7.95	5.21	353
Posttraumatic Stress	8.83	5.90	937	7.00	5.13	353
Dissociation	7.88	5.07	935	6.28	4.59	352
Sexual Concerns	3.59	3.42	937	3.31	3.76	353

Table 24. Paired Samples T-tests for TSCC Subscales from Intake to Termination

	Intake	Termination	t	d
Anxiety	4.83 (SD=3.99; n=780)	3.73 (SD=3.29; n=780)	8.59***	.30
Depression	6.23 (SD=4.83; n=780)	4.54 (SD=3.63; n=780)	10.92***	.40
Anger	9.27 (SD=5.65; n=780)	7.22 (SD=4.83; n=780)	10.67***	.39
Posttraumatic Stress	7.54 (SD=5.49; n=779)	5.79 (SD=4.69; n=779)	10.21***	.34
Dissociation	7.08 (SD=4.79; n=778)	5.56 (SD=4.25; n=778)	9.65***	.34
Sexual Concerns	3.91 (SD=3.59; n=779)	3.19 (SD=3.47; n=779)	6.11***	.20

***p < .001

Figure 5. TSCC Scores from Intake to Termination



* all comparisons significant at the p < .001 level

SUBSTANCE ABUSE

SUBSTANCE USE SURVEY

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 25 presents the percentages of BHJJ youth who reported ever using alcohol or drugs and the average age of first use by gender. For both females and males, alcohol, cigarettes, and marijuana were the three most commonly used substances. Chi-square tests revealed that significantly more females than males reported lifetime use of cocaine and heroin. A significantly higher proportion of males reported lifetime use of chewing tobacco and marijuana. For the three most commonly reported substances, we examined whether youth who had reported no lifetime use at intake had reported any use at termination. Among youth reporting no lifetime use of alcohol at intake, 26.4% (n = 98) of males and 19% (n = 44) of females reported any use at termination. Of those who reported no cigarette use at intake, 19.9% (n = 86) of males and 14.5% (n = 37) of females reported any use at termination. Among those who reported no lifetime use of marijuana at intake, 17% (n = 45) of males and 15.2% (n = 33) of females reported marijuana use at termination. Chi-square analyses revealed that a similar proportion of males and females reported lifetime use of alcohol, cigarettes, and marijuana.

Youth were also asked 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 of each specific substance. Overall, both males and females reported a decrease in six month use with respect to the most commonly used substances with the exception of cigarette use for both genders. Chi-square tests showed a significant decrease from intake to termination in six month alcohol, marijuana, cocaine, and tranquilizer use among both genders.

The percentage of males using alcohol in the past six months dropped from 53.8% (n = 630) to 40.1% (n = 219) from intake to termination. For females, 62.3% (n = 444) reported past six month use at intake while 33.2% (n = 103) reported past six month alcohol use at termination. About three-quarters of males (75.0%, n = 817) and females (79.7%, n = 550) reported past six month cigarette use at intake. At termination, 72.2% (n = 350) of males and 74.7% (n = 230) of females reported past six month cigarette use.

Past six month marijuana use declined from 71.5% (n = 976) at intake to 50.0% (n = 325) at termination for males and 66.8% (n = 495) at intake and 37.5% (n = 124) at termination for females. Self-report pain killer use in the past six months declined from 46.7% (n = 122) to 23.0% (n = 23) in males and from 57.8% (n = 111) to 19.0% (n = 15) in females. About 51% (50.9%, n = 55) of females reported past six month cocaine use at intake while 13.6% (n = 6) reported past six month cocaine use at termination. At intake, 39.3% (n = 70) of males reported past six month tranquilizer use at intake, and at termination 24.7% (n = 18) reported past six month tranquilizer use. At intake, 51.6% (n = 66) of females reported past six month tranquilizer use while 19.2% (n = 10) had used tranquilizers at termination. Nearly 49% of males (48.8%, n = 146) of males reported past six month use of chewing tobacco while 34.7% (n = 42) reported six month use at termination.

If youth reported any lifetime use and if they had reported use in the past six months, youth were asked whether they had used each substance in the past 30 days. Figure 8 and Figure 9 show the percentage of those youth who reported any 30 day use for the three most commonly reported substances by gender (alcohol, cigarettes, and marijuana). We restricted our analyses to alcohol,

cigarettes, and marijuana due to a small sample size of youth who had reported using other substances in the past 30 days. The data show a reduction in past 30 day use of all of the most commonly reported substances from intake to termination. Past 30 day use of alcohol declined from 55.9% (n = 284) at intake to 21.9% (n = 56) at termination for males and from 55.5% (n = 203) at intake to 15.2% (n = 30) at termination for females. Past 30 day use of cigarettes declined from 90.8% (n = 645) at intake to 72.8% (n = 254) at termination for males and decreased from 89.5% (n = 434) at intake to 76% (n = 187) at termination for females. For males, past 30 day marijuana use declined from 66.5% (n = 535) at intake to 30.1% (n = 126) at termination and from 58.2% (n = 237) to 18.0% (n = 41) for females.

In addition to the percentage of youth reporting 30 day use, Figure 10 and Figure 11 present the average number of days youth reported using alcohol, cigarettes, and marijuana in the past 30 days. Prior to conducting these analyses, we restricted the sample to those who had reported lifetime use and 30 day use at intake. For both gender groups, the average number of days declined from intake to termination for all three substances. In the past 30 days, males reported using alcohol for an average of 2.26 days (SD = 5.00; n = 508) at intake and 0.68 days termination (SD = 2.19; n = 256). Females reported using alcohol for an average of 2.34 days (SD = 4.95; n = 366) at intake and 0.56 days (SD = 2.48; n = 197) at termination. For cigarette use, males reported using for an average of 19.86 days (SD = 14.39, n = 710) at intake and 17.93 days (SD = 16.01, n = 349) at termination. For females, they reported an average of 19.62 days (SD = 12.68, n = 487) at intake and 18.78 days (SD = 16.21, n = 246) at termination. For marijuana, males reported using for an average of 7.19 days (SD = 11.28; n = 804) out of the past 30 days at intake and 2.89 days (SD = 6.75; n = 419) at termination while females reported using for an average of 5.94 days (SD = 9.91; n = 407) at intake and 1.55 days (SD = 4.97; n = 228) at termination. Paired samples t-tests revealed a statistically significant decrease in the average number of days from intake to termination for alcohol and marijuana for both males and females.

Table 25. Self-Reported Substance Use at Intake for All BHJJ Youth

	Males		Females	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	62.6% (n = 1,225)	13.30 (SD = 2.83)	63.7% (n = 765)	13.33 (SD = 1.88)
Cigarettes	57.1% (n = 1,116)	12.69 (SD = 3.39)	58.3% (n = 706)	12.58 (SD = 2.29)
Chewing Tobacco	14.5% (n = 309)***	13.69 (SD = 2.79)	5.5% (n = 66)	13.92 (SD = 2.05)
Marijuana	71.9% (n = 1,410)***	13.06 (SD = 2.16)	63.7% (n = 767)	13.27 (SD = 1.75)
Cocaine	5.3% (n = 104)	14.63 (SD = 1.79)	9.4% (n = 113)***	14.55 (SD = 1.63)
Pain Killers (use inconsistent with prescription)	14.3% (n = 280)	14.14 (SD = 1.59)	17.7% (n = 213)	14.14 (SD = 1.59)
GHB	0.3% (n = 5)	14.75 (SD = 0.96)	0.3% (n = 4)	14.25 (SD = 1.26)
Inhalants	3.3% (n = 65)	13.55 (SD = 2.15)	3.9% (n = 47)	13.37 (SD = 2.09)
Heroin	1.1% (n = 22)	14.86 (SD = 1.42)	2.9% (n = 35)***	14.49 (SD = 1.42)
Amphetamines	3.0% (n = 58)	15.17 (SD = 7.26)	3.2% (n = 38)	14.00 (SD = 2.07)
Ritalin (use inconsistent with prescription)	7.7% (n = 151)	13.25 (SD = 2.87)	8.6% (n = 103)	13.94 (SD = 1.67)
Barbiturates	1.9% (n = 37)	14.38 (SD = 1.23)	2.9% (n = 35)	14.36 (SD = 1.22)
Non-prescription Drugs	7.3% (n = 142)	14.19 (SD = 2.15)	8.8% (n = 105)	13.99 (SD = 1.76)
Hallucinogens	6.7% (n = 132)	14.53 (SD = 1.33)	5.9% (n = 71)	14.56 (SD = 1.47)
PCP	1.3% (n = 26)	14.69 (SD = 1.59)	1.8% (n = 22)	14.52 (SD = 1.03)
Ketamine	0.9% (n = 17)	15.38 (SD = 1.15)	1.2% (n = 14)	14.62 (SD = 1.26)
Ecstasy	6.1% (n = 119)	14.70 (SD = 1.40)	7.9% (n = 94)	14.50 (SD = 1.38)
Tranquilizers	9.4% (n = 183)	14.37 (SD = 1.61)	11.0% (n = 132)	14.42 (SD = 1.46)

***p < .001

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

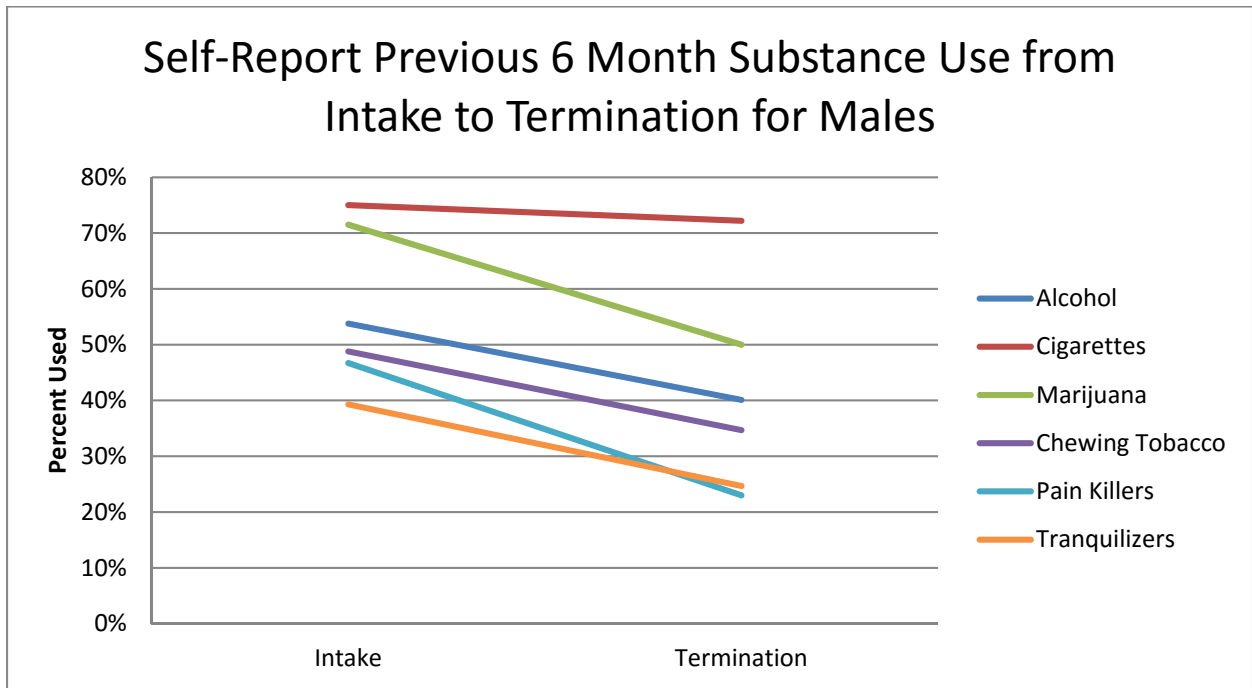


Figure 7. Self-Report Previous 6 Month Substance Use from Intake to Termination for Females

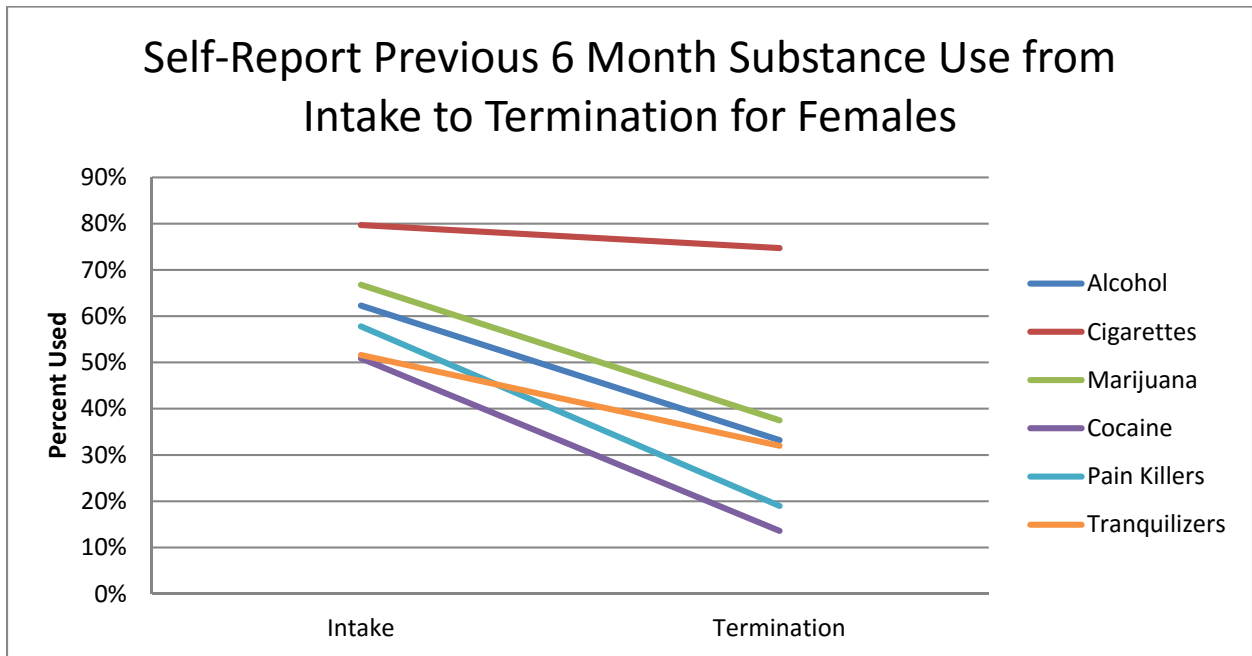


Figure 8. Self-Report Previous 30 Day Substance Use from Intake to Termination for Males

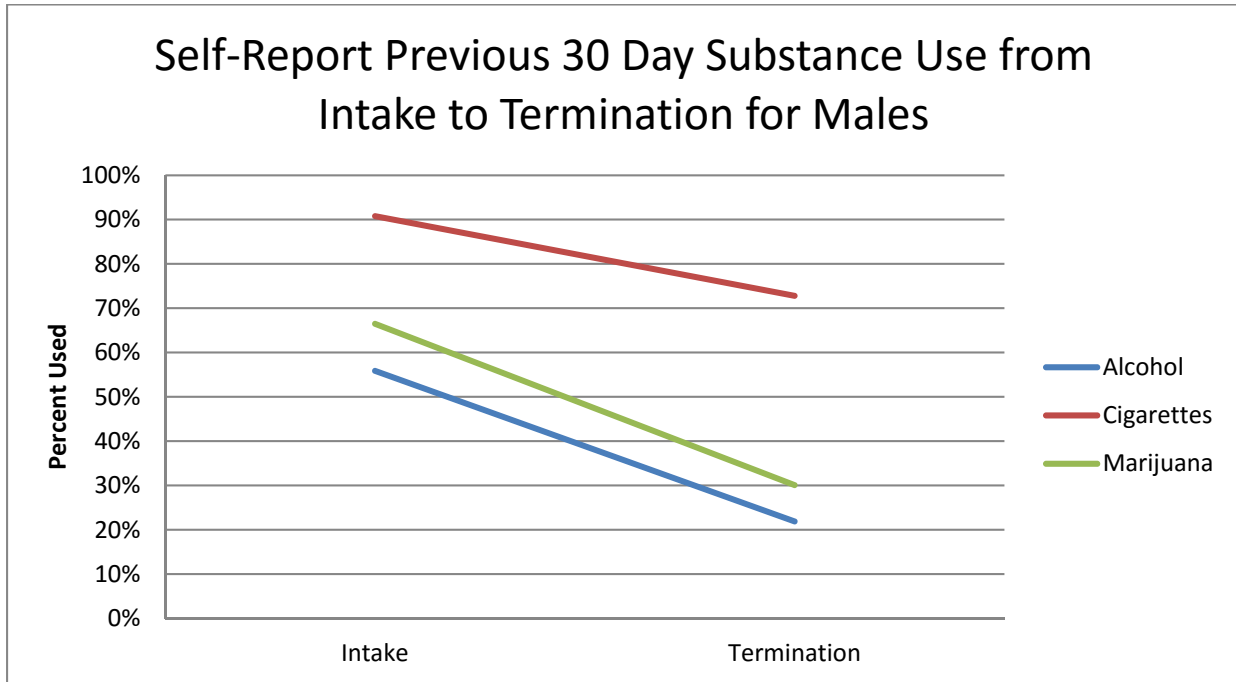


Figure 9. Self-Reported Previous 30 Day Substance Use from Intake to Termination for Females

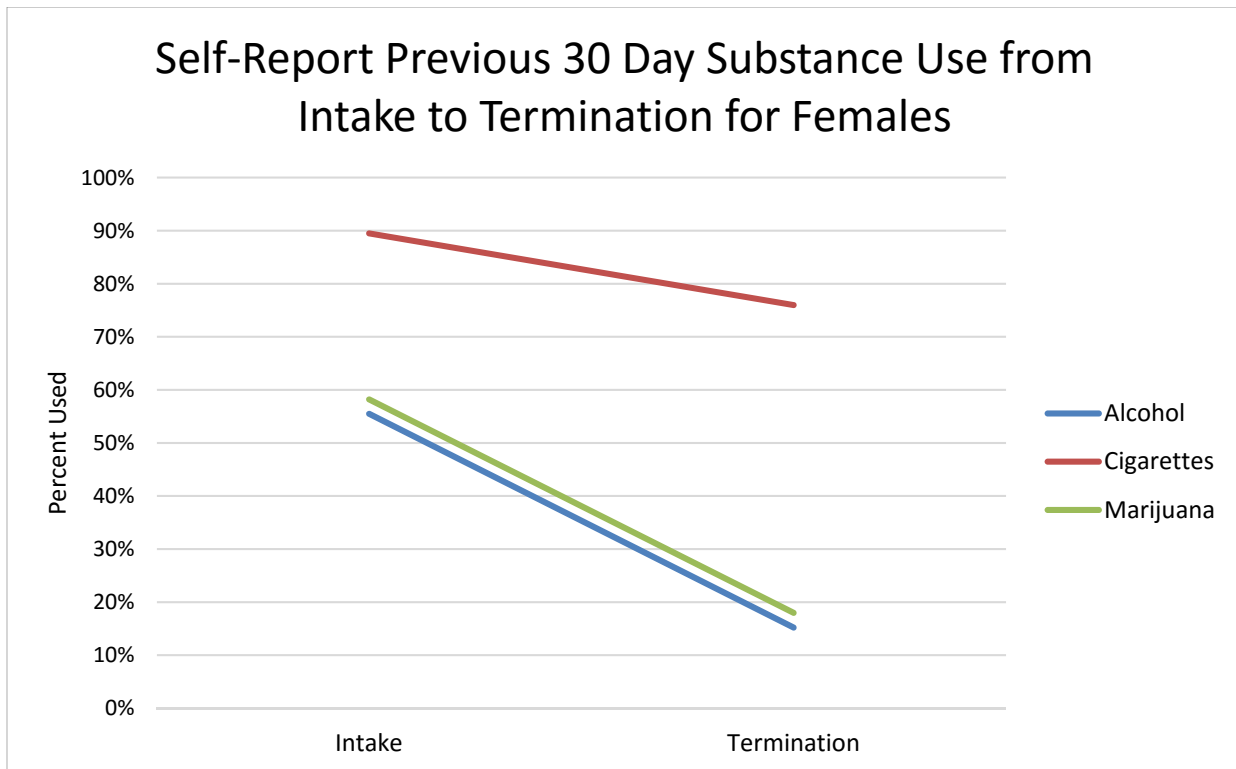


Figure 10. Average Previous 30 Day Substance Use from Intake to Termination for Males

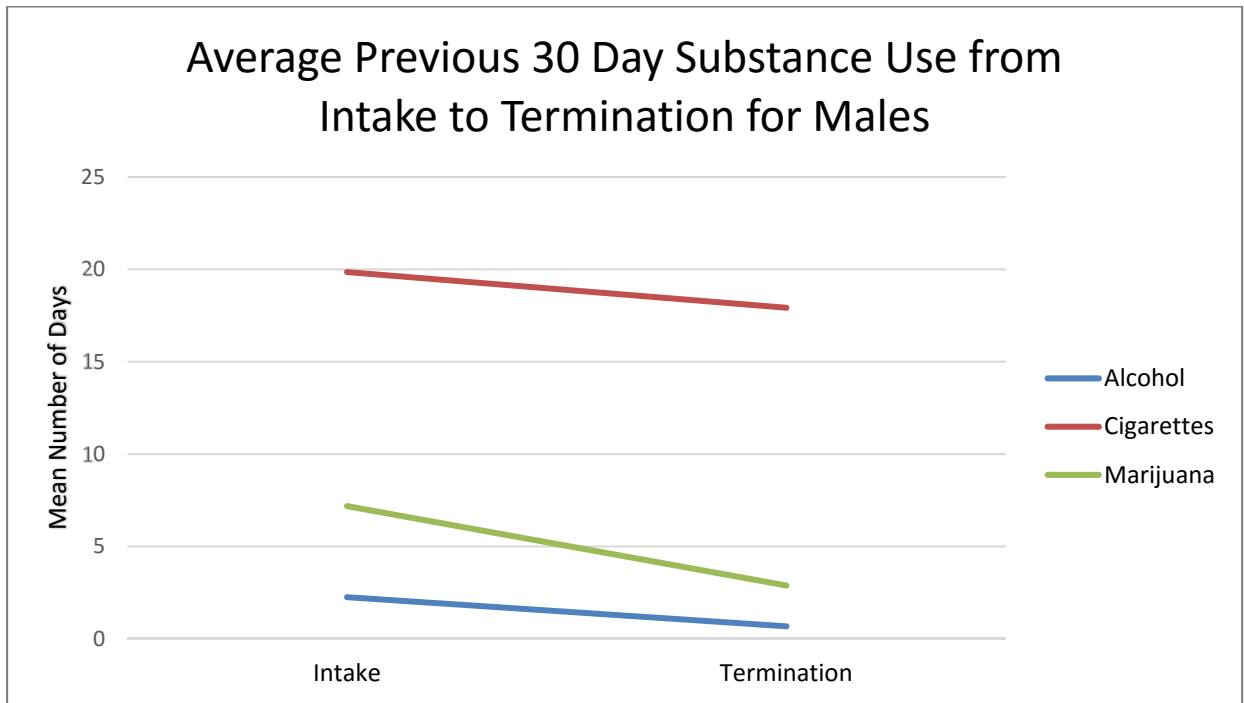
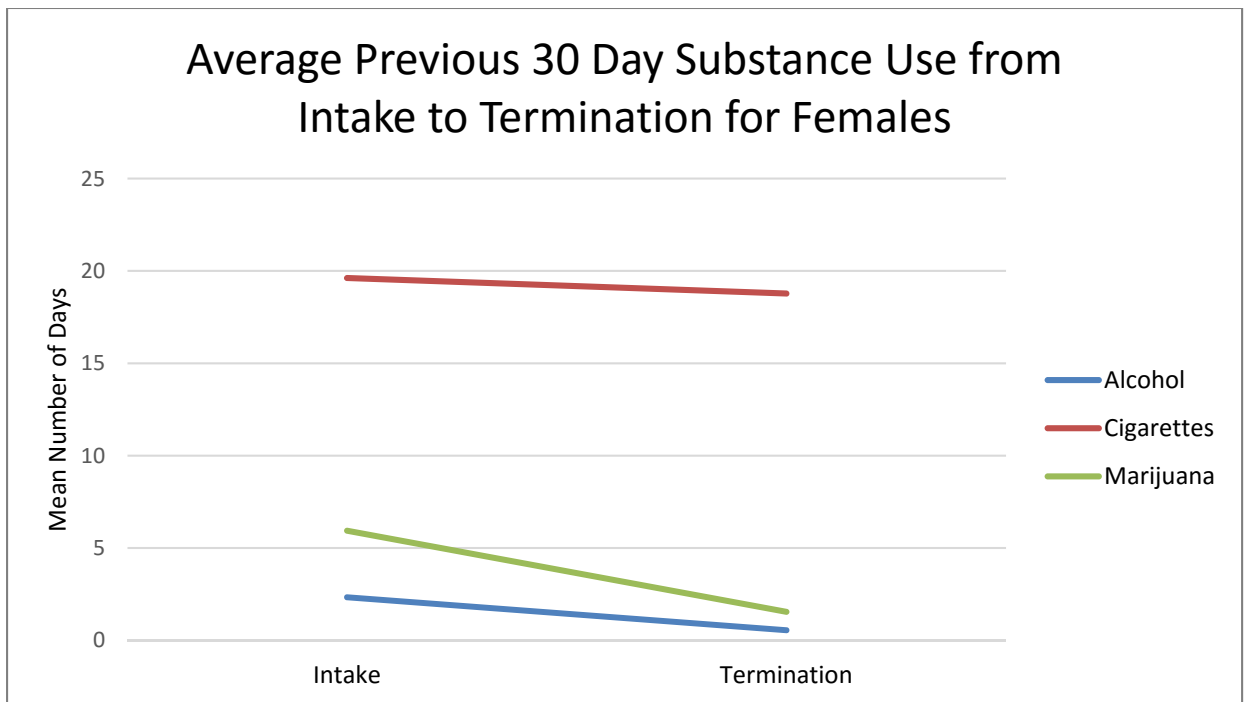


Figure 11. Average Previous 30 Day Substance Use from Intake to Termination for Females



OHIO SCALES AND SUBSTANCE USE

The Ohio Scales contain one Likert-scale item about the youth’s problems with alcohol and drugs during the previous 30 days. This question appears on all three versions of the Ohio Scales (Caregiver, Worker, and Youth). The scale ranges from zero to five, with zero indicating no problems at all with drugs or alcohol in the past 30 days and five indicated 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 12, Figure 13, and Figure 14). For all three raters, a larger percentage of respondents indicated that the youth had no problems with drugs or alcohol at termination in comparison with responses at intake. At intake, 55.9% (n = 1531) of caregivers and 44.5% (n = 1440) of workers reported no problems with alcohol or drugs while 74.5% (n = 1112) of caregivers and 64.9% (n = 1455) of workers reported no problems at termination. Similarly, 60.6% (n = 1931) of youth reported no problems with alcohol or drugs at intake and 76.8% (n = 1379) at termination.

Figure 12. Problems with Drugs or Alcohol in the Past 30 Days - Caregiver Ratings

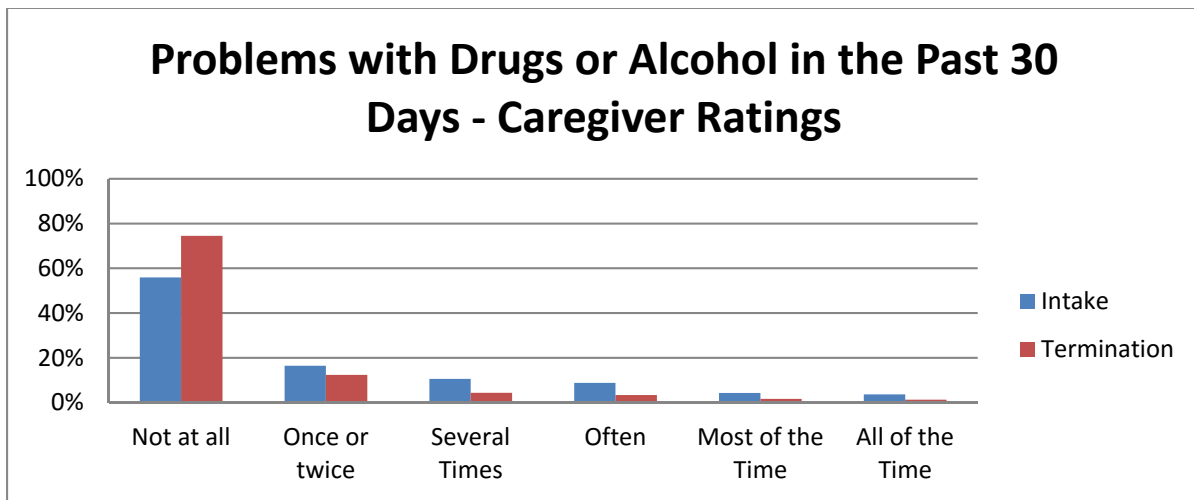


Figure 13. Problems with Drugs or Alcohol in the Past 30 Days - Worker Ratings

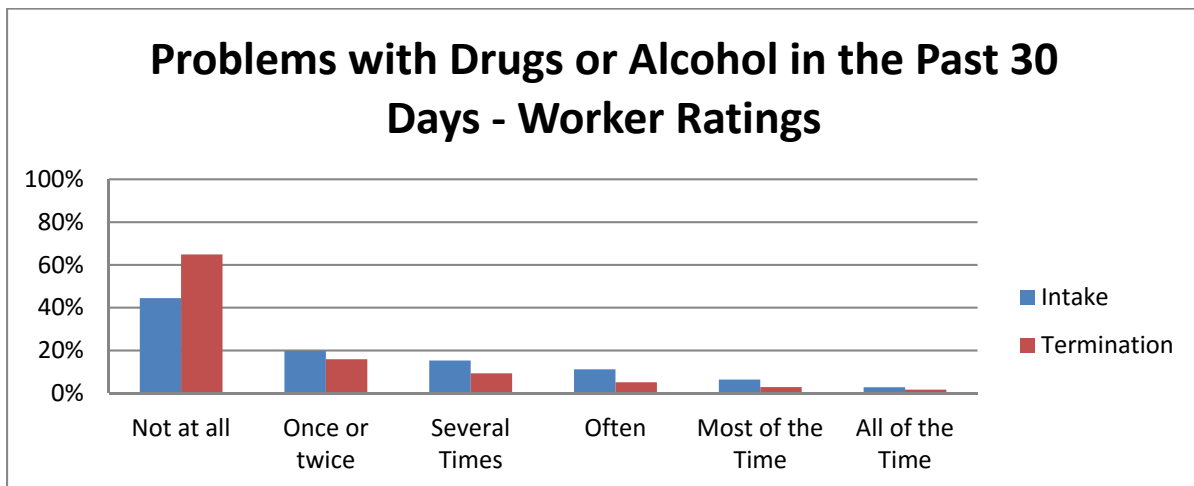
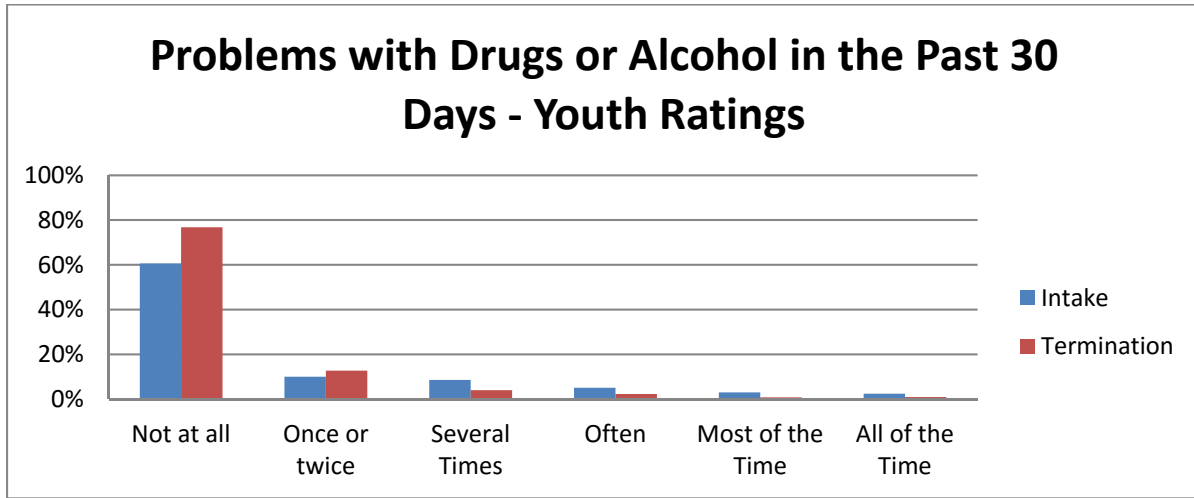


Figure 14. Problems with Drugs or Alcohol in the Past 30 Days - Youth Ratings



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 2,760 youth terminated from the BHJJ program. **Nearly 66% (65.7%, n = 1,813) of the youth terminated from the BHJJ program were identified as successful treatment completers.** Eighty youth (2.9%) were terminated from the program when the youth or family moved out the county. Therefore over two-thirds (68.6%, n = 1,893) 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. About 3% (2.9%, n = 81) of youth were terminated due to some level of incarceration. The most frequently identified termination reason that fell into the 'other' category included aging out of the program, revocation of the court order requiring participation in BHJJ, and various types of family emergencies. In the latest evaluation period that began July 2013 and ended in June 2015, 63.9% (n = 387) of BHJJ youth terminated successfully. Table 26 presents all of the reasons for termination from BHJJ.

Table 26. Reasons for Termination from BHJJ

Termination Reason	All Youth	Youth Enrolled from July 2013 to June 2015
Successfully Completed Services	65.7% (n = 1,813)	63.9% (n = 387)
Client Did Not Return/Rejected Services	6.6% (n = 180)	6.6% (n = 40)
Out of Home Placement	7.6% (n = 209)	9.7% (n = 59)
Client/Family Moved	2.9% (n = 80)	3.3% (n = 20)
Client Withdrawn	6.5% (n = 179)	5.6% (n = 34)
Client AWOL	2.8% (n = 78)	3.1% (n = 19)
Client Incarcerated	2.9% (n = 81)	3.3% (n = 20)
Other	5.1% (n = 140)	4.5% (n = 27)

AVERAGE LENGTH OF STAY

The average length of stay in the BHJJ program was 206 days. For youth identified as completing treatment successfully, the average length of stay was 219 days and for youth identified as unsuccessful treatment completers, the average length of stay was 182 days. For youth enrolled since July 1, 2013, the average length of stay in BHJJ was 167 days with successful treatment completers averaging 175 days and unsuccessful treatment completers averaging 151 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, 54.5% of the youth (n = 1560) were at risk for out of home placement. At termination, 24.0% (n = 642) of youth were at risk for out of home placement. Of those youth who successfully completed BHJJ treatment, 8.0% (n = 142) were at risk for out of home placement at termination while 55.4% (n = 474) of youth who completed unsuccessfully 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 66.9% (n = 1,310) of the youth and had stayed the same for 24.4% (n = 478) of the youth. Police contacts increased for 6.2% (n = 121) of the youth and the worker was unable to estimate for 2.5% of youth (n = 48).

SATISFACTION WITH SERVICES

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the BHJJ program. The Youth Services Survey for Families (YSSF) was introduced as part of the data collection efforts in the 2009-2011 evaluation period. For the current evaluation, the YSSF was retained as an optional form in the termination data packet. Given the low number of YSSF forms completed for youth enrolled after June 1, 2011, some county specific reports may reflect data that are similar to those presented in the previous reporting period.

At termination from the BHJJ program, 93% (n = 938) of caregivers either strongly agreed or agreed that they were satisfied with the services their child received (see Figure 15) and 88.6% (n = 891) either strongly agreed or agreed that the services their child and/or family receive were right for them (see Figure 16). A strong majority (97.6%, n = 984) of caregivers either strongly agreed or agreed that staff treated them with respect (see Figure 17) and 96.1% (n = 961) indicated that they strongly agreed or agreed with the statement that they were satisfied with the cultural and ethnic sensitivity of BHJJ staff (see Figure 18).

Figure 15. Caregiver Satisfaction with the BHJJ Program

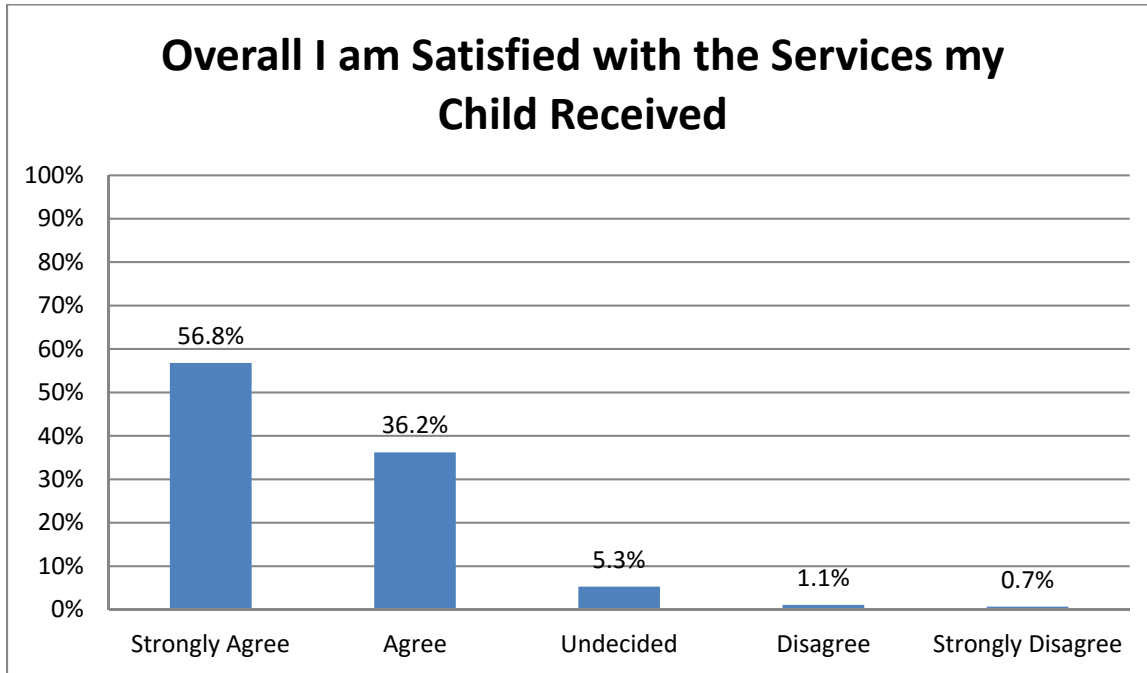


Figure 16. Services Received Were Right for Us

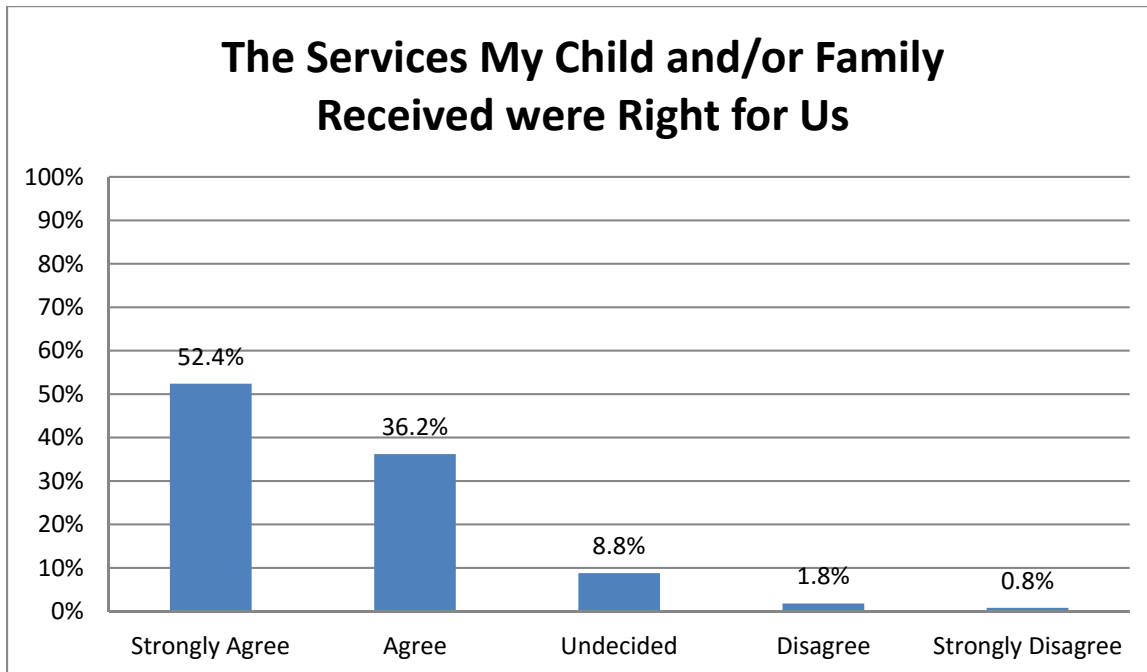


Figure 17. Staff Treated Me with Respect

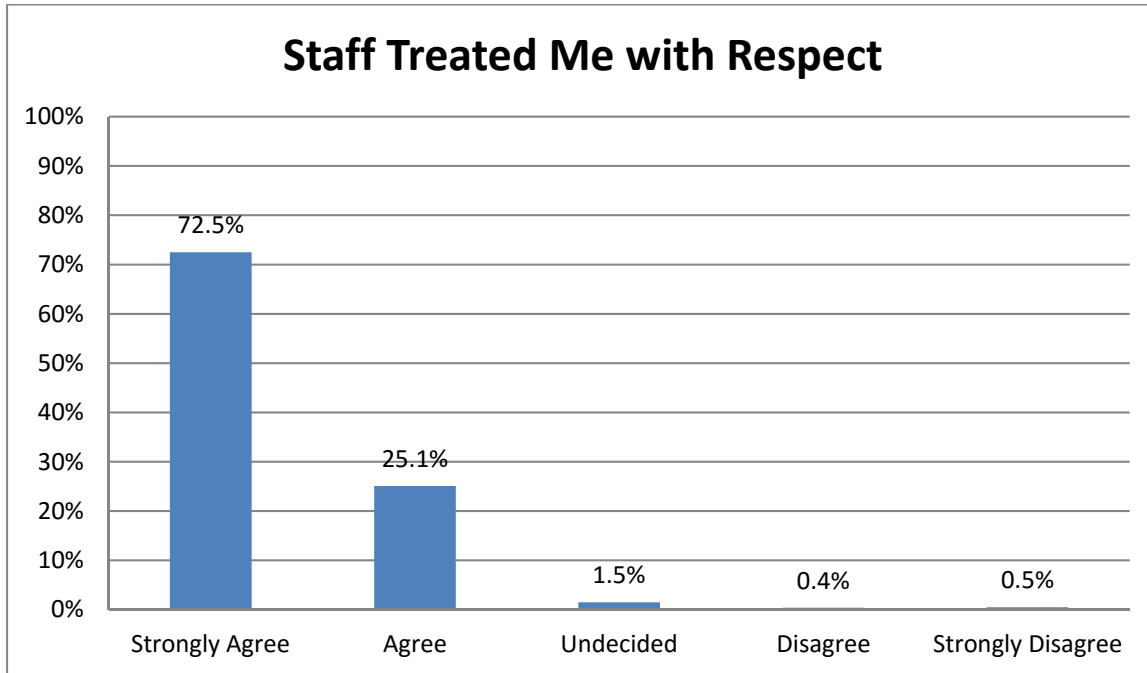
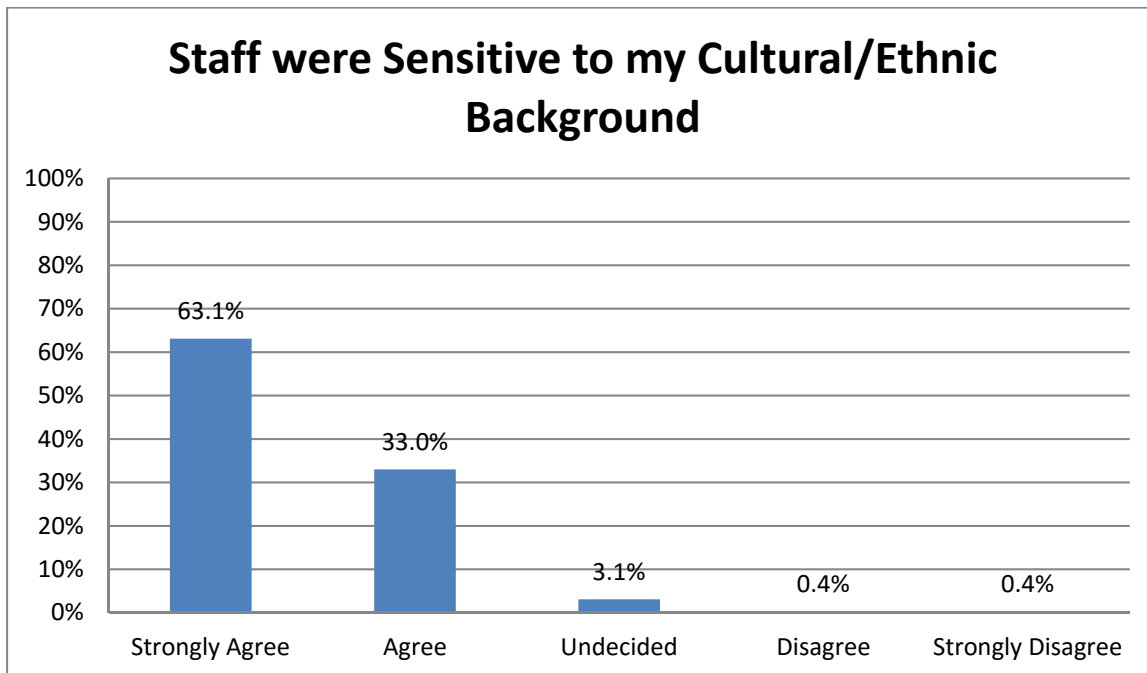


Figure 18. Cultural Competency of BHJJ Services



RECIDIVISM

METHODOLOGY

Court data were provided by the local juvenile courts in each BHJJ county, 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, and 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.

The data presented here consists of juvenile court history and recidivism data for all of the counties that have participated in the BHJJ program since 2006. Some of the original counties are still participating in the program, while others are no longer involved. Up to date recidivism information was not gathered for those counties that are no longer participating. For those counties, the data collection date was adjusted to reflect the last date of their participation in the BHJJ program. Adjudication information was not provided for two former BHJJ counties and thus those counties are not included in the present adjudication analyses. Information on the dates of participation can be found in Table 3.

RESULTS

PREVIOUS JUVENILE COURT INVOLVEMENT

Overall, 69.6% (n = 2,317) of BHJJ youth had a misdemeanor charge, 35.4% (n = 1,178) had a felony charge, and 69.3% (n = 2,310) had been adjudicated delinquent in the 12 months prior to enrollment. Previous juvenile court information was similar for youth regardless of completion status (successful vs. unsuccessful). In the 12 months prior to enrollment, 69.9% (n = 1,240) of successful completers and 71.3% (n = 626) of unsuccessful completers were adjudicated delinquent in the 12 months prior to their enrollment in BHJJ. A slightly higher percentage of successful completers had a felony charge in the 12 months prior to intake (35.7%; n = 633) than unsuccessful completers (33.6%; n = 295). Chi-square analyses revealed that a significantly higher percentage of unsuccessful completers (73.7%; n = 647) than successful completers (68.8%; n = 1,219) were charged with a misdemeanor offense in the 12 months prior to intake. No statistically significant differences in prior felony charges and delinquent adjudications based on program completion status emerged.

Table 27. Charges Prior to BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
3 months (N = 3,331)	39.6% (n = 1,318)	16.5% (n = 549)	38.2% (n = 1,274)
6 months (N = 3,331)	58.0% (n = 1,932)	27.6% (n = 921)	58.0% (n = 1,933)
12 months (N = 3,331)	69.6% (n = 2,317)	35.4% (n = 1,178)	69.3% (n = 2,310)
18 months (N = 3,331)	73.9% (n = 2,461)	37.6% (n = 1,253)	72.5% (n = 2,414)

Table 28. Charges Prior to BHJJ Enrollment for Youth who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
3 months (N = 1,773)	38.7% (n = 687)	16.1% (n = 285)	38.5% (n = 682)
6 months (N = 1,773)	57.2% (n = 1,014)	27.5% (n = 487)	58.7% (n = 1,040)
12 months (N = 1,773)	68.8% (n = 1,219)	35.7% (n = 633)	69.9% (n = 1,240)
18 months (N = 1,773)	73.4% (n = 1,302)	37.8% (n = 671)	73.1% (n = 1,296)

Table 29. Charges Prior to BHJJ Enrollment for Youth who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
3 months (N = 878)	42.8% (n = 376)	15.7% (n = 138)	41.1% (n = 361)
6 months (N = 878)	60.4% (n = 530)	26.3% (n = 231)	59.0% (n = 518)
12 months (N = 878)	73.7% (n = 647)	33.6% (n = 295)	71.3% (n = 626)
18 months (N = 878)	76.9% (n = 675)	35.4% (n = 311)	73.8% (n = 648)

TRENDS IN FELONY CHARGES

We examined trends in felony charges at the county level and found some differences in the proportion of felony level youth enrolled in BHJJ in the current evaluation period compared to the previous evaluation period. These differences are specific to the counties that participated in BHJJ in the 2013 evaluation period. These counties are generally known as the Big 6, which refers to the counties that have historically contributed the most youth to ODYS facilities (Cuyahoga, Franklin, Montgomery, Hamilton, Lucas, and Summit). In the previous report, 40.4% of youth enrolled during 2011-2013 were charged with a felony in the 12 months prior to enrollment (these data vary by county, see Table 30). For the current reporting period, 43.8% of youth enrolled in the Big 6 counties were charged with a felony in the 12 months prior to enrollment. While at first glance, this looks like a modest 3% increase, this actually represents an 8.4% proportional increase from the previous reporting period in the proportion of felony level youth being enrolled in BHJJ in the Big 6 counties. Specifically, Cuyahoga (37.1% proportional increase), Hamilton (64.0% proportional increase), and Lucas (38.0% proportional increase) counties all saw noticeable increases in the proportion of felony level youth enrolled in the current reporting period. Additional information regarding felony charges prior to enrollment in the current BHJJ counties can be found in Table 30.

Table 30. Number of Youth with Felony Charges in the 12 Months Prior to Enrollment among Current BHJJ Counties

County	2011 – 2013	2013 – 2015
Cuyahoga	28.3% (n = 26)	38.8% (n = 31)
Franklin	77.5% (n = 86)	77.0% (n = 67)
Montgomery	21.0% (n = 69)	25.7% (n = 106)
Hamilton	20.3% (n = 12)	33.3% (n = 16)
Lucas	52.3% (n = 34)	72.2% (n = 39)
Summit	91.9% (n = 68)	93.7% (n = 74)
Wayne	n/a	15.8% (n = 3)
Holmes	n/a	11.1% (n = 1)
Trumbull	n/a	11.1% (n = 1)
Mahoning	n/a	22.7% (n = 5)
Lorain	n/a	22.9% (n = 8)
Wood	n/a	33.3% (n = 1)
Total	40.4% (n = 295)	43.8% (n = 333)

RECIDIVISM AFTER ENROLLMENT

We defined recidivism after enrollment as receiving a new charge or adjudication at 3, 6, 12, and 18 after a youth’s BHJJ enrollment date. In the 12 months after enrollment in BHJJ, 52.6% (n = 1,119) were charged with at least one new misdemeanor and 21.3% (n = 453) were charged with at least one new felony. Less than 50% (48.5%; n = 1,033) of the youth were adjudicated delinquent in the 12 months after their enrollment in BHJJ.

Table 31. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
3 months (N = 2,987)	24.4% (n = 729)	8.6% (n = 257)	23.5% (n = 699)
6 months (N = 2,724)	38.0% (n = 1,035)	14.8% (n = 402)	36.1% (n = 983)
12 months (N = 2,129)	52.6% (n = 1,119)	21.3% (n = 453)	48.5% (n = 1,033)
18 months (N = 1,577)	59.8% (n = 945)	25.8% (n = 407)	55.2% (n = 871)

In the 12 months after enrollment in BHJJ, 48.1% (n = 596) of successful completers were charged with at least one new misdemeanor, 16.5% (n = 204) were charged with at least one new felony, and 43.2% (n = 535) were adjudicated delinquent. Of the youth who completed unsuccessfully, 59.5% (n = 350) were charged with at least one new misdemeanor, 29.6% (n = 174) were charged with at least one new felony, and 58.5% (n = 344) were adjudicated delinquent in the 12 months after their enrollment in BHJJ. Chi-square analyses revealed that **a significantly higher percentage of unsuccessful completers were charged with misdemeanors, felonies, and adjudicated delinquent than successful completers at each of the examined time points after enrollment.**

Table 32. Recidivism after BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
3 months (N = 1,651)	20.4% (n = 336)	5.6% (n = 92)	18.7% (n = 306)
6 months (N = 1,552)	32.9% (n = 510)	10.2% (n = 159)	30.7% (n = 476)
12 months (N = 1,238)	48.1% (n = 596)	16.5% (n = 204)	43.2% (n = 535)
18 months (N = 923)	57.3% (n = 529)	21.2% (n = 196)	51.5% (n = 475)

Table 33. Recidivism after BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
3 months (N = 812)	32.6% (n = 265)	13.5% (n = 110)	33.5% (n = 272)
6 months (N = 751)	47.3% (n = 355)	23.0% (n = 173)	47.7% (n = 358)
12 months (N = 588)	59.5% (n = 350)	29.6% (n = 174)	58.5% (n = 344)
18 months (N = 433)	63.5% (n = 275)	32.9% (n = 142)	61.0% (n = 263)

RECIDIVISM AFTER BHJJ TERMINATION

We defined recidivism after termination as receiving a new charge or adjudication any time after a youth's BHJJ termination date. In the 12 months after termination from BHJJ, 42.0% (n = 563) of youth were charged with at least one new misdemeanor and 18.4% (n = 247) were charged with at least one new felony. Less than 40% (39.7%; n = 533) of youth were adjudicated delinquent in the 12 months following their termination from BHJJ.

Table 34. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
3 months (N = 2,074)	18.8% (n = 390)	7.1% (n = 147)	18.2% (n = 377)
6 months (N = 1,824)	29.4% (n = 537)	11.8% (n = 215)	27.7% (n = 506)
12 months (N = 1,341)	42.0% (n = 563)	18.4% (n = 247)	39.7% (n = 533)
18 months (N = 950)	53.4% (n = 507)	24.0% (n = 227)	49.3% (n = 468)

In the 12 months following their termination from BHJJ, 41.2% (n = 353) of successful completers were charged with at least one new misdemeanor, 16.2% (n = 139) were charged with at least one new felony, and 37.9% (n = 325) were adjudicated delinquent. Of the youth who completed unsuccessfully, 43.6% (n = 203) were charged with at least one new misdemeanor, 22.1% (n = 103) were charged with at least one new felony, and 43.1% (n = 201) were adjudicated delinquent in the 12 months after their termination from BHJJ. Chi-square analyses showed that **a significantly higher percentage of youth who terminated unsuccessfully were charged with felonies than youth who terminated successfully in each of the time periods examined following termination.**

Table 35. Recidivism after BHJJ Termination for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
3 months (N = 1,342)	17.7% (n = 238)	6.0% (n = 80)	16.6% (n = 223)
6 months (N = 1,166)	28.6% (n = 334)	10.3% (n = 120)	25.6% (n = 298)
12 months (N = 857)	41.2% (n = 353)	16.2% (n = 139)	37.9% (n = 325)
18 months (N = 618)	52.3% (n = 323)	21.5% (n = 132)	47.7% (n = 295)

Table 36. Recidivism after BHJJ Termination for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
3 months (N = 707)	19.9% (n = 141)	9.1% (n = 64)	19.7% (n = 139)
6 months (N = 635)	30.2% (n = 192)	14.3% (n = 91)	29.9% (n = 190)
12 months (N = 466)	43.6% (n = 203)	22.1% (n = 103)	43.1% (n = 201)
18 months (N = 318)	55.3% (n = 176)	28.6% (n = 91)	51.3% (n = 163)

PREVIOUS FELONY

We analyzed the recidivism data further by examining youth who had been charged with a felony in the 12 months prior to intake. Of the 438 youth entering the program with at least one felony charge in the 12 months prior to intake and for whom data at 12 months after termination were available, 29.9% (n = 131) were charged with a new felony in the 12 months following termination.

More than 70% of youth who were charged with a felony in the 12 months prior to their BHJJ enrollment were not charged with a new felony in the 12 months after their termination. We separated the data further based upon completion status. Twenty seven percent (27.2%; n = 76) of youth with a felony charge in the 12 months prior to enrollment who successfully completed treatment were charged with a new felony 12 months following termination. Of those youth with a felony charge in the 12 months prior to enrollment who completed treatment unsuccessfully, 34.2% (n = 53) were charged with a new felony in the 12 months following termination.

ODYS COMMITMENTS

Among the 2,906 BHJJ youth in the currently participating counties for whom we had recidivism data, 3.7% (n = 108) were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ (see Table 37). **Conversely, 96.3% of youth participating in BHJJ were not admitted to an ODYS facility at any point after enrollment.**

Table 37. ODYS Admissions for Youth Enrolled in BHJJ

BHJJ County	Number of Youth in Recidivism Analysis	Youth Committed to ODYS after BHJJ Enrollment
Cuyahoga	354	13 (3.7%)
Franklin	445	29 (6.5%)
Hamilton	217	4 (1.8%)
Holmes	9	0 (0.0%)
Lorain	32	0 (0.0%)
Lucas	183	10 (5.5%)
Mahoning	22	0 (0.0%)
Montgomery	1,392	25 (1.8%)
Summit	212	26 (12.3%)
Trumbull	18	1 (5.5%)
Wayne	19	0 (0.0%)
Wood	3	0 (0.0%)
Total	2,906	108 (3.7%)

OHIO YOUTH ASSESSMENT SYSTEM

The Ohio Youth Assessment System (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. In this section we focus on the three risk levels; low, moderate, or high based on scores provided by each county's juvenile court. The OYAS scores provided by each of the juvenile courts were those closest to a youth's enrollment in BHJJ. While we used these data to predict future recidivism, we acknowledge that OYAS scores at termination would be more appropriate predictors of recidivism. Results should be interpreted with caution.

To test whether OYAS risk levels at intake predicted recidivism and successful completion of the BHJJ program, two separate analyses are presented. Chi-square analyses are presented to test the bivariate relationship between OYAS risk levels and recidivism as well as successful completion. Recidivism was defined as whether the individual had a new felony charge or a new delinquent adjudication within 12 months of termination. Table 38 shows the percentages of successful completion and recidivism by the OYAS risk categories. For example, of youth who scored high risk to reoffend on the OYAS at intake and who had available data at 12 months after termination, 38.0% were charged with a felony in the 12 months after termination. Chi-square analyses revealed significant group differences for the percentage of youth with a felony charge at 12 months after termination ($\chi^2(2) = 8.89, p < .05, n = 353$), the percentage of youth with delinquent adjudications ($\chi^2(2) = 10.04, p < .01, n = 353$), and the percentage of those who successfully completed BHJJ treatment ($\chi^2(2) = 17.13, p < .001, n = 561$) significantly differed by OYAS risk categories.

Table 38. Recidivism at 12 Months Following Termination and Percentage of Successful Completers by OYAS Risk Categories

	OYAS Low	OYAS Moderate	OYAS High
Felony Charge at 12 months ***	11.1% (n = 26)	26.1% (n = 85)	38.0% (n = 63)
Delinquent Adjudications at 12 months ***	29.4% (n = 69)	46.3% (n = 151)	48.2% (n = 80)
Successful Completers ***	80.4% (n = 292)	70.2% (n = 373)	58.8% (n = 154)

***p < .001

Table 39 presents three separate models predicting recidivism at 12 months after termination and successful completion of BHJJ from gender, age, race, and OYAS risk categories. The model chi-square statistic indicated that the proposed model predicting delinquent adjudications at 12 months after termination represented the data well ($\chi^2(5) = 29.05, p < .001, n = 696$). In comparison to youth in the high risk category, the odds of being adjudicated delinquent for youth in the low risk category were 2.08 times lower.

The model predicting a felony charge within 12 months following termination represented the data well ($\chi^2(5) = 75.06, p < .001, n = 696$). The odds of BHJJ males charged with a felony at 12 months after termination was 2.36 times greater than for BHJJ females. The odds of White youth charged with a felony at 12 months following termination was 2.32 times less than for Nonwhite youth. Compared to youth in the high risk category, the odds of a youth in the low risk category being charged with a felony within 12 months after termination was 4.35 times less and 1.67 times lower for youth in the moderate risk category.

For the logistic regression model predicting successful completion from the BHJJ program, the proposed model represented the data well ($\chi^2(5) = 35.52, p < .001, n = 1108$). Compared to youth in the high risk category, the odds of successful BHJJ completion for youth in the low risk category was 2.67 times greater and 1.63 times greater for youth in the moderate risk category. These models suggest that the OYAS at intake predicts both recidivism and successful completion of BHJJ beyond what is explained by demographics.

Table 39. Logistic Regression Models Predicting Recidivism at 12 Months and Successful Completion

	Delinquent at 12 months			Felony at 12 Months			Successful Completion		
	B	SE B	e ^b	B	SE B	e ^b	B	SE B	e ^b
Male (Female)	.28	.18	1.32	.86*	.24	2.36	-.06	.15	1.06
Age	-.09	.07	1.33	.00	.08	1.00	-.10	.05	1.10
White (Nonwhite)	-.29	.07	1.09	-.85*	.22	2.32	.11	.14	1.12
OYAS Low (High)	-.73*	.22	2.08	-1.45*	.29	4.35	.98*	.19	2.67
OYAS Moderate (High)	-.07	.20	1.07	-.51*	.21	1.67	.49*	.16	1.63
N	696			696			1108		
χ^2	29.05*			75.06*			35.52*		
Df	5			5			5		

*p < .05

FINANCIAL IMPLICATIONS

The FY14 per diem to house a youth at an Ohio Department of Youth Services institution was \$541 and the average length of stay was 12.6 months. Based on these numbers, the estimated cost of housing the average youth at an ODYS facility in FY14 was approximately \$205,000. Since 2006, 3,495 youth have been enrolled in BHJJ and the direct State contribution to the program has been approximately \$17.6 million. This does not include additional county resources, Medicaid dollars, or other sources of funding. Using these figures, the average cost per youth enrolled in BHJJ was \$5,035.

SUCCESS STORIES

While the collection of empirical data is crucial to demonstrate program effectiveness and help secure additional funding, qualitative data can be an additional source of valuable information that may at times be obscured by means, tables, and figures. Counties were asked to provide information on memorable youth and families who participated in the BHJJ program in the form of success stories.

CUYAHOGA COUNTY

The youth, who was on community control for Assault F-5 was referred to the Cuyahoga County BHJJ program by the Court's Alternative Case Planning (ACP) team due to being considered for an out of home placement. The concerns reported by the previous Probation Officer included: significant mental health and substance abuse concerns, aggression, criminogenic behavior, associating with negative peers, poor child/parent relationship and disruptive behavior at school. This youth was previously unsuccessful on traditional probation through the court and continued to acquire new charges.

After receiving his mental health assessment, the youth was recommended by the BHJJ Assessor to receive Bellefaire Integrated Co-Occurring Treatment (ICT) Services to address the co-occurring disorders. A referral was made by the Care Coordinator for this service shortly after receiving the case. Since services started with Bellefaire ICT, the youth consistently provided clean drug screens. He and his mother consistently participated in these services and with family therapy. His mother showed improvement holding the youth more accountable in the home and decreasing enabling behavior. Initially, the youth was getting into verbal and physical altercations as well as lacking focus and concentration with school work. However, since working with the BHJJ Placement Aftercare Coordinator, BHJJ Care Coordinator, ICT therapist and school professionals, the youth was able to increase compliance and reduce the amount of behavioral concerns at school. School professionals reported an increase in completed school work, focus, and respect with school rules and adults.

Over the last couple months there have been no reported physical altercations. Also, the youth was referred to a youth employment program and was successfully linked to a job at a local retailer within the completion of the 6 week program. He was also referred for the Youth Advisory Committee for Juvenile Court and completed his assigned community service hours. During his time in the BHJJ program the youth had no new charges and was recently successfully terminated from community control.

FRANKLIN COUNTY

Youth A is currently involved in Franklin County Juvenile Court for a Burglary F2. The youth had been with his co-defendant and unlawfully entered a residence with the intention of removing property. Eventually, A was placed on Felony Probation. From the start of Probation, A has displayed no resistance to the Terms & Conditions of Probation. He attends school every day and puts forth a great deal of effort. He is respectful of staff and other peers. A is linked with counseling through Directions for Youth and Families and has set appropriate goals to work towards. He is making excellent progress and should be done with counseling fairly soon.

Throughout his life, A has been exposed to negativity and violence, particularly in the home. His mother and father separated, and there is very little contact with his biological father. However, mother had entered into a few other relationships but these relationships typically involved domestic violence. This has caused overwhelming feelings for A such as lack of trust, anger, depression, and anxiety. There are times where he fears for the safety of his family.

We are truly very proud of all the work he has done. He continues to amaze us each day and is dependable and a joy to work with. We are able to see A in his daily environments – school and home. He looks forward to our visits and usually questions when one of us is not present with the other. We keep in constant contact regarding A – sending text messages, emails, phone calls, and face to face check in's.

HAMILTON COUNTY

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

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

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

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

HOLMES COUNTY

The client was a 16 yr. old Caucasian male who lived with his Mom and step-Dad. The client moved in with his Mom in August 2014 after living with his Dad and step-Mom for 10 yrs. The relationship between biological parents has always been negative with limited communication. The case opened in early 2015. The client displayed verbal aggression, substance use, leaving without permission, and poor school performance. The client was referred to the MST program through the Holmes County Juvenile Court. The client would swear and call his Mom names, argue, rebel against anything she would say to him. He would refuse to comply with any rules she would try to enforce. The client smoked cigarettes and marijuana. He refused to believe marijuana was a dangerous drug and used as often as he could. He would leave without permission and be gone for days associating with other negative peers with like behaviors. The client was attending a local high school and was in the program where he went a half day to school and worked the other half at a local restaurant.

Mom was very frustrated and stated many times that she was worried her son would never love her. This was very hard for her due to past guilt when the client lived with his Dad. One of the first interventions was to stop engaging with the client. This was very hard but very effective. She would not argue and would exit and wait which decreased the negative comments because if she was not engaging with him there was no one to argue with and it stopped. Mom and step-Dad were very good at working the program and involved the other children by putting a list of rules on the refrigerator and having a reward and consequence jar. This was very impressive and worked well.

The client continued to rebel against rules, rewards, and consequences that were put in place to decrease the negative behaviors. It seemed that after 3 months of treatment there was very little progress. The client had spiraled down to the bottom, he had lost his job, his phone, he was skipping school, his grades were dropping, he was testing positive for all drug screens, he lost his girlfriend, and there was no communication with his family. The client left without permission for three days. Mom worked the plan by calling all friends (positive and negative) which she had by having a friends approval list and a 4W plan which had the information of who, where, when, and what the client was doing. Mom went to places she thought he might be, called the police and filed a missing person report, and put his picture on social media. The client turned himself in because he did not like having his picture on Facebook. The client would sleep all the time and was displaying signs of depression.

Mom and therapist agreed that something needed to change because he had nothing and did not care. The client would soon turn 17 yrs. old and needed to learn accountability and responsibility. When we went to a probation violation hearing we discussed a plan with his probation officer to increase the clients' freedom with boundaries. Mom had a cell phone on her account that she could monitor and gave it to the client. The client needed to spend a certain amount of time with the family (not by himself). He was allowed to spend a certain amount of time with approved friends as long as he would check in, was where he was supposed to be, and Mom knew who he was with and approved. Mom would drug screen him on Friday mornings and the client would go to the courthouse on Monday morning and do a drug screen for his probation officer. There were rules, rewards, and consequences for any leaving without permission and for any positive drug screens.

This new plan of giving freedoms with boundaries has worked amazingly. Verbal aggression decreased and there was more open communication between Mom and the client. The client did not leave without permission and was compliant with checking in. He applied for and was hired at another restaurant. At the time of discharge, the client had 5 weeks and 2 days clean from substances.

LORAIN COUNTY

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

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

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

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

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

*Name changed to protect client's confidentiality.

LUCAS COUNTY

M. had extensive involvement in the past with Harbor, Lucas County Board of Developmental Disabilities, (LCBDD), and the Lucas County Juvenile Court (LCJC). Since childhood M. exhibited complex and intense behavioral needs which steadily increased in frequency, severity, and level of community risk. His behavior created extreme family conflict, including recurring domestic violence incidents between his mother and him. At one point his behaviors were so severe he was placed in a residential treatment facility.

M. was referred to wraparound by LCJC following burglary and menacing charges. The relationship between M. and his mother had become unhealthy and unsafe. His mother claimed that just being near him made her fear for her own physical and psychological well-being. She described him as a “cunning, manipulative, sociopath”. In addition, his mother was dealing with her own untreated mental health issues. His father was unable to provide the level of involvement and supervision needed due to extensive traveling required by his work. Prior to being referred to Wraparound, M. was months away from turning 18, truant, and had disengaged from community services for over a year. With all of these combined factors the Juvenile Court Judge ordered emergency respite to keep M. safe until an alternative plan was identified. At that time Lucas County Children Services (LCCS) became involved as well. Wraparound became the chosen option to facilitate a transition plan from respite home to home and community, and incorporate non-traditional options within the community to support his needs.

Wraparound helped M. assemble a team, develop a safety/crisis plan, and address immediate needs and concerns. His small team grew to include: former and current probation officers, representatives from the court’s Crossover program, his guardian ad litem, the court psychologist, transitional living workers, a child services caseworker, family members, group home staff, LCBDD, and various natural and informal supports.

M. worked with his parents to identify goals, root causes of conflict, and a means to maintain their relationships in safe and healthy ways. He was able to identify the foundational steps toward his transition into adulthood, areas in which he would need support and help, and the skills he needed to transition into adulthood. Through this process short and long term goals were established regarding: family, education, vocation, mental and physical health, and independent living. A collaborative transition plan was created, and M. was able to successfully transition home.

M. was able to meet his identified needs, began attending school regularly, and was linked with a vocational program. He reengaged with Harbor, his previous services provider for mental health and transitional living needs. M. also became compliant with taking his prescribed medications. In addition, his mother began to take better care of her mental and physical health needs. He had no new criminal charges or domestic violence incidents, and his case was closed from probation. M. made positive connections with new individuals and improved existing ones. He attended all of his Wraparound meetings, taking a leadership role in shaping his plan. Upon discharge he had a safe place to live, access to transportation, supports in place, and the ability to communicate his needs in more appropriate ways. He reported Wraparound was helpful and that he has a better outlook on life as a result of the process. He believed that his voice mattered, and that the right people were in his life to help him meet his goals. He was successfully closed with Wraparound after eight months of planning and meaningful work.

MAHONING COUNTY

J is a 15 year old male who lives at home with his mother, two sisters and his brother. J had been in and out of detention and court for two months before he was referred to MST. A month before starting MST treatment J had run from a group home that he was placed in due to his aggressive and unruly behaviors. J's referral behaviors were AWOL/ leaving without permission, THC use, verbal aggression, physical aggression and oppositional behaviors at school.

Prior to starting MST, J would run for many days at a time, get into fights with peers, destroy property in the home and was asked to permanently leave his mainstream school. At this time, J's mom was trying to manage J as well as his younger brother and older sister who also had mental health and behavior health concerns, along with her own mental health symptoms. J's mom was feeling hopeless and like she had lost control of her household.

Within the first month of MST, Mom and the therapist worked to get J enrolled into an alternative school, and to establish clear expectations and consequences for "big"/charge-worthy behaviors. J provided a lot of intense kick-back when his mom started to implement plans that were developed in MST and was in and out of the juvenile justice center for AWOL and aggressive behaviors.

During month two of MST, J's behaviors were starting to decrease and there was finally stability in the home. J and mom were communicating better and he was able to earn privileges. J's mom was very engaged throughout treatment we were able to develop plans to increase her skills to manage his behavior inside and outside of the home. Mom was able to increase her contact with peer's parents to help increase supervision of youth when he was outside of the house. During treatment, mom also improved her communication skills and parenting skills pertaining to setting consistent and effective consequences with the youth and his siblings. The family was able to maintain a level of stability for 4-5 weeks, which was the longest period of time for the family in a year.

At the end of the 5 months, J had passed 9th grade at a local high school with no suspensions. He also remained clean from substances throughout treatment and got involved with boxing as a prosocial activity. J's leaving without permission episodes were reduced from leaving for many days at a time to leaving for 30 minutes to cool down. J had maintained his behaviors enough to not return to the juvenile justice center in over 8 weeks, which was the longest stability for him in over 6 months. J and mom showed improvement in communication and ability to diffuse arguments during treatment. When there are intense arguments, mom is more comfortable using natural family and friend supports to help with respite and managing J's behaviors. Although there are still arguments and bursts of aggression at times, J's mom demonstrates that she has gotten better at managing J and his siblings behaviors and has the confidence to be an effective parent.

MONTGOMERY COUNTY

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."

SUMMIT COUNTY

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.

TRUMBULL COUNTY

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

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

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

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The probation department had been working with a sibling set for some time. The brother and sister had what was becoming an extensive juvenile court history which included numerous admissions to the detention center. The siblings' charges included unruly, domestic violence, assault and unauthorized use of a motor vehicle. Both siblings were exhibiting serious verbal and physical behaviors at home and in the community and would leave the home on a daily basis without permission. Due to their behaviors, the family had to bounce between homes as the siblings would quickly overstay their welcome due to their behaviors. Although the Judge did not specifically deal with these siblings, she saw their names come across her desk enough that she returned the file with a note stating that she wanted them considered for MST.

The father and his fiancé were willing to work with MST and acknowledged that the siblings' behavior created an unsafe environment for not only the siblings but everyone around them. The siblings' on the other hand were not interested in the program or the therapist, as this would threaten their way of life. The MST therapist worked with the adults on communication and putting up a united front. This included a great deal of time role playing scenarios so they felt comfortable in their united front. This new approach by the adults put a kink in the siblings' efforts to play the caregivers against each other and allowed for the adults to work with the therapist on the youths' specific behaviors. Initially the larger behaviors were addressed and as those became under control the focus shifted to the smaller ones. The adults were in contact with the therapist either by phone or in person on almost a daily basis and this along with the interventions allowed the father and his fiancé to gain control of their home.

After four months in the program every behavior that caused the referral to the program had decreased significantly or was eliminated completely. The father and his fiancé expressed that they felt in control of their household, which they hadn't been in some time. On the day of the last session the sister reported to the MST therapist that she was angry and left the home without permission the previous day and by the time she reached the end of the street she turned around and went back because the consequences were not worth the action. The siblings earned their way off of probation and no new charges have been filed with the Court since they completed the program. The father and his fiancé remain in regular contact with the MST therapist and report that almost a year later the siblings are doing well and they still use the techniques they learned in MST.

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