An Evaluation of Ohio's Behavioral Health/Juvenile Justice (BHJJ) Initiative

August 2020

Fredrick Butcher, PhD | Jeff Kretschmar, PhD | Liuhong Yang, MS | David Rinderle, BA | Margarid Turnamian, BA

JACK, JOSEPH AND MORTON MANDEL
SCHOOL OF APPLIED SOCIAL SCIENCES
CASE WESTERN RESERVE
UNIVERSITY

Begun Center for Violence Prevention
Research and Education

Table of Contents

Executive Summary 15
Juvenile Justice and Mental Health 17
Juvenile Justice/Mental Health Diversion Programs 17
Ohio's Behavioral Health/Juvenile Justice (BHJJ) Initiative 18
Measures and Instrumentation 19
Data Collection Schedule 21
Date of BHJJ Participation 22
Project Descriptions 22
Ashtabula/Mahoning/Trumbull Counties 22
Cuyahoga County 24
Franklin County 26
Hamilton County 27
Lorain County 30
Lucas County 31
Montgomery County 35
Summit County 37
Wayne/Holmes Counties 39
Data Analysis Plan 40
Description of the Analyses Used in the Report 40
Sample Size 41
Results 42
Demographics 42
Custody Arrangement and Household Information (July 1, 2017 – June 30, 2019) 43
Youth and Family History (July 1, 2017 – June 30, 2019) 44
Problems Leading to Service (July 1, 2017 – June 30, 2019) 46
Ohio Youth Assessment System (July 1, 2017 – June 30, 2019) 47
DSM Diagnoses (July 1, 2017 – June 30, 2019) 48
Educational Information (July 1, 2017 – June 30, 2019) 49
Ohio Scales (July 1, 2017 – June 30, 2019) 50
Problem Severity 51
Functioning 54

Violence and Delinquency Questionnaire....57
Resilience (July 1, 2017 – June 30, 2019)....61
TSCC (July 1, 2016 – June 30, 2019)....66
Substance Use Survey (July 1, 2017 – June 30, 2019)....68
Thirty-Day Substance Use....69
Reasons for Termination....72
Average Length of Stay....72
Risk for Out of Home Placement (July 1, 2017 – June 30, 2019)....72
Police Contacts (July 1, 2017 – June 30, 2019)....74
YSSF (July 1, 2017 – June 30, 2019)....74
Recidivism (July 1, 2015 – June 30, 2019)....75
Methodology....75
Results....76
Previous Juvenile Court Involvement....76
Trends in Felony Charges....78
Recidivism after Enrollment....79
Recidivism after BHJJ Termination....80
ODYS Commitments....82
Average Numbers of Charges and Adjudications....82
Recidivism and the Ohio Youth Assessment System....85
Financial Implications....85
Success Stories....86
Ashtabula County....86
Cuyahoga....86
Franklin County....88
Hamilton County....89
Holmes County....90
Lucas County....90
Mahoning County....91
Montgomery County....92
Summit County....92
Trumbull County....93
Lorain County....94

Wayne County 96
Cuyahoga 97
Demographics 97
Custody Arrangement and Household Information 97
Youth and Family History 99
Problems Leading to Service 101
Ohio Youth Assessment System 102
DSM Diagnoses 103
Educational Information 104
Ohio Scales 105
Problem Severity 106
Worker Ratings 106
Youth Ratings 107
Caregiver Ratings 107
Functioning Scores 108
Worker Ratings 108
Youth Ratings 109
Caregiver Ratings 109
Violence and Delinquency Questionnaire 109
Resilience 113
TSCC 118
Substance Use Survey 120
Thirty-Day Substance Use 121
Reasons for Termination 124
Average Length of Stay 124
Risk for Out of Home Placement 125
Police Contacts 125
YSSF 125
Recidivism (July 1, 2015 – June 30, 2019) 127
Methodology 127
Results 127
Previous Juvenile Court Involvement 127
Recidivism after Enrollment 129

Recidivism after BHJJ Termination 130
ODYS Commitments 132
Average Numbers of Charges and Adjudications 132
Franklin 135
Demographics 135
Custody Arrangement and Household Information 135
Youth and Family History 137
Problems Leading to Service 139
Ohio Youth Assessment System 140
DSM Diagnoses 141
Educational Information 142
Ohio Scales 144
Problem Severity 144
Worker Ratings 145
Youth Ratings 145
Functioning Scores 146
Worker Ratings 146
Youth Ratings 146
Resilience 147
TSCC 149
Substance Use Survey 151
Reasons for Termination 153
Average Length of Stay 153
Risk for Out of Home Placement 154
Police Contacts 154
Recidivism (July 1, 2015 – June 30, 2019) 155
Methodology 155
Results 156
Previous Juvenile Court Involvement 156
Recidivism after Enrollment 157
Recidivism after BHJJ Termination 158
ODYS Commitments 160
Average Numbers of Charges and Adjudications 160

Montgomery 163
Demographics 163
Custody Arrangement and Household Information 163
Youth and Family History 165
Problems Leading to Service 167
DSM Diagnoses 168
Ohio Youth Assessment System 169
Educational Information 170
Ohio Scales 172
Problem Severity 172
Worker Ratings 173
Youth Ratings 173
Caregiver Ratings 173
Functioning Scores 174
Worker Ratings 175
Youth Ratings 175
Caregiver Ratings 175
Violence and Delinquency Questionnaire 175
Resilience 179
TSCC 184
Substance Use Survey 186
Reasons for Termination 188
Average Length of Stay 188
Risk for Out of Home Placement 189
Police Contacts 189
YSSF 189
Recidivism (July 1, 2015 – June 30, 2019) 191
Methodology 191
Results 191
Previous Juvenile Court Involvement 191
Recidivism after Enrollment 193
Recidivism after BHJJ Termination 194
Average Numbers of Charges and Adjudications 195

Hamilton 198
Demographics 198
Custody Arrangement and Household Information 198
Youth and Family History 200
Problems Leading to Service 202
Ohio Youth Assessment System 203
DSM Diagnoses 204
Educational Information 205
Ohio Scales 206
Problem Severity 207
Worker Ratings 208
Youth Ratings 208
Caregiver Ratings 208
Functioning Scores 209
Worker Ratings 210
Youth Ratings 210
Caregiver Ratings 210
Violence and Delinquency Questionnaire 210
Resilience 214
TSCC 218
Substance Use Survey 220
Reasons for Termination 222
Average Length of Stay 222
Risk for Out of Home Placement 223
Police Contacts 223
YSSF 223
Recidivism (July 1, 2015 – June 30, 2019) 225
Methodology 225
Results 225
Previous Juvenile Court Involvement 225
Recidivism after Enrollment 227
Recidivism after BHJJ Termination 228
ODYS Commitments 229

Average Numbers of Charges and Adjudications 230
Lucas 233
Demographics 233
Custody Arrangement and Household Information 233
Youth and Family History 235
Problems Leading to Service 237
Ohio Youth Assessment System 238
DSM Diagnoses 239
Educational Information 240
Ohio Scales 242
Problem Severity 242
Worker Ratings 243
Youth Ratings 243
Caregiver Ratings 243
Functioning Scores 244
Worker Ratings 244
Youth Ratings 245
Resilience 249
TSCC 254
Substance Use Survey 255
Reasons for Termination 257
Average Length of Stay 257
Risk for Out of Home Placement 258
Police Contacts 258
YSSF 258
Recidivism (July 1, 2015 – June 30, 2019) 260
Methodology 260
Results 261
Previous Juvenile Court Involvement 261
Recidivism after Enrollment 261
Recidivism after BHJJ Termination 262
ODYS Commitments 262
Average Numbers of Charges and Adjudications 262

Summit 264
Demographics 264
Custody Arrangement and Household Information 264
Youth and Family History 266
Problems Leading to Service 268
Ohio Youth Assessment System 269
DSM Diagnoses 270
Educational Information 271
Ohio Scales 273
Problem Severity 273
Worker Ratings 274
Youth Ratings 274
Caregiver Ratings 274
Functioning Scores 275
Worker Ratings 276
Youth Ratings 276
Caregiver Ratings 276
Violence and Delinquency Questionnaire 276
Resilience 280
TSCC 284
Substance Use Survey 285
Reasons for Termination 287
Average Length of Stay 287
Risk for Out of Home Placement 287
Police Contacts 288
YSSF 288
Recidivism (July 1, 2015 – June 30, 2019) 290
Methodology 290
Results 290
Previous Juvenile Court Involvement 290
Recidivism after Enrollment 292
Recidivism after BHJJ Termination 293
ODYS Commitments 294

Average Numbers of Charges and Adjudications 294
Wayne 297
Demographics 297
Custody Arrangement and Household Information 297
Youth and Family History 299
Problems Leading to Service 301
Ohio Youth Assessment System 302
DSM Diagnoses 303
Educational Information 304
Ohio Scales 306
Problem Severity 306
Worker Ratings 307
Youth Ratings 307
Caregiver Ratings 307
Functioning Scores 308
Worker Ratings 309
Youth Ratings 309
Caregiver Ratings 309
Violence and Delinquency Questionnaire 310
Resilience 313
TSCC 317
Substance Use Survey 319
Reasons for Termination 321
Average Length of Stay 321
Risk for Out of Home Placement 322
Police Contacts 322
YSSF 322
Recidivism (July 1, 2015 – June 30, 2019) 324
Methodology 324
Results 325
Previous Juvenile Court Involvement 325
Recidivism after Enrollment 325
Recidivism after BHJJ Termination 326

ODYS Commitments 326
Average Numbers of Charges and Adjudications 326
Holmes 328
Demographics 328
Custody Arrangement and Household Information 328
Youth and Family History 330
Problems Leading to Service 332
Ohio Youth Assessment System 333
DSM Diagnoses 334
Educational Information 335
Ohio Scales 337
Problem Severity 337
Worker Ratings 338
Youth Ratings 338
Caregiver Ratings 338
Functioning Scores 339
Worker Ratings 340
Youth Ratings 340
Caregiver Ratings 340
Violence and Delinquency Questionnaire 341
Resilience 344
TSCC 346
Substance Use Survey 348
Reasons for Termination 350
Average Length of Stay 350
Risk for Out of Home Placement 351
Police Contacts 351
YSSF 351
Recidivism (July 1, 2015 – June 30, 2019) 353
Methodology 353
Results 354
Previous Juvenile Court Involvement 354
Recidivism after Enrollment 354

Recidivism after BHJJ Termination 355
ODYS Commitments 355
Average Numbers of Charges and Adjudications 355
Trumbull 357
Demographics 357
Custody Arrangement and Household Information 357
Youth and Family History 359
Problems Leading to Service 361
Ohio Youth Assessment System 362
DSM Diagnoses 363
Educational Information 364
Ohio Scales 366
Problem Severity 366
Worker Ratings 367
Youth Ratings 367
Caregiver Ratings 367
Functioning Scores 368
Worker Ratings 369
Youth Ratings 369
Caregiver Ratings 369
Violence and Delinquency Questionnaire 369
Resilience 371
TSCC 373
Substance Use Survey 374
Reasons for Termination 376
Average Length of Stay 376
Risk for Out of Home Placement 377
Police Contacts 377
YSSF 377
Recidivism (July 1, 2015 – June 30, 2019) 379
Methodology 379
Results 380
Previous Juvenile Court Involvement 380

Recidivism after Enrollment 380
Recidivism after BHJJ Termination 381
ODYS Commitments 381
Average Numbers of Charges and Adjudications 381
Mahoning 383
Demographics 383
Custody Arrangement and Household Information 383
Youth and Family History 385
Problems Leading to Service 387
Ohio Youth Assessment System 388
DSM Diagnoses 389
Educational Information 390
Ohio Scales 392
Resilience 394
TSCC 396
Substance Use Survey 397
Reasons for Termination 398
Average Length of Stay 398
Risk for Out of Home Placement 399
Police Contacts 399
YSSF 399
Recidivism (July 1, 2015 – June 30, 2019) 401
Methodology 401
Results 402
Previous Juvenile Court Involvement 402
Recidivism after Enrollment 402
Recidivism after BHJJ Termination 402
ODYS Commitments 403
Lorain 404
Demographics 404
Custody Arrangement and Household Information 404
Youth and Family History 406
Problems Leading to Service 408

Ohio Youth Assessment System 409
DSM Diagnoses 410
Educational Information 411
Ohio Scales 413
Problem Severity 413
Worker Ratings 414
Youth Ratings 414
Caregiver Ratings 414
Functioning Scores 415
Worker Ratings 416
Youth Ratings 416
Caregiver Ratings 416
Violence and Delinquency Questionnaire 417
Resilience 420
TSCC 424
Substance Use Survey 426
Thirty-Day Substance Use 427
Reasons for Termination 430
Average Length of Stay 430
Risk for Out of Home Placement 431
Police Contacts 431
YSSF 431
Recidivism (July 1, 2015 – June 30, 2019) 433
Methodology 433
Results 433
Previous Juvenile Court Involvement 433
Recidivism after Enrollment 435
Recidivism after BHJJ Termination 437
ODYS Commitments 438
Average Numbers of Charges and Adjudications 439
Ashtabula 442
Demographics 442
Custody Arrangement and Household Information 442

Youth and Family History 444
Problems Leading to Service 446
Ohio Youth Assessment System 447
DSM Diagnoses 448
Educational Information 449
Ohio Scales 451
Problem Severity 451
Worker Ratings 452
Youth Ratings 452
Caregiver Ratings 452
Functioning Scores 453
Worker Ratings 454
Youth Ratings 454
Caregiver Ratings 454
Resilience 458
TSCC 462
Substance Use Survey 463
Reasons for Termination 465
Average Length of Stay 465
Risk for Out of Home Placement 466
Police Contacts 466
YSSF 466
Recidivism (July 1, 2015 – June 30, 2019) 468
Methodology 468
Results 469
Previous Juvenile Court Involvement 469
Recidivism after Enrollment 469
Recidivism after BHJJ Termination 470
ODYS Commitments 470
Average Numbers of Charges and Adjudications 470
References 472

Executive Summary: An Evaluation of Ohio's Behavioral Health Juvenile Justice (BHJJ) Initiative

Fredrick Butcher, Ph.D., Jeff Kretschmar, Ph.D., Liuhong Yang, M.S., David Rinderle, B.A., & Margarid Turnamian, B.A.

Begun Center for Violence Prevention Research and Education
Jack, Joseph, and Morton Mandel School of Applied Social Sciences
Case Western Reserve University

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: Ashtabula, Cuyahoga, Franklin, Hamilton, Holmes, Lorain, Lucas, Mahoning, Montgomery, Summit, Trumbull, and Wayne. BHJJ was funded through a partnership between the Ohio Departments of Youth Services (ODYS) and Mental Health and Addiction Services (OhioMHAS). The Begun Center for Violence Prevention Research and Education at Case Western Reserve University provided evaluation services for the program. **The majority of findings presented here represent data collected between July 1, 2017 through June 30, 2019.**

Demographics and Youth Characteristics

- Since 2006, 5,338 youth have been enrolled in BHJJ (64% male, 52% non-white). The average age of youth entering the program was 15.6 years old.
- Between July 1, 2017 and June 30, 2019, 641 youth were enrolled in BHJJ (71% male, 55% non-White). The average age of youth entering the program was 15.3 years old.
- The most common DSM diagnosis for BHJJ youth was Oppositional Defiant Disorder.
- 44% of males and 27% of females had both a mental health and substance use diagnosis.
- Caregivers reported that 21% of the females had a history of sexual abuse, 54% talked about suicide, and 23% had attempted suicide. 56% of females and 53% of males had family members who were diagnosed with or showed signs of depression.
- 21% of youth reported someone close to them was murdered in the last year.
- 74% of BHJJ youth scored moderate or high risk to reoffend on the OYAS.
- 31% of youth had at least one felony charge in the 12 months prior to BHJJ enrollment (counties ranged between 0% and 95%).
- Prior to BHJJ, 44% of the youth had a history of child welfare involvement, 11% had received substance use treatment, and 69% had received mental health treatment.

Educational Information

- About 57% of the youth were suspended or expelled from school in the year prior to their BHJJ enrollment. During treatment, 29% were suspended or expelled.

- 31% of the unsuccessful completers and 60% of successful completers earned mostly A's, B's, or C's at termination from BHJJ. At termination, 86% of youth were attending school.

- At termination, workers reported that 92% 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 related to anger, anxiety, depression, dissociation, posttraumatic stress, and sexual concerns from intake to termination.

- Results from the Ohio Scales indicated the caregiver, worker, and youth reported increased youth functioning and decreased problem severity while in BHJJ treatment.

- Past 30-day alcohol use dropped from 5.1 days to 0.7 days while past 30-day marijuana use dropped from 5.7 days to 3.3 days.

Termination and Recidivism Information (2015-2019)

- 81% of the youth terminated from the BHJJ program completed treatment successfully. The average length of stay in the program was 197 days.

- Workers reported that police contacts have been reduced for 79% of the youth.

- The percentage of youth who reported pushing/hitting/kicking another youth in the last year dropped from 56% at intake to 26% at termination.

- At intake, 53% of the youth were at risk for out of home placement. At termination, 25.0% of youth were at risk for out of home placement. Of those youth who successfully completed BHJJ treatment, 8% were at risk for out of home placement at termination.

- One year after termination, 15% of successful completers and 20% of unsuccessful completers had a new felony charge.

- Since 2015, 3.8% (n = 148) of the youth enrolled in BHJJ for whom we had recidivism data were committed to an ODYS facility at any time following their enrollment in BHJJ.

- The average number of misdemeanor charges in the 12 months prior to and after BHJJ declined from 1.9 to 0.9. The average number of felony charges in the 12 months prior to and after BHJJ declined from 0.7 to 0.4.

- Using only the direct State contribution to BHJJ of $27.6 million since 2006, the average cost per youth enrolled in BHJJ was $5,170. Based on ODYS data, the estimated cost of housing the average youth at an ODYS facility in FY18 was approximately $196,000.

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 meet the needs of 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 comprehensive 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

Twenty 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 youths 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, this initiative was designed to divert JJI youth with mental health or substance use issues from detention 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 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, 18 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 agree 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 & Singer, 2016; Kretschmar, Butcher, Kanary, & Devens, 2015). For information or copies of previous evaluation reports, please contact Dr. Jeff Kretschmar at jeff.kretschmar@case.edu or visit http://begun.case.edu/research/juvenile-justice/bhjj/.

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 Problems, 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 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 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.

Victimization and Delinquency Questionnaire (VDQ)

The Victimization and Delinquency Questionnaire (VDQ) is a 33-item survey designed to gather information on childhood victimization as a witness or victim, delinquency, and negative peer interactions. This self-report instrument is measured on a 0 (Never) to 4 (Almost every day) scale. The items were adapted from a variety of sources, including the Juvenile Victimization Questionnaire (Finkelhor, Hamby, Ormrod, & Turner, 2005). This survey replaced the Recent Exposure to Violence Scale (REVS) used in previous BHJJ evaluations.

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.

Resiliency Survey

The Resiliency Survey is a 16-item, self-report survey designed to measure the external and internal assets associated with positive youth development. This survey is completed by youth at both intake into and termination from the BHJJ program. Items are scored on a four-point Likert scale ranging from "Not at all True" to "Very Much True".

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 required 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
Resiliency Survey	Youth	Intake, Term

Table 2. Optional BHJJ Questionnaires

Measure	Who Completes	When Administered
Ohio Scales	Caregiver	Intake, every 3 months, Term
Victimization and Delinquency Questionnaire	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, 18 counties throughout Ohio have participated in the BHJJ program (see Table 3). The aggregate report includes data from all 18 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
Ashtabula	2016 - present
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

Ashtabula/Mahoning/Trumbull Counties

The BHJJ program that serves Trumbull, Ashtabula, and Mahoning Counties is part of a collaborative project that allows for the implementation of evidence-based programs across the three most northeastern counties in Ohio. Cadence Care Network (formerly Homes For Kids) provides 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, incarceration, or who are returning from an out of home placement. All youth entering the program are identified as Severely Emotionally Disturbed (SED) and many will have a co-occurring substance abuse diagnosis. The program implements two evidence based practices, Multisystemic Therapy (MST) and the Transition to Independence Process (TIP), as well as evidence informed High Fidelity Wraparound. The primary goals are to: reduce out of home placements; divert youth from juvenile court programs or ODYS institutions to evidence based, family-focused programming in the community; maintain or reduce commitments to ODYS; improve intersystem

communication and collaboration; and share outcomes (successes and failures) across three contiguous counties that have some distinct similarities and differences.

Due to the project's 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, the juvenile court administers the Ohio Youth Assessment System (OYAS) to determine the risk of recidivism. Cadence Care Network (formerly 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 are transferred to Wraparound within the counties' System of Care framework. Wraparound Facilitators 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 with trauma informed protocols. Cultural Competence is also embedded through the entire project, as it is a core component of MST, TIP, and High-Fidelity Wraparound models. Youth participating in the program are screened and assessed (at intake and discharge) for trauma utilizing the Trauma Symptom Checklist for Children (TSCC) and for substance abuse utilizing the Substance Use Survey (SUS) also at intake and discharge.

The project provides the region with two teams of four MST Therapists, capable of serving approximately 120 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 eight MST Therapists are employed by Cadence Care Network.

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 the family's home to conduct family therapy sessions utilizing the MST model of treatment. MST therapists meet with families at minimum three times a week in the 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 idle time. 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 Therapist Adherence Measures (TAMs) two weeks into treatment and every 30 days thereafter on their assigned therapist to ensure the therapist is adhering to the MST model. The MST supervisor enters these TAMs onto the MST services secure website. To date, adherence to the model falls within the expected targets. The eight 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 by the Center for Innovative Practices at Case Western Reserve University. In addition to weekly three-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: completed the three to five 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, are living in the home or community at time of discharge, and are attending work or school and has no new charges since entering the program.

Cuyahoga County

Cuyahoga County's BHJJ model has evolved as a highly intensive, structured program delivering a continuum of effective, evidenced based treatment and culturally-appropriate services for youth involved in the juvenile justice system. Data provided by Ohio Department of Youth Services (ODYS) in 2018 reflect that among youth adjudicated in Cuyahoga County, 80% are African American and 86% are male. Many of the youth enrolled in the BHJJ program are residents of the City of Cleveland, English speaking, indigent, and multi-system involved.

Eligibility Criteria:

- Resident of Cuyahoga County
- Male or female, ages 12-18
- Pre-adjudicated or adjudicated for misdemeanors or felonies
- Screened and diagnosed with Mental Health/Serious Emotional Disturbance, Substance Use, or Co-Occurring Disorder
- Youth with serious violent charges are individually reviewed
- Youth on traditional probation that are at risk of deeper involvement are individually reviewed

Services and Treatment Models: The BHJJ program within Cuyahoga County is composed of many pieces, including a specialized Juvenile Court docket, a newly implemented Intervention Center, a diversion program for low risk domestic violence offenses, Intensive Probation monitoring, pharmacological and mental health screening and assessment, and intensive use of high fidelity wraparound services. During this grant cycle, the Intervention Center became a part of the diversionary continuum of Cuyahoga County BHJJ. All youth with alleged offenses, with the exception of those youth with the highest level felony offenses, are referred to the Intervention Center. Intervention Specialists are responsible for screening and interviewing all youth referred by Juvenile Court and referring youth to on-site behavioral health clinicians for a further behavioral health consultation and linkage to appropriate services. Project CALM is a part of the Intervention Center programming that provides diversion, assessment, case management, linkage and access to respite through Juvenile Court's contracted services. Respite allows parents to have time to engage in treatment recommendations made during the assessment, preventing immediate refusal of services and parents requesting admission to the Detention Center.

The primary evidenced based treatment models utilized are Integrated Co-Occurring Treatment and Multi-Systemic Therapy, however other evidenced based practices and treatment models may be accessed when deemed appropriate.

- *Integrated Co-Occurring Treatment (ICT):* 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 focuses 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.

The BHJJ model shifted in the 2018-2019 grant period to fully integrate the project within the Mental Health Court Specialized Docket (Phoenix Court). This has allowed for more fluid, cohesive and individualized planning, as measured through the court's three graduated phases and evidence-based treatment planning. The timeframe to move through the phases is determined by the progress of the youth, and is usually twelve (12) months or less.

Key Stakeholders: In Cuyahoga County, the BHJJ program operates through the partnership between the Alcohol, Drug Addiction & Mental Health Services (ADAMHS) Board of Cuyahoga County, Cuyahoga County Juvenile Court, Family and Children First Council of Cuyahoga County, and Bellefaire Jewish Children's Bureau. These partners meet quarterly in order to discuss progress of the project model.

Referral and Enrollment Process: In 2018-2019 BHJJ project, the court expanded screening and referral of youth to intervention and diversion programming. BHJJ participants are identified through the court by the Intervention Center, Phoenix Court, Probation, Jurists, Alternative Case Planning (ACP) Review process or the ODYS Review Committee. Referrals can be made for youth who staff suspect has mental health concerns and/or has an identified substance abuse problem, and all referrals to the BHJJ Phoenix Court are accompanied with copies of youth's most recent collateral information including clinical documents related to their behavioral health needs such as recent diagnostic assessments and Ohio Youth Assessment System (OYAS). The BHJJ Manager administers the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) with the youth. The BHJJ Phoenix Court Review Committee is comprised of the Jurist, defense counsel, Guardian Ad Litem, BHJJ Mental Health Coordinator and both MST and ICT staff. They review the case to determine appropriateness of referral and select the appropriate EBP(s) to meet the behavioral health needs of the youth. The BHJJ Clinical Coordinator presents the referral information and screening results to the BHJJ Review Committee, comprised of BHJJ staff, ICT/MST Clinicians, Defense Counsel, Guardian Ad Litem, and the Phoenix Court Jurist. The Review Committee determines program eligibility and selects the appropriate EBP. Upon Phoenix Court enrollment, the youth and family meet with their BHJJ Treatment Team, which include their BHJJ Care Coordinator, BHJJ Intervention Specialist, and EBP Clinician to develop Individualized Service and Court Plans. Upon development of the plans, services are implemented.

Successful Completion: At the clinical level, progress is determined through clinical outcomes from the EBP in which each youth is involved, and reflected by a youth's movement through the Phoenix Court's

three graduated phases. The combination of graduated phases and treatment advances serve as a catalyst to transition toward community-based stabilization and successful completion.

The Cuyahoga County BHJJ project has been a 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 from 293 commitments in 2009 to 68 commitments in 2019 which is a 76% reduction and since 2011 the rate of 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 identify youth offenders with significant behavioral health impairments, who can also be safely served and maintained in the community with the support of appropriate treatment interventions. The overarching goals are early identification of behavioral health needs; to reduce out of home placement; to increase access to community based treatment; to ensure that children and families receive treatment that facilitates recovery and resiliency; to increase referrals to evidence-based care and to reduce commitments to the Ohio Department of Youth Services. 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. Franklin County's BHJJ program provides behavioral health diagnostic assessments, a family resource specialist and care coordination services to serious youth offenders with significant behavioral health impairments, who are referred to the Pre-Sentencing Investigation Unit (PSI). While these youth are prioritized, Franklin County also serves youth from all areas of court including: Bench orders, Intake, JDC, Probation and Preliminary hearings. The service delivery team includes the youth and family, probation officer (if applicable), care coordinator, school, family-defined support, treatment providers, and other system representatives as necessary.

Franklin's BHJJ model identifies eligible youth through the Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2) screenings. Youth who are determined to need further evaluation are then referred for a diagnostic assessment with the BHJJ assessors. The assessors, who are 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. Youth are also administered the Ohio Youth Assessment System (OYAS). The OYAS results are shared with the behavioral health clinician and are considered in the development of treatment 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. Youth are then linked with a family resource specialist, who assists the family in navigating systems, educational advocacy and linkage to prosocial activities. The youth and family are also assigned a care coordinator who helps link the youth and family with treatment services while engaging the youth and family and encouraging cooperation with the referred services.

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 some of the more frequently utilized services available in Franklin County:

Treatment Model	Funding
MST (Multisystemic Therapy)	ADAMH Board of Franklin County, Franklin County Children Services, Franklin County Juvenile Court& Franklin County Family and Children First Council
FFT (Functional Family Therapy)	ADAMH Board of Franklin County, & Franklin County Juvenile Court
ICT (Integrated Co-occurring Treatment)	ADAMH Board of Franklin County
ACRA-A	ADAMH Board of Franklin County; Franklin County Juvenile Court

The BHJJ service team carefully selects youth who meet the criteria of the grant at the time of pre-sentencing. Eligibility criteria for this initiative are as follows, although every criterion may not apply to all youth:

- Male or female ages 12 to 17
- DSM V 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

Successful completion of the Franklin County BHJJ program 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 and Family Services (LYFS). 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.

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 to effectively address those youth overrepresented within the Juvenile Court system. Referrals are received by court personnel, primarily Probation, 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. Most of the youth and their families participate in Functional Family Therapy (FFT), an evidenced based model that is family focused. If indicated, the youth may also receive individual mental health therapy, case management services, and individual and group substance abuse services using Seven Challenges - an evidenced based model for young people that is designed to motivate youth to evaluate their lives, consider changes they may wish to make and then succeed in implementing the desired changes. This program has a dedicated substance abuse counselor and interventions are individualized and based on assessment and youth needs. Additionally, the program uses Structured Sensory Interventions for Traumatized Children, Adolescents, Parents (SITCAP), to provide trauma informed interventions for the youth and their families and Motivational Interviewing, an evidence-based counseling method.

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 adjudications with juvenile court (Pretrial Diversion Docket -PDD only),
- Adjudication of delinquency (Individualized Disposition Docket-IDD only),
- As defined by DSM V, 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 V 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 identify the youth's mental health diagnosis. After admission, additional assessment occurs with a variety of instruments, including the FFT Outcome Questionnaire (OQ) Measures, the Child and

Adolescent Needs and Strengths scale (CANS), the BAM (Brief Addiction Monitor) and the Daniel Memorial Life Skills Assessment.

Through BHJJ funding, the Hamilton County Juvenile Mental Health Court is able to deliver evidence-based services in a cross-system model with MHAP, Juvenile Court and LYFS. 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 LYFS 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.

During the previous biennium, the program expanded to include an Educational Liaison to strengthen school performance as evidenced by academics, attendance, and improved relationships between youth/family, school and the community partners. The Educational Liaison completes an educational assessment on all youth when they enter the program to determine strengths and areas that need to be addressed and develops an educational plan in collaboration with all parties. The liaison provides structured follow-up services to each family to ensure the families and school are working together to maintain the Individual Education Plan (IEP) and other established school based interventions. The involvement of the Educational Liaison is phased out as appropriate once the youth completes the Mental Health Docket but works to ensure strong partnerships and relationships are established between the school and family for on-going success. This past year, the Educational Liaison started a summer enrichment program to help youth stay on track or work toward additional academic credits so they have an opportunity to start the new school year in good standing and not lose momentum with a two-month break.

Additionally, the program added an Intake Coordinator position to bridge communication and coordination with Juvenile Court staff, particularly probation officers. The Intake Coordinator attends the Disposition Hearings to allow them to quickly engage with the families, maintain communication with the probation officer and clarify or alleviate any questions or concerns the family may have regarding expectations of the Mental Health Docket. The Intake Coordinator meets with the family to complete intake, introducing them to the program and also completing the diagnostic assessment review. This allows for a seamless transition to treatment services.

Typical length of stay in the program is about 4-6 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.

As an agency, Lighthouse Youth and Family Services has a menu of evidence-based practices and programs, including Positive Behavioral Intervention Services (PBIS), Girls' Circle, Parents As Teachers, Work Appreciation for Youth (WAY), 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 and evidence-based interventions offered in the LIDS program are Functional Family Therapy (FFT) and Seven Challenges. Each youth is assessed and the individual needs of the youth and family guide treatment services.

The LIDS program is a model of successful community intersystem collaboration. HCJC and HCMHRSB have worked through a period of extensive planning and careful implementation to develop these systems. Monthly Infrastructure meetings with LYFS, HCJC, MHAP, and HCMHRSB enable ongoing program review and development as well as ongoing process improvement. The LIDS Advisory Committee provides oversight and coordination of care between systems. The Committee meets quarterly, is chaired by the HCMHRSB and includes partners from LYFS, HCJC, MHAP and NAMI. Youth and families who have graduated from the LIDS program are invited to share their story to the LIDS Advisory Committee, which aides in the identification of program strengths and areas for improvement.

Lorain County

The Lorain County Behavioral Health/Juvenile Justice (BHJJ) project is a collaboration between Bellefaire JCB, the Lorain County Juvenile Court, and the Lorain County Board of Mental Health (now known as the Mental Health, Addiction and Recovery Services Board of Lorain County). 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- and 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 Bellefaire completes the financial intake, the youth is assigned to an ICT therapist and services begin in the home. The ICT therapist utilizes a variety of instruments to assess functioning and to assist with the 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, SASSI (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 focuses 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-confrontation 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: cognitive behavior therapy, motivational interviewing, family therapy, crisis management, role play/rehearsal of skills, contingency management protocols, advocacy for youth across life domains, psycho-education about the impact of trauma, life skills building, connection to prosocial activities and skills, and collaboration with the court staff to reduce re-offending behaviors. The ICT staff and Juvenile Court staff engage the family in team meetings to gauge progress towards case plan goals, reinforce successes, and to collaboratively problem solve any existent or emerging barriers to progress.

One month before expected ICT completion, planning is initiated with the 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. Several facets are evaluated to determine whether a youth has successfully completed treatment including: 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 termination of services/avoiding 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

The Lucas County Behavioral Health and Juvenile Justice Initiative has transformed the child-serving systems' ability to screen, identify, assess, and treat multi-need, multi-system youth since 2009. The Lucas County Juvenile Court is committed to the care, protection, treatment and guidance of the children and families in its care. Both BHJJ and the Court continue to provide opportunities to develop, sustain, and enhance evidence-based approaches designed to serve serious juvenile offenders who have behavioral health care needs. The initiative's goals remain consistent and geared towards treating youth within the community by using 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 LCBHJJ Initiative uses two treatment models to accomplish its goal: 1) Multi-systemic Therapy (MST) and 2) Functional Family Therapy, both evidence-based approaches which include supportive services, pro-social activities, and an individualized service plan.

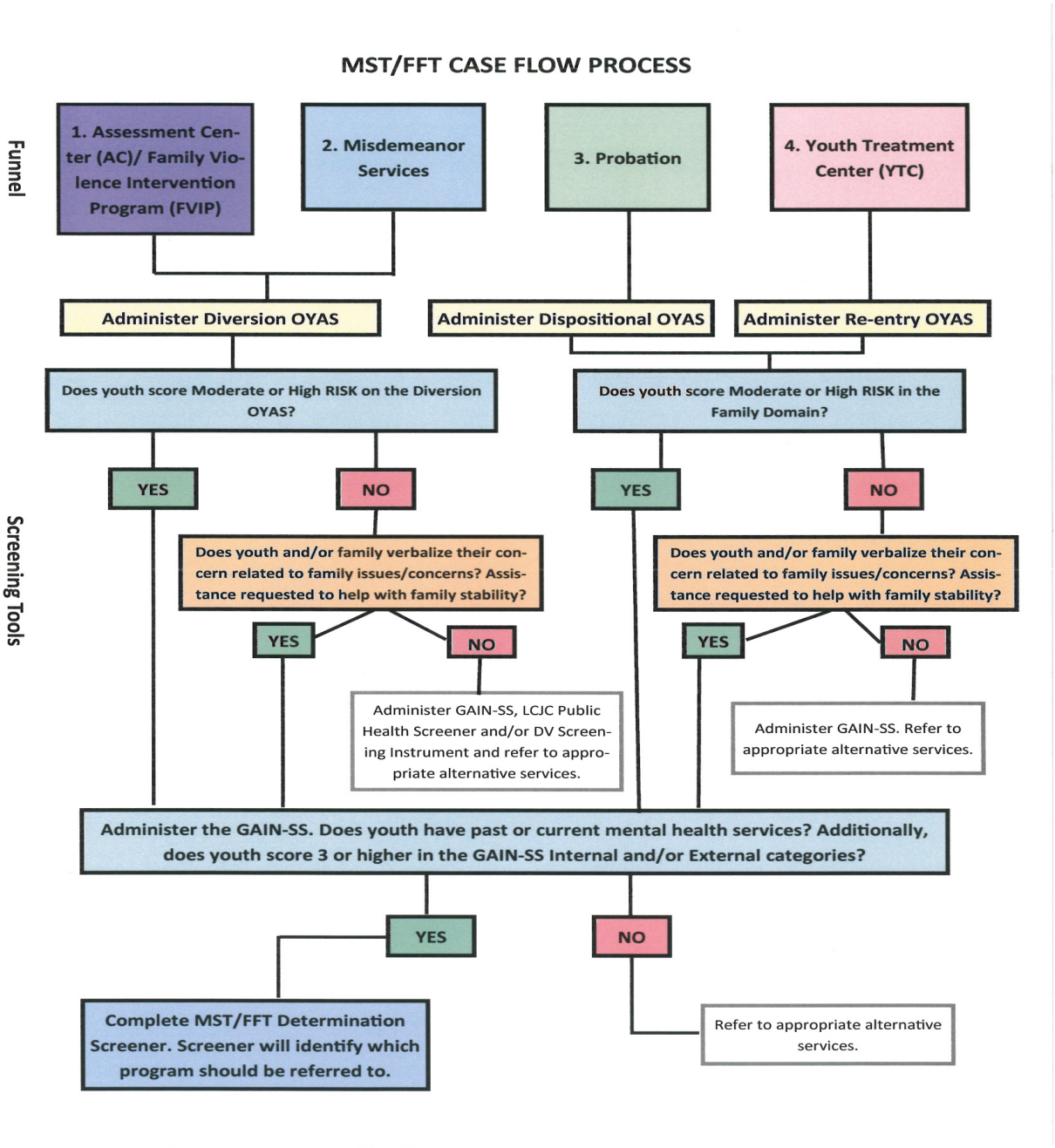
MST's long-term outcome is to empower families to build a healthier environment through the mobilization of existing child, family, and community resources. MST addresses risk factors in an individualized, comprehensive, and integrated fashion, allowing families to enhance protective factors. Specific treatment techniques used to facilitate these gains are based on empirically supported therapies, including behavioral, cognitive behavioral, and pragmatic family therapies. The MST team works diligently to engage families, especially caregivers at the beginning of treatment, as the caregiver is the primary change agent in the home.

The typical duration of home-based MST services is approximately four months, with multiple therapist-family contacts occurring weekly. MST's definition of success is that the youth meets all three Ultimate Outcome goals: 1) living in the home or with a relative 2) attending school regularly or working 20+ hours per week and 3) no rearrests during treatment. The overarching goal of treatment is to equip the family with skills and supports that will require them to be able to handle behaviors in the home and out in the community on their own before involving formal services.

FFT is a high quality, evidence-based intervention program for juvenile justice, child welfare, and behavioral health system involved adolescents. At FFTs core is a focus on assessment and intervention to address risk and protective factors within and outside of the family that impact the adolescent and his/her adaptive development. Working primarily with 11 to 18 year olds, it is short term (averaging between 12 to 14 sessions over a three to five month time frame) and can be conducted in both clinical and home settings. The model's focus on familial factors and sustained adaptive behavior change is in line with the goal of the project to increase and support family engagement and reduce continued delinquent behavior. There are five major components to FFT, all of which have specified goals, focuses, intervention strategies and techniques. The components are: Engagement, Motivation, Relational Assessment, Behavioral Change, and Generalization Phase.

Consideration for both MST and FFT services are generated by four points of entry within the Juvenile Court: The Assessment Center, Misdemeanor Services, Family Violence Intervention Services, and the Probation Department. In order to be accepted into the program youth must score moderate to high risk on the Ohio Youth Assessment Survey (OYAS). Youth reentering the community from the Lucas County Youth Treatment Center may also be referred to FFT.

The LCBHJJ team spent many hours streamlining the referral process to MST and FFT. It is highlighted in the chart below.


MST/FFT CASE FLOW PROCESS
Funnel
Screening Tools
1. Assessment Center (AC)/ Family Violence Intervention Program (FVIP)
2. Misdemeanor Services
3. Probation
4. Youth Treatment Center (YTC)
Administer Diversion OYAS
Administer Dispositional OYAS
Administer Re-entry OYAS
Does youth score Moderate or High RISK on the Diversion OYAS?
Does youth score Moderate or High RISK in the Family Domain?
YES
NO
YES
NO
Does youth and/or family verbalize their concern related to family issues/concerns? Assistance requested to help with family stability?
Does youth and/or family verbalize their concern related to family issues/concerns? Assistance requested to help with family stability?
YES
NO
YES
NO
Administer GAIN-SS, LCJC Public Health Screener and/or DV Screening Instrument and refer to appropriate alternative services.
Administer GAIN-SS. Refer to appropriate alternative services.
Administer the GAIN-SS. Does youth have past or current mental health services? Additionally, does youth score 3 or higher in the GAIN-SS Internal and/or External categories?
YES
NO
Complete MST/FFT Determination Screener. Screener will identify which program should be referred to.
Refer to appropriate alternative services.

The MST/FFT Determination screener also helped staff determine which service was the best fit for the client.

FFT Check List:	MST Check List:
FFT serves youth aged 10-18	MST serves youth aged 12-17
Diagnosis may include youth with conduct disorder, oppositional defiant disorder, ADHD etc.	Diagnosis may include youth with conduct disorder, oppositional defiant disorder, ADHD etc.
Length of treatment is approximately 3 months, up to 5 months in serious cases	Length of treatment 3-5 months with brief extension if clinically necessary/indicated
Monthly follow up calls, and up to 3 Booster Sessions	The team assists with the transferring process, however does not follow-up with the family after closing. MST no longer provides Booster Sessions after closing
Youth is identified client, entire family is focus of treatment	*Youth is identified client,* ***caregivers are the primary agents of change***
Sessions in an office, home setting, community, or detention with primary emphasis initially on engaging & motivating, then changing, family emotional and behavioral interaction patterns. Sessions take place 3-4 times per month	Sessions take place in the home and/or community, with focus on increasing responsibility of the caregivers in addressing youth's behaviors in the home, school and community. **Sessions take place average of 2-3 times a week**
Treatment focuses on development of parenting skills and enhancement of family relationships when clinically indicated, and often include "homework assignments" between sessions. Adjust the frequency of sessions to meet the clinical needs of the family. **Strength-focused, Empowers family**	Treatment focuses on increasing the caregivers' responsibility in addressing the youth's behaviors in the home, in the school and in the community. Homework is given throughout the course of treatment to encourage daily effort. Strength-focused, Empowers family
On-call not available	*24/7 on-call services available to the family*
Private and/or Medicaid Insurance	Private and/or Medicaid Insurance
Trauma Therapy	Trauma informed therapy
Proceeds through five phases of treatment, each designed to reduce specific risk factors and enhance protective factors.	Start working with multi-systems immediately, while continuing to address behavioral issues in the home.
Family/Individual Substance Abuse Counseling	Substance abuse addressed if along with other below behaviors.
Youth leaves home without permission **Physical aggression in the home (DV)** **Verbal aggression or verbal threats**	Youth leaves home without permission Physical aggression in the home (DV) Verbal aggression or verbal threats

Criminal offenses (low to high risk) **Truancy**	Criminal offenses (low to high risk) Truancy
Based on Risk Factors, family may be referred for case management services to reduce barriers that prevent successful completion of FFT program.	Therapist supports family in identifying and obtaining needed community services
Treatment focuses on development of parenting skills and enhancement of family relationships when clinically indicated, and often include "homework assignments" between sessions	Treatment focuses on increasing the caregivers' responsibility in addressing the youth's behaviors in the home, in the school and in the community. Homework is given throughout the course of treatment to encourage daily effort
Staff explores prosocial activities, Expressive Arts, Job readiness skills and coaching	Staff explores prosocial activities and job opportunities

The two mental health agencies and Court staff work together with the family to determine the best fit for each family. MST tends to focus on the caregivers as the primary agents of change while in FFT, the entire family unit is the focus of treatment. Both are in-home based models; however, FFT sessions only take place 3-4 times a month whereas MST averaged 2-3 meetings per week. If a youth or family had many other commitments, FFT was often a better fit. Families in need of 24-hour crisis intervention were a better fit for MST as they provided a 24/7 on call crisis intervention.

The LCBHJJ team met monthly over the course of the grant to review cases in an effort to improve client participation and engagement in services. This process was streamlined by the end of the grant cycles and there was an increase in referrals during the last six months of the grant.

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.; Montgomery County Alcohol Drug Addiction & Mental Health Services (ADAMHS Board); Ohio Department of Mental Health and Addiction Services (OhioMHAS) and the Ohio Department of Youth Services – Southern Regional District 1. 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-5 diagnosis and meet at least one of the following criteria:

- Substantial mental status impairment in behavioral, cognitive and/or affective domains
- Primary or 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 can also identify an adolescent who meets program criteria and refer the youth directly to the LIFE Program. If there are barriers to the client and family completing a Diagnostic Assessment and a referral is made by the court, the LIFE program is able to go into the home and complete the assessment. Referrals can also be made to the LIFE Program in other instances including: 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. Number of 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 the referred behavior and have increased overall youth and family functioning. If the family has trouble 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 sessions at the same time FFT is provided. The Seven Challenges program is designed specifically for adolescents with drug problems, to motivate a decision and commitment to change, and supports success in implementing the desired changes. 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 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 regarding 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 to ensure Fidelity to the therapeutic model. Global Therapist Ratings are completed by the FFT Site Lead/Program Manager, and families complete surveys periodically throughout the course of treatment to monitor fidelity of the FFT model. The Care Specialists meet 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 may 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 Behavioral Health Juvenile Justice program in Summit County is a partnership among: The Summit County Juvenile Court (SCJC), 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 Akron Area YMCA. The two main evidence-based practiced utilized are Integrated Co-occurring Treatment (ICT) through CGFS and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) through the Village Network. The program is further supported using Greenleaf Family Center Parent Advocates for caregivers and Akron Area YMCA mentoring for youth along with intensive court supervision and case management.

Approximately 50 youth can be referred to the BHJJ program annually. Since 2011, additional supports have been in place to further promote program engagement and success, including opportunities for youth to be assessed and tutored by Sylvan Learning Center staff both individually and in small group settings. Sylvan staff and Greenleaf Parent Advocates often work directly with the local public schools in IEP development for the youth whom they tutor.

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.).

Referred youth have been placed on probation or intensive probation, some of whom have received suspended ODYS commitments. Once the youth has been admitted into the program and assigned to a treatment provider, the BHJJ team (Probation Officer and Supervisor, Felony Disposition Supervisor, program Case Manager and program Supervisor, and other relevant organizations (i.e. mental health professional, chemical dependency counselor, school personnel, etc.)) meet to develop individual/family case plans 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. Court staff administer these assessments throughout the early stages of the youth's court involvement. In many cases, BHJJ program participants have been previously involved with the court. Often in those cases an assessment history has already been compiled. Still, new assessments are administered each time a youth becomes re-involved with the court.

When 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 are scheduled to gauge progress, service gaps and any non-compliance issues. A Behavioral Health Court Docket (BHCD) was implemented during FY2011 to bolster judicial oversight and provide structure to the application of incentives and sanctions to both youth and their caregivers.

Once an initial treatment recommendation has been made, The Village Network or Child Guidance and Family Solutions begins delivering services and conducting additional assessments as needed. One of the key components of the treatments offered by both organizations is the flexibility built into both models. This flexibility ensures that services are delivered in a culturally competent manner and that youth and families referred are not immediately rejected or ejected from services when difficulties arise.

Successful treatment completion is determined by the service provider based on number of sessions completed and compliance with court orders, probation and the individual and family case plan as set forth by the program case manager. For the Village Network's TFCBT program, successful completion is measured by:

- Improvement in overall level of functioning.
- Decrease in recidivism risk factors.
- Increase in school engagement (more days present at school) and GPA.
- No additional felony charges or commitments to ODYS.
- 40 or more successful engagements with the counselor (face to face contacts).
- Consistent compliance with medication orders.

Child Guidance and Family Solutions deems someone as "successful" in the ICT program on the basis of two overarching factors: 1) Whether the youth attended treatment services throughout the duration of the program and 2) Whether they remained in the home (i.e., 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.

Wayne/Holmes Counties

The Wayne and Holmes BHJJ Partnership serves to meet the treatment needs of youth and families where there is high risk for out of home placement, with the goal of strengthening families and keeping them intact. Therapists work in the home with the families to remove barriers and promote family functioning. Funding is also used for drug test kits, window and door alarms, safes, cell phones for parents, and money for prosocial activities that will help build family relationships and prosocial activities. This grant cycle, the goal was to be more proactive, and to accept referrals from CSB for youth who are at risk of juvenile court involvement, and/or out of home placement earlier in the process.

Multisystemic Therapy (MST) is the treatment modality used for this partnership. Trained therapists work under this model, with supervision and oversight to assure high fidelity is occurring. The grant contracts with Child and Adolescent Behavioral Health (CABH) in Stark County, to provide the in-home services. Referrals come through juvenile court, and are for ages 10 to 17.5. The OYAS is used for assessing youth, and determining if appropriate for placement into the MST program. Youth must have displayed delinquent or other behaviors that have brought them to the attention of Juvenile Court, have a mental health condition, and be at risk for out of home placement. Families must also be willing to work with the program.

The key stakeholders are Wayne and Holmes County Juvenile Courts, Wayne Holmes Mental Health and Recovery Board, CABH, Wayne and Holmes County Family and Children First Councils, Case Western Reserve University—The Center for Innovative Practices at the Begun Center, and Wayne and Holmes County Children's Services. Youth who may be a fit for the BHJJ program are screened by Juvenile Court and assessed with the OYAS. If a family agrees to participate, the case if referred to CABH. CABH also does an evaluation and meets with the family to discuss the service and process. While Wayne County utilizes MST Problem Sexual Behavior (PSB) for appropriate youth and families, currently Holmes County does not.

Measures of success include reduced juvenile recidivism rates (total number of charges and severity), family stabilization designed to prevent out of home placement, and low commitment rates to ODYS. We also measure success through the goals of MST: improved caregiver discipline practices, enhanced family relations, decreased youth association with deviant peers, increased prosocial activities, improved school or vocational performance, engagement in positive recreational outlets, and development of a natural support network of extended family, neighbors, and friends to help caregivers achieve and maintain changes.

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, 2019 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.

Description of the Analyses Used in the Report

Several types of inferential statistics are used throughout the report. Three types of bivariate analyses are discussed throughout both the overall report and the county specific reports. The chi-square analysis refers to a bivariate technique where a relationship between two variables is tested to determine if there are any significant differences. For example, if we are interested in whether males and females differ on whether they have ever used alcohol, a chi-square test is used. If there is a statistically significant result, this indicates that the difference between females and males is unlikely to have occurred by chance. Thus, we would describe the difference for the gender groups as a *real difference* rather than one that could have occurred by chance.

In instances where the bivariate relationship of interest is a measure that is both a yes/no measure and one that is repeated, a McNemar's test is used. For example, if we are interested in whether there is a statistically significant decrease in the proportion of youth using alcohol in the past six months from intake to termination, we would use a McNemar's test. A statistically significant result would indicate that the observed difference in six-month use from intake to termination is a real difference and one that likely did not occur by chance.

The third type of bivariate analysis used throughout the report is the t-test. T-tests are similar to chi-square tests in that they test two variables to determine whether there are significant differences. For example, if we are interested in whether females and males differ on their levels of posttraumatic stress symptoms, a t-test is used. Since the variable posttraumatic stress lies on a continuous scale, we examine whether the corresponding means for the two gender groups significantly differ. Independent samples t-tests are used when there are two distinct groups (e.g. female and male) while paired samples t-tests are used when we are interested in whether means for the same group from different time points differ significantly (e.g. pre/post differences).

While statistical significance is an indication of how likely differences between groups or time points could occur by chance, effect sizes measure the magnitude of these observed differences. In other words, while statistical significance tells us whether a difference exists, effect sizes tell us how much of a difference exists. Effect sizes as represented by Cohen's *d* are also presented using the recommended criteria for its interpretation in Cohen's (1988) seminal work. Interpretation of Cohen's *d* is based on the criteria where 0.2 indicates a small effect size, 0.5 indicates a medium effect, and 0.8 indicates a large effect[1].

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

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

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.

Sample Size

In the last report, we reported 4,338 enrollments into the BHJJ program through June 30, 2017. Upon completion of that report, we received over one hundred intake packets for enrollments that occurred close to the data cutoff date for that report. While those youth were enrolled prior to July 1, 2017, we did not receive the intake packet in time to include it in the analyses. In addition, an item on the CIUF indicates whether youth received treatment services through BHJJ. This item identifies youth who may have completed an assessment and intake packet, but who did not go on to receive treatment services. A misunderstanding at the county level about how to complete that item led to the erroneous exclusion of some youth from the analyses. Therefore, the change in the number of enrollments reported from the last report to the current report seems abnormally high. These two issues account for the abnormally large increase in enrollment numbers from the last report to the current report.

In the overall report, where possible, we included data from July 1, 2017 through June 30, 2019. This is a departure from previous reports, where all project data from every project site that ever participated, was included. We decided to include only the most recent data to allow stakeholders at the State and local level to detect recent changes in their outcomes, that otherwise may be masked by analyzing such a large sample size. However, if a larger dataset was needed to conduct statistical analyses, we expanded the pool to include additional years. A few sections contain data from the entire sample as well as from the previous biennium (e.g. termination reasons). **For county-specific reports, where possible, we included data from July 1, 2015 through June 30, 2019.**

Results

Demographics

As of June 30, 2019, there were 5,338 enrollments into the BHJJ program (see Table 4). The average age at enrollment was 15.55 years (SD=1.59). More males (63.9%, n = 3,384) than females (36.1%, n = 1,911) have been enrolled. White youth (47.8%, n = 2,524), Black youth (41.8%, n = 2,207), and Multiracial youth (8.5%, n = 451) comprised the majority of the total sample.

There were 641 new enrollments in the current reporting period (July 1, 2017 through June 30, 2019). Males (70.5%, n = 450) outnumbered females (29.5%, n = 188), and similar numbers of White (45.5%, n = 290) and Black (45.1%, n = 288) youth were enrolled. Over six percent (6.4%, n = 41) of the youth self-identified as Hispanic/Latinx. The average age at the time of enrollment was 15.33 (SD = 1.81).

Table 4. Enrollment by County

County	Total Number of Youth Enrolled	Youth Enrolled between July 1, 2017 and June 30, 2019
Ashtabula	75	43
Butler	29	NA
Champaign	98	NA
Cuyahoga	509	61
Fairfield	33	NA
Franklin	701	31
Hamilton	396	75
Holmes	45	17
Logan	270	NA
Lorain	148	38
Lucas	345	66
Mahoning	48	8
Montgomery	2,107	190
Summit	347	66
Trumbull	84	20
Union	31	NA
Wayne	67	25
Wood	5	NA
Total	5,338	641

Custody Arrangement and Household Information (July 1, 2017 – June 30, 2019)

At intake, the majority of youth lived with the biological mother (52.8%, n = 327), while 20.7% (n = 128) lived with two biological parents or one biological and one step/adoptive parent (see Table 5). More than seventy-eight percent (78.5%, n = 486) of BHJJ youth lived with at least one biological parent at enrollment.

Over 87% (87.2%; n = 530) of the BHJJ caregivers had at least a high school diploma or GED, and 13.3% (n = 81) had a bachelor's degree or higher. Over 12 percent of caregivers (12.8%; n = 78) reported they did not graduate from high school (see Table 6).

Caregivers were asked to report their annual household income (see Table 7). For the entire sample, the income range with the highest endorsement was "Less than $5,000" (18.6%, n = 111). When examined by race, 12.0% (n = 33) of white families and 26.2% (n = 69) of black families reported a household income of $5,000 or less. Overall, nearly 40 percent (39.0%, n = 233) of the BHJJ caregivers reported household earnings less than $15,000 (29.1% of White families and 49.8% of Black families). Table 7 displays the reported household income overall and by race.

Table 5. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	20.7% (n = 128)
Biological Mother Only	52.8% (n = 327)
Biological Father Only	5.0% (n = 31)
Adoptive Parent(s)	6.6% (n = 41)
Aunt/Uncle	1.9% (n = 12)
Grandparents	10.0% (n = 62)
Other	2.9% (n = 18)

Table 6. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	12.8% (n = 78)
High School Graduate or G.E.D.	36.5% (n = 222)
Some College or Associate Degree	37.4% (n = 227)
Bachelor's Degree	7.4% (n = 45)
More than a Bachelor's Degree	5.9% (n = 36)

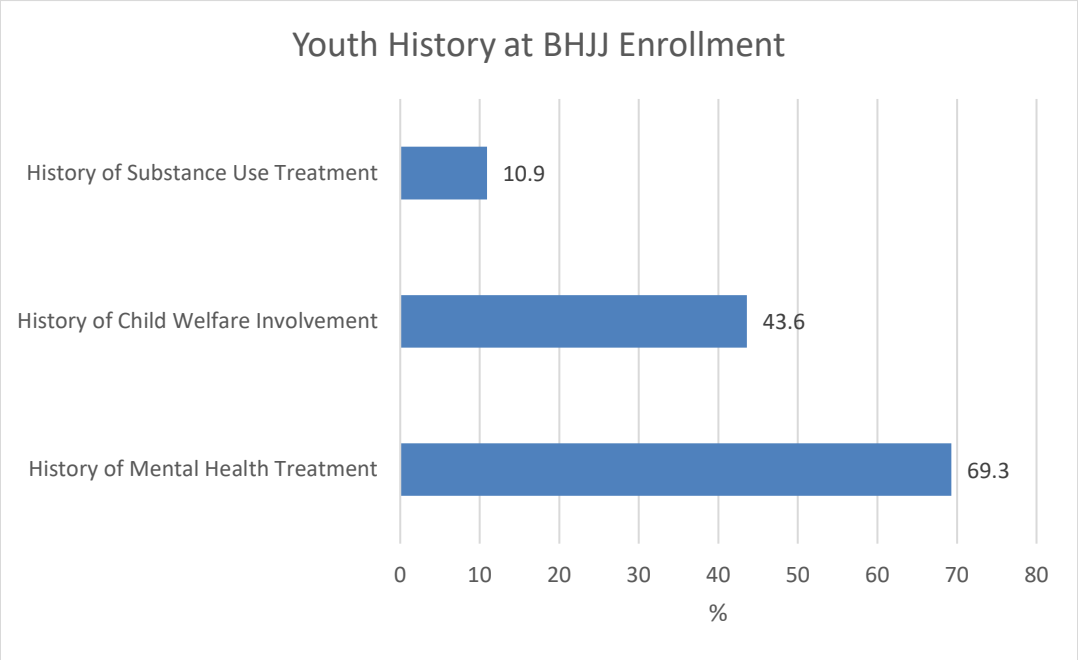
Table 7. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Black	Multiracial
Less than $5,000	18.6% (n = 111)	12.0% (n = 33)	26.2% (n = 69)	14.0% (n = 7)
$5,000 - $9,999	6.7% (n = 40)	5.8% (n = 16)	6.5% (n = 17)	10.0% (n = 5)
$10,000 - $14,999	13.7% (n = 82)	11.3% (n = 31)	17.1% (n = 45)	8.0% (n = 4)
$15,000 - $19,999	6.4% (n = 38)	5.8% (n = 16)	7.2% (n = 19)	6.0% (n = 3)
$20,000 - $24,999	14.7% (n = 88)	13.1% (n = 36)	16.7% (n = 44)	14.0% (n = 7)
$25,000 - $34,999	10.9% (n = 65)	11.6% (n = 32)	8.7% (n = 23)	20.0% (n = 10)
$35,000 - $49,999	12.7% (n = 76)	14.5% (n = 40)	9.9% (n = 26)	18.0% (n = 9)
$50,000 - $74,999	9.2% (n = 55)	13.1% (n = 36)	5.3% (n = 14)	6.0% (n = 3)
$75,000 or greater	7.2% (n = 43)	12.7% (n = 35)	2.3% (n = 6)	4.0% (n = 2)

Youth and Family History (July 1, 2017 – June 30, 2019)

Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history (see Figure 1). Over 40 percent (43.6%, n = 197) of youth had a history of child welfare involvement prior to BHJJ enrollment. Ten percent (10.9%, n = 51) of youth had received substance use treatment in their lifetime prior to BHJJ enrollment and 69.3% (n = 318) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 1.



Additional intake items explored child maltreatment, suicide ideation and attempts, and family history of behavioral health issues. 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 sexual abuse, running away, talking about suicide, and attempting suicide. Forty-seven percent (47.2%, n = 83) of female participants and 33.0% (n = 139) of male participants were taking medication related to emotional/behavioral problems upon enrollment to BHJJ. Caregivers reported 55.8% (n = 241) of male participants and 40.3% (n = 71) of female participants had substance use problems.

Table 8. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	17.3% (n = 30)	13.0% (n = 56)
Has the child ever been sexually abused?	21.4% (n = 36)***	6.9% (n = 29)
Has the child ever run away?	61.2% (n = 109)***	43.6% (n = 190)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	40.3% (n = 71)	55.8% (n = 241)**
Has the child ever talked about committing suicide?	53.6% (n = 96)***	35.0% (n = 151)
Has the child ever attempted suicide?	23.0% (n = 40)***	10.9% (n = 47)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	39.0% (n = 69)	35.3% (n = 153)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	65.5% (n = 116)	65.6% (n = 280)
Has anyone in the child's biological family had a mental illness, other than depression?	56.2% (n = 95)	53.3% (n = 218)
Has the child ever lived in a household in which someone was convicted of a crime?	41.3% (n = 71)	38.5% (n = 162)
Has anyone in the child's biological family had a drinking or drug problem?	53.4% (n = 95)	47.2% (n = 199)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	47.2% (n = 83)**	33.0% (n = 139)

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

Problems Leading to Service (July 1, 2017 – June 30, 2019)

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 (79.0% and 77.9% respectively) (see Table 9). Chi-square analysis indicated females had significantly higher rates of problems related to anxiety, depression, and suicide. Males had significantly higher rates of hyperactive and attention-related problems as well as problems related to school performance.

Table 9. Problems Leading to Services

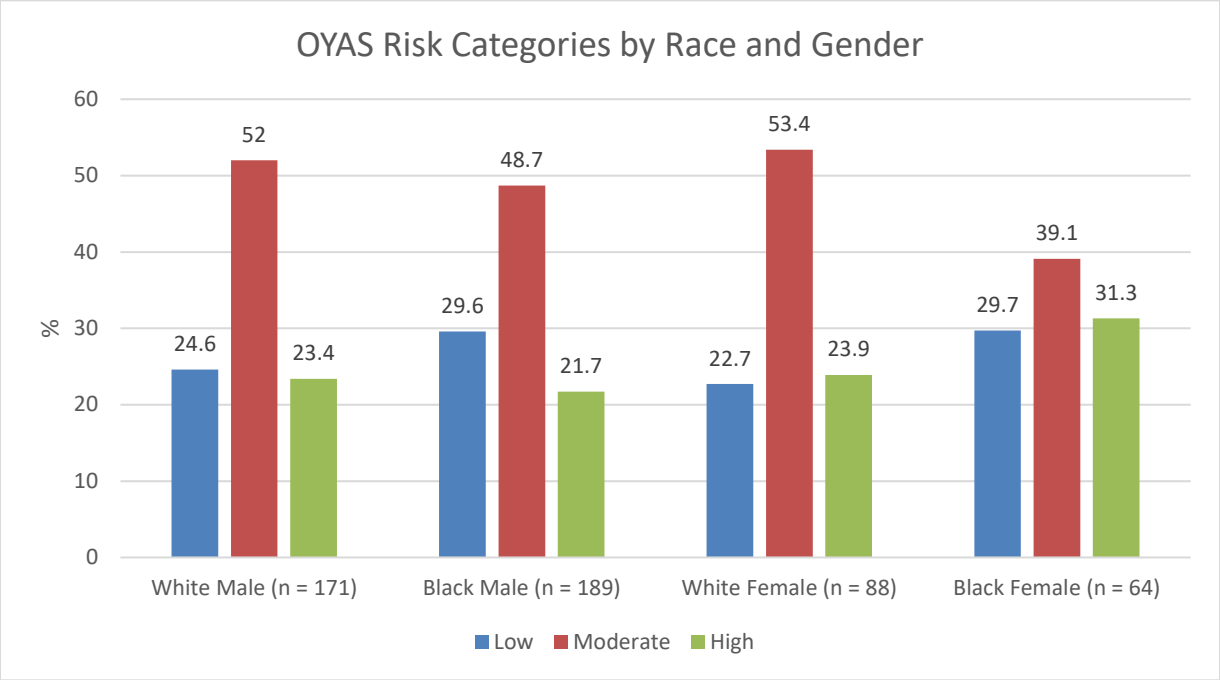
Problems Leading to Services	Females	Males
Adjustment-related problems	14.4% (n = 26)	12.1% (n = 53)
Anxiety-related problems	32.6% (n = 59)**	21.7% (n = 95)
Conduct/delinquency-related problems	79.0% (n = 143)	77.9% (n = 341)
Depression-related problems	42.0% (n = 76)*	31.1% (n = 136)
Eating disorders	1.1% (n = 2)	0
Hyperactive and attention-related problems	22.1% (n = 40)	38.1% (n = 167)***
Learning disabilities	6.6% (n = 12)	10.7% (n = 47)
Pervasive development disabilities	1.7% (n = 3)	2.7% (n = 12)
Psychotic behaviors	2.8% (n = 5)	2.1% (n = 9)
School performance problems not related to learning disabilities	28.2% (n = 51)	40.2% (n = 176)**
Specific developmental disabilities	0.6% (n = 1)	1.4% (n = 6)
Substance use, abuse, dependence-related problems	27.8% (n = 10)	40.8% (n = 42)
Suicide-related problems	16.6% (n = 30)**	7.8% (n = 38)

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

Ohio Youth Assessment System (July 1, 2017 – June 30, 2019)

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 2 shows the distribution of OYAS risk categories for BHJJ youth by race and gender. In the past two years, 23.4% (n = 40) of White males and 21.7% (n = 41) of Black males enrolled in the BHJJ program were identified as High risk on the OYAS, while 23.9% (n = 21) of White females and 31.3% (n = 20) of Black females were identified as High risk. Overall, 73.5% (n = 415) of the youth enrolled in BHJJ between July 1, 2017 and June 30, 2019 were classified as Moderate (50.5%, n = 285) or High (23.0%, n = 130) risk on the OYAS.

Figure 2



DSM Diagnoses (July 1, 2017 – June 30, 2019)

Workers were asked to report any DSM 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 diagnosis for females and males was Oppositional Defiant Disorder (ODD) (see Table 10).

A total of 1,270 diagnoses were identified for 576 youth with diagnostic information (2.20 diagnoses per youth). Data related to diagnoses per youth vary greatly by county (see county reports for additional information). Chi-square analysis indicated females were significantly more likely to be diagnosed with Depressive Disorders, Bipolar Disorder, and Post-traumatic Stress Disorder (PTSD). Males were significantly more likely to be diagnosed with Cannabis-related Disorders, ADHD, and Conduct Disorder. Nearly 44 percent of males (43.7%, n = 179) and over one-quarter of females (26.7%, n = 44) were identified as having both a DSM mental health diagnosis and a substance use diagnosis.

Table 10. Most Common DSM Diagnoses

DSM Diagnosis	Females	Males
Adjustment Disorder	4.6% (n = 7)	3.1% (n = 12)
Alcohol-related Disorders	2.6% (n = 4)	2.9% (n = 11)
Attention Deficit Hyperactivity Disorder	28.6% (n = 44)	42.7% (n = 164)**
Bipolar Disorder	7.3% (n = 11)*	2.1% (n = 8)
Cannabis-related Disorders	25.5% (n = 42)	43.9% (n = 180)***
Conduct Disorder	5.8% (n = 9)	14.7% (n = 57)**
Depressive Disorders	29.3% (n = 44)*	20.5% (n = 78)
Disruptive Behavior Disorder	0.7% (n = 1)	1.6% (n = 6)
Mood Disorder	2.5% (n = 4)	1.5% (n = 6)
Oppositional Defiant Disorder	**50.6% (n = 82)**	**44.3% (n = 179)**
Post-traumatic Stress Disorder	16.5% (n = 27)*	8.9% (n = 36)
Trauma and Stressor Related Disorder	3.0% (n = 5)	4.6% (n = 19)
Disruptive Mood Dysregulation Disorder	10.3% (n = 17)	10.0% (n = 41)
Co-occurring Disorders	26.7% (n = 44)	43.7% (n = 179)***

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

Educational Information (July 1, 2017 – June 30, 2019)

Several items focused on educational 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. Two-thirds of the youth (57.4%, n = 335) were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in treatment with BHJJ, 28.5% (n = 91) 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, 85.4% (n = 345) of youth were currently attending school while at termination, 86.2% (n = 237) 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 11 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 12 displays this information based on completion status. At intake, 39.3% of youth were earning mostly A's and B's, and C's while at termination, 54.2% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 12). For example, at intake, 32.8% of youth who would go on to be unsuccessful completers and 40.1% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 31.2% of unsuccessful completers and 59.8% of successful completers received mostly A's, B's, or C's.

Table 11. Academic Performance

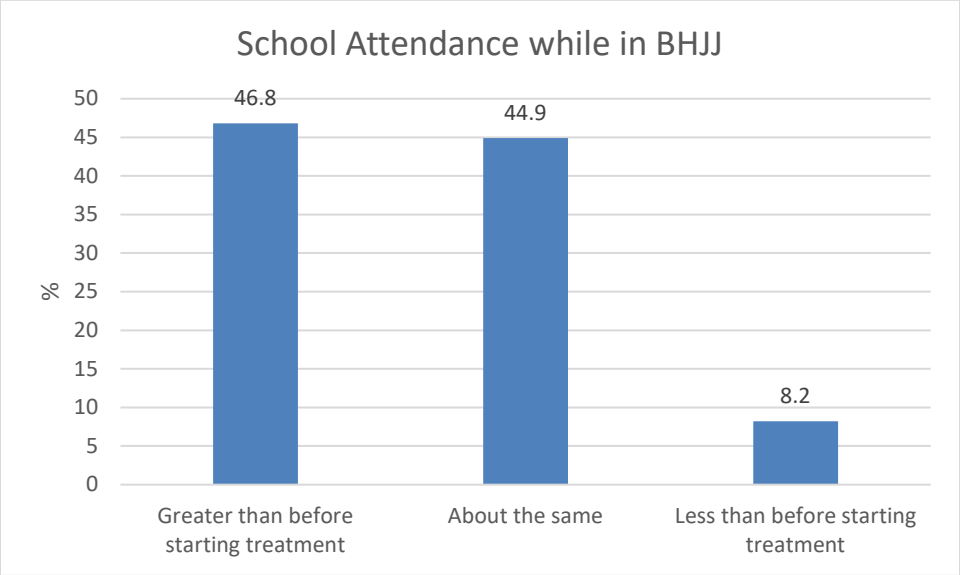
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	15.0% (n = 87)	19.6% (n = 61)
Mostly B's and C's	24.3% (n = 141)	34.6% (n = 108)
Mostly C's and D's	30.6% (n = 178)	24.7% (n = 77)
Mostly D's and F's	30.1% (n = 175)	21.2% (n = 66)

Table 12. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	7.8% (n = 5)	6.6% (n = 4)	16.5% (n = 39)	22.7% (n = 57)
Mostly B's and C's	25.0% (n = 16)	24.6% (n = 15)	23.6% (n = 56)	37.1% (n = 93)
Mostly C's and D's	21.9% (n = 14)	29.5% (n = 18)	34.2% (n = 81)	23.5% (n = 59)
Mostly D's and F's	45.3% (n = 29)	39.3% (n = 24)	25.7% (n = 61)	16.7% (n = 42)

At termination, workers reported that 46.8% (n = 148) of youth were attending school more than before starting treatment and 44.9% (n = 142) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 3). At intake, 43.8% (n = 195) of the youth attending school had Individualized Education Plans (IEPs) while at termination, 46.6% (n = 144) of the youth attending school had Individualized Education Plans (IEPs).

Figure 3



Ohio Scales (July 1, 2017 – June 30, 2019)

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 for all BHJJ youth can be found in Table 13. Tables Table 13 and Table 14 present non-dependent means at intake and termination. In other words, means represent data for all youth, workers, and caregivers who responded to the Ohio Scales. Additional county-level information can be found in the individual county reports. Problem Severity means for youth enrolled between July 1, 2017 and June 30, 2019 are presented in Table 14.

Table 13. Problem Severity - Overall

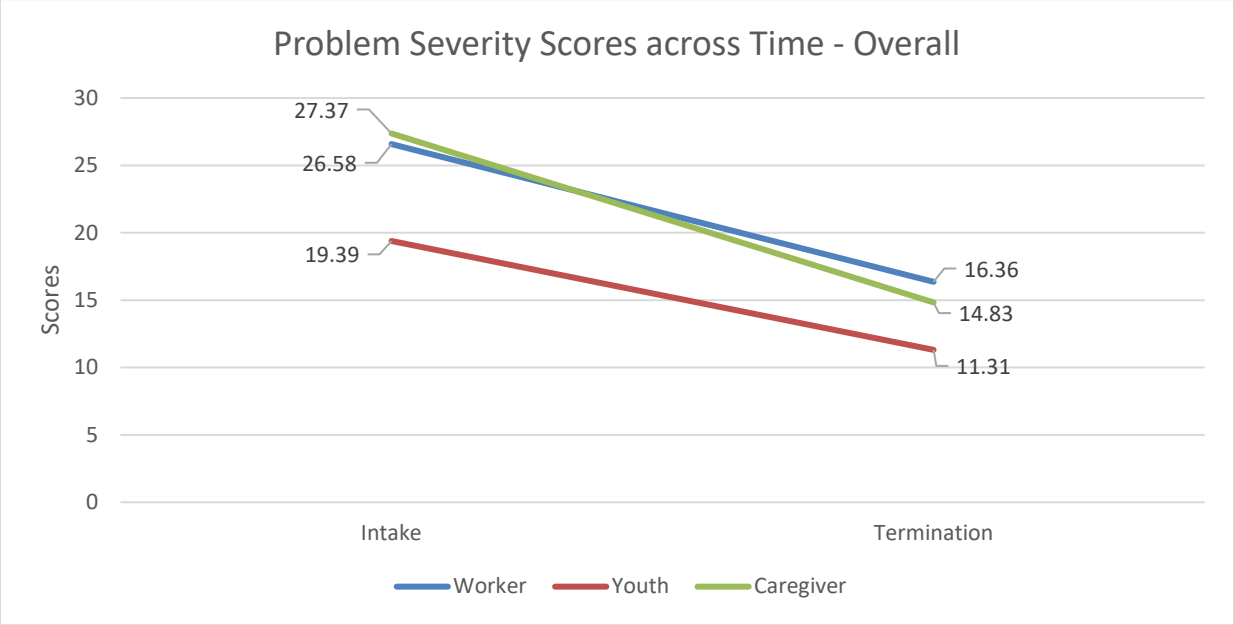
	Worker			Youth			Caregiver		
	M	SD	n	M	SD	n	M	SD	n
Intake	26.93	13.61	4,811	20.04	14.88	4,752	28.16	21.63	4,129
3 Months	19.13	11.97	2,076	14.64	12.31	1,994	20.19	17.64	1,591
6 Months	17.89	11.58	855	13.41	12.20	814	18.85	17.89	650
9 Months	17.55	11.22	387	12.56	11.12	378	18.90	20.70	341
Termination	16.43	12.51	3,501	11.47	10.81	2,729	15.11	15.34	2,308

Table 14. Problem Severity -Youth Enrolled between 2017-2019

	Worker			Youth			Caregiver		
	M	SD	n	M	SD	n	M	SD	n
Intake	27.38	13.55	582	21.40	15.71	580	28.98	17.65	518
3 Months	17.80	11.44	152	13.14	12.74	146	17.96	14.18	118
6 Months	14.98	9.84	49	12.61	12.45	50	17.02	15.80	34
Termination	14.97	10.60	285	10.96	11.02	259	14.83	13.91	235

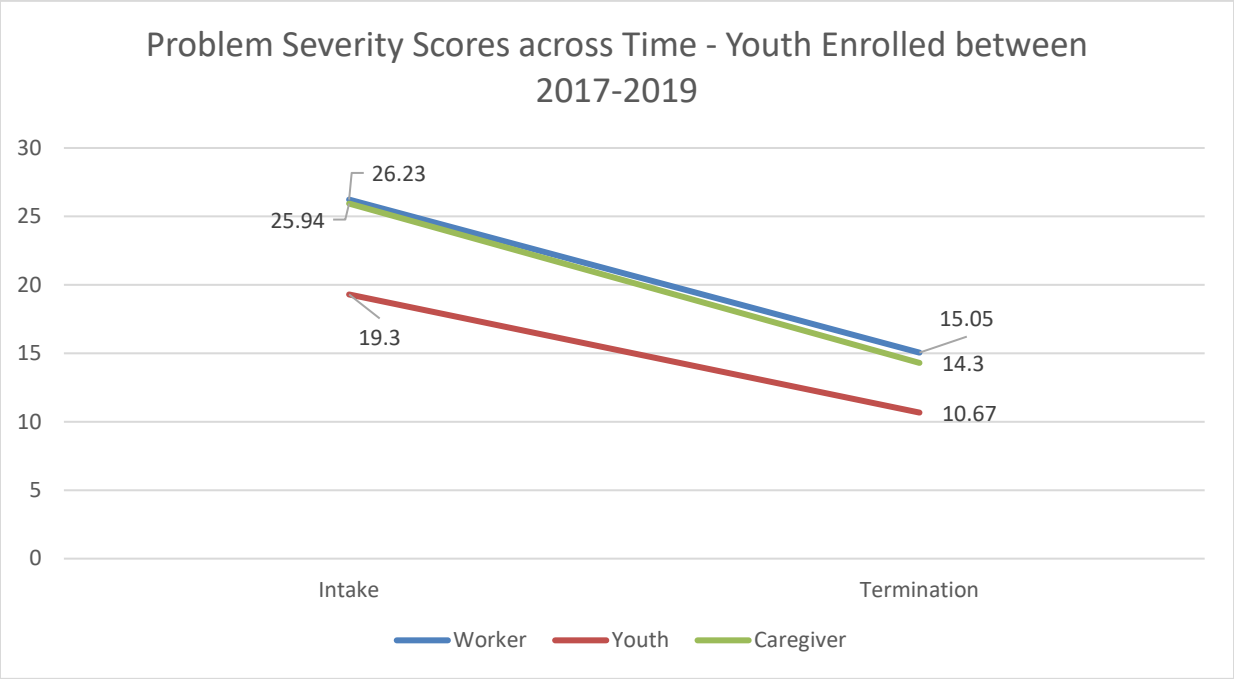
Figure 4 and Figure 5 present paired means which includes means for a limited sample of youth who completed both an intake and a termination form. This allows us to examine improvement in scale scores from intake to termination. Paired samples *t*-tests revealed significant improvements in Problem Severity from intake to termination for all three raters including workers ($t(3,246) = 38.39$, $p < .001$), youth ($t(2,523) = 30.17$, $p < .001$), and caregivers ($t(2,087) = 25.13$, $p < .001$) (see Figure 4). Medium effect sizes were found for all three raters.

Figure 4.



Similarly, for youth enrolled in the past biennium, paired samples *t*-tests revealed significant statistically improvements for workers ($t(276) = 14.51$, $p < .001$), youth ($t(253) = 10.61$, $p < .001$), and caregivers ($t(226) = 11.56$, $p < .001$) (see Figure 5). A large effect size was found for worker report Problem Severity scores while a medium effect size was reported by youth and caregivers.

Figure 5.



Functioning

Means for the Functioning scale by reporter and assessment period for all BHJJ youth can be found in Table 15. Similar to the Problem Severity section, tables present non-dependent means. Additional county-level information can be found in the individual county reports. Functioning scale means for youth enrolled between July 1, 2017 and June 30, 2019 are presented in Table 16.

Table 15. Functioning - Overall

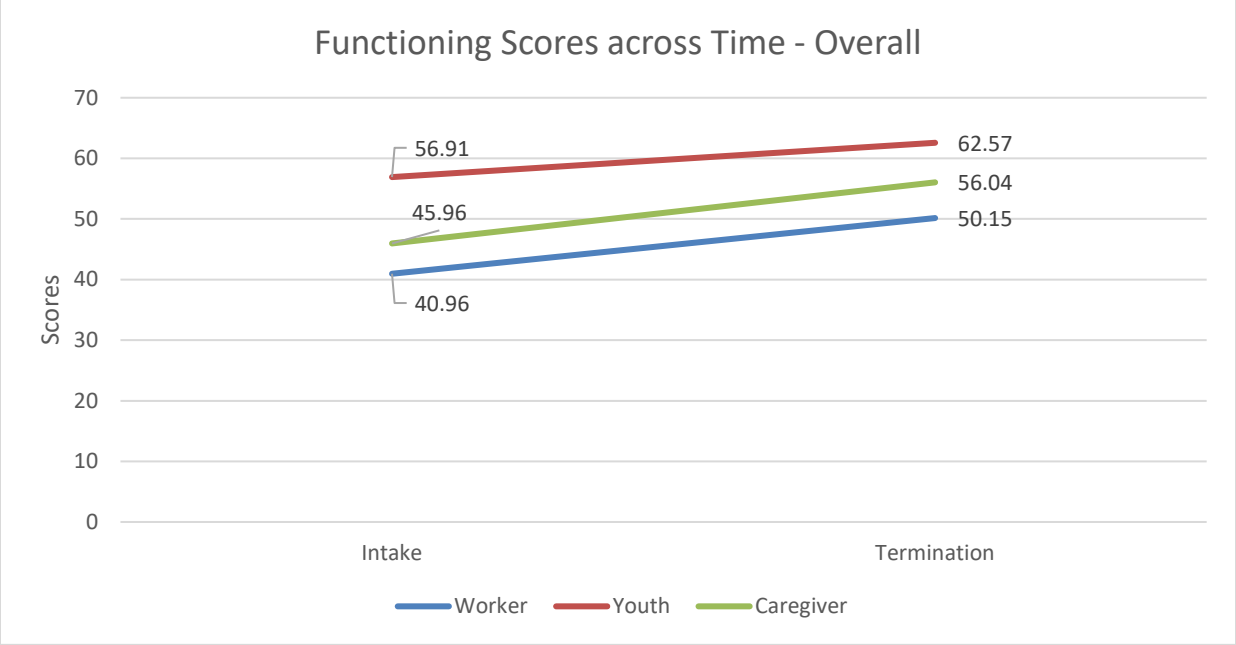
	Worker			Youth			Caregiver		
	M	SD	n	M	SD	n	M	SD	n
Intake	41.03	11.80	4,794	56.51	13.18	4,739	45.54	24.67	4,131
3 Months	46.49	13.46	2,066	59.83	13.45	2,000	51.22	22.94	1,588
6 Months	48.04	13.41	855	61.22	13.13	812	50.32	18.13	653
9 Months	49.28	13.25	389	62.53	12.59	380	53.69	20.21	338
Termination	50.20	14.43	3,501	62.45	13.31	2,740	55.82	21.47	2,323

Table 16. Functioning - Youth Enrolled between 2017-2019

	Worker			Youth			Caregiver		
	M	SD	n	M	SD	n	M	SD	n
Intake	41.53	11.58	614	55.55	13.51	612	39.72	16.57	552
3 Months	47.32	13.49	158	61.33	13.12	152	48.82	16.21	123
6 Months	52.66	12.21	53	61.86	14.17	50	51.05	18.04	36
Termination	52.85	13.75	314	63.83	14.03	288	55.50	16.78	266

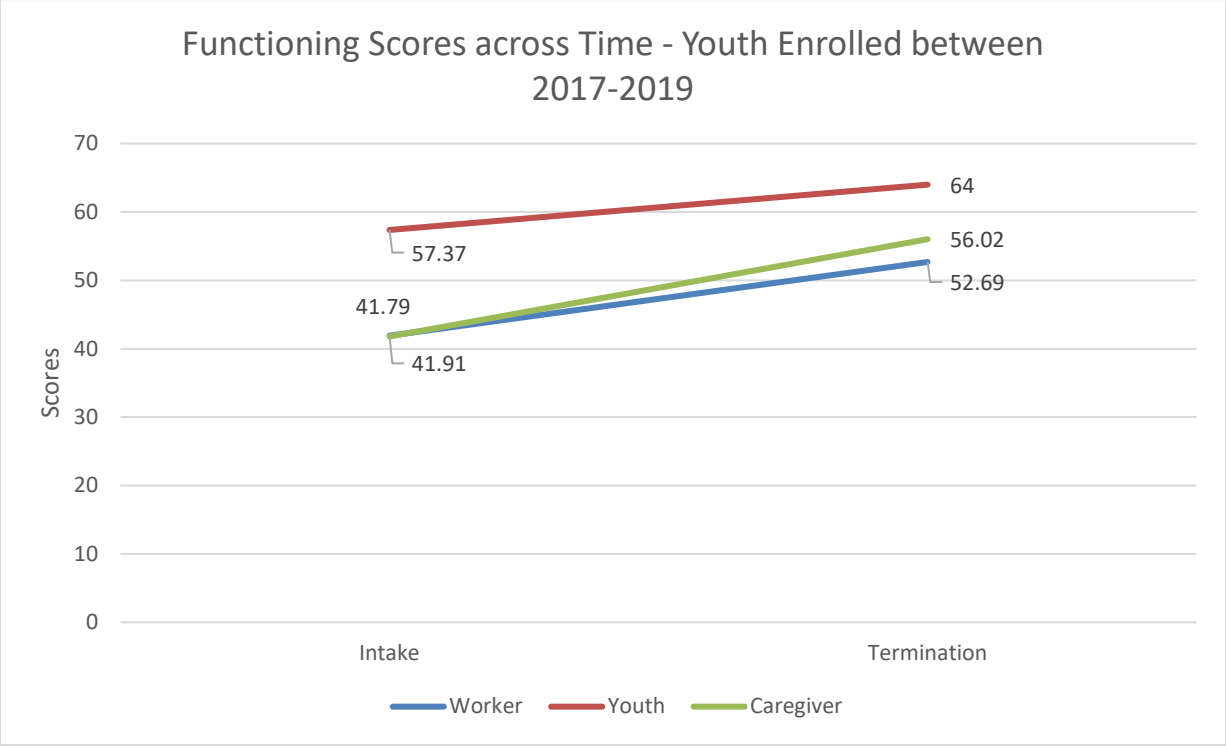
Paired samples *t*-tests revealed significant improvements in the Functioning scores from intake to termination for all three reporters including workers ($t(3,237) = -33.28$, $p < .001$), youth ($t(2,520) = -19.79$, $p < .001$), and caregivers ($t(2,095) = -17.77$, $p < .001$) (see Figure 6). A medium effect size was found for workers while small effect sizes were found for youth and caregivers.

Figure 6.



Similarly, for youth enrolled in the past biennium, paired samples *t*-tests revealed significant improvements for workers ($t(277) = -12.30$, $p < .001$), youth ($t(253) = -7.11$, $p < .001$), and caregivers ($t(228) = -12.38$, $p < .001$) (see Figure 7). A large effect size was found for worker report Problem Severity scores while a medium effect size was reported by youth and caregivers. A large effect size was found for caregivers while a medium effect size was found for workers. While youth reported the highest means for functioning scores at intake and termination, the effect size was small.

Figure 7.



Violence and Delinquency Questionnaire

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey composed of three general domains: exposure to violence, violence perpetration, and peer delinquency. The VDQ is offered at intake and termination into the BHJJ program. At intake, each item prompts the youth to answer within the context of the past year. At termination, youth are directed to answer "since the last time you answered these questions".

This section will be divided into three distinct parts that examine the prevalence of violence exposure as either a victim or witness, self-reported delinquent behavior from intake to termination, and delinquent behavior by peers from intake to termination. Table 17 provides the percentage of those who had experienced violence as either a victim or witness in the past year. The data are presented for the 1,193 youth in the BHJJ sample who completed the VDQ (the VDQ was first included in the evaluation in 2015). The data are also presented for youth who were enrolled during the present evaluation period (July 2017 through June 2019). Generally, the prevalence of violence exposure for the cohort of youth from the most recent evaluation period did not differ greatly from the overall numbers.

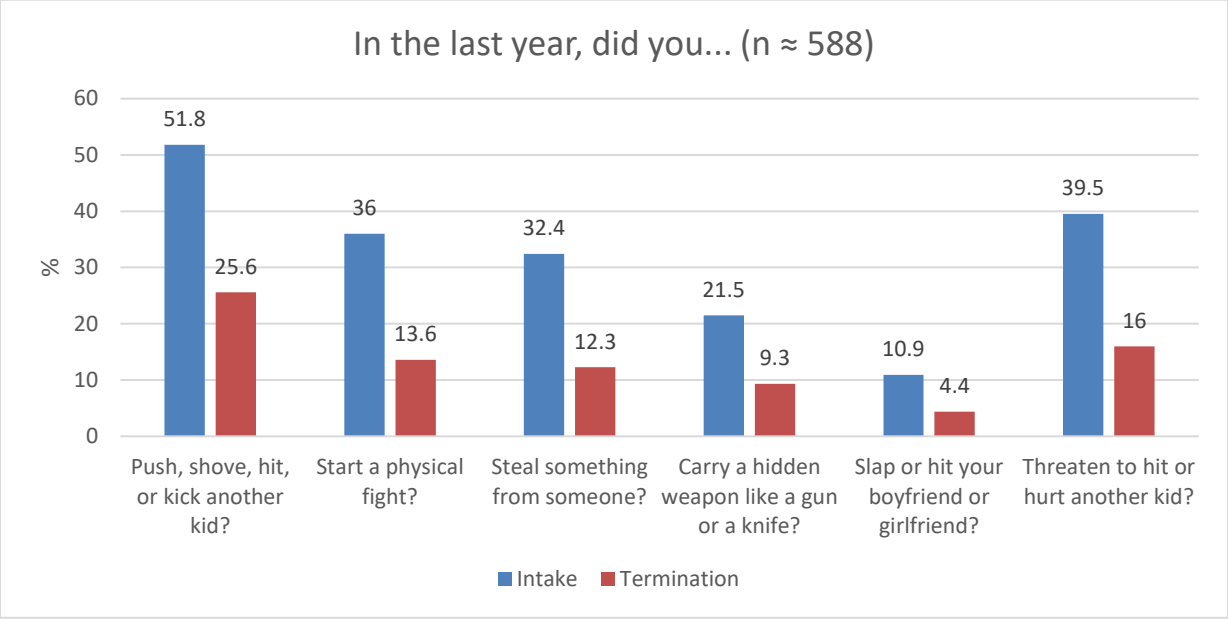
Table 17. Violence Exposure

	% Yes BHJJ Sample (n = 1,193)	% Yes '17 – '19 (n = 476)
In the last year, did someone threaten to hurt you when you thought they might really do it?	36.5%	36.3%
In the last year, have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?	10.2%	12.6%
In the last year, did a boyfriend or girlfriend or anyone you went on a date with slap or hit you?	12.9%	13.6%
In the last year, did anyone steal anything from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?	45.6%	41.9%
Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	16.6%	17.6%
In the last year, did anyone hit or attack you WITHOUT using an object or weapon?	38.2%	38.9%
In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?	25.4%	24.2%
In the last year, did a grown-up touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?	4.1%	4.5%

Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. In the last year, did another child or teen make you do sexual things?	4.3%	5.1%
In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	12.9%	11.6%
In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	27.5%	26.3%
In the last year, in real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt them?	41.8%	40.0%
In the last year, was anyone close to you murdered, like a friend, neighbor, or someone in your family?	22.8%	21.2%
In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	31.0%	33.5%
Not including spanking on your bottom, did a grown-up in your life hit, beat, kick or physically hurt you in any way?	22.8%	23.0%
When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. In the last year, were you neglected?	9.5%	9.7%

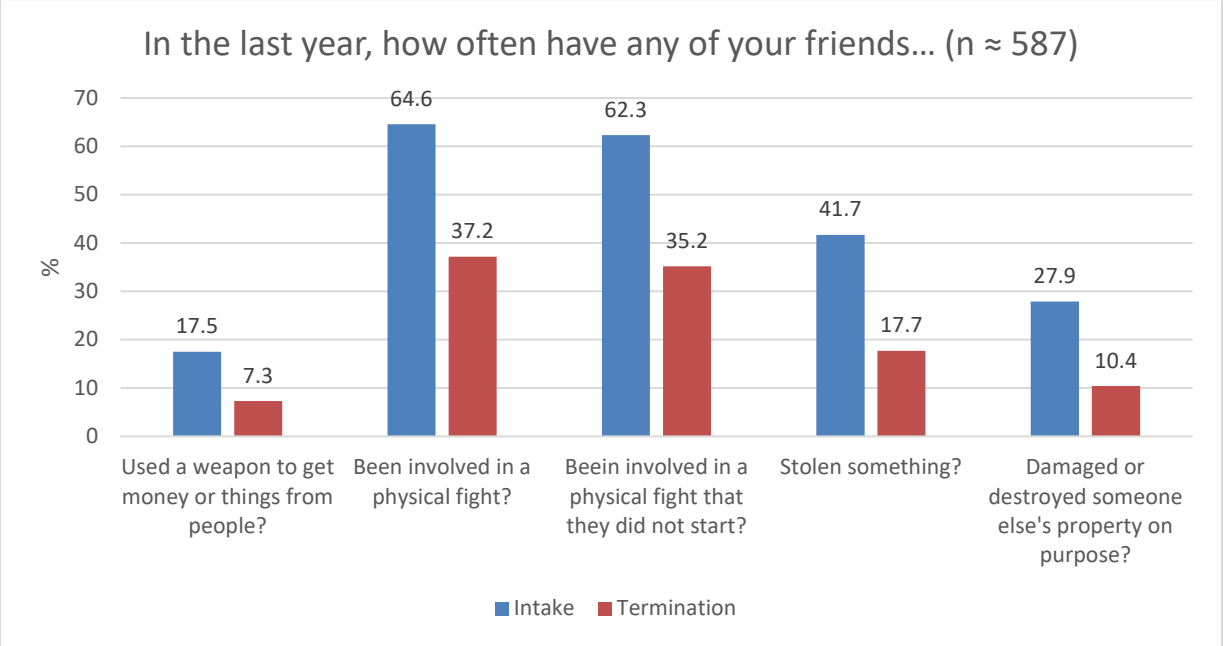
Delinquent behaviors were measured as self-report items of violent and weapon carrying behaviors as well as stealing. At intake, youth were asked how often they engaged in each behavior in the last year while at termination, youth were asked how often they engaged in the behavior since the last time they were asked. Figure 8 presents the percentage of youth who identified that they had engaged in each type of behavior at least once. Depending on the item, data were available for a range between 586 and 592 matched pairs (Mode = 588). McNemar's tests revealed statistically significant differences for each of the 7 items presented in Figure 8 from intake to termination.

Figure 8.



Self-reported peer delinquency was also measured at intake (how often in the last year) and at termination (how often since the last time they were asked). Figure 9 presents the percentage of youth who identified how often their friends had engaged in delinquent behavior at intake and termination. Depending on the item, data were available for a range between 586 and 588 matched pairs (Mode = 587). Statistically significant differences were found for each of the items between intake and termination.

Figure 9.



Resilience (July 1, 2017 – June 30, 2019)

As part of the 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family.

Figure 10 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were "pretty much true" and "very much true", we combined these responses. Generally, the majority of youth indicated high levels of each one of these items. It is important to note, that the largest proportion of youth responding "not at all" or "a little true" were for the three items that measure empathy. Over 15% (15.4%; n = 80) identified that the statement "I feel bad when someone gets their feelings hurt" was "not at all true" and a further 28.8% (n = 150) responded "a little true".

Figure 10.

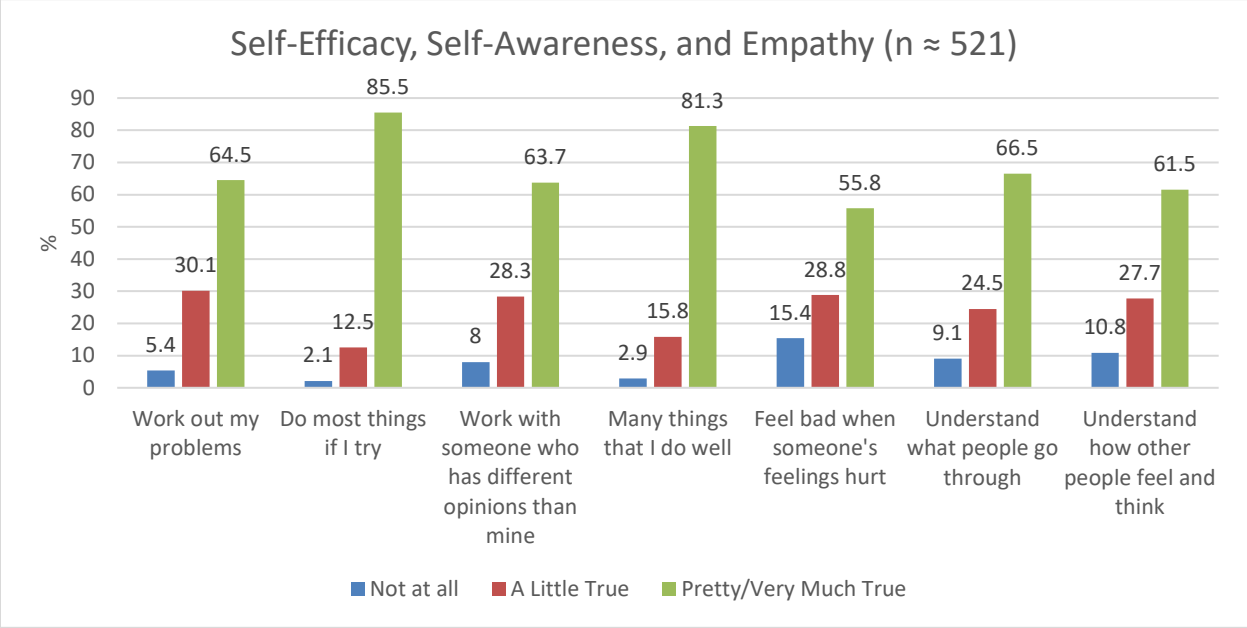


Figure 11 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. The majority of youth identified that each of the statements were pretty much or very much true. However, 35.8% (n = 185) identified that the statement, “I have a friend about my own age who talks with me about my problems” was either “not at all” or “a little true”.

Figure 11.

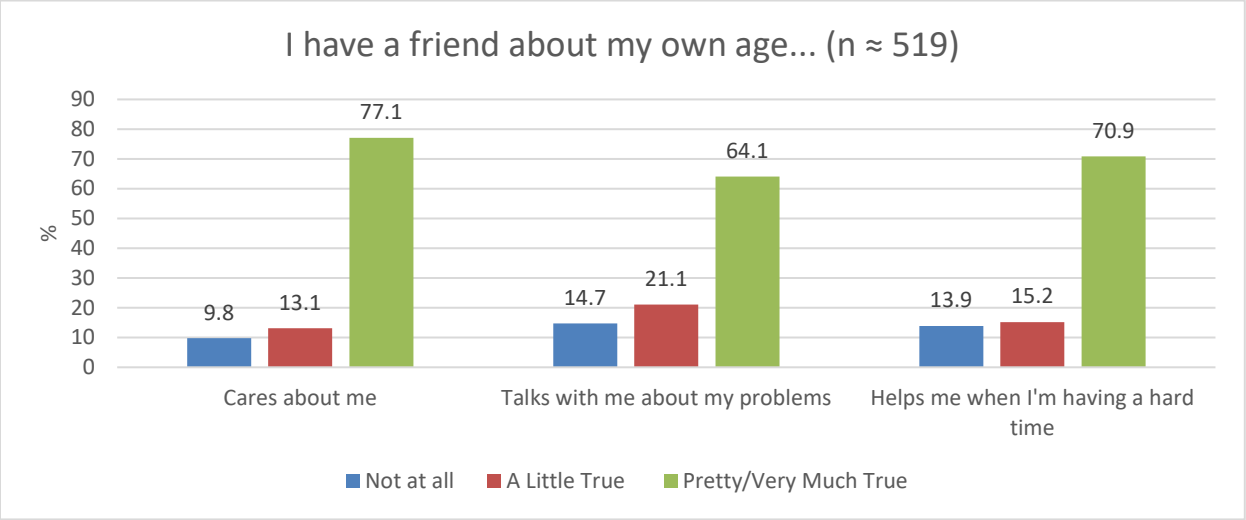
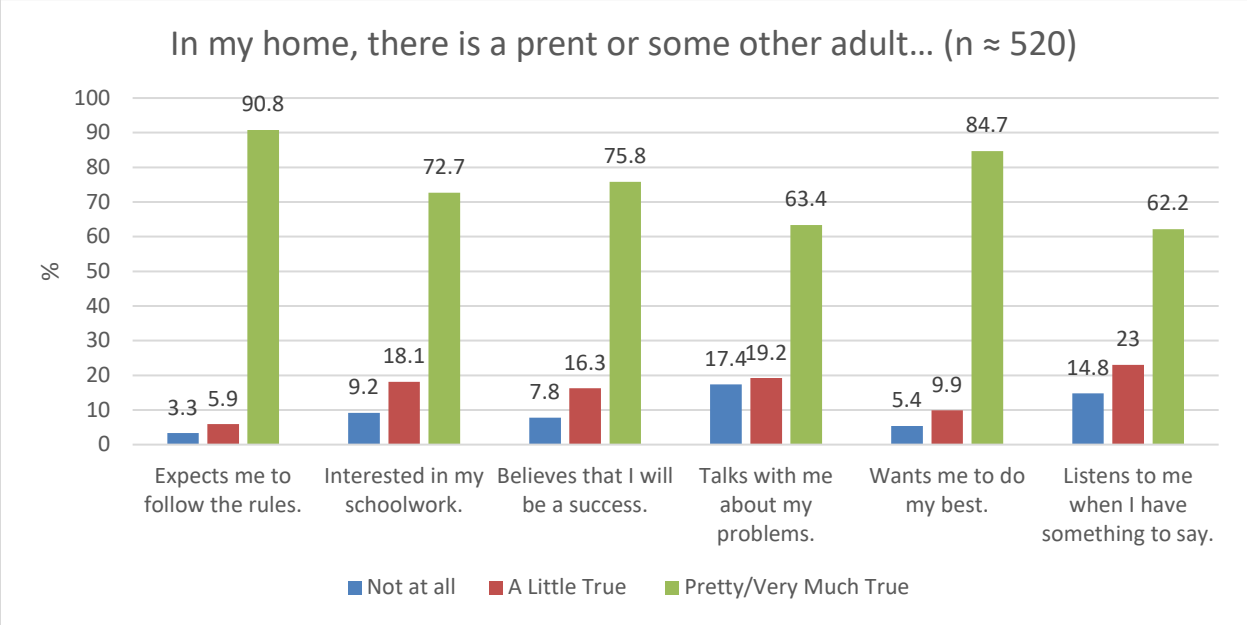


Figure 12 shows intake data on parental or support from other adults in their house. Similar to the questions around peer support, 36.6% (n = 187) identified that the statement “In my home, there is a parent or some other adult who talks with me about my problems” was either “not at all true” or “a little true”. Further 37.8% (n = 187) identified that the statement “In my home, there is a parent or some other adult who listens to me when I have something to say” was either “not at all true” or “a little true”.

Figure 12.



In addition to intake data, Figure 13 through Figure 15 show the proportion of youth who identified that each of the statements were either pretty much or very much true from intake to termination. McNemar's tests were conducted to examine whether the difference in proportions were significant. Figure 13 shows differences from intake to termination for the items measuring self-efficacy, self-awareness, and empathy. Youth exhibited improvement in each of the items measuring self-efficacy, self-awareness, and empathy. McNemar's tests indicated statistically significant improvements in the proportion of youth who identified that the statements "I can work out my problems" and "I feel bad when someone gets their feelings hurt" were either pretty much or very much true.

Figure 13.

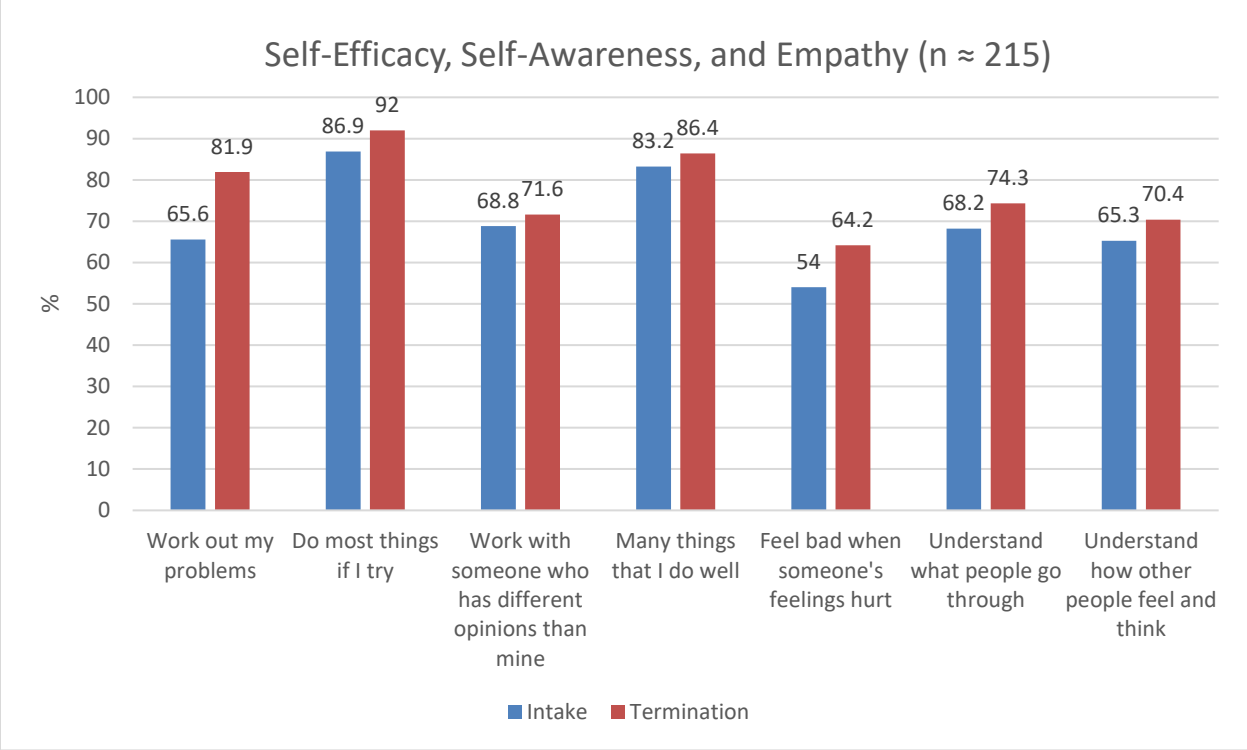


Figure 14 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring peer support. At termination a slightly larger proportion of youth indicated that they had a friend who talks with them about their problems.

Figure 14.

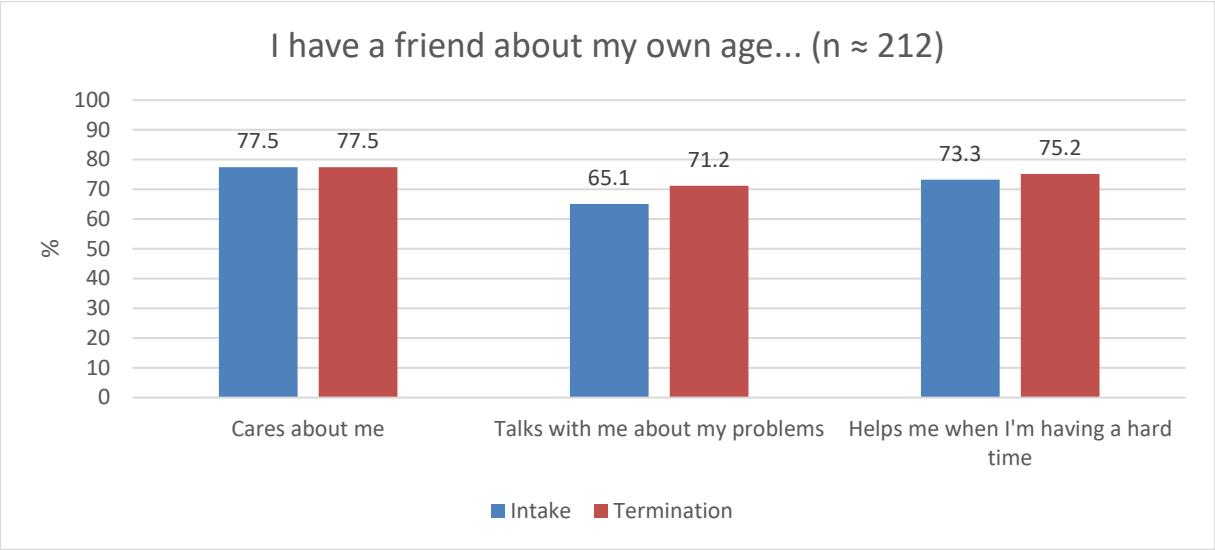
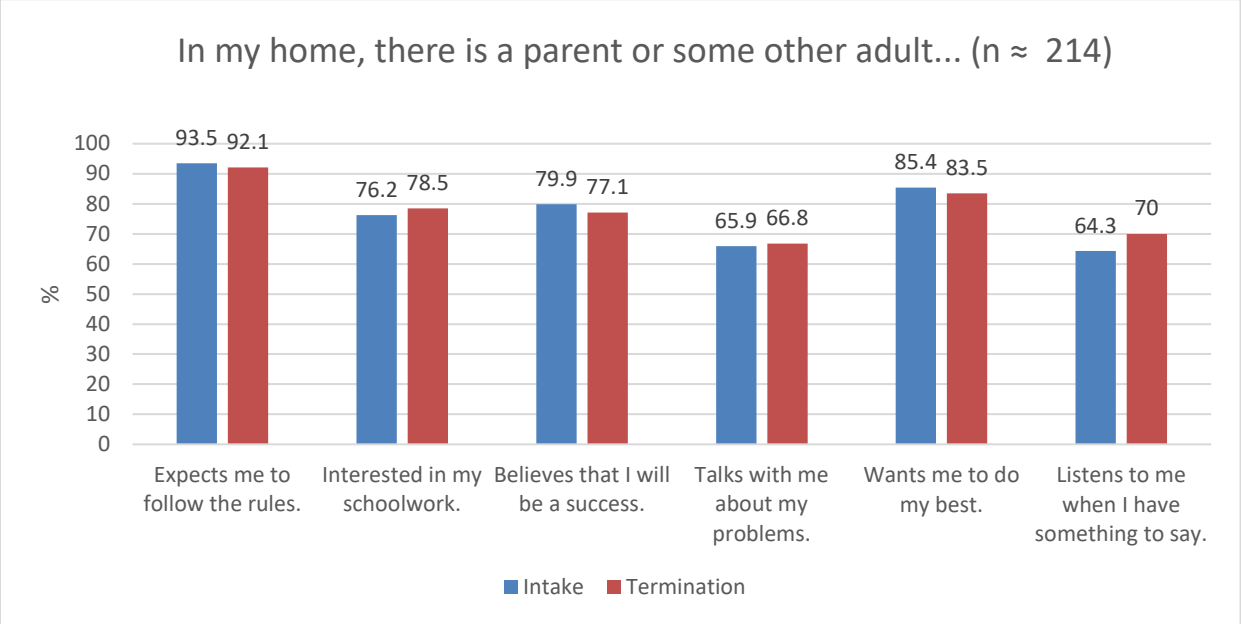


Figure 15 shows the proportion of youth who responded pretty much or very much true to each of the items measuring parental support or support from other adults in the home. The proportion of positive responses declined slightly for three items: “expects me to follow the rules”, “believes that I will be a success”, and “always wants me to do my best”. None of these decreases were statistically significant.

Figure 15.



TSCC (July 1, 2016 – June 30, 2019)

The Trauma Symptom Checklist for Children (TSCC) is a 54-item, self-report 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. Paired-samples t-tests were conducted to show whether means at intake and termination on each TSCC subscale differed significantly. Data were analyzed separately for females (see Figure 16) and males (see Figure 17) who had completed the TSCC at both intake and termination.

Research has found that females consistently report more trauma symptoms than males (Singer et al., 1995). We examined trauma symptoms for females and males in the BHJJ sample. Consistent with previous research, BHJJ females reported higher scores on each trauma symptom subscale than males. For example, at intake, the average score on the Depression domain for females was 7.3 and for males was 3.9. Paired samples t-tests revealed significant improvements in trauma symptoms for each subscale at termination for both females and males (see Table 18 and Table 19).

Table 18. TSCC Subscales from Intake to Termination among Females

Females	Intake	Termination	t	d
Anxiety	4.99 (SD = 4.71; n = 130)	3.05 (SD = 3.77; n = 130)	5.14***	.45
Depression	7.27 (SD = 5.70; n = 130)	4.49 (SD = 4.75; n = 130)	5.52***	.48
Anger	7.97 (SD = 5.92; n = 130)	4.68 (SD = 4.94; n = 130)	5.91***	.52
Posttraumatic Stress	6.72 (SD = 6.34; n = 130)	4.91 (SD = 5.76; n = 130)	3.23**	.28
Dissociation	6.31 (SD = 5.57; n = 130)	4.46 (SD = 4.79; n = 130)	3.95***	.35
Sexual Concerns	3.23 (SD = 3.40; n = 130)	1.97 (SD = 2.69; n = 130)	4.36***	.38

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

Figure 16.

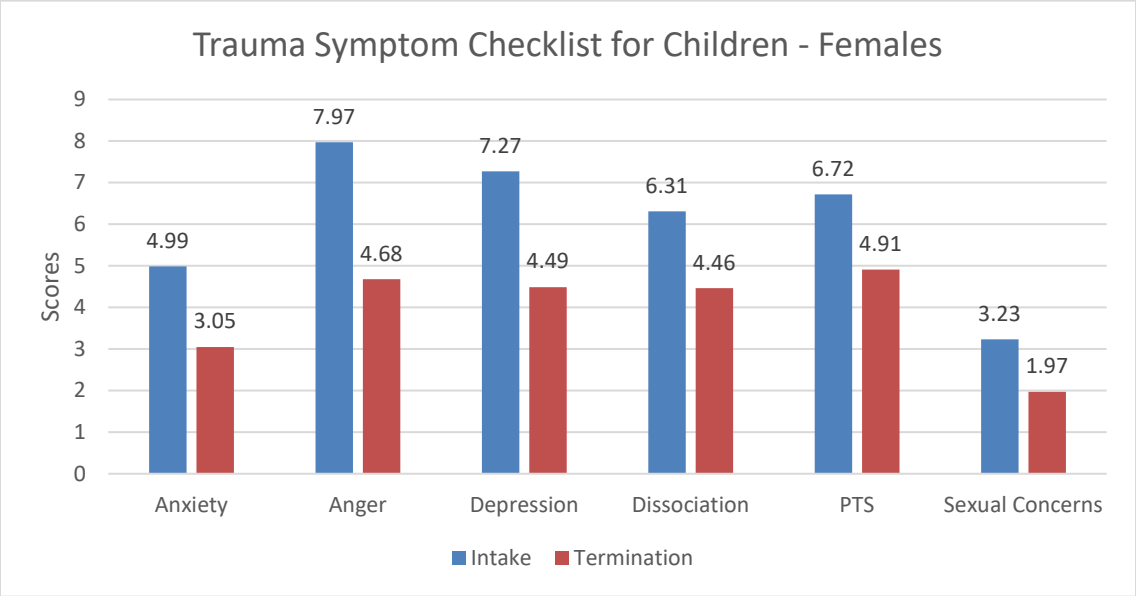
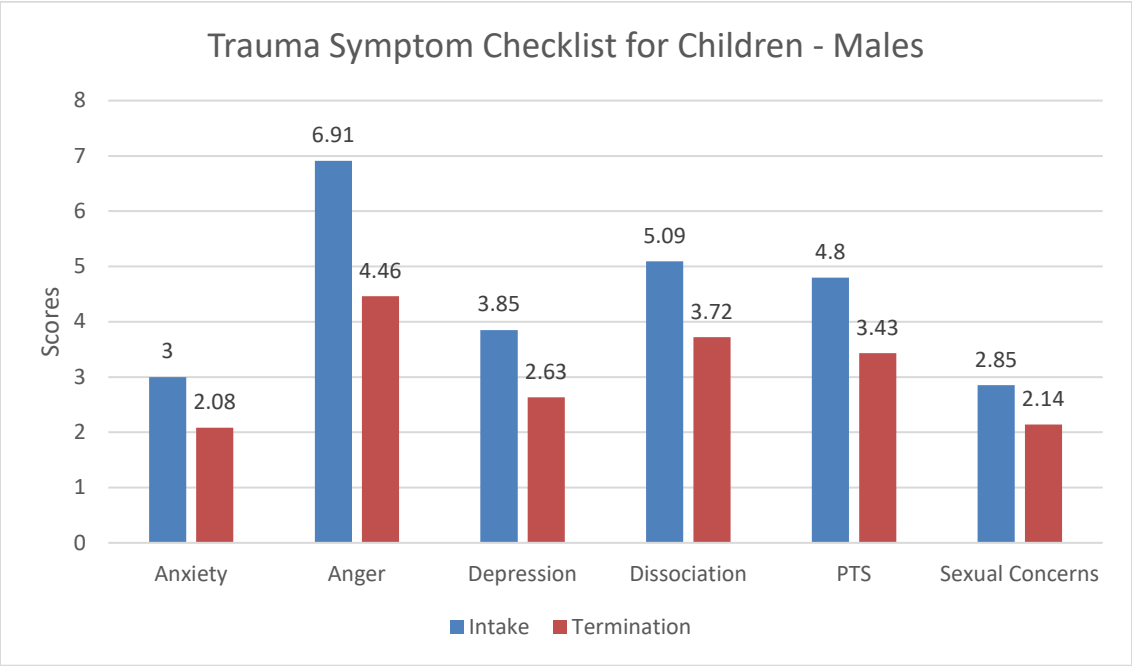


Table 19. TSCC Subscales from Intake to Termination for Males

Males	Intake	Termination	t	d
Anxiety	3.00 (SD = 3.40; n = 262)	2.08 (SD = 2.85; n = 262)	5.07***	.31
Depression	3.85 (SD = 4.21; n = 262)	2.63 (SD = 3.41; n = 262)	5.22***	.33
Anger	6.91 (SD = 5.37; n = 262)	4.46 (SD = 4.59; n = 262)	7.87***	.49
Posttraumatic Stress	4.80 (SD = 4.77; n = 262)	3.43 (SD = 4.19; n = 262)	5.41***	.34
Dissociation	5.09 (SD = 4.45; n = 259)	3.72 (SD = 3.93; n = 259)	5.58***	.35
Sexual Concerns	2.85 (SD = 3.38; n = 261)	2.14 (SD = 2.74; n = 261)	3.86***	.24

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

Figure 17.



Substance Use Survey (July 1, 2017 – June 30, 2019)

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 20 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use by gender. For both females and males, alcohol, tobacco, and marijuana were the most commonly used substances. Chi-squared tests revealed that a significantly higher proportion of males reported ever having used marijuana than females ($\chi^2(1) = 4.23$, $p < .05$).

Table 20. Self-Reported Substance Use at Intake by Gender

	Males		Females	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	49.4% (n = 157)	13.06 (SD = 2.70)	53.1% (n = 69)	13.18 (SD = 2.61)
Tobacco	48.9% (n = 155)	12.99 (SD = 2.49)	42.3% (n = 55)	12.48 (SD = 2.36)
Cannabis	**69.1% (n = 219)**	12.74 (SD = 2.55)	**58.9% (n = 76)**	13.31 (SD = 1.81)
Hallucinogens	8.3% (n = 26)	14.77 (SD = 1.53)	4.7% (n = 6)	14.00 (SD = 2.45)
Inhalants	1.0% (n = 3)	11.67 (SD = 4.04)	2.3% (n = 3)	10.50 (SD = 3.54)
Opioids	6.6% (n = 21)	14.47 (SD = 1.35)	3.9% (n = 5)	14.40 (SD = 2.51)
Sedatives	10.1% (n = 32)	14.34 (SD = 1.43)	8.6% (n = 11)	14.56 (SD = 1.94)
Caffeine	31.9% (n = 101)	10.34 (SD = 3.96)	37.2% (n = 48)	9.13 (SD = 4.73)
Stimulants	7.0% (n = 22)	14.81 (SD = 1.08)	7.9% (n = 10)	14.75 (SD = 2.49)
Over the counter medications	10.1% (n = 32)	14.23 (SD = 1.20)	7.8% (n = 10)	11.80 (SD = 5.12)
Other prescription drugs	6.3% (n = 20)	11.53 (SD = 3.79)	5.5% (n = 7)	13.50 (SD = 2.26)
Herbs/Flowers	0.6% (n = 2)	15.00	1.6% (n = 2)	NA

Thirty-Day Substance Use

If youth reported any lifetime use, they were also asked the number of days out of the past 30 in which had used each substance. Figure 18 shows the past 30-day use from intake to termination expressed as the average number of days for each of the 4 most commonly reported substances (alcohol, tobacco, marijuana, and caffeine). The data here are restricted to the youth who had reported having ever used each of the four substances. Alcohol and marijuana use declined from intake to termination while tobacco and caffeine use increased. Paired samples *t*-tests indicated that alcohol ($t(31) = 2.06$, $p < .05$) and marijuana use ($t(67) = 2.14$, $p < .05$) declined significantly.

Figure 18.

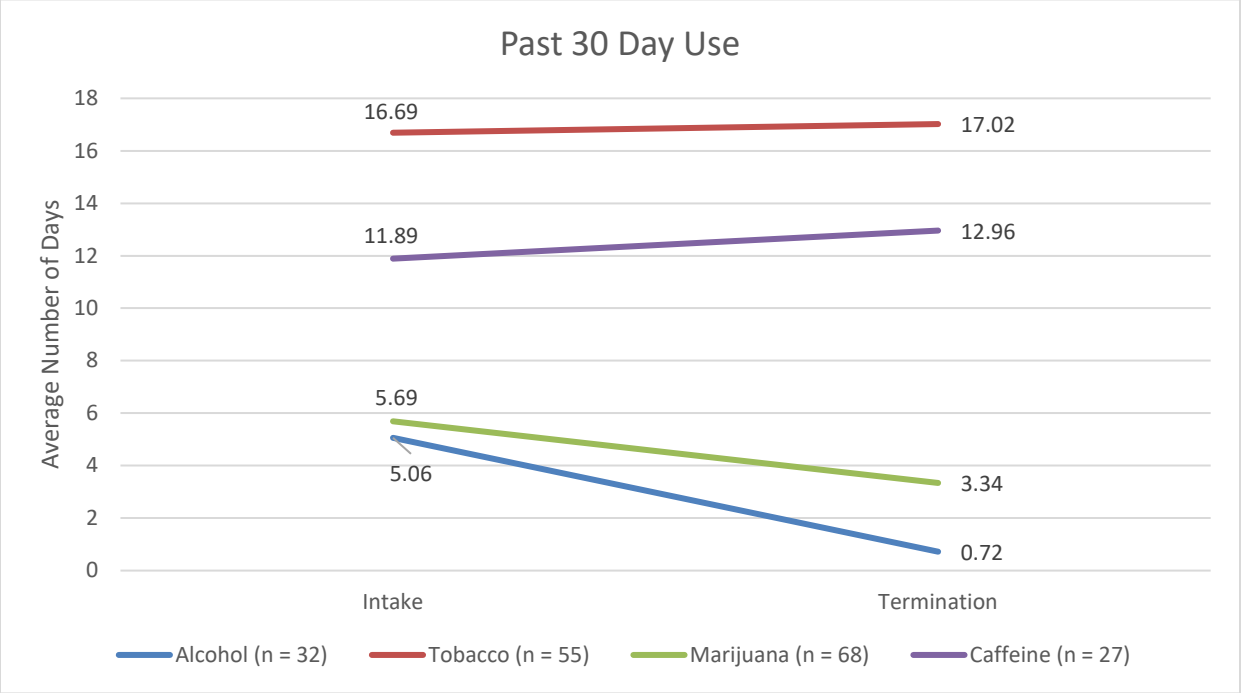
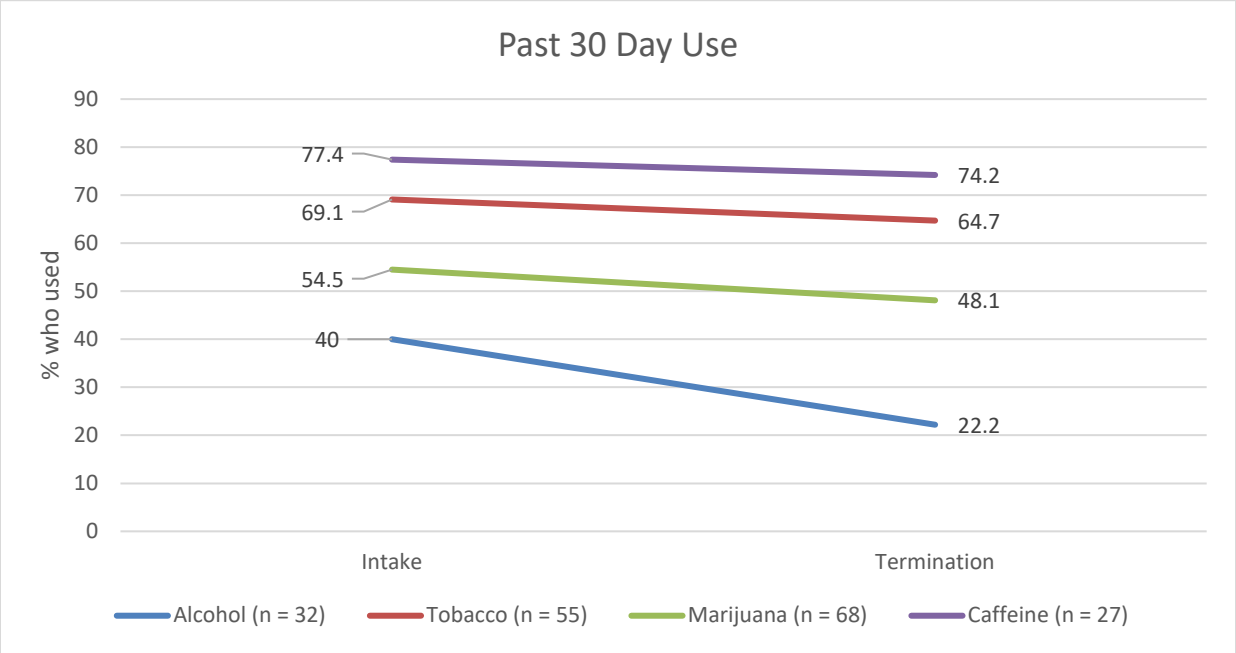


Figure 19 reports the proportion of youth who reported having used any of the four substances at all. For each of the four most commonly reported substances, the proportion of youth who had reported past 30-day use declined. McNemar's tests revealed no statistically significant differences.

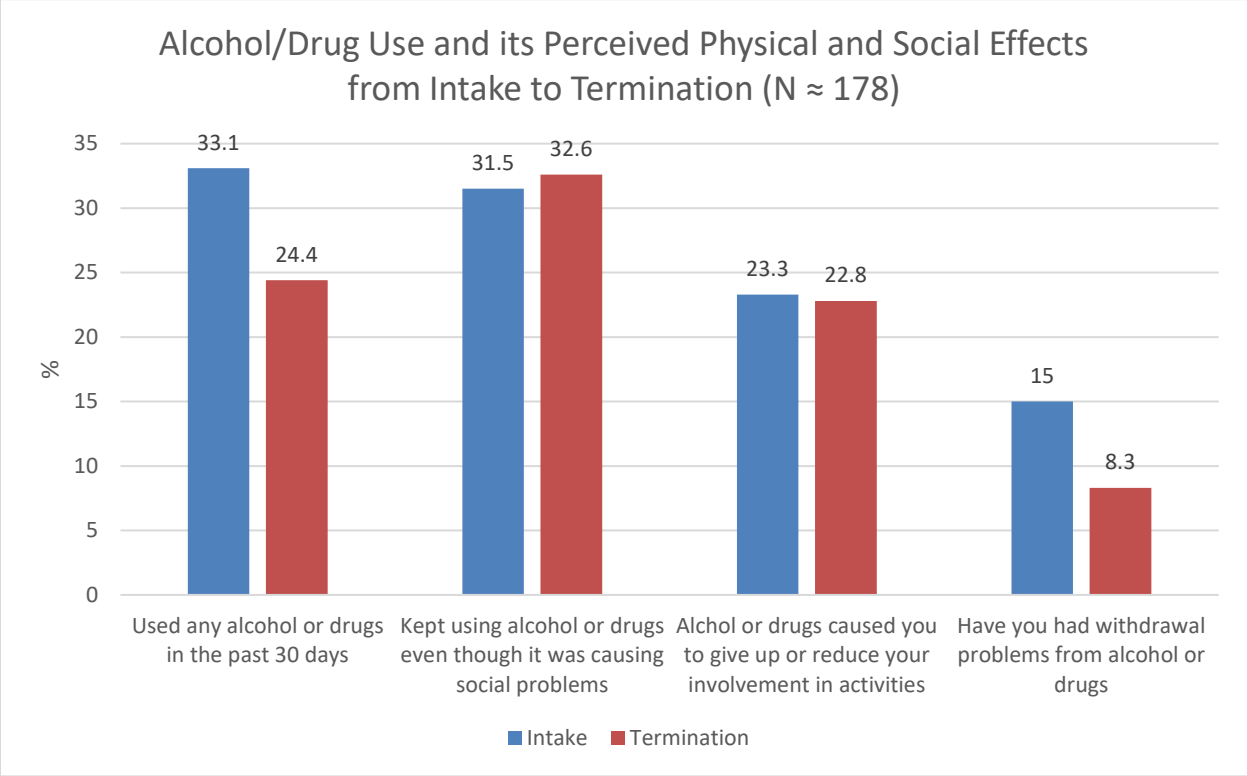
Figure 19.



In addition to questions pertaining to the use of specific substances, youth were asked questions around general alcohol/drug use and its perceived effects on physical health and social functioning. The proportion of youth who indicated that they had used any alcohol or drugs in the past 30 days decreased from 33.1% at intake to 24.4% at termination (see Figure 20). A McNemar's test indicated that this difference was statistically significant. It is important to note here that the percentage of youth who indicated that they had used in the past 30 days in this more general question seems lower than the percentage who indicated past 30-day use in the questions that asked about specific substances. Percentages in Figure 20 included only those who had indicated they had ever used the specific substance. Further, we suspect that when asked a general question about alcohol or drugs, many of the youth may not consider a substance to be a drug and therefore may answer no to a general question about alcohol/drugs.

From intake to termination, the proportion of youth who indicated that they had continued to use alcohol/drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people at least sometimes increased slightly. The proportion of youth who indicated that alcohol/drugs caused them to give up or reduce involvement in activities at work, school, home, and social events decreased only slightly. Neither of these changes were statistically significant. A McNemar's test revealed a significant decrease in the proportion of youth who indicated that they had withdrawal problems from alcohol/drugs.

Figure 20.



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 4,317 youth terminated from the BHJJ program. Sixty-six percent (66.2%, n = 2,858) of the youth terminated from the BHJJ program were identified as successful treatment completers. Slightly over three percent (3.3%, n = 141) were terminated from the program due to some level of incarceration. In the latest evaluation period that began July 2017 and ended in June 2019, 81.1% (n = 261) of BHJJ youth terminated successfully. Table 21 presents all of the reasons for termination from BHJJ.

Table 21. Reasons for Termination from BHJJ

Termination Reason	Youth from all Years	Youth Enrolled between July 2017 and June 2019
Successfully Completed Services	66.2% (n = 2,858)	81.1% (n = 261)
Client Did Not Return/Rejected Services	5.7% (n = 246)	1.6% (n = 5)
Out of Home Placement	7.9% (n = 341)	3.4% (n = 11)
Client/Family Moved	2.6% (n = 113)	1.2% (n = 4)
Client Withdrawn	6.0% (n = 257)	2.8% (n = 9)
Client AWOL	3.0% (n = 130)	1.9% (n = 6)
Client Incarcerated	3.3% (n = 141)	2.5% (n = 8)
Other	5.4% (n = 231)	5.6% (n = 18)

Average Length of Stay

Since the start of BHJJ, the average length of stay (ALOS) in the program was 197.4 days. For youth identified as successful treatment completers, the ALOS was 208.7 days while for unsuccessful treatment completers, the ALOS was 175.6. For youth enrolled in the past two years (July 1, 2017 through June 30, 2019), the average length of stay in the program was 159.4 days, with successful treatment completers averaging 163.7 days and unsuccessful completers averaging 137.7 days.

Risk for Out of Home Placement (July 1, 2017 – June 30, 2019)

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, 53.3% of the youth (n = 2,367) were at risk for out of home placement. At termination, 25.0% (n = 1,051) of youth were at risk for out of home placement (see Figure 21). Of those youth who successfully completed BHJJ treatment, 7.9% (n = 221) were at risk for out of home placement at termination while 59.4% (n = 819) of youth who completed unsuccessfully were at risk for out of home placement (see Figure 22).

For youth enrolled in BHJJ from July 1, 2017 through June 30th, 2019, 35.6% (n = 191) were identified as at risk for out of home placement at intake while at termination, 15.7% (n = 49) were at risk for out of home placement. Of the recently enrolled youth who successfully completed BHJJ treatment, 7.1% (n = 18) were at risk for out of home placement at termination while 56.4% (n = 31) of youth who completed unsuccessfully were at risk for out of home placement at termination.

Figure 21.

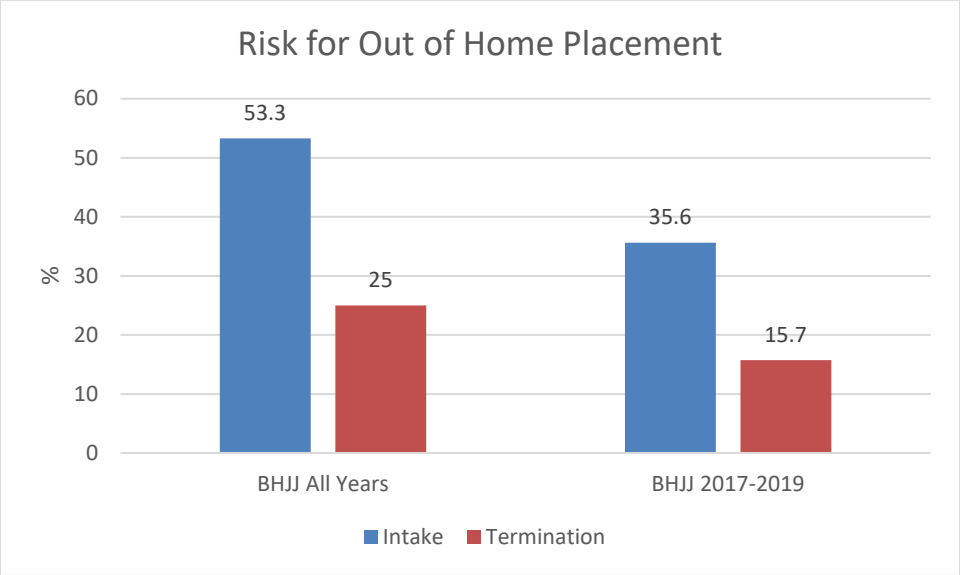
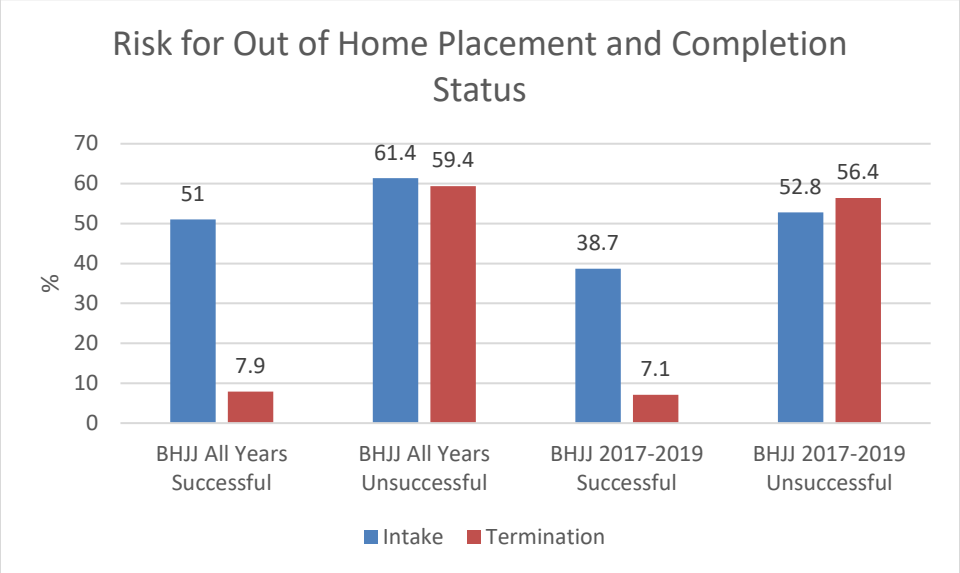


Figure 22.



Police Contacts (July 1, 2017 – June 30, 2019)

With help from the caregiver and youth, the worker was asked to estimate the frequency of police contacts since the youth has been receiving services through BHJJ. Workers reported that police contacts had been reduced for 79.1% (n = 254) of the youth and had stayed the same for 11.2% (n= 36) of the youth. Police contacts increased for 4.4% (n = 14) of the youth and the worker was unable to estimate for 5.3% of youth (n = 17).

YSSF (July 1, 2017 – June 30, 2019)

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the services they received through the BHJJ program as well as how services impacted their children and family. 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.

At termination from the BHJJ program, 94.7% (n = 447) of caregivers either strongly agreed or agreed that BHJJ staff were sensitive to their cultural/ethnic background and 95.2% (n =455) either strongly agreed or agreed that the location of the services was convenient (Figure 23). Over 70 percent (72.5%, n = 345) of caregivers reported that as a result of the services their child/family received, their child gets along better with family members and 69.4% (n = 329) reported their child is better able to do the things they want to do (see Figure 24).

Figure 23.

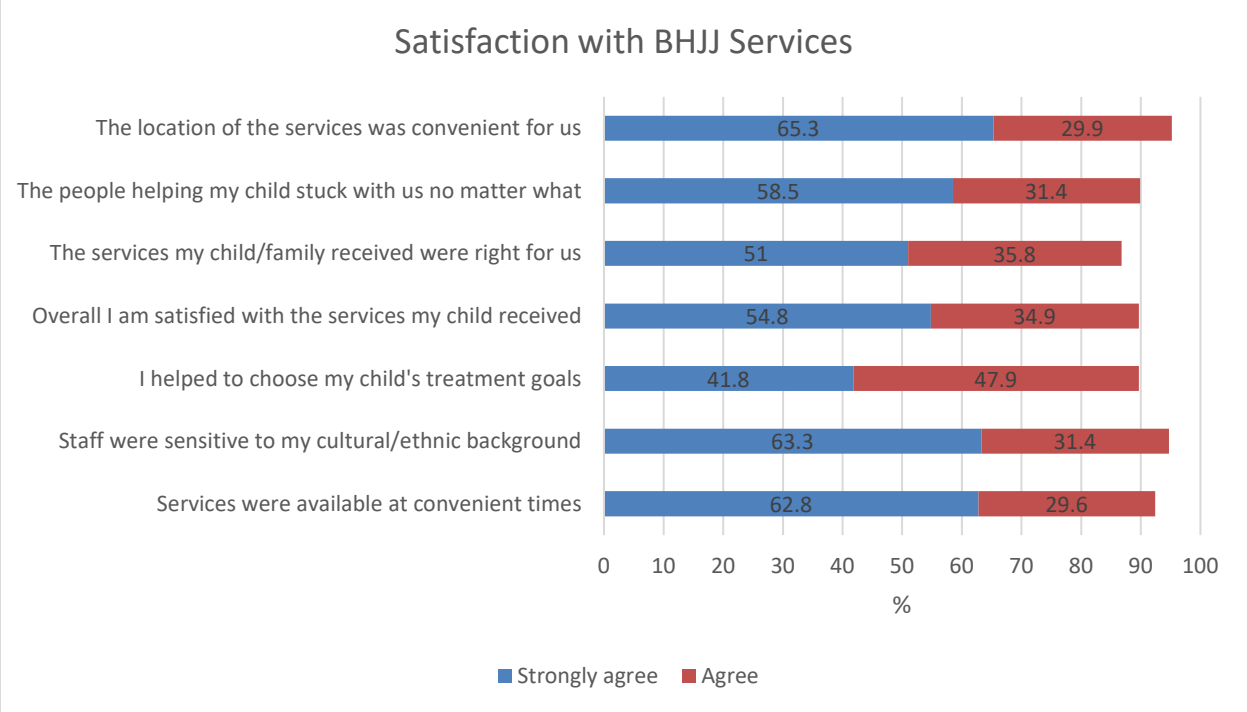
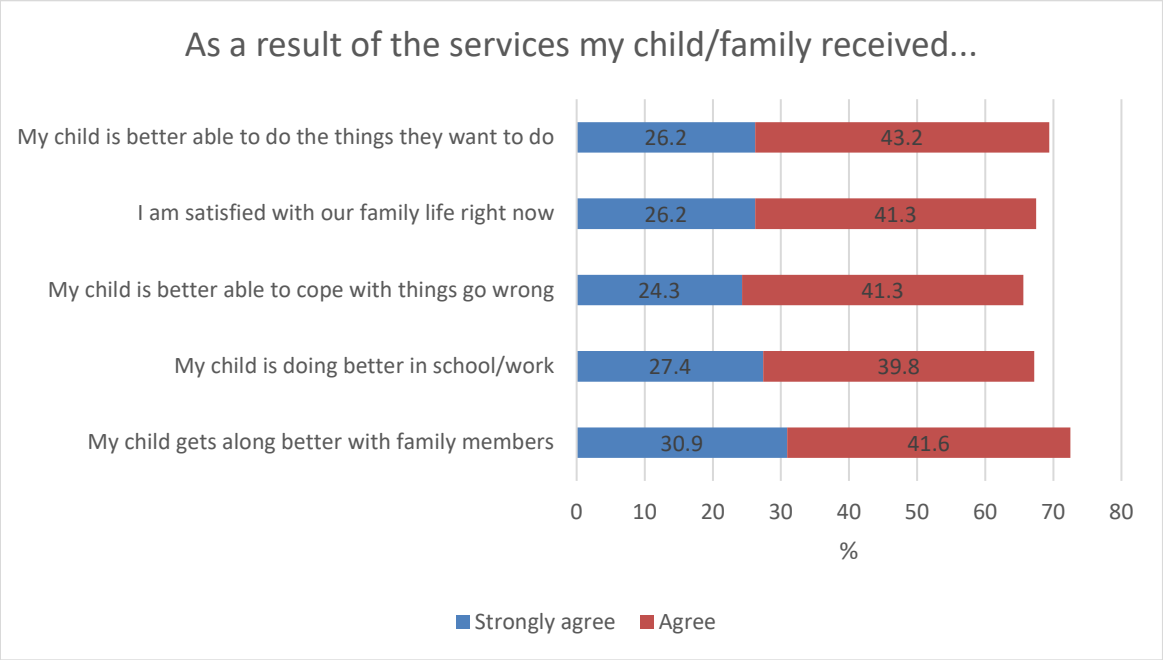


Figure 24.



Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve 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 currently participating BHJJ counties. A list of the currently participating counties can be found in Table 3 . These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 68.6% (n = 1,331) of BHJJ youth enrolled between July 1, 2015 and June 30, 2019 had a misdemeanor charge, 32.1% (n = 427) had a felony charge, and 74.1% (n = 986) had been adjudicated delinquent in the 12 months prior to enrollment (see Table 22. Charges Prior to Enrollment). Previous juvenile court information was similar for youth regardless of their completion status (successful vs. unsuccessful). In the 12 months prior to enrollment in BHJJ, 70.1% (n = 444) of successful completers and 73.4% (n = 213) of unsuccessful completers were adjudicated delinquent (see Table 23 and Table 24). A slightly higher proportion of unsuccessful completers had a felony charge in the 12 months prior to enrollment (35.5%; n = 103) than successful completers (31.1%; n = 197). Chi-square analyses revealed that a significantly higher proportion of unsuccessful completers had at least one misdemeanor and/or a felony charge in the 18 months prior to enrollment.

Table 22. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (N = 1,331)	55.1% (n = 733)	22.4% (n = 298)	66.1% (n = 880)
12 months (N = 1,331)	68.6% (n = 913)	32.1% (n = 427)	74.1% (n = 986)
18 months (N = 1,331)	73.0% (n = 972)	34.9% (n = 465)	75.9% (n = 1,010)

Table 23. Charges Prior to BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (N = 633)	57.7% (n = 365)	21.2% (n = 134)	67.6% (n = 428)
12 months (N = 633)	70.1% (n = 444)	31.1% (n = 197)	74.4% (n = 471)
18 months (N = 633)	73.3% (n = 464)	33.5% (n = 212)	76.3% (n = 483)

Table 24. Charges Prior to BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (N = 290)	55.2% (n = 160)	24.1% (n = 70)	65.5% (n = 190)
12 months (N = 290)	73.4% (n = 213)	35.5% (n = 103)	75.2% (n = 218)
18 months (N = 290)	80.0% (n = 232)	40.3% (n = 117)	75.5% (n = 219)

Trends in Felony Charges

We examined the proportion of youth with at least one felony charge in the 12 months prior to enrollment in each of the currently participating BHJJ counties. Generally, a similar proportion of youth from the current evaluation period compared to the last evaluation period had a felony charge in the 12 months prior to enrollment. Additional information regarding felony charges prior to enrollment in the current BHJJ counties can be found in Table 25.

Table 25. Number of Youth with Felony Charges in the 12 Months Prior to Enrollment among Current BHJJ Counties

County	2015-2017	2017-2019
Ashtabula	0.0% (n = 0)	7.0% (n = 3)
Cuyahoga	50.6% (n = 42)	45.0% (n = 27)
Franklin	70.9% (n = 61)	70.4% (n = 19)
Hamilton	43.8% (n = 28)	38.6% (n = 27)
Holmes	0.0% (n = 0)	0.0% (n = 0)
Lorain	25.0% (n = 16)	23.7% (n = 9)
Lucas	52.4% (n = 11)	26.6% (n = 17)
Mahoning	11.1% (n = 1)	0.0% (n = 0)
Montgomery	16.3% (n = 49)	16.5% (n = 28)
Summit	100.0% (n = 30)	94.6% (n = 53)
Trumbull	10.7% (n = 3)	0.0% (n = 0)
Wayne	12.5% (n = 2)	16.7% (n = 4)
Total	32.9% (n = 243)	31.0% (n = 184)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 26). In the 12 months after enrollment in BHJJ, 42.6% (n = 462) of participants were charged with at least one new misdemeanor and 20.1% (n = 218) were charged with at least one new felony. Approximately 55% (54.9%; n = 595) of the youth were adjudicated delinquent in the 12 months after their enrollment in BHJJ.

Table 26. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 1,232)	31.0% (n =382)	13.1% (n = 162)	39.7% (n = 489)
12 months (n = 1,084)	42.6% (n = 462)	20.1% (n = 218)	54.9% (n = 595)
18 months (n = 902)	49.3% (n = 445)	23.9% (n = 216)	59.1% (n = 533)

In the 12 months after enrollment in BHJJ, 37.2% (n = 190) of successful completers were charged with at least one new misdemeanor, 15.7% (n = 80) were charged with at least one new felony, and 49.9% (n = 255) were adjudicated delinquent (see Table 27). Of the youth who completed unsuccessfully, 56.4% (n = 133) were charged with at least one new misdemeanor, 32.6% (n = 77) were charged with at least one new felony, and 63.6% (n = 150) were adjudicated delinquent in the 12 months after their enrollment in BHJJ (see Table 28). 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. Definitions of successful completion can be found in each county's program description.**

Table 27. Recidivism after BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 583)	26.1% (n = 152)	10.3% (n = 60)	34.6% (n = 202)
12 months (n = 511)	37.2% (n = 190)	15.7% (n = 80)	49.9% (n = 255)
18 months (n = 430)	45.1% (n = 194)	20.7% (n = 89)	56.3% (n = 242)

Table 28. Recidivism after BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 267)	43.4% (n = 116)	21.3% (n = 57)	46.8% (n = 125)
12 months (n = 236)	56.4% (n = 133)	32.6% (n = 77)	63.6% (n = 150)
18 months (n = 198)	61.6% (n = 122)	34.3% (n = 68)	66.7% (n = 132)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 29). In the 12 months after termination from BHJJ, 35.9% (n = 229) of youth were charged with at least one new misdemeanor and 17.1% (n = 109) were charged with at least one new felony. Thirty-eight percent (38.4%; n = 245) of youth were adjudicated delinquent in the 12 months following their termination from BHJJ.

Table 29. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 745)	23.6% (n = 176)	9.9% (n = 74)	29.9% (n = 223)
12 months (n = 638)	35.9% (n = 229)	17.1% (n = 109)	38.4% (n = 245)
18 months (n = 510)	42.5% (n = 217)	20.8% (n = 106)	45.7% (n = 233)

In the 12 months following their termination from BHJJ, 32.8% (n = 141) of successful completers were charged with at least one new misdemeanor, 15.3% (n = 66) were charged with at least one new felony, and 34.9% (n = 150) were adjudicated delinquent (see Table 30). Of the youth who completed unsuccessfully, 42.2% (n = 86) were charged with at least one new misdemeanor, 20.1% (n = 41) were charged with at least one new felony, and 44.6% (n = 91) were adjudicated delinquent in the 12 months after their termination from BHJJ (see Table 31). Chi-square analyses showed that **a significantly higher percentage of youth who terminated unsuccessfully were charged with misdemeanors and felonies than youth who terminated successfully in the 12 months and 18 months following termination. A significantly higher percentage of youth who terminated unsuccessfully were adjudicated delinquent in each of the time periods examined after termination.**

Table 30. Recidivism after BHJJ Termination for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 499)	21.8% (n = 109)	9.2% (n = 46)	25.3% (n = 126)
12 months (n = 430)	32.8% (n = 141)	15.3% (n = 66)	34.9% (n = 150)
18 months (n = 333)	39.0% (n = 130)	18.3% (n = 61)	41.4% (n = 138)

Table 31. Recidivism after BHJJ Termination for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 240)	27.1% (n = 65)	10.8% (n = 26)	38.8% (n = 93)
12 months (n = 204)	42.2% (n = 86)	20.1% (n = 41)	44.6% (n = 91)
18 months (n = 173)	49.1% (n = 85)	24.9% (n = 43)	52.6% (n = 91)

ODYS Commitments

Among all 3,899 BHJJ youth who were ever enrolled in BHJJ in the currently participating counties and for whom we had recidivism data, 3.8% (n = 148) were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ. **Conversely, 96.2% of youth participating in BHJJ were not admitted to an ODYS facility at any point after enrollment.**

Average Numbers of Charges and Adjudications

In addition to whether a youth was charged or adjudicated delinquent, we examined whether there were differences in the average number of charges and adjudications in equivalent periods of time prior to enrollment and after termination. We conducted paired samples *t*-tests to examine whether there were statistically significant differences in the mean number of charges and adjudications at each time period prior to and after BHJJ participation. Figure 25 shows the average number of charges for youth who had data at both time periods. This restriction resulted in a sample of 745 youth at 6 months, 638 youth at 12 months, and 510 youth at 18 months. **Paired samples *t*-tests revealed a statistically significant decline in the average number of charges and adjudications we examined except for felony charges at 18 months.** For example, the average number of misdemeanor charges 12 months prior to BHJJ enrollment was 1.9 while the average number of misdemeanor charges 6 months after BHJJ termination was 0.9.

Figure 25.

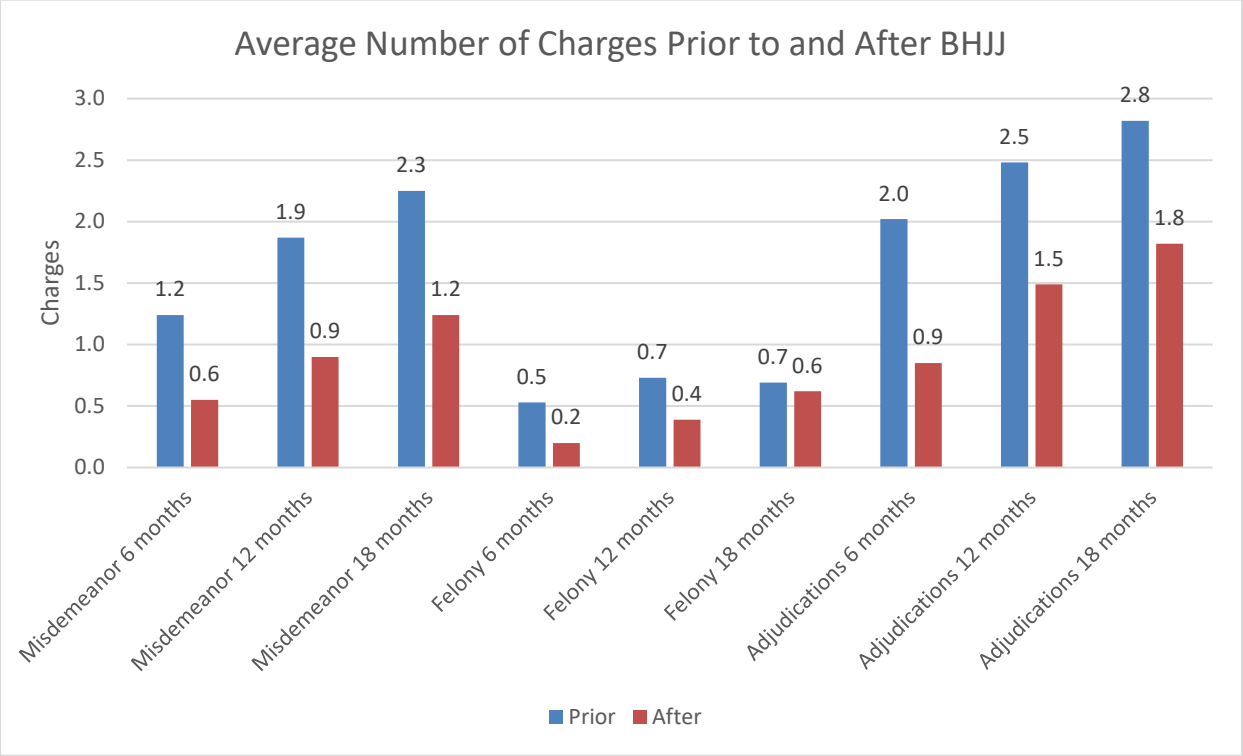


Figure 26 and Figure 27 show mean differences in charges and adjudications for youth who successfully completed the program and those who did not successfully terminate. **For both groups, paired samples *t*-tests revealed that there was a significant reduction in the average number of charges and adjudications after BHJJ participation except for felony charges at 18 months.** For the group of youth who were identified as having completed programming successfully, the average number of misdemeanor charges in the 12 months prior to enrollment was 1.7 while the average number of misdemeanor charges in the 12 months after BHJJ was 0.8. For those youth who were identified as unsuccessfully completing programming, the average number of misdemeanor charges in the 12 months prior to enrollment was 2.2 while the average number of misdemeanor charges in the 12 months after BHJJ was 1.1.

Figure 26.

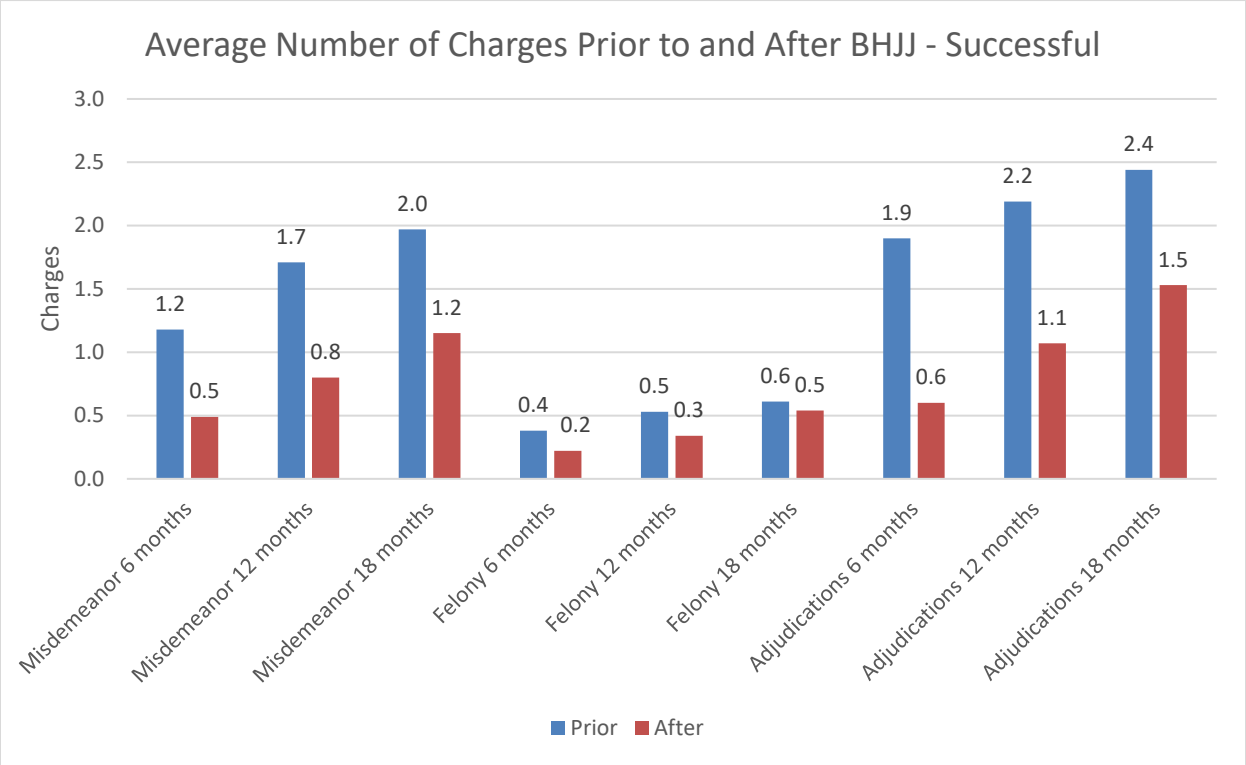
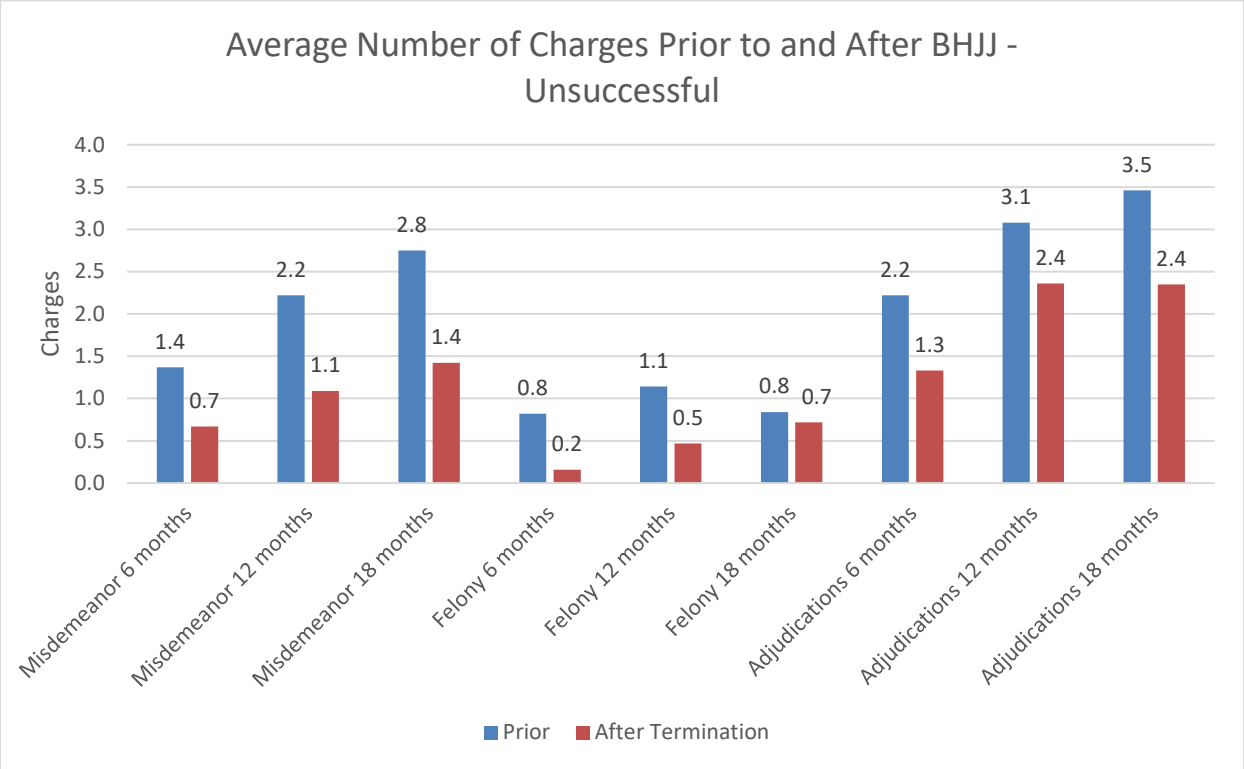


Figure 27.


Average Number of Charges Prior to and After BHJJ - Unsuccessful
Charges
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
1.4
0.7
2.2
1.1
2.8
1.4
0.8
0.2
1.1
0.5
0.8
0.7
2.2
1.3
3.1
2.4
3.5
2.4
Misdemeanor 6 months
Misdemeanor 12 months
Misdemeanor 18 months
Felony 6 months
Felony 12 months
Felony 18 months
Adjudications 6 months
Adjudications 12 months
Adjudications 18 months
Prior
After Termination

Recidivism and the 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 determine whether there were group differences on future recidivism, we acknowledge that OYAS scores at termination would be more appropriate indicators of recidivism. Results should be interpreted with caution.

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 32 shows the percentages of successful completion and recidivism by the OYAS risk categories. Chi-square analyses revealed significant group differences for the percentage of youth with a felony charge at 12 months after termination ($\chi^2(2) = 7.08$, $p < .05$), the percentage of youth with delinquent adjudications ($\chi^2(2) = 5.98$, $p = .05$), and the percentage of those who successfully completed BHJJ treatment ($\chi^2(2) = 32.04$, $p < .001$) by OYAS risk categories. When compared with youth who scored moderate or low, a higher proportion of youth who scored high on the OYAS were charged with a felony or adjudicated delinquent in the 12 months after termination. Further, a significantly lower proportion of high risk youth successfully completed treatment.

Table 32. 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***	13.7% (n = 21)	16.9% (n = 43)	24.6% (n = 43)
Delinquent Adjudications at 12 months***	35.9% (n = 55)	35.3% (n = 90)	46.3% (n = 81)
Successful Completers***	78.1% (n = 185)	69.9% (n = 276)	54.0% (n = 122)

Financial Implications

The FY18 per diem to house a youth at an Ohio Department of Youth Services institution was $508 and the average length of stay was 12.7 months. Based on these numbers, the estimated cost of housing the average youth at an ODYS facility in FY16 was approximately $196,000. Since 2006, 5,338 youth have been enrolled in BHJJ and the direct State contribution to the program has been approximately $27.6 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 $5,170.

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 can be obscured by averages, tables, and figures. Counties were asked to provide information on one or two memorable families who participated in the BHJJ program in the form of success stories.

Ashtabula County

Youth is a 16 year old who was referred to treatment after and Unruly Charge for potential domestic violence against her mother. When treatment began, Mother was not sure she was willing to commit to MST with her daughter. During the assessment, both Youth and Mother did not look at one another and refused to interact with one another.

Youth had challenges with substance use, verbal aggression, and leaving without permission. Mother needed help working to be assertive as well as improving her relationship with their daughter. In the beginning, Mother had challenges even verbalizing strengths Youth had. Mother became engaged in treatment and began developing her skills to calmly address Youth when she became verbally aggressive and began screening for drug use on a consistent basis. Mother began working hard to use "I statements" and supportive language to Youth when she would do something positive. Mother also implemented a behavior contract with expectations for Youth's behavior.

In the middle of treatment, Mother's mother passed away, which affected the whole family. There were a few challenges that arose but Mother was able to manage them with Youth. Mother even implemented a consequence for the Youth's positive drug screen. At the next court mandated drug screen, Youth screened negative. In addition, Youth has attended school and maintained stable employment at the Animal Protective League. Mother and Youth have spent more time together without arguing. Youth has also been spending more time at home with her mom and younger sister. Mother reported feeling more hopeful and is looking forward to their future. At the start of treatment, Mother was not sure if Youth being home was the best decision for the family, but now is happy she went through MST to maintain her family's stability.

Cuyahoga

Youth 1

This youth was identified as a candidate for BHJJ Phoenix Court Program due to the youth's trauma history and mental health needs. The youth was able to successfully complete the program after 9 months. The BHJJ Phoenix Court Team identified in the review process that she would be appropriate for services through Bellefaire ICT/TFCBT Program. This program addressed previous sexual abuse trauma, mental health, anger management, domestic violence between family members, and medication management. The youth and family reported the youth had a history of hospitalizations and struggled to regulate her emotions, leading to her increased aggression in the home and at school. There were also concerns with the parents' on-going aggression in the home. Despite attempts for Bellefaire to provide family therapy to all parties, it was determined the home was not a safe environment for the youth. Subsequently, the Cuyahoga County Department of Children and Family Services (CCDCFS) was granted custody and she was placed with a family friend through Kinship Care. While removing a child from a home is never a desired outcome, BHJJ and Bellefaire realized the youth's potential for success was being hindered in her home environment. Being placed out of the home

allowed the youth the opportunity to embrace the trauma services being provided. This was made possible by the unwavering support of the new caregiver. Shortly after being placed, she was able to become more self-aware, increase communication, and become more reflective. She was able to problem solve, self-regulate her emotions, and no longer required medications. These positive progressions continued in the community as her academic performance also improved. Moreover, she continued to maintain contact with her family while having a realistic understanding of the family dynamics. At this time, the youth is working towards reunification and has been linked to independent living skills treatment through Bellefaire. The BHJJ and Bellefaire team along with the support of the caregiver recognized the path to reunification began with identifying the individual needs of the child. The youth now has a healthy foundation to begin the family healing that is necessary for reunification.

Youth 2

This youth was placed on probation in 2017 for M1 Assault. His only court order was to participate in and complete the program requirements for BHJJ and Phoenix Court. When he first started in the BHJJ/Phoenix Court program, he was very defiant and disrespectful in the home. He would not follow the rules of the home and refused to take his medication as prescribed (he has multiple mental health diagnoses). He would constantly argue with his parents, and he would get into frequent verbal altercations with his parents that would sometimes lead to minor physical altercations. In addition, his parents did not know how to properly consequence him because when they tried, he would threaten to harm himself. The parents took these threats very seriously. This allowed the youth to manipulate them.

A referral for Multisystemic Therapy (MST) was made for the family. This intensive family therapy focused on empowering parents to be able to better communicate with and manage their children. The therapist worked with the family for five months in 2017. She helped the family a great deal. She worked with the youth to be able to understand him better, and that allowed her to help the parents be able to set proper rules and provide appropriate consequences for the youth. The youth continued to make improvements on a daily basis and by the end of the program, he was abiding by the rules, he decreased the arguments and conflict, and he was taking his medication as prescribed. He came a long way since when he first started the program.

At the beginning of the 2017-2018 school year, the youth was enrolled in an alternative school. His parents realized that it was important for him to attend school outside of the home (he was previously home-schooled) to help improve his social anxieties and become used to physically attending a school should he decide to go to college, which he indicated that he wanted to do. The youth was very hesitant at first: he was very anxious and did not want to attend school. His attendance at the beginning of the school year was very poor and he would only attend once or twice per week. However, with the help of the MST worker, youth's attendance during his participation in the program increased dramatically. He was attending school every day. With the help of consistent medication and the implementation of stricter rules and consequences from his parents, the youth was able to overcome his anxiety in the school setting and understand the importance of being in school every day. He had good relationships with teacher and other school staff members, and he made new friends. His first semester grades were excellent. He is very smart. The youth received an A in Biology, A- in English, A in Family Consumer Science, A in Physical Education, and A in World Geography. He made Honor Roll in both of his first two quarters. He was on pace to graduate on time and had no behavior issues at school. His parents were very supportive of his education. One of the youth's goals at the start of the program was to stay active

to help counteract his mental health symptoms. He participated in several pro-social activities throughout the duration of the program. At the beginning of the program, he was having a difficult time being active. As a result, he was ordered to complete 25 hours of community service. He successfully completed all of these hours. The family also received case management services through a Care Coordinator. They were compliant with this service as well. Youth did not have any drug issues and tested negative on all of his urine screens. Youth did not pick up any new offenses during his time in the BHJJ/Phoenix Court program. He graduated from the program and was successfully terminated from probation in early 2018.

Franklin County

Youth 1

TS, who was sixteen years old at intake into the BHJJ program, was placed on Probation in the Spring of 2019. He was adjudicated on an F5 Attempted Receiving Stolen Property. This was his first offense in the juvenile justice system. A Pre-Sentence Investigation and a Behavioral Health Assessment were conducted.

TS had lived with his maternal grandmother since he was two years old. Grandmother took custody of TS due to his father being incarcerated and his mother testing positive for cocaine. It was important for Grandma to step in as she did not want the grandchildren in the system. TS has an incredible bond with his Grandmother. She has never had a negative or concerning report of TS. He told the Pre-Sentence Investigator, "I love her. She could be struggling, but she still always puts me first." His father is currently incarcerated in an Ohio Department of Rehabilitation and Corrections facility in Ohio. TS spoke to his father when he was able to call. His mother was doing well and he spoke to her often and spent the weekends with her and his other siblings.

TS was in 11th grade at a local school, where his attendance improved along with his participation in class. He also got a job that started in early summer at Burger King. This was a good thing for him, keeping TS motivated and on track. TS was ordered to cooperate with programming through a court contract. He had no previous counseling or treatment of any kind and was open to the idea of having someone to speak with about almost anything. He was assigned a mentor through Guidestone. TS reported that they would mostly go out on the weekends, but the mentor was able to assist him with seeing issues from a different perspective. TS was able to see what the world has to offer outside of his own experience.

TS successfully completed all the Terms and Conditions of Probation in early Fall 2019. When it was time to complete the Discharge Packet, it was an emotional goodbye! Grandmother said she was so blessed to have worked with the Care Coordinator and the Probation Officer. And TS even asked if he could keep in touch to update the Care Coordinator on his life!

Youth 2

HT was placed on Probation in early 2019 at 17 years of age where he remains at the time of this story. He was adjudicated on an F2 Felonious Assault. A Pre-Sentence Investigation and a Behavioral Health Assessment were conducted.

HT, his mother, and his five siblings live together and comprise a close-knit family. He has minimal contact with his father who lives in London, England. HT does not wish to speak to his father. It is

evident that HT and his family cherish their cultural traditions and values. If his mother is away for any reason, he will step up and take charge, as he is the oldest boy. His siblings all love and respect him.

HT is a student at a preparatory high school where he is doing incredibly well! He had truancy and behavior problems at his last school, but once he transferred to his current school, everything changed. We were recently told that he has one of the highest GPA's in the school. If he continues to progress at this rate, he will be able to graduate by Spring of 2021.

HT was ordered to cooperate with programming through a court contract. He was linked with The Village Network – Mental Health Program. This was a challenge for HT, but pushed him in the direction he needed to go. While working with his clinician, he was unable to stop smoking marijuana and agreed to also be linked with Guidestone - Drug and Alcohol Program. He is now sober and has had continuous clean screens for the past few months. HT is on schedule to be released from Probation just before he reaches his one year program anniversary.

Hamilton County

P was referred to the LIDS program at age 16, through the PDD program for incorrigible charges filed by his Dad. Dad was at such a loss he was planning to drop P off at a shelter. When P arrived with his Dad to his first family session, he had a winter ski cap down all the way to his mouth, and the therapist was unable to see his face. P presented as hopeless and stated he slept about 18-20 hours a day, never left his room or house, and never talked to his brother or father.

During therapy sessions, the therapist spent a lot of time talking about changing thought processes using some skills from CBT. On days when P would not talk, therapist would talk with Dad, who would participate actively. P later shared that he got a lot out of those sessions, and was able to repeat back the skills. At first, P expressed that he felt like no one liked him and that was why he was bullied. Through treatment, P began to believe that he was bullied, not because he was an unlikeable person, but because sometimes bullies target nice kids. P started to understand that he was capable of having meaningful relationships with others. P also stated one thing that stuck out in early sessions was the idea that just because someone says something about you does not mean it is true, and even if it is rooted in truth, it does not define you.

Therapist encouraged P and Dad to talk about positive qualities they see in each other during sessions. As sessions progressed, P started to practice coping skills at home such as listening to music, following through with schedules, going on walks outside, and spending intentional time outside of his room. The Probation staff, Case Manager, therapist and Education Liaison all worked to ensure P would be successful in school, which included providing door to door transportation to school when P was nervous about attending. The treatment team members would show up at the school to check on P, showing their support. Court staff, the Case Manager, and the Education Liaison collaborated with school staff to ensure his needs were being met. His Probation Officer and Case Manager helped introduce P to socialization activities, such as going to the library and the Music Resource Center. During this time, the magistrate also encouraged P to attend school, therapy and case management sessions. The Case Manager also worked with P weekly on social skills, problem solving skills, and social functioning.

P now goes to school regularly and is on track to graduate this spring. At intake, P had only earned eight credit hours and had not attended school for a full semester. In August of 2019, P was reenrolled at a

local school. He gained the confidence to ride the bus to school in the morning, attended class regularly, communicated with his teachers, and passed all of his exams. P now has 16 credits to start the new semester and could graduate from high school in May 2020. When we started with P, one of his goals was to earn a high school diploma, and is well on his way to achieving that diploma this year.

His teachers speak positively about P, and Dad does as well. They have a positive relationship and Dad looks forward to spending time with P. When he turns 18, P is now welcome to live with him. Dad also shared that he and P have meaningful conversations on a regular basis. P sleeps about 8 hours a day now, and when the weather permits goes for walks or spends time outside. P utilizes his coping skills, and even removed his ski hat during graduation for a baseball cap. Both reported feeling hopeful about the future.

Holmes County

G is a 14-year-old juvenile with multiple mental health diagnoses whose grandparents have custody of him and his 12-year-old sister. Grandpa is 73 and grandma is 57. G's offense that brought him to the court was Criminal Damaging or Endangering - within a week he destroyed two televisions in the home. It was also reported that other furniture and gaming equipment in the home had been destroyed previously.

Grandma reported that as G got bigger, he was harder to control; he yelled at his grandpa, he called him names, and told him to shut up. G also yelled at his sister and started hitting and punching her. In school he struggled to get along with authority figures, often arguing and yelling with fits of anger. As a result of his behaviors he had few friends. He reported having trouble controlling his anger to the point that he claimed he got so mad he sometimes forgot what he had done and wasn't able to calm down.

Grandma reports today that because of the skills they were taught by their MST counselor, life at home is wonderful. They practice consistency with both G and his sister. The family is now enjoying a close family bond without the stress and turmoil before they started working with MST.

Lucas County

One youth in the BHJJ program started out at risk of expulsion and was a regular visitor to our assessment center. By closing, she had completed her driving courses and passed the test with the highest grade in the class. We worked with Juvenile Court staff to develop an incentive program related to her school attendance. She was able to earn a certain amount of money per week if school was attended (no money earned if a day was missed or she was late without an excuse verified by her parents) towards her driving classes. The family ended up only being responsible for $100 dollars of the almost $400 for the course. During her BHJJ services, this youth transitioned to another school with smaller classrooms and was excelling at the time of program closure and was on target to graduate in May of 2020. She also maintained her job at a fast food restaurant! We connected her with our transitional youth services program to assist her when she turns 18.

Mahoning County

"T" is a 12-year-old female, who resides with her mother and visits regularly with her father. "T" has had severe truancy issues since the 2nd grade and was identified as an MST candidate after a referral through the early warning system. "T"'s referral behaviors were truancy, and verbal and physical aggression. "T" was very defiant to authority and told her Therapist that she would rather go to JJC than to school. At the initial school meeting, the school verbalized little hope that "T" would return to traditional schooling let alone pass the current school year. "T" often hit, kicked, bit, and threw water on her Mom and shortly after MST began "T" was arrested for domestic violence.

The Therapist and Mom worked together to identify familial supports that could step in and provide respite for Mom and Youth. Aunt "J" and Uncle "C" were identified and "T" moved in with them to allow time for Mom to gain the skills needed to take control of her household and parent "T". The Therapist provided weekly family sessions that included aunt and uncle. Mom visited with "T" several days per week at Aunt and Uncle's home, and "T" continued to visit with her dad as regularly scheduled.

Mom met almost daily with the Therapist and worked extensively on using strategies to de-escalate "T"'s aggression, managing her own anger, and implementing behavior plans. Mom and Therapist role-played various scenarios to allow mom to feel comfortable using the skills she was learning. The Therapist worked with her Mom to overcome Mom's reluctance to have open and working communication with "T"'s dad.

The Therapist offered joint sessions with Mom and Dad at a mutually agreeable place and worked on them becoming a unified front so that "T" could no longer use them against each other. Soon after, "T"'s stepmother became an active part of "T"'s treatment. Mom and step-mom were able to work together to address discrepancies in "T"'s stories and dispel myths that would usually tear them apart.

Aunt and Uncle worked together with Mom and The Therapist to implement the new skills Mom was learning into their household, as well as use a congruent behavior plan. Soon after "T" began attending school daily. The family and Therapist worked with the school to identify what schoolwork "T" needed to make up to pass the school year. The school was still hesitant that "T" would return to school permanently and pass her current grade. Plans were developed for "T" to work nightly on her current schoolwork as well as some past schoolwork. "T" worked for rewards and incentives, and began to like school so much that she wanted to go to "before school care" and became a "big sister" figure to younger students.

Mom and the Therapist continued to work toward reunification. Mom began working with "T" to continue her homework success. Shortly after, "T" started spending weekends at Mom's. Mom then became responsible for getting "T" on the bus in the mornings. After these positive interactions, Mom was able to build confidence and review the sequences of events with the Therapist. Soon Mom was ready for "T" to return home permanently.

In case the reunification became problematic, the therapist worked with Mom to develop back up plans. Luckily, these plans were not needed because things have gone smoothly. "T" is now completing the school year and passing on to the 7th grade with no absences since completing MST. Mom continues to report a strong familial support system, increased communication with "T"'s Dad and stepmom, no physical aggression, and only the "typical" teenage argument from time to time.

Montgomery County

A youth was referred to the LIFE program by the intervention center for issues with theft and family conflict. The LIFE therapist taught the family communication (impact statements, active listening, and check-ins) and goal-setting skills. Both the youth and his mother were invested and engaged in treatment. His mother would take notes and ask follow-up questions to better understand skills. The family faithfully utilized check-ins and reported significant improvement in their communication and overall relationship. During treatment, the youth came out as transgender. With coaching, the youth and his mother processed this information using impact statements and active listening. During this session, his mother expressed that she now has a better understanding of the youth and that "things make a lot more sense now." Since then, his mother has demonstrated a great deal of support for the youth. She assists him in expressing his gender identity and encourages his involvement in the LGBTQ+ community. The youth is currently using goal-setting skills to plan for college and opening his own boutique.

His mother reported that she has seen a lot of change in the youth – "He's motivated. He's not just sitting on the couch anymore." Mom also stated, "[Before treatment], I couldn't wait until he turned eighteen and left, but now I don't want him to go." The family is on track to successfully complete LIFE in a week. The youth has no new charges and is no longer involved with the intervention center.

Summit County

For most teens, success is measured by their school performance, how well they do in any extracurricular activities they might be involved in or maybe even what university they are hoping to attend post high school graduation. But for a lot of the youth who come through the juvenile justice system at the Summit County Juvenile Court, success sometimes has a very different meaning.

Success looks a lot different when talking about a youth who has been involved with the juvenile court because they deal with much more complex issues than just the youth's struggles with personal goals. Instead, they are often dealing with family trauma that has never been diagnosed or addressed. The BHJJ program is a great opportunity for some of these underserved youth to take advantage of a therapeutic environment where they can finally start to address some of the traumatic experiences that continue to create barriers for them in their everyday life.

"G" is a youth who was brought into the BHJJ program after receiving a Carrying Concealed Weapon Charge (4th degree felony) and was placed on Crossroads probation for one year. G has a very supportive family at home, but sometimes the home environment can descend into chaos and become volatile due to the family yelling at each other when in a disagreement rather than talking through their problems to resolve conflict. Early in the BHJJ programming process, when asking G how all the yelling in the house makes him feel, he would just say "that's just how we handle our issues, so I am used to it." As G began meeting with his therapist from Child Guidance & Family Solutions and started to learn new skills through the Integrated Co-occurring Treatment (ICT) model on how to handle his anger, he voiced his desire for his family to learn these skills as well so that they could better communicate within the household as a family.

Since entering the program G has really taken full advantage of the services put in place around him. He meets with his therapist on a regular basis and reports that he's noticed a positive change in himself since engaging in therapy. As a result of G starting to feel better about himself and gaining more self-

esteem, he began attending school more regularly and even got into a nursing program at his alternative school because of his strong desire to have a career in the medical field. He knew that nursing would be challenging, but he wants to have a career where he can help people in need while also making a decent living for himself and decided he was going to go for it!

G was excited about all the positive changes in his life and was happy that things were finally going in his favor for once. G was motivated to start working so he began putting in job applications wherever he saw a hiring sign. He was able to land a job at Walmart as a member of the stock crew and reports that he enjoys working because it not only helps him earn income, but it also keeps him busy and away from negative peer influences. Shortly after he started working at Walmart, G realized that depending on someone to take him to and from work every day was starting to become inconvenient, but he knew he wanted to continue working so he started to save up his money to buy a car. After saving for some time G was able to purchase a used car and also obtained and paid for his own car insurance so that he would be in compliance with the law.

At this time, G is in the final stages of Phase 3 of Crossroads Probation and will complete the program successfully after reaching Phase 4. He is still engaging with his ICT therapist and has requested family counseling for he and his family after his individual sessions are done. He states he really wants to continue to build on the skills he's learned and understands that he will need his family to work towards those changes too if he wants to avoid falling back into bad habits. Since G was attending school at an alternative high school he was able to complete schoolwork at his own pace and has successfully completed all Ohio requirements and graduated January 7th 2020. He will continue to attend school twice a week on Tuesdays and Thursdays to have in person study sessions with other students in the nursing program until it is time for him to take the state nursing exam. It has been very rewarding working with G and his family, and I hope he continues to believe that his future is as bright as we all think it is here at the Summit County Juvenile Court.

Trumbull County

The following testimonial is from the parents of an MST youth in Trumbull County that was referred for the following behaviors: Physical and Verbal aggression at home, Self-harming behaviors and Truancy.

At the start of treatment, the youth was very aggressive towards family members in the home. The youth would yell, cuss, and get in the parent's face. The youth would frequently threaten family members, push and grab parents and brother, punch holes in the walls, and damaged several doors in the home. Youth presented with self-harming behaviors, such as cutting on arms, thighs and torso. The youth missed several days of school and refused to get out of bed to attend, which resulted in enrolling in summer school. This testimonial describes how the parents felt at the end of MST treatment.

It has been a long and challenging road for our family as we learn to adapt our behaviors to help our son, and each one of us reach positive healthy behavior goals that provide strong loving relationships as well as respect each of our individual emotional and psychological needs. I realize that the behaviors of one are directly connected to the reactions and relationships of others in the family and in order for a positive change to take place, all persons involved have to have a clear understanding of the goals and expectations.

"L" has made so many positive improvements in the past three months with his behaviors. Although some of the behaviors have not met our standards, there is now a clear set of expectations and

rewards/losses that helps him choose which path to follow. I have faith that the system will continue to facilitate positive growth in "L"'s behaviors and I'm optimistic that he will begin to see that he is the author of his life story and he can make responsible rational decisions.

"L"'s physical outbursts are now very brief and do not involve destruction of property. "L" has been able to "walk away" at times, when in the past he would just continue to be in our space and at times would threaten us. Again, this is not totally removed from his behavior but I see a successful transition into proper coping behaviors.

The defiant behaviors that have seemingly always been part of "L's normal fight or flight behaviors are starting to become less frequent and quite abbreviated. I think the clarity of our behavior plan and the consistency with which my wife and I have been following the plan have been successful in redirecting some of these behaviors into positive decision-making instead of emotional reactions. This is one of "L"'s most rooted behaviors and I know he is always overthinking his action/consequence outcomes to the point where he has left himself nowhere to turn but to fight back. The clarity of our plan has improved this behavior and we may have to continually modify the plan as incidences decrease and turn to a more reward oriented vs. consequence oriented plan overall.

I am encouraged by our progress and my wife and I have been able to breathe a sigh of relief that there is hope for our family's future and the future of our son. He is a wonderful and hilarious boy with so many talents. I have to believe that he will put those talents to good use one day, maybe to help others with similar stories. I feel like we are back at the helm, where parents belong, and not at the mercy of fear and loss of control.

Lorain County

M, a 17 year old female, was referred to the Integrated Co-Occurring Treatment (ICT) program by the Lorain County Juvenile Court to participate in the Behavioral Health and Juvenile Justice (BHJJ) program. The ICT program focuses on working with adolescents with substance use and mental health concerns and will meet in the home for 3-6 hours per week for 3-6 months. The ICT program provides individual/family counseling, case management services, and crisis intervention services. M became involved with court due to an argument that became physical, between parent and child about privileges. Fortunately, there were no injuries or damages reported. The youth was diagnosed client with Major Depressive Disorder, recurrent, severe; Oppositional Defiant Disorder; Marijuana Use Disorder, mild; and Alcohol Use Disorder, mild.

Initially, the therapist struggled with getting client and/or family to be honest about situations; however, as treatment continued engagement and honesty improved within the family system. Initially, each family member would tell a different story and arguments would ensue. Sadly, M was in an abusive relationship with her boyfriend, and he would influence her to do drugs, skip school, or stay out after curfew. She was making impulsive decisions that were putting her and her mother at risk of legal repercussions (for example: loaning her car to unlicensed drivers). M encountered some challenges, on social media, where her family members would post hurtful comments. There was a clear lack of boundaries amongst the family members, and M needed to learn how to increase her assertiveness skills in order to survive this family dynamic. She often felt that her Mom and sister were both against her, and she had nowhere to turn accept her therapist. Through the course of therapy M learned new ways of communicating her needs to her family members, which resulted in feeling more empowered

and lessened her depressive symptoms. In August, M used a substance, which she thought was heroin, in a suicide attempt. After evaluation determined she did not require psychiatric hospitalization, the therapist and probation officer collaborated with the family and youth together, in order to develop a plan to help keep M safe. The co-developed plan included increasing supervision, increasing the frequency and duration of therapy hours provided each week, identifying new ways the family could provide supervision and monitoring as well as the identification of new ways to support M in her recovery.

M was able to gain insight, and awareness, regarding the path she was on and how she needed to make some changes in her life. Her self-esteem began to improve as she started to believe that she could make better choices.

M started to open up about the death of her father and her feelings of guilt about not being there more to see him. She was able to plan ways to celebrate her father during her day-to-day life and make special occasions more meaningful around his memory. She opened up about what she was doing in the home/community and started to see how her behaviors/choices had consequences. M started to see how her depression worsened when her family members did not support her, and steps she could take to help improve these relationships. Additionally, M started to realize that using alcohol and drugs made her feel worse, and solidly made the link between her co-occurring disorders. She voiced how much therapy helped her to open up and trust again. She benefited from having someone listen to her in a non-judgmental/open dyanmic. This resulted in M feeling empowered in her life, to make better choices, to refuse drugs and alcohol, and create goals for her future. By the end of treatment M stated, 'I never want to be in trouble with the law again' and by observing the significant changes made, during therapy, M has a bright future ahead of herself.

J is a 16-year-old Caucasian male, referred to receive counseling through the Integrated Co-Occurring Treatment [ICT] program as part of his involvement in the Behavioral Health and Juvenile Justice Program at the Lorain County Juvenile Court. ICT is an intensive, home-based, individual and family counseling program. Services are provided for 3-6 months and address both substance use and mental health concerns at home and in the community. He was diagnosed, at Bellefaire JCB, with Oppositional Defiant Disorder, and Cannabis Use Disorder, Mild. At the time of admission, J had pending charges for assault and domestic violence. In the initial interview, J and his mother identified that J does not get along with his family and that he frequently fights with his siblings because he "provokes them." Through the family assessment process, we learned that J's step-father had recently died from cancer. J was deeply affected by this and his grief contributed to increased outbursts at home, in the community, and at school. Paired with his feelings of grief, J's biological father had started to try to reconnect with him, which resulted in some resentment, as his bio-dad hadn't tried to be involved in his life before this. J had a lot of anger toward the adults in his life and this was exacerbated by chaos in his home life as his mother needed to spend a lot of time at work to financially support him and his siblings. J started to use marijuana, the year before starting in treatment services and appeared to use it to help deal with stress that he was experiencing in his life. He denied that his use of marijuana presented any negative consequences and this therapist was able to observe that his use constituted a negative coping mechanism for him to deal with symptoms of stress related to his environment. At the beginning of services, J was expelled from school for 2 months.

J seemed to enjoy the counseling process and actively engaged in therapeutic activities during sessions. As an incentive, for engagement in therapy, and as an opportunity to demonstrate skills discussed in sessions, J and this therapist would engage in playing chess. J showed a lot of skill in the game and informed this therapist that he used to play with his step-father when he was alive. J was able to become actively engaged in conversation about his use of marijuana, influences in his peer group, emotional responses, and behavioral patterns that resulted in consequences. J gain the insight that he regretted his expulsion from school and that he wanted to try to keep up with his education during his expulsion and worked to explore what his options were to get back into school. J directed his efforts toward achieving other goals as well, including getting a job at a local sandwich shop. J asked for help preparing for his interview and creating a resume that he would be able to take with him. He got the job and disclosed that it made him feel very proud to accomplish something, and that other people in his life provided praise and encouragement.

At discharge, J managed to achieve negative urine drug screens, for all substances, and received no new charges. J, and his mother, both reported improved relationships at home, with J taking increased responsibility for himself and volunteering some money from his paychecks to help support the family. He returned to school and immediately started working to try to catch up, to where he should have been, with help from academic programs. J readily accepted a referral for outpatient services, following the completion if ICT, and started with his new therapist immediately upon finishing the ICT program. Reports from his new therapist indicated that J continued to do well and he made improvements that helped him achieve success at home and at school. His therapist mentioned that he also continued working at his job and helping his family make ends meet.

Wayne County

MST received a referral from a Wayne County Probation Officer for a youth struggling with verbal aggression, physical aggression, poor academics, and leaving without permission. The youth and their parents often engaged in conflict resulting in the youth being physically aggressive, leaving without permission, and making suicidal threats/attempt. The parents sometimes struggled to agree on how they would manage youth's behaviors. MST Services began with the family in November of 2017. Throughout the course of treatment de-escalation plans, prevention plans, a safety plan, and a behavior contract were developed collaboratively with the parents. Parents consistently implemented and enforced plans. This high level of commitment resulted in the youth's behaviors being decreased/eliminated for approximately seven weeks. The parents also enjoyed the benefits from consistent team parenting. The youth was working part time and actively involved in a local martial arts studio where they mentored other youth at the time of closing. Progress occurred quickly which resulted in the successful closing of services at three months instead of the allowed 5 months of MST. MST successfully closed this case in February of 2018. Parents reported approximately four months ago that all progress with the family has been sustained since closing. The youth is graduating from high school and has signed up for the United States Army.

Cuyahoga

Demographics

As of June 30, 2019, 537 youth were enrolled into the BHJJ program in Cuyahoga County. The average age at enrollment was 16.06 years (SD=1.20). More males (57.5%, n = 308) than females (42.5%, n = 228) have been enrolled. White youth (34.5%, n = 185), Black youth (55.8%, n = 299), and Multiracial youth (7.1%, n = 38) comprised the majority of the total sample.

There were 61 new enrollments in Cuyahoga County during the current reporting period (July 1, 2017 through June 30, 2019). The average age at enrollment was 15.93 (SD = 1.30). Males (70.0%, n = 42) outnumbered females (30.0%, n = 18), and more Black youth (73.3%, n = 44) than White youth (16.7%, n = 10) were enrolled. Over six percent (6.7%, n = 4) of the youth self-identified as Hispanic/Latinx.

Unless otherwise noted, the following sections describe data from the past four years of BHJJ programming from July 1, 2015 through June 30, 2019.

Custody Arrangement and Household Information

The remainder of the analyses are based on 148 enrollments between July 1, 2015 and June 30, 2109. At intake, the majority of youth lived with the biological mother (64.6%, n = 93), while 14.6% (n = 21) lived with two biological parents or one biological and one step/adoptive parent (see Table 33). Eighty-two percent (82.0%, n = 118) of BHJJ youth lived with at least one biological parent at enrollment.

Eighty-four percent (84.0%; n = 121) of the BHJJ caregivers had at least a high school diploma or GED, and 13.2% (n = 19) had a bachelor's degree or higher. Sixteen percent of caregivers (16.0%; n = 23) reported they did not graduate from high school (see Table 34).

Caregivers were asked to report their annual household income (see Table 35). The income range with the highest endorsement was between $20,000 and $24,999 (18.4%, n = 26). Overall, 63.8% (n = 90) reported a family income of $24,999 or less. When examined by race, 8.0% (n = 2) of White families, 43.0% (n = 43) of Black families, and 40.0% of Multiracial families reported a household income of $14,999 or less. Table 35 displays the reported household income overall and by race.

Table 33. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	14.6% (n = 21)
Biological Mother Only	64.6% (n = 93)
Biological Father Only	2.8% (n = 4)
Adoptive Parent(s)	6.9% (n = 10)
Aunt/Uncle	3.5% (n = 5)
Grandparents	4.9% (n = 7)
Other	2.8% (n = 4)

Table 34. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	16.0% (n = 23)
High School Graduate or G.E.D.	33.3% (n = 48)
Some College or Associate Degree	37.5% (n = 54)
Bachelor's Degree	8.3% (n = 12)
More than a Bachelor's Degree	4.9% (n = 7)

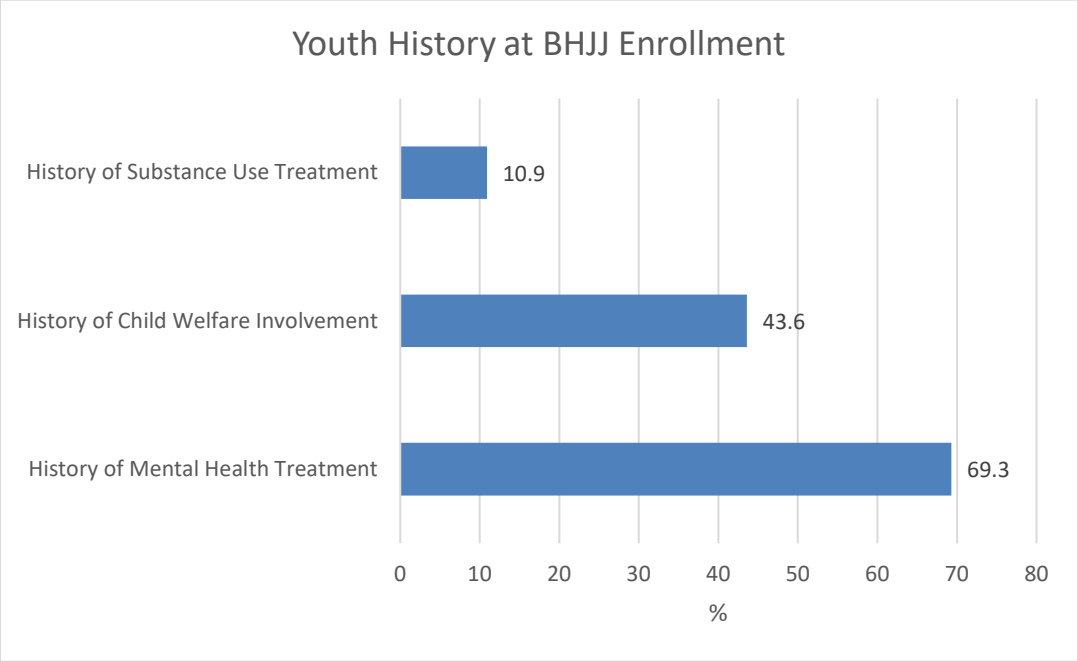
Table 35. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Black	Multiracial
Less than $5,000	10.6% (n = 15)	NA	15.0% (n = 15)	NA
$5,000 - $9,999	11.3% (n = 16)	4.0% (n = 1)	11.0% (n = 11)	26.7% (n = 4)
$10,000 - $14,999	14.9% (n = 21)	4.0% (n = 1)	17.0% (n = 17)	13.3% (n = 2)
$15,000 - $19,999	8.5% (n = 12)	4.0% (n = 1)	11.0% (n = 11)	NA
$20,000 - $24,999	18.4% (n = 26)	20.0% (n = 5)	16.0% (n = 16)	33.3% (n = 5)
$25,000 - $34,999	13.5% (n = 19)	12.0% (n = 3)	13.0% (n = 13)	20.0% (n = 3)
$35,000 - $49,999	12.8% (n = 18)	24.0% (n = 6)	11.0% (n = 11)	6.7% (n = 1)
$50,000 - $74,999	4.3% (n = 6)	8.0% (n = 2)	4.0% (n = 4)	NA
$75,000 or greater	5.6% (n = 8)	24.0% (n = 6)	2.0% (n = 2)	NA

Youth and Family History

Workers were asked to identify a youth's prior behavioral health and child welfare system involvement (see Figure 28). These three items were new to the past biennium, therefore, data are only available for youth enrolled between July 1, 2017 and June 30, 2019. Over 40 percent (41.5%, n = 22) of youth had a history of child welfare involvement prior to BHJJ enrollment. Seventeen percent (17.3%, n = 9) of youth had received substance use treatment in their lifetime prior to BHJJ enrollment and 75.5% (n = 40) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 28.



Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history. Chi-square analyses were conducted to test for gender differences on each item and significant differences are identified in Table 36. A significantly larger proportion of the caregivers of females reported lifetime histories of sexual abuse, running away, talking about suicide and attempting suicide. Caregivers reported BHJJ males had significantly higher levels of substance abuse than female participants.

Caregivers reported that 12.5% (n = 5) of females and 12.9% (n = 13) of males had a history of being physically abused while 36.8% (n = 14) of females and 3.9% (n = 4) of males had a history of being sexual abused. Caregivers of 59.5% (n = 25) of females and 38.2% (n = 39) of males reported hearing the child talking about committing suicide and 40.5% (n = 17) of females and 19.6% (n = 20) of males had attempted suicide at least once. A majority of the caregivers of females (67.5%, n = 27) and males (56.4%, n = 57) reported a family history of depression. Almost half of the caregivers of females (48.8%, n = 20) and males (49.5%, n = 50) reported a family history of problems with substance use.

Table 36. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	12.5% (n = 5)	12.9% (n = 13)
Has the child ever been sexually abused?	36.8% (n = 14)***	3.9% (n = 4)
Has the child ever run away?	78.6% (n = 33)**	53.0% (n = 53)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	57.1% (n = 24)	78.4% (n = 80)*
Has the child ever talked about committing suicide?	59.5% (n = 25)*	38.2% (n = 39)
Has the child ever attempted suicide?	40.5% (n = 17)**	19.6% (n = 20)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	38.1% (n = 16)	32.4% (n = 33)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	67.5% (n = 27)	56.4% (n = 57)
Has anyone in the child's biological family had a mental illness, other than depression?	57.5% (n = 23)	47.4% (n = 46)
Has the child ever lived in a household in which someone was convicted of a crime?	33.3% (n = 13)	35.0% (n = 35)
Has anyone in the child's biological family had a drinking or drug problem?	48.8% (n = 20)	49.5% (n = 50)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	57.5% (n = 23)	41.4% (n = 41)

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

Problems Leading to Service

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-related problems (88.1% and 85.1% respectively) (see Table 37). Chi-square analyses indicated females had significantly higher rates of problems related to depression-related problems and suicide-related problems. Males had significantly higher rates of hyperactive and attention-related problems.

Table 37. Problems Leading to Services

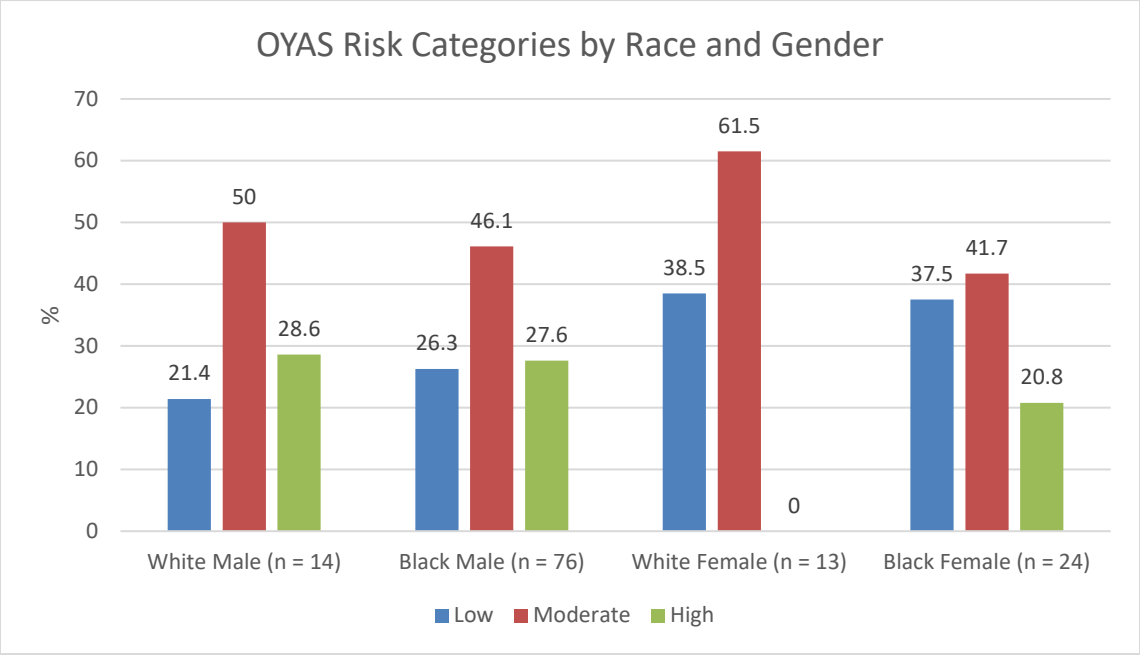
Problems Leading to Services	Females	Males
Adjustment-related problems	33.3% (n = 14)	40.6% (n = 41)
Anxiety-related problems	33.3% (n = 14)	32.7% (n = 33)
Conduct/delinquency-related problems	88.1% (n = 37)	85.1% (n = 86)
Depression-related problems	69.0% (n = 29)**	41.6% (n = 42)
Eating disorders	0	3.0% (n = 3)
Hyperactive and attention-related problems	38.1% (n = 16)	60.4% (n = 61)*
Learning disabilities	11.9% (n = 5)	22.8% (n = 23)
Pervasive development disabilities	2.4% (n = 1)	4.0% (n = 4)
Psychotic behaviors	9.5% (n = 4)	8.9% (n = 9)
School performance problems not related to learning disabilities	59.5% (n = 25)	60.4% (n = 61)
Specific developmental disabilities	0	4.0% (n = 4)
Substance use, abuse, dependence-related problems	65.4% (n = 17)	75.4% (n = 49)
Suicide-related problems	40.5% (n = 17)**	18.8% (n = 19)

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

Ohio Youth Assessment System

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 29 shows the distribution of OYAS risk categories for BHJJ youth by race and gender. In Cuyahoga County, 28.6% (n = 4) of White males and 27.6% (n = 21) of Black males enrolled in the BHJJ program were identified as High risk on the OYAS, while no White females and 20.8% (n = 5) of Black females were identified as High risk.

Figure 29.



DSM Diagnoses

Workers were asked to report any DSM 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 diagnosis for females and males were Cannabis-related Disorders (see Table 38).

Chi-square analysis indicated females were significantly more likely than males to be diagnosed with Depressive Disorders while males were significantly more likely than females to be diagnosed with Cannabis-related Disorders, ADHD, and co-occurring disorders (both a DSM mental health diagnosis and a substance use diagnosis).

Table 38. Most Common DSM Diagnoses

DSM Diagnosis	Females (n = 41)	Males (n = 101)
Adjustment Disorder	0	4.0% (n = 4)
Alcohol-related Disorders	4.9% (n = 2)	12.9% (n = 13)
Attention Deficit Hyperactivity Disorder	19.5% (n = 8)	41.6% (n = 42)**
Bipolar Disorder	0	4.0% (n = 4)
Cannabis-related Disorders	**56.1% (n = 23)**	**77.2% (n = 78)***
Conduct Disorder	7.3% (n = 3)	16.8% (n = 17)
Depressive Disorders	31.7% (n = 13)*	15.8% (n = 16)
Disruptive Behavior Disorder	0	1.0% (n = 1)
Mood Disorder	14.6% (n = 6)	12.9% (n = 13)
Oppositional Defiant Disorder	29.3% (n = 12)	20.8% (n = 21)
Post-traumatic Stress Disorder	12.2% (n = 5)	7.9% (n = 8)
Trauma and Stressor Related Disorder	4.9% (n = 2)	2.0% (n = 2)
Disruptive Mood Dysregulation Disorder	22.0% (n = 9)	16.8% (n = 17)
Co-Occurring Disorder	53.7% (n = 22)	70.3% (n = 71)*

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

Educational Information

Several items focused on educational 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. The wording on some items (e.g. IEP at intake, attendance at intake) was changed from previous versions of the forms. For those items, we present data from only the past biennium (when the new forms were in use). Those items will have smaller sample sizes compared to items that have been consistent for the past four years.

Over fifty-six percent (56.8%, n = 79) of youth were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in BHJJ treatment BHJJ, 38.2% (n = 50) of the youth were expelled or suspended from school (a 32.3% decrease from intake to termination).

Educational data were analyzed for youth who were eligible for inclusion (youth on summer break or who had graduated at the time of the survey were not included in the analyses). At intake, 87.2% (n = 41) of youth were currently attending school while at termination, 86.3% (n = 101) 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 39 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 12 displays this information based on completion status. At intake, 43.5% of youth were earning mostly A's and B's, and C's while at termination, 48.0% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 40). For example, at intake, 44.8% of youth who would go on to be unsuccessful completers and 45.5% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 25.6% of unsuccessful completers and 58.6% of successful completers received mostly A's, B's, or C's.

Table 39. Academic Performance

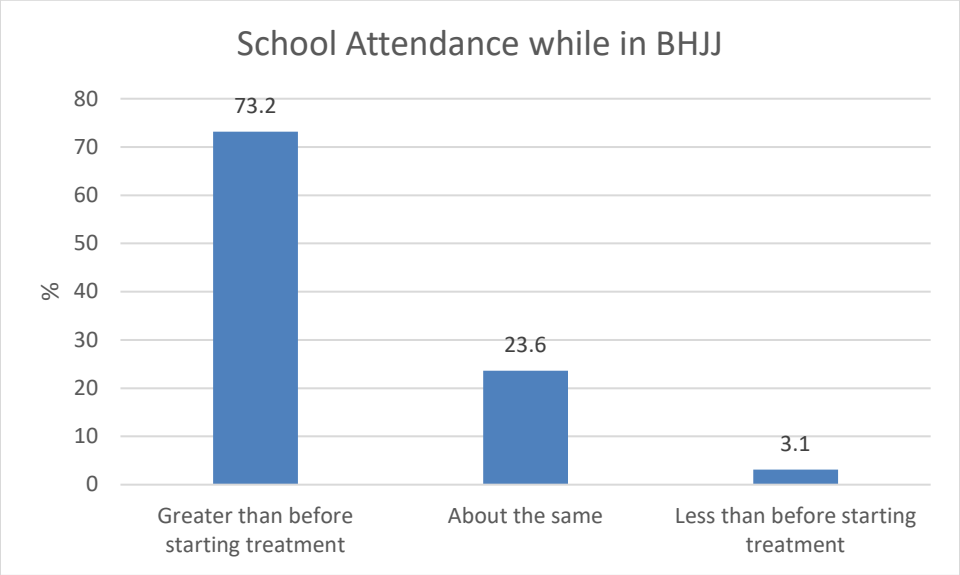
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	16.8% (n = 22)	17.6% (n = 22)
Mostly B's and C's	26.7% (n = 35)	30.4% (n = 38)
Mostly C's and D's	24.4% (n = 32)	26.4% (n = 33)
Mostly D's and F's	32.1% (n = 42)	25.6% (n = 32)

Table 40. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	23.7% (n = 9)	7.7% (n = 3)	15.6% (n = 12)	22.0% (n = 18)
Mostly B's and C's	21.1% (n = 8)	17.9% (n = 7)	29.9% (n = 23)	36.6% (n = 30)
Mostly C's and D's	18.4% (n = 7)	33.3% (n = 13)	26.0% (n = 20)	23.2% (n = 19)
Mostly D's and F's	36.8% (n = 14)	41.0% (n = 16)	28.6% (n = 22)	18.3% (n = 15)

At termination, workers reported that 73.2% (n = 93) of youth were attending school more than before starting treatment and 23.6% (n = 30) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 30). At intake, 52.0% (n = 26) of the youth attending school had Individualized Education Plans (IEPs) while at termination, 58.3% (n = 74) of the youth attending school had Individualized Education Plans (IEPs).

Figure 30.



Ohio Scales

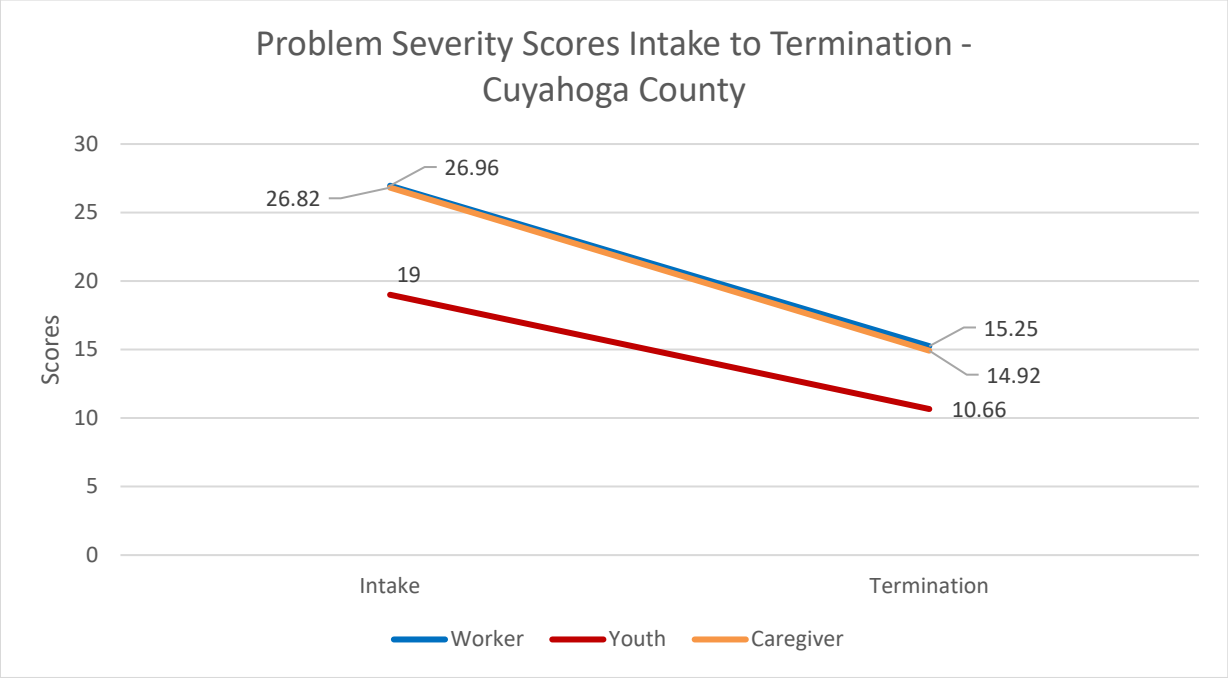
One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum of service, separate charts are included that display the means from intake to termination. Decreases in Problem Severity and increases in Functioning correspond to positive change.

All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Paired samples t-tests were used to compare Problem Severity scores at intake to Problem Severity scores at the other assessment periods. A paired samples t-test compares the means of two variables by computing the difference between the two variables for each case and testing to see if the average difference is significantly different from zero. In order for a case to be included in the analyses, the rater must have scores for both assessment periods. For example, a caregiver must supply scores for both the intake and three-month assessment period to be included in the paired samples t-test for that time point. If the caregiver only has an intake score, his or her data is not included in the analysis.

Problem Severity

Overall means for the Problem Severity scale by rater between intake and termination for Cuyahoga County youth are presented in Figure 31.

Figure 31.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Problem Severity from intake to each successive data collection point (see Table 41). Significant improvements were noted at three months: $t(124) = 4.67$, $p < .001$; six months: $t(92) = 4.93$, $p < .001$; nine months: $t(52) = 3.90$, $p < .001$; and at termination $t(120) = 9.56$, $p < .001$. A small effect size was found for the period between intake to three months. Moderate effect sizes were found for the period between intake to six months and the period between intake to nine months. A large effect size was found for the time period between intake to termination.

Table 41. Paired Samples T-Tests for Problem Severity – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	27.86 (SD=12.46; n=125)	21.94 (SD=11.74; n=125)	4.67***	.42
Intake to Six Months	27.20 (SD=11.34; n=93)	19.76 (SD=10.25; n=93)	4.93***	.51
Intake to Nine Months	27.07 (SD=11.10; n=53)	19.06 (SD=11.61; n=53)	3.90***	.54
Intake to Termination	27.12 (SD=12.07; n=121)	15.25 (SD=9.10; n=121)	9.56***	.87

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvements in Problem Severity at each data collection point (see Table 42). Significant improvements were noted at three months: $t(121) = 2.37$, $p < .05$; six months: $t(85) = 2.47$, $p < .05$; nine months: $t(50) = 4.31$, $p < .001$; and at termination $t(110) = 6.28$, $p < .001$. Small effect sizes were noted for the period between intake to three months and the period between intake to six months. Moderate effect sizes were noted for the period between intake to nine months and the period between intake to termination.

Table 42. Paired Samples T-Tests for Problem Severity – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	19.60 (SD=16.38; n=122)	15.91 (SD=14.07; n=122)	2.37*	.21
Intake to Six Months	19.14 (SD=15.24; n=86)	14.27 (SD=15.23; n=86)	2.47*	.27
Intake to Nine Months	18.49 (SD=14.30; n=51)	11.14 (SD=10.50; n=51)	4.31***	.60
Intake to Termination	19.52 (SD=16.78; n=111)	10.66 (SD=10.17; n=111)	6.28***	.60

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Problem Severity at each measurement interval compared to intake (see Table 43). Significant improvements were noted at three months: $t(123) = 4.28$, $p < .001$; six months: $t(85) = 4.41$, $p < .001$; nine months: $t(52) = 3.73$, $p < .001$; and at termination $t(104) = 6.94$, $p < .001$. Small effect sizes were noted for the period between intake to three months and the period between intake to six months. Moderate effect sizes were noted for the period between intake to nine months and the period between intake to termination.

Table 43. Paired Samples T-Tests for Problem Severity – Caregiver

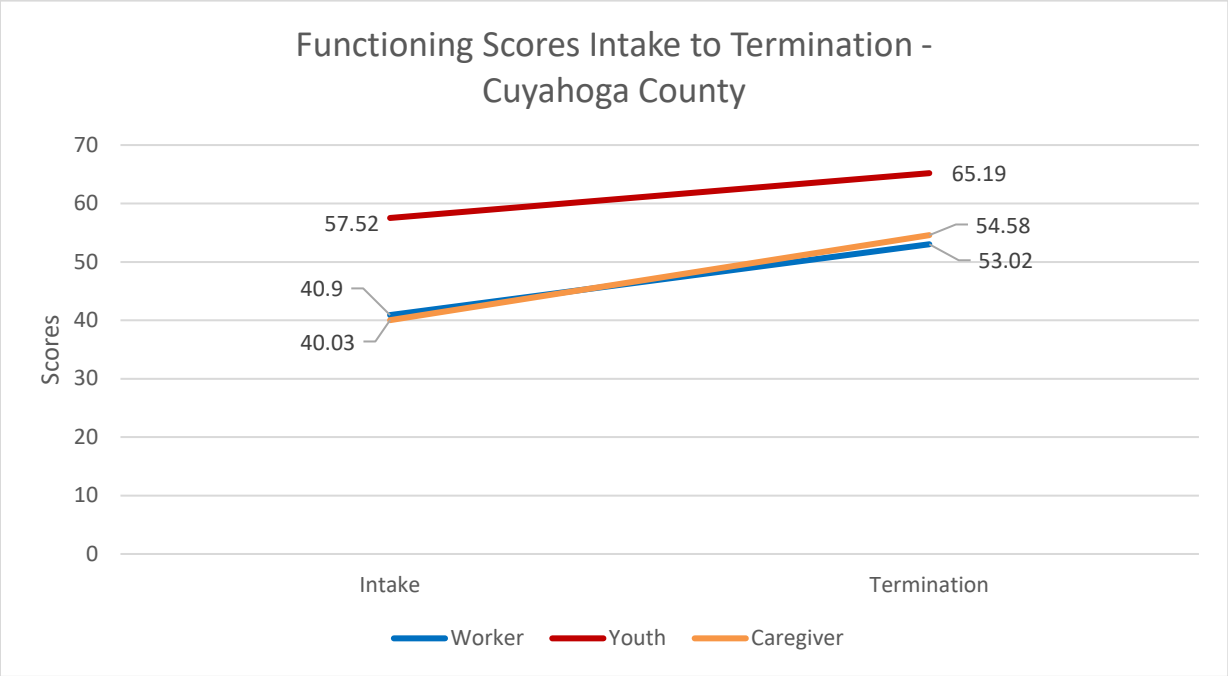
	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	28.26 (SD=17.60; n=124)	21.45 (SD=14.66; n=124)	4.28***	.38
Intake to Six Months	27.21 (SD=16.54; n=86)	18.98 (SD=15.50; n=86)	4.41***	.48
Intake to Nine Months	27.54 (SD=15.97; n=53)	17.73 (SD=15.14; n=53)	3.73***	.51
Intake to Termination	27.40 (SD=17.26; n=105)	14.92 (SD=14.56; n=105)	6.94***	.68

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

Functioning Scores

Overall means for the Functioning scale by rater between intake and termination for Cuyahoga County youth are presented in Figure 32.

Figure 32.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Functioning scores at each measurement interval compared to intake (see Table 44). Significant improvements were noted at three months: $t(128) = -3.09$, $p < .01$; six months: $t(93) = -5.04$, $p < .001$; nine months: $t(53) = -3.81$, $p < .001$; and at termination $t(118) = -9.22$, $p < .001$. A small effect size was found for the period between intake to three months. Moderate effect sizes were found for the period between intake to six months and the period between intake to nine months. A large effect size was found for the time period between intake to termination.

Table 44. Paired Samples T-Tests for Functioning Scores – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	40.36 (SD=9.61; n=129)	44.21 (SD=12.86; n=129)	-3.09**	.27
Intake to Six Months	40.42 (SD=8.56; n=94)	47.87 (SD=11.46; n=94)	-5.04***	.52
Intake to Nine Months	39.48 (SD=8.98; n=54)	47.87 (SD=12.52; n=54)	-3.81***	.52
Intake to Termination	40.62 (SD=9.87; n=119)	53.02 (SD=12.73; n=119)	-9.22***	.84

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvements in Functioning scores at each measurement interval compared to intake (see Table 45). Significant improvements were noted at nine months: $t(50) = -3.06$, $p < .01$; and at termination $t(109) = -5.28$, $p < .001$. A small effect size was found for the time period between intake to nine months. A moderate effect size was found for the time period between intake to termination.

Table 45. Paired Samples T-Tests for Functioning Scores – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	57.28 (SD=13.22; n=123)	59.05 (SD=14.64; n=123)	-1.31	.12
Intake to Six Months	57.31 (SD=12.07; n=86)	60.17 (SD=15.23; n=86)	-1.66	.18
Intake to Nine Months	57.74 (SD=11.41; n=51)	63.25 (SD=11.48; n=51)	-3.06**	.43
Intake to Termination	57.50 (SD=12.79; n=110)	65.19 (SD=14.64; n=110)	-5.28***	.50

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Functioning scores at each measurement interval compared to intake (see Table 46). Significant improvements were noted at three months: $t(123) = -2.88$, $p < .01$; six months: $t(85) = -3.79$, $p < .001$; nine months: $t(51) = -3.66$, $p < .01$; and at termination $t(106) = -8.91$, $p < .001$. Small effect sizes were found for the period between intake to three months and the period between intake to six months. A moderate effect size was found for the period between intake to nine months. A large effect size was found for the time period between intake to termination.

Table 46. Paired Samples T-Tests for Functioning Scores – Caregiver

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	39.42 (SD=16.22; n=124)	43.99 (SD=18.01; n=124)	-2.88**	.26
Intake to Six Months	40.92 (SD=15.15; n=86)	48.01 (SD=16.46; n=86)	-3.79***	.41
Intake to Nine Months	41.44 (SD=15.13; n=52)	50.46 (SD=16.12; n=52)	-3.66**	.51
Intake to Termination	39.76 (SD=16.32; n=107)	54.44 (SD=16.47; n=107)	-8.91***	.86

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

Violence and Delinquency Questionnaire

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey composed of three general domains: exposure to violence, violence perpetration, and peer delinquency. The VDQ is offered at intake and termination into the BHJJ program. At intake, each item prompts the youth to answer within the context of the past year. At termination, youth are directed to answer "since the last time you answered these questions".

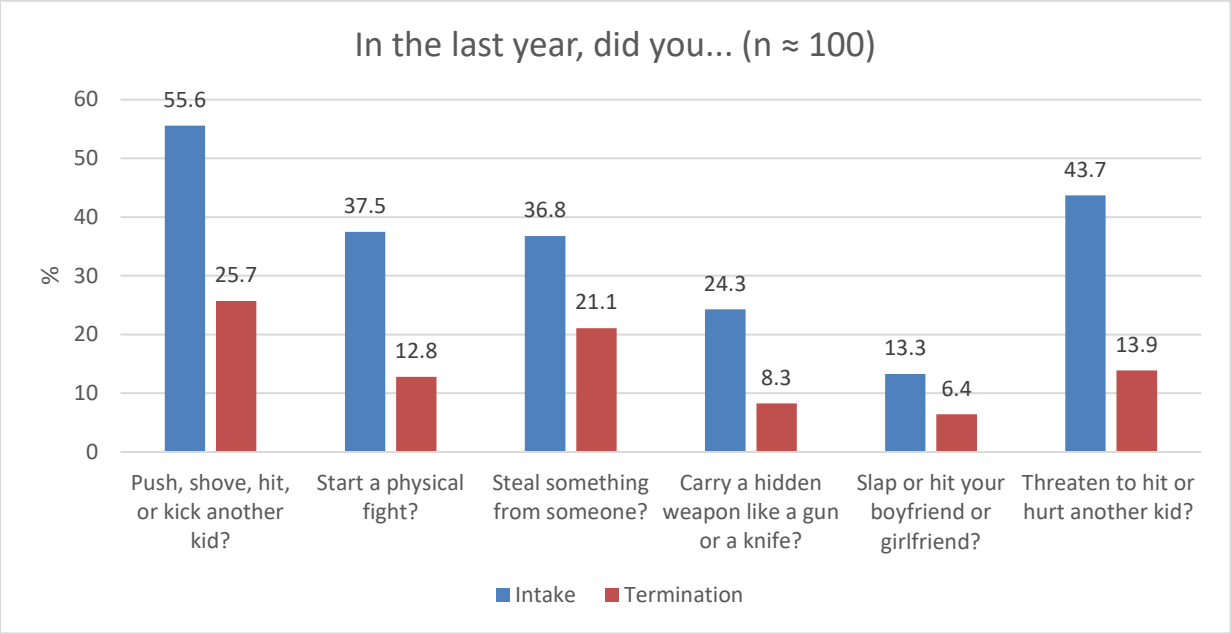
This section will be divided into three distinct parts that examine the prevalence of violence exposure as either a victim or witness, self-reported delinquent behavior from intake to termination, and delinquent behavior by peers from intake to termination. Table 47 provides the percentage of those who had experienced violence as either a victim or witness in the past year.

Table 47. Violence Exposure

	% Yes BHJJ Sample (n = 136)
In the last year, did someone threaten to hurt you when you thought they might really do it?	30.9%
In the last year, have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?	6.6%
In the last year, did a boyfriend or girlfriend or anyone you went on a date with slap or hit you?	18.4%
In the last year, did anyone steal anything from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?	44.1%
Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	16.2%
In the last year, did anyone hit or attack you WITHOUT using an object or weapon?	43.4%
In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?	14.0%
In the last year, did a grown-up touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?	3.7%
Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. In the last year, did another child or teen make you do sexual things?	3.7%
In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	11.0%
In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	33.1%
In the last year, in real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt them?	50.0%
In the last year, was anyone close to you murdered, like a friend, neighbor, or someone in your family?	36.3%
In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	27.2%
Not including spanking on your bottom, did a grown-up in your life hit, beat, kick or physically hurt you in any way?	18.4%
When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. In the last year, were you neglected?	5.9%

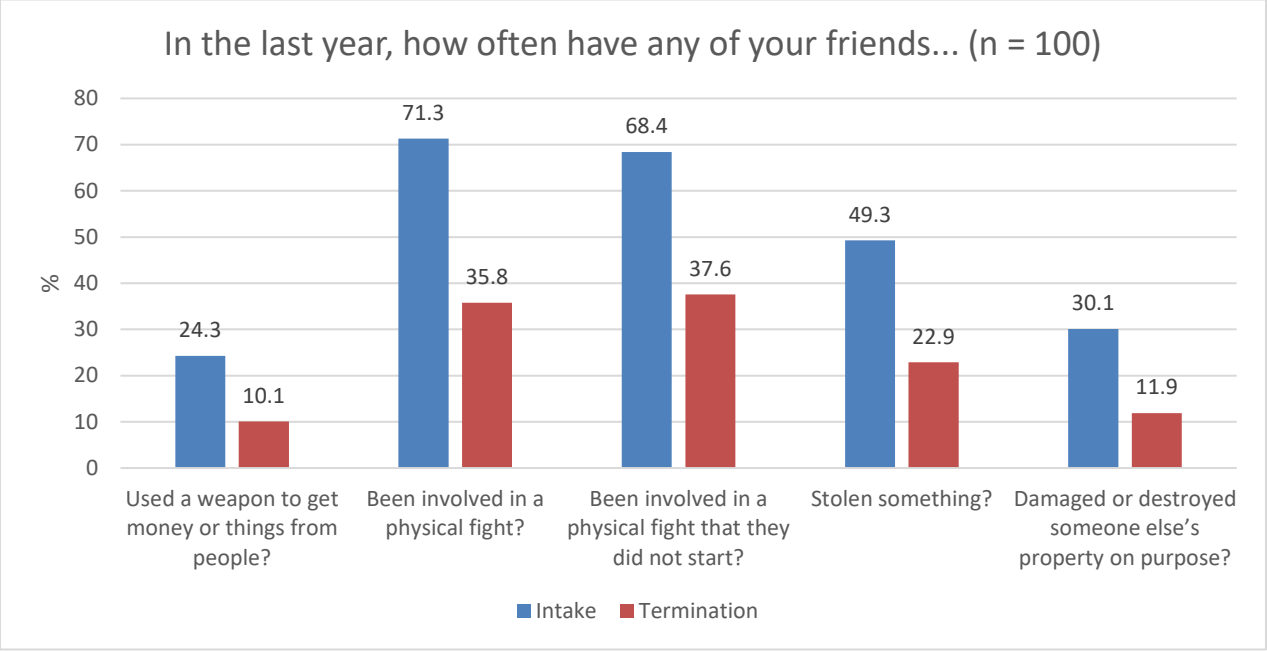
Delinquent behaviors were measured as self-report items of violent and weapon carrying behaviors as well as stealing. At intake, youth were asked how often they engaged in each behavior in the last year while at termination, youth were asked how often they engaged in the behavior since the last time they were asked. Figure 33 presents the percentage of youth who identified that they had engaged in each type of behavior at least once. Depending on the item, data were available for a range between 98 and 100 matched pairs (Mode = 100). McNemar's tests revealed statistically significant improvements from intake to termination for each of the 6 items.

Figure 33.



Self-reported peer delinquency was also measured at intake (how often in the last year) and at termination (how often since the last time they were asked). Figure 34 presents the percentage of youth who identified how often their friends had engaged in delinquent behavior at intake and termination. Depending on the item, data were available for 100 pairs. Statistically significant improvements were found for each of the items between intake and termination.

Figure 34.



Resilience

As part of the 2017 - 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family.

Figure 35 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were “pretty much true” and “very much true”, we combined these responses. The number of valid responses for these questions was 57. Generally, the majority of youth indicated high levels of endorsement for each one of these items. It is important to note, that the largest proportion of youth responding “not at all” or “a little true” were for the three items that measure empathy. Less than half (48.1%; n = 27) identified that the statement “I feel bad when someone gets their feelings hurt” was either pretty much or very much true.

Figure 35.

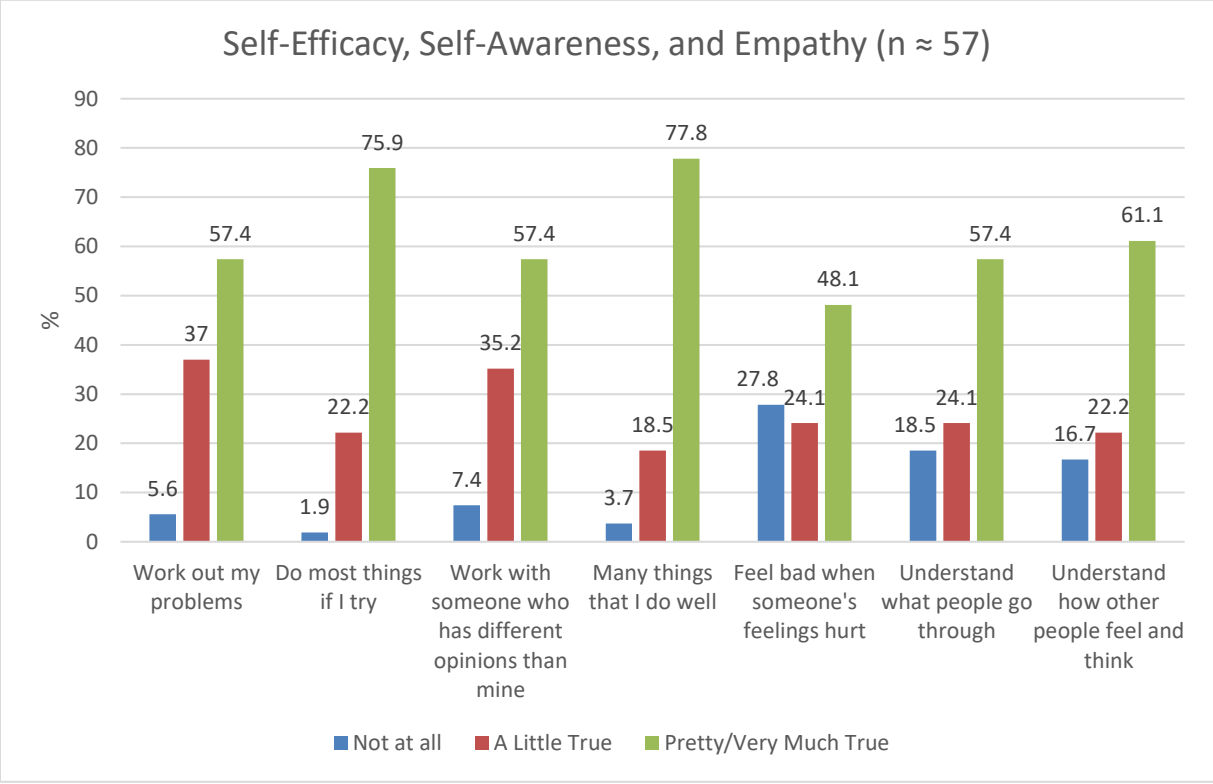


Figure 36 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. The majority of youth identified that each of the statements were either pretty much or very much true.

Figure 36.

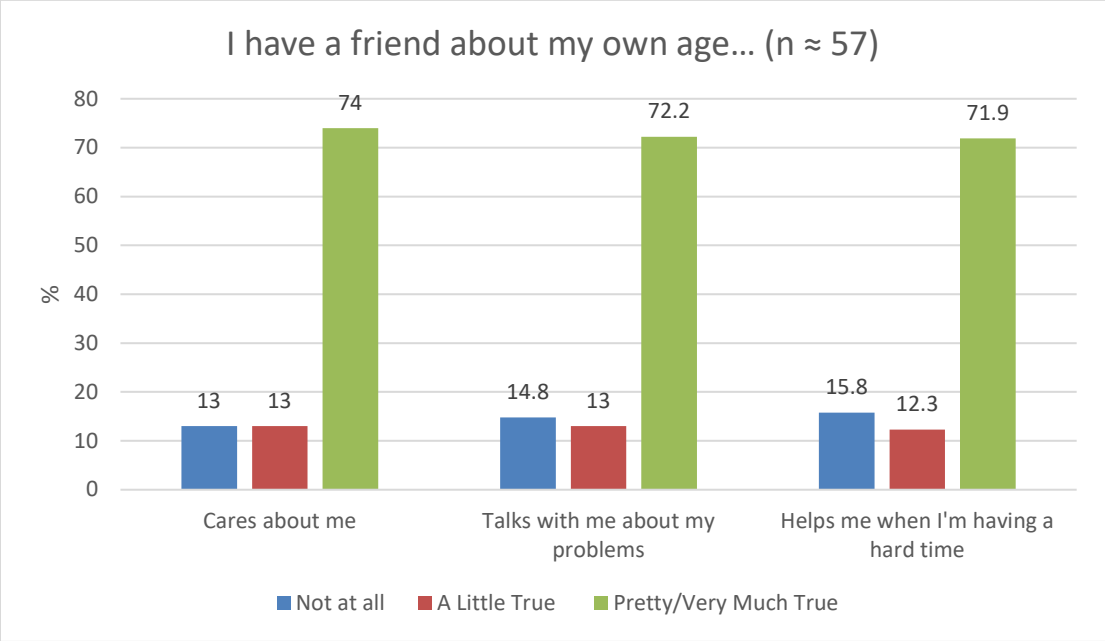
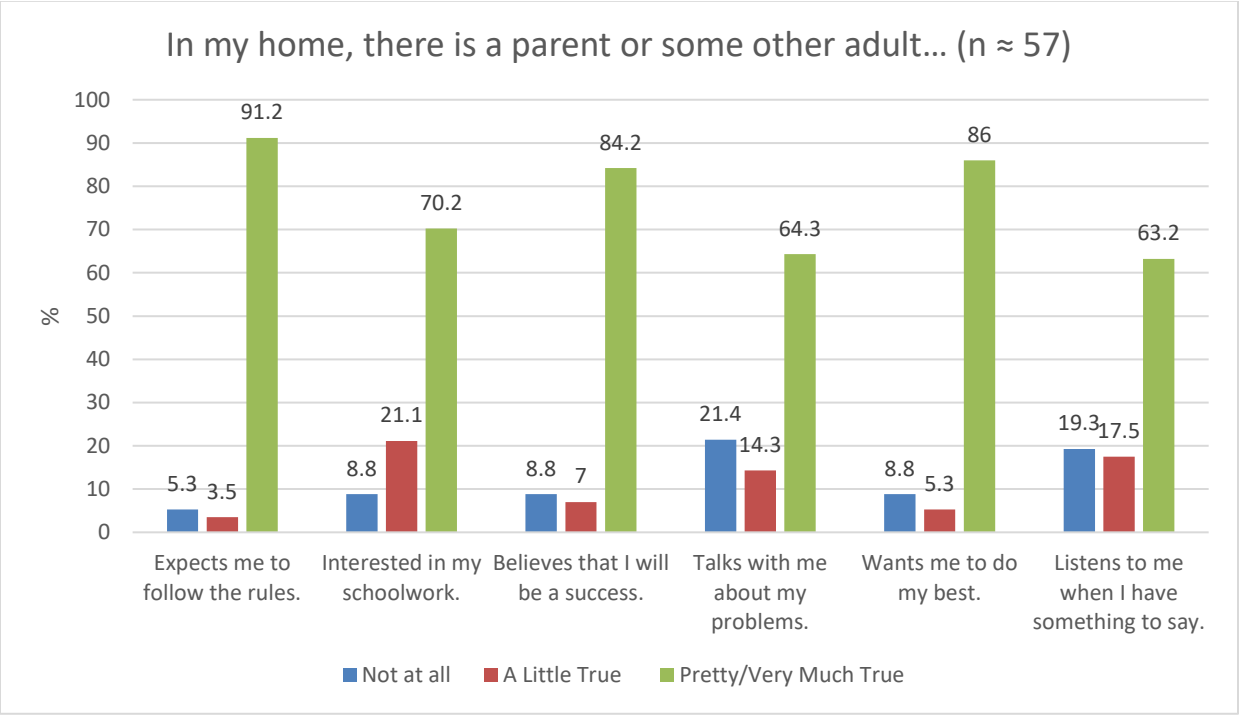


Figure 37 shows intake data on parental or support from other adults in their house. The number of valid responses at intake ranged between 56 and 57. While the majority of youth identified that each of the items were either pretty much or very much true, the two items with the lowest endorsement was "talks with me about my problems" and "listens to me when I have something to say".

Figure 37.



In addition to intake data, Figure 38 through Figure 40 show the proportion of youth who identified that each of the statements were either pretty much or very much true from intake to termination. Due to sample size restrictions, McNemar's tests were not conducted. Figure 38 shows differences from intake to termination for the items measuring self-efficacy, self-awareness, and empathy. The number of valid responses ranged between 38 and 39 for each of the items. Youth exhibited improvement in each of the items measuring self-efficacy, self-awareness, and empathy. For example, 56.4% (n = 22) at intake and 69.2% (n = 27) at termination indicated that the item "I can work out my problems" was either pretty much or very much true.

Figure 38.

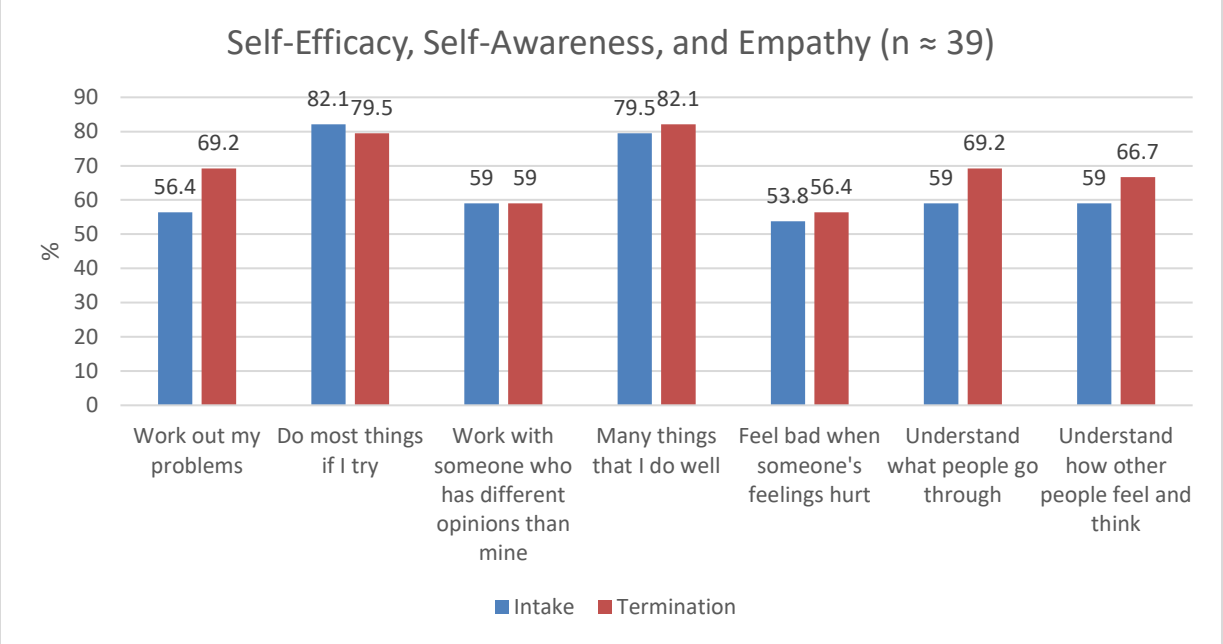


Figure 39 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring peer support. The number of valid responses was 39. For all three items, a slightly lower proportion of youth indicated that the statements were either pretty much or very much true at termination compared to intake.

Figure 39.

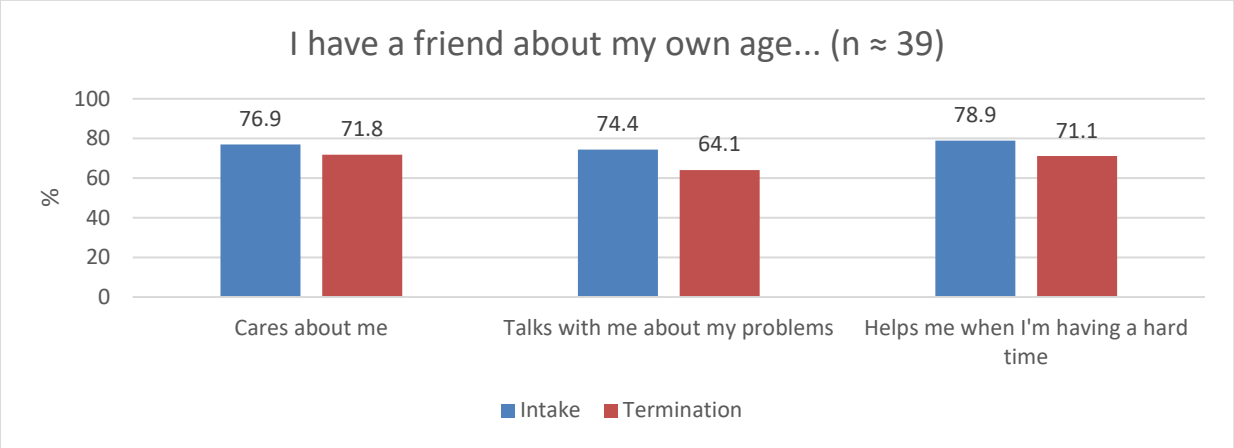
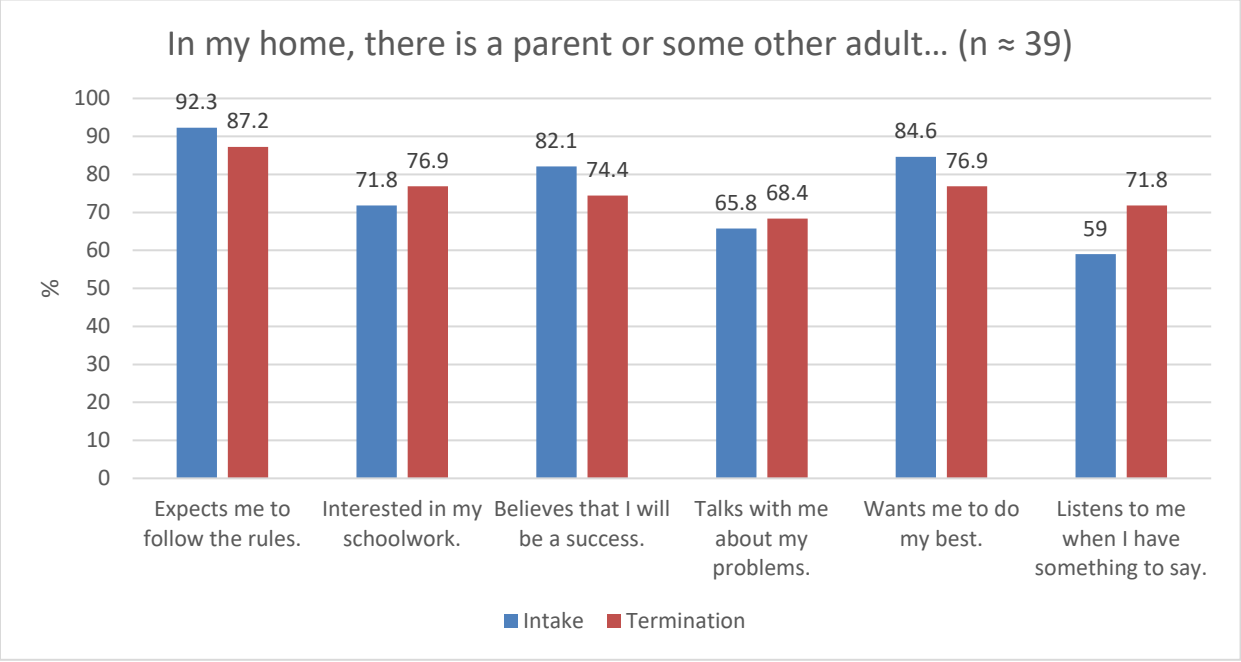


Figure 40 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring parental support or support from other adults in the home. Valid responses to these 6 items ranged between 38 and 39. The proportion of positive responses declined slightly for three items: “expects me to follow the rules”, “believes that I will be a success”, and “always wants me to do my best”.

Figure 40.



TSCC

The TSCC was administered at intake and termination from BHJJ. Paired-samples t-tests were conducted to show whether means at intake and termination on each TSCC subscale differed significantly. Data were analyzed separately for females (see Figure 41) and males (see Figure 42) who had completed the TSCC at both intake and termination in Cuyahoga County.

Research has found that females consistently report more trauma symptoms than males (Singer et al., 1995). We examined trauma symptoms for females and males in the BHJJ sample. Consistent with previous research, BHJJ females reported higher scores on each trauma symptom subscale than males. For example, at intake, the average score on the Posttraumatic Stress domain was 7.36 females and 4.85 for males. Paired samples t-tests revealed significant improvements on every domain from intake to termination for females, and significant improvements on Anger, Posttraumatic Stress, and Dissociation domains for males (see Table 48 and Table 49).

Table 48. TSCC Subscales from Intake to Termination among Females

Females	Intake	Termination	t	d
Anxiety	4.93 (SD = 4.94; n = 28)	2.39 (SD = 4.70; n = 28)	2.37*	.45
Depression	7.68 (SD = 6.52; n = 28)	3.54 (SD = 4.47; n = 28)	3.57***	.67
Anger	8.93 (SD = 7.80 ; n = 28)	3.75 (SD = 3.95; n = 28)	3.77***	.71
Posttraumatic Stress	7.36 (SD = 6.31; n = 28)	3.43 (SD = 4.80; n = 28)	3.05**	.58
Dissociation	6.75 (SD = 5.80; n = 28)	3.82 (SD = 5.29; n = 28)	2.67*	.51
Sexual Concerns	3.96 (SD = 3.74; n = 28)	1.07 (SD = 1.54; n = 28)	3.98***	.75

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

Figure 41.

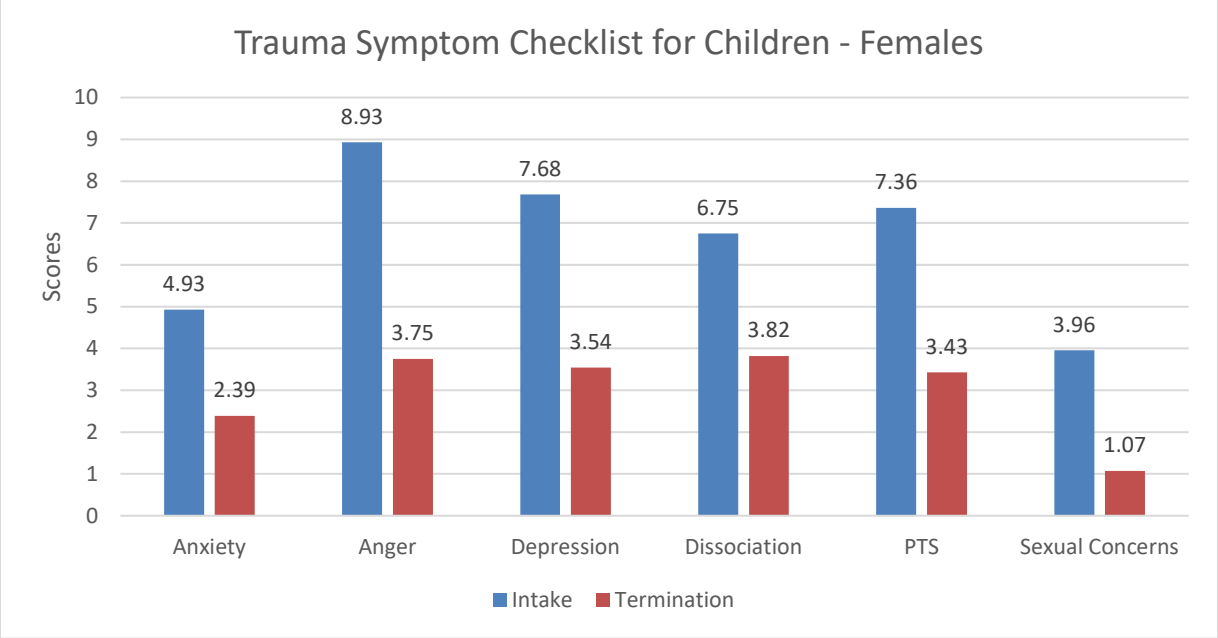
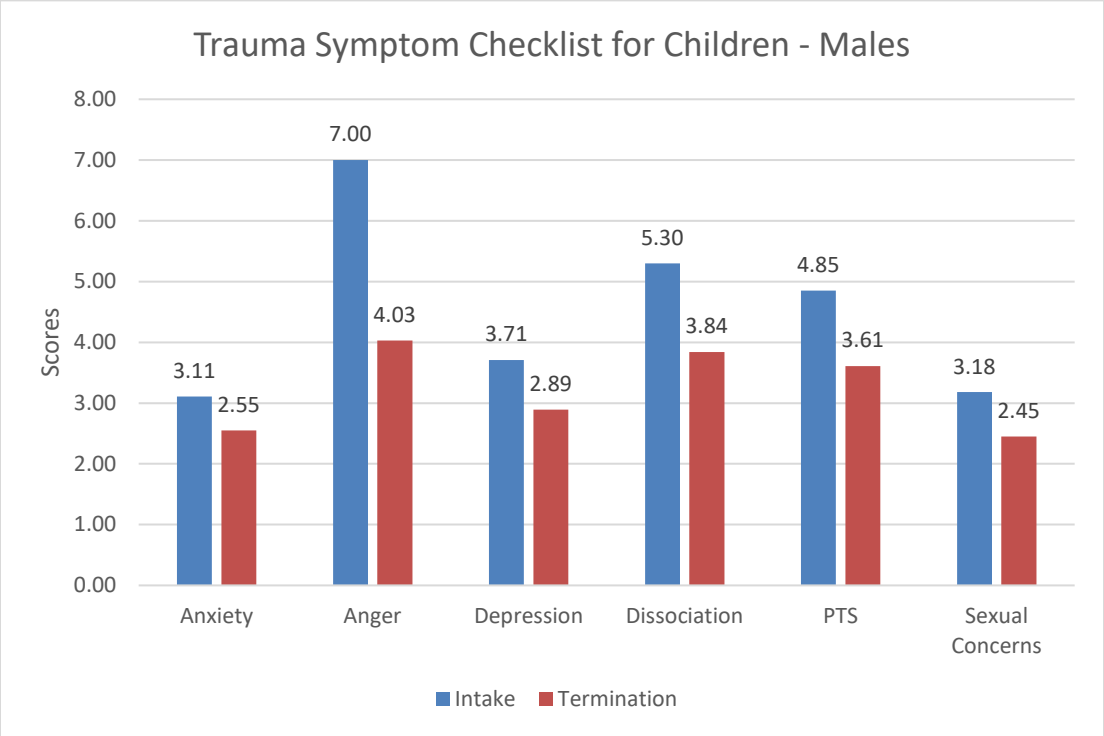


Table 49. TSCC Subscales from Intake to Termination for Males

Males	Intake	Termination	t	d
Anxiety	3.11 (SD = 3.43; n = 66)	2.55 (SD = 3.19; n = 66)	1.43	.18
Depression	3.71 (SD = 4.62; n = 66)	2.89 (SD = 3.61; n = 66)	1.53	.19
Anger	7.00 (SD = 6.08; n = 66)	4.03 (SD = 4.28; n = 66)	4.64***	.57
Posttraumatic Stress	4.85 (SD = 5.53; n = 66)	3.61 (SD = 4.56; n = 66)	2.04*	.25
Dissociation	5.30 (SD = 4.64; n = 66)	3.84 (SD = 4.76; n = 66)	2.59*	.33
Sexual Concerns	3.18 (SD = 3.76; n = 66)	2.45 (SD = 2.99; n = 66)	1.66	.21

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

Figure 42.



Substance Use Survey

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 50 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use by gender in Cuyahoga County. For both females and males, alcohol, tobacco, and marijuana were the most commonly used substances. Chi-squared tests revealed that a significantly higher proportion of males reported ever having used marijuana than females ($\chi^2(1) = 3.99$, $p < .05$).

Table 50. Self-Reported Substance Use at Intake by Gender – Cuyahoga County

	Male		Female	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	67.5% (n = 27)	14.22 (SD = 1.74)	66.7% (n = 10)	13.90 (SD = 1.79)
Tobacco	65.0% (n = 26)	13.69 (SD = 2.56)	40.0% (n = 6)	12.50 (SD = 2.59)
Cannabis	**85.0% (n = 34)**	**13.03 (SD = 2.26)**	**60.0% (n = 9)**	**13.78 (SD = 2.33)**
Hallucinogens	7.9% (n = 3)	15.33 (SD = 0.58)	6.7% (n = 1)	16.00[a]
Inhalants	2.6% (n = 1)	8.00[a]	0.0% (n = 0)	
Opioids	10.0% (n = 4)	15.75 (SD = 1.26)	6.7% (n = 1)	16.00[a]
Sedatives	12.5% (n = 5)	14.60 (SD = 1.14)	6.7% (n = 1)	16.00[a]
Caffeine	22.5% (n = 9)	12.89 (SD = 2.52)	33.3% (n = 5)	10.80 (SD = 5.02)
Stimulants	12.5% (n = 5)	15.60 (SD = 0.89)	7.1% (n = 1)	16.00[a]
Over the counter medications	15.0% (n = 6)	15.00 (SD = 1.00)	6.7% (n = 1)	16.00[a]
Other prescription drugs	5.0% (n = 2)	9.00 (SD = 7.07)	0.0% (n = 0)	
Herbs/Flowers	0.0% (n = 0)		0.0% (n = 0)	

[a] No Standard Deviations are calculated.

Thirty-Day Substance Use

If youth reported any lifetime use, they were also asked the number of days out of the past 30 in which had used each substance. Figure 43 shows the past 30-day use from intake to termination expressed as the average number of days for each of the 4 most commonly reported substances (alcohol, tobacco, marijuana, and caffeine). The data here are restricted to the youth who had reported having ever used each of the four substances. For each of the four substances, the average number of days in which the youth used each of the four substances declined from intake to termination.

Figure 43.

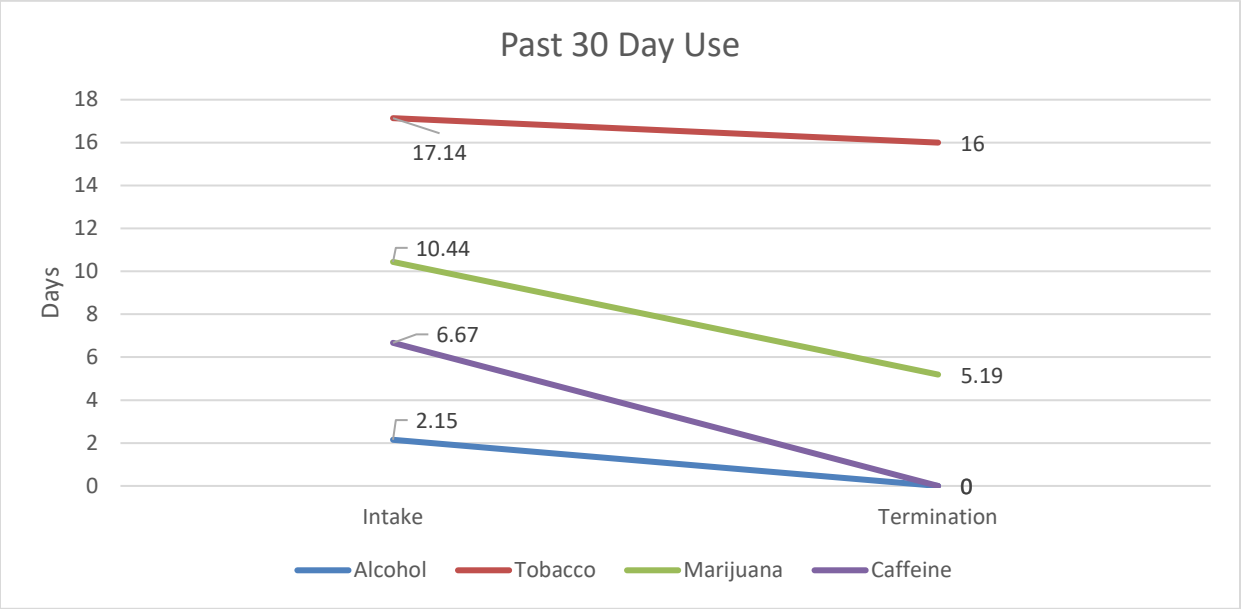
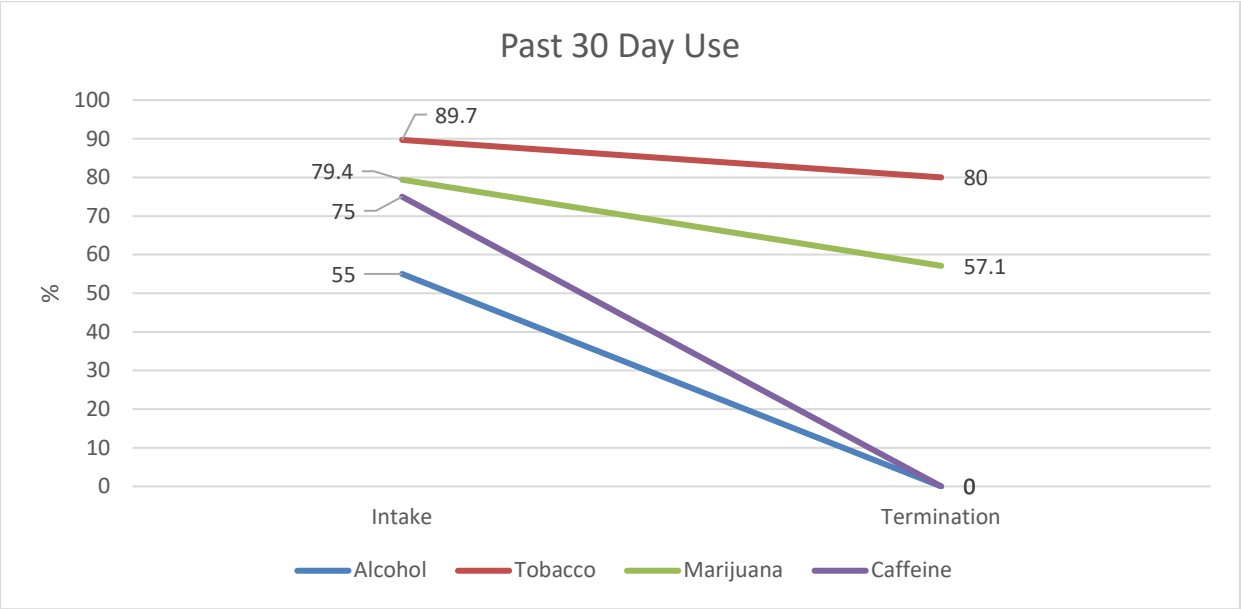


Figure 44 reports the proportion of youth who reported having used any of the four substances at all in the past 30 days. For each of the four most commonly reported substances, the proportion of youth who had reported past 30-day use declined.

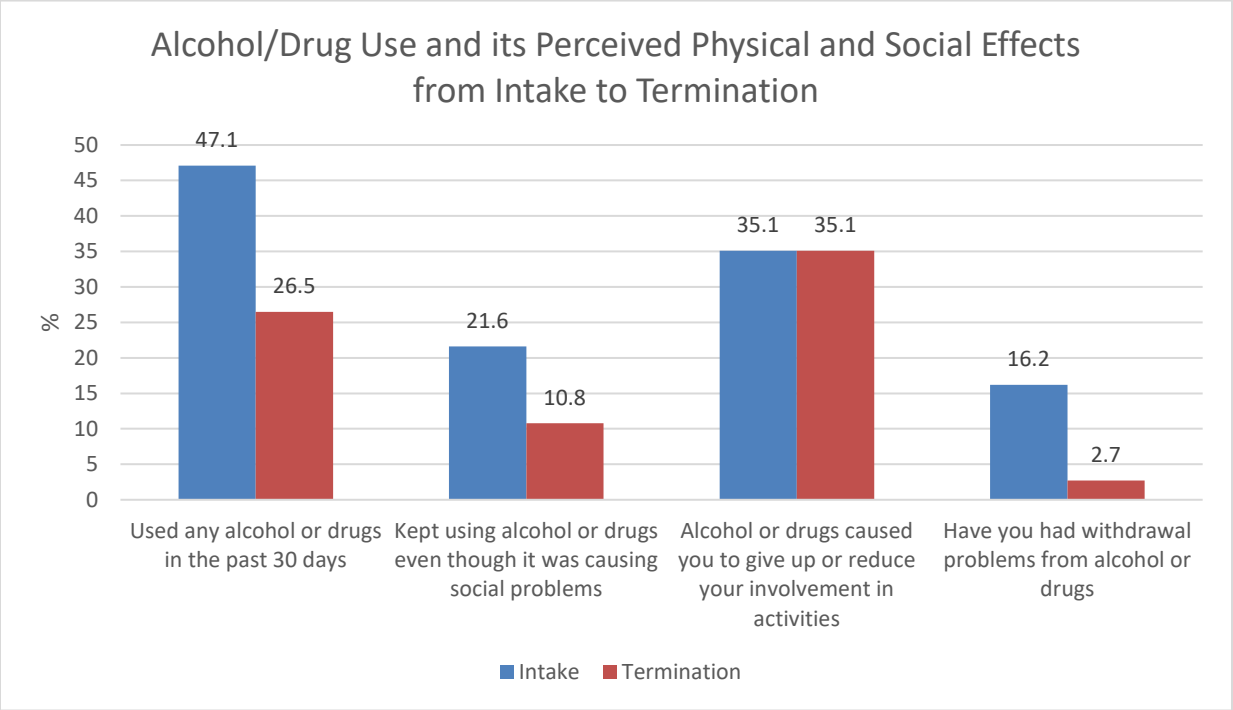
Figure 44.



In addition to questions pertaining to the use of specific substances, youth were asked questions around general alcohol/drug use and its perceived effects on physical health and social functioning (see Figure 45). The proportion of youth who indicated that they had used any alcohol or drugs in the past 30 days decreased from 47.1% at intake to 26.5% at termination. It is important to note here that the percentage of youth who indicated that they had used in the past 30 days in this more general question seems lower than the percentage who indicated past 30-day use in the questions that asked about specific substances. Percentages in Figure 45 included only those who had indicated they had ever used the specific substance. Further, we suspect that when asked a general question about alcohol or drugs, many of the youth may not consider a substance to be a drug and therefore may answer no to a general question about alcohol/drugs.

From intake to termination, the proportion of youth who indicated that they had continued to use alcohol/drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people at least sometimes and those who had withdrawal problems from alcohol or drugs decreased from intake to termination. The proportion of youth who indicated that alcohol/drugs caused them to give up or reduce involvement in activities at work, school, home, and social events stayed the same from intake to termination. While none of these differences were statistically significant, it is likely a function of low cell sizes.

Figure 45.



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.

Between July 1, 2015 and June 30, 2019, there have been 128 youth terminated from the BHJJ program in Cuyahoga County. Sixty-five percent (64.8%, n = 83) of the youth terminated from the BHJJ program were identified as successful treatment completers. Slightly under eight percent (7.8%, n = 10) were terminated from the program due to some level of incarceration. Table 51 presents all of the reasons for termination from BHJJ and displays reasons for termination for White and Black participants.

Table 51. Reasons for Termination from BHJJ

Termination Reason	All Youth Enrolled between July 2015 and June 2019	White Youth Enrolled between July 2015 and June 2019	Black Youth Enrolled between July 2015 and June 2019
Successfully Completed Services	64.8% (n = 83)	63.6% (n = 14)	61.3% (n = 57)
Client Did Not Return/Rejected Services	1.6% (n = 2)	4.5% (n = 1)	1.1% (n = 1)
Out of Home Placement	10.9% (n = 14)	9.1% (n = 2)	11.8% (n = 11)
Client/Family Moved	0.8% (n = 1)	0	1.1% (n = 1)
Client Withdrawn	1.6% (n = 2)	0	2.2% (n = 2)
Client AWOL	3.9% (n = 5)	0	5.4% (n = 5)
Client Incarcerated	7.8% (n = 10)	4.5% (n = 1)	9.7% (n = 9)
Other	8.6% (n = 11)	18.2% (n =4)	7.5% (n = 7)

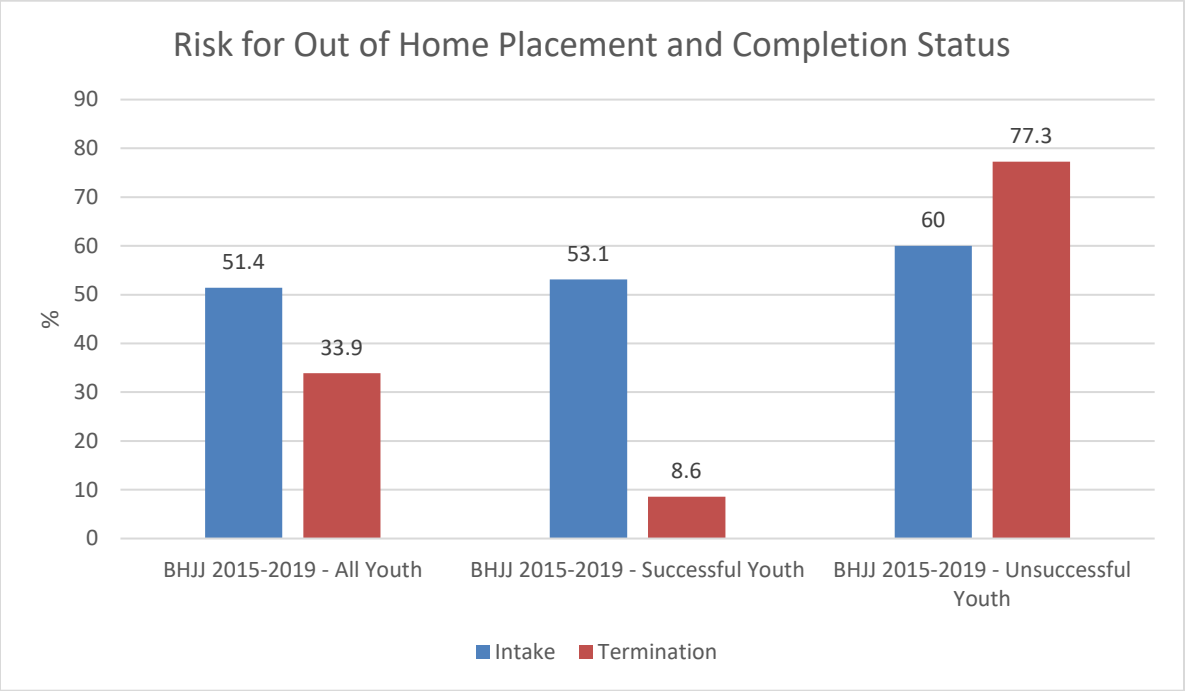
Average Length of Stay

Since the start of BHJJ, the average length of stay (ALOS) in the program was 290.6 days. For youth identified as successful treatment completers, the ALOS was 283.8 days while for unsuccessful treatment completers, the ALOS was 307.2 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, 51.4% of the youth (n = 55) were at risk for out of home placement. At termination, 33.9% (n = 43) of youth were at risk for out of home placement (see Figure 46). Of those youth who successfully completed BHJJ treatment, 8.6% (n = 7) were at risk for out of home placement at termination while 77.3% (n = 34) of youth who completed unsuccessfully were at risk for out of home placement (see Figure 46).

Figure 46.



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 services through BHJJ. Workers reported that police contacts had been reduced for 74.4% (n = 96) of the youth and had stayed the same for 15.5% (n= 20) of the youth. Police contacts increased for 5.4% (n = 7) of the youth and the worker was unable to estimate for 4.7% of youth (n = 6).

YSSF

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the services they received through the BHJJ program in Cuyahoga County as well as how services impacted their children and family. At termination from the BHJJ program, 93.3% (n = 98) of caregivers either strongly agreed or agreed that BHJJ staff were sensitive to their cultural/ethnic background and 88.8% (n =95) either strongly agreed or agreed that the location of the services was convenient (see Figure 47). Seventy-two percent (72.0%, n = 77) of caregivers reported that as a result of the services their

child/family received, their child gets along better with family members and 66.0% (n = 70) reported their child is better able to do the things they want to do (see Figure 48).

Figure 47.

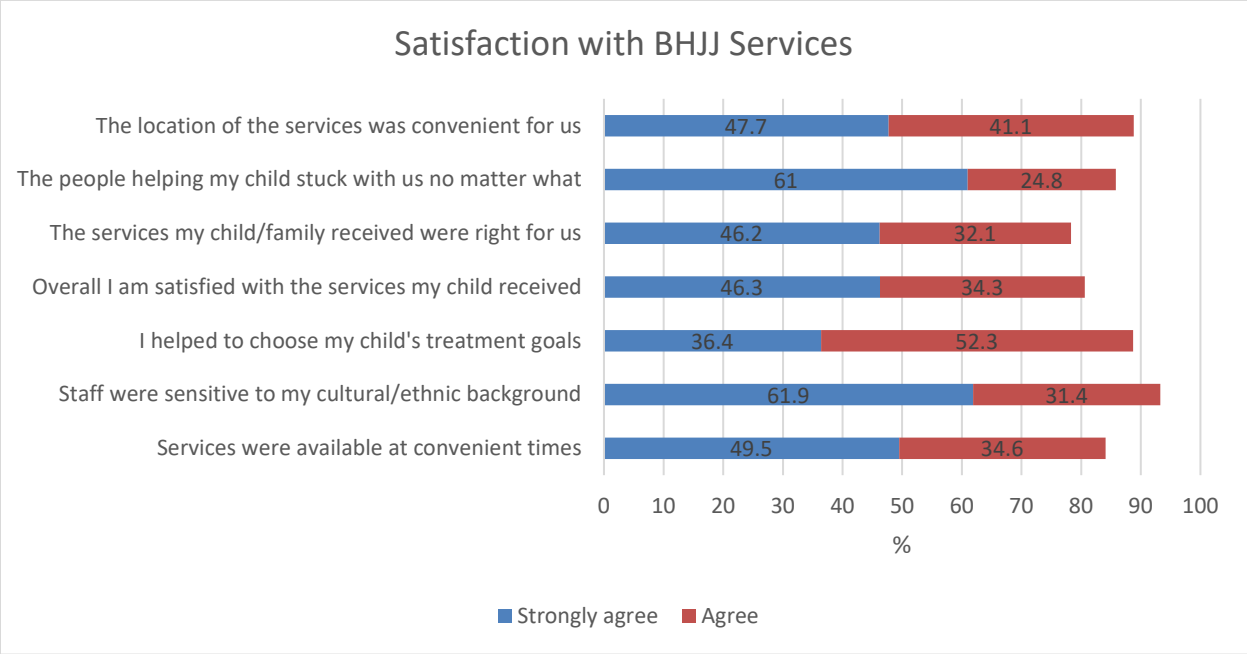
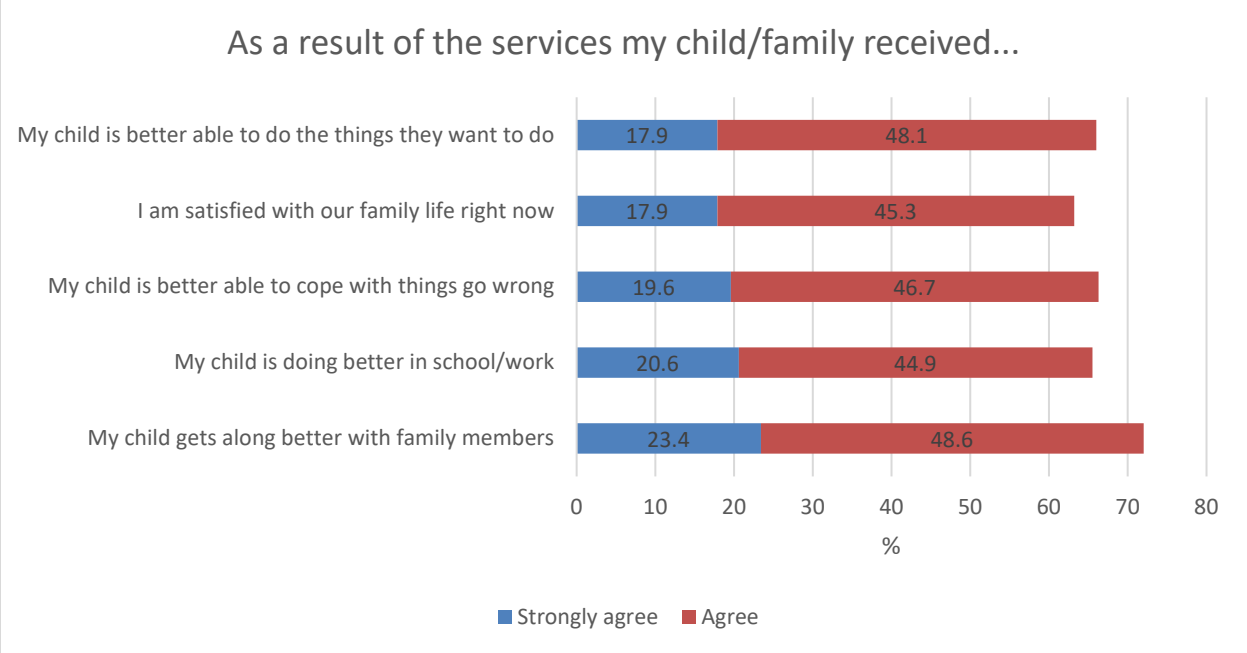


Figure 48.



Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve months prior to the end of the data collection period for inclusion in the analysis. These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 83.9% (n = 120) of BHJJ youth in Cuyahoga county enrolled between July 1, 2015 and June 30, 2019 had a misdemeanor charge, 48.3% (n = 69) or a felony charge, and 95.8% (n = 137) had been adjudicated delinquent in the 12 months prior to enrollment (see Table 52). Previous juvenile court information was similar for youth regardless of their completion status (successful vs. unsuccessful). In the 12 months prior to enrollment in BHJJ, 94.0% (n = 78) of successful completers and 100.0% (n = 44) of unsuccessful completers were adjudicated delinquent (see Table 53 and Table 54). A slightly higher proportion of successful completers had a felony charge in the 12 months prior to enrollment (53.0%; n

= 44) than unsuccessful completers (50.0%; n = 22). Chi-square analyses revealed no statistically significant differences based on completion status.

Table 52. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (N = 143)	58.0% (n = 83)	23.8% (n = 34)	81.8% (n = 117)
12 months (N = 143)	83.9% (n = 120)	48.3% (n = 69)	95.8% (n = 137)
18 months (N = 143)	91.6% (n = 131)	55.9% (n = 80)	97.9% (n = 140)

Table 53. Charges Prior to BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (N = 83)	56.6% (n = 47)	25.3% (n = 21)	83.1% (n = 69)
12 months (N = 83)	83.1% (n = 69)	53.0% (n = 44)	94.0% (n = 78)
18 months (N = 83)	88.0% (n = 73)	60.2% (n = 50)	96.4% (n = 80)

Table 54. Charges Prior to BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (N = 44)	59.1% (n = 26)	27.3% (n = 12)	84.1% (n = 37)
12 months (N = 44)	86.4% (n = 38)	50.0% (n = 22)	100.0% (n = 44)
18 months (N = 44)	97.7% (n = 43)	61.4% (n = 27)	100.0% (n = 44)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 55). In the 12 months after enrollment in BHJJ, 66.1% (n = 74) of participants were charged with at least one new misdemeanor and 38.4% (n = 43) were charged with at least one new felony. More than two-thirds (67.9%; n = 76) of the youth were adjudicated delinquent in the 12 months after their enrollment in BHJJ.

Table 55. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 130)	47.7% (n = 62)	26.2% (n = 34)	40.8% (n = 53)
12 months (n = 112)	66.1% (n = 74)	38.4% (n = 43)	67.9% (n = 76)
18 months (n = 89)	76.4% (n = 68)	46.1% (n = 41)	77.5% (n = 69)

In the 12 months after enrollment in BHJJ, 77.1% (n = 27) of successful completers were charged with at least one new misdemeanor, 26.5% (n = 22) were charged with at least one new felony, and 67.7% (n = 44) were adjudicated delinquent (see Table 56). Of the youth who completed unsuccessfully, 63.1% (n = 41) were charged with at least one new misdemeanor, 54.3% (n = 19) were charged with at least one new felony, and 77.1% (n = 27) were adjudicated delinquent in the 12 months after their enrollment in BHJJ (see Table 57). Chi-square analyses revealed that **a significantly higher percentage of unsuccessful completers were charged with at least one felony than successful completers at each of the examined time points after enrollment.**

Table 56. Recidivism after BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 77)	49.4% (n = 38)	27.3% (n = 21)	40.3% (n = 31)
12 months (n = 65)	77.1% (n = 27)	26.5% (n = 22)	67.7% (n = 44)
18 months (n = 52)	76.9% (n = 40)	46.2% (n = 24)	76.9% (n = 40)

Table 57. Recidivism after BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 40)	52.5% (n = 21)	32.5% (n = 13)	47.5% (n = 19)
12 months (n = 35)	63.1% (n = 41)	54.3% (n = 19)	77.1% (n = 27)
18 months (n = 30)	80.0% (n = 24)	56.7% (n = 17)	86.7% (n = 26)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 58). In the 12 months after termination from BHJJ, 52.8% (n = 38) of youth were charged with at least one new misdemeanor and 34.7% (n = 25) were charged with at least one new felony, and 56.9% (n = 41) were adjudicated delinquent in the 12 months following their termination from BHJJ.

Table 58. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 92)	34.8% (n = 32)	19.6% (n = 18)	39.1% (n = 36)
12 months (n = 72)	52.8% (n = 38)	34.7% (n = 25)	56.9% (n = 41)
18 months (n = 56)	60.7% (n = 34)	37.5% (n = 21)	64.3% (n = 36)

In the 12 months following their termination from BHJJ, 54.3% (n = 25) of successful completers were charged with at least one new misdemeanor, 34.8% (n = 16) were charged with at least one new felony, and 58.7% (n = 27) were adjudicated delinquent (see Table 59). Of the youth who completed unsuccessfully, 48.0% (n = 12) were charged with at least one new misdemeanor, 36.0% (n = 9) were charged with at least one new felony, and 52.0% (n = 13) were adjudicated delinquent in the 12 months after their termination from BHJJ (see Table 60). Chi-square analyses showed no statistically significant differences.

Table 59. Recidivism after BHJJ Termination for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 59)	35.6% (n = 21)	20.3% (n = 12)	35.6% (n = 21)
12 months (n = 46)	54.3% (n = 25)	34.8% (n = 16)	58.7% (n = 27)
18 months (n = 34)	64.7% (n = 22)	35.3% (n = 12)	64.7% (n = 22)

Table 60. Recidivism after BHJJ Termination for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 32)	31.3% (n = 10)	18.8% (n = 6)	46.9% (n = 15)
12 months (n = 25)	48.0% (n = 12)	36.0% (n = 9)	52.0% (n = 13)
18 months (n = 21)	52.4% (n = 11)	42.9% (n = 9)	61.9% (n = 13)

ODYS Commitments

Among a total of 143 youth who enrolled since July 1, 2015, 4.2% (n = 6) were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ. **Conversely, 95.8% of youth participating in BHJJ were not admitted to an ODYS facility at any point after enrollment.**

Average Numbers of Charges and Adjudications

In addition to whether a youth was charged or adjudicated delinquent, we examined whether there were differences in the average number of charges and adjudications in equivalent periods of time prior to enrollment and after termination. We conducted paired samples *t*-tests to examine whether there were statistically significant differences in the mean number of charges and adjudications at each time period prior to and after BHJJ participation. Figure 49 shows the average number of charges for youth who had data at both time periods. This restriction resulted in a sample of 92 youth at 6 months, 72 youth at 12 months, and 56 youth at 18 months. **Paired samples *t*-tests revealed a statistically significant decline in the average number of misdemeanors for each time period and adjudications at 6 and 18 months.** For example, the average number of misdemeanor charges 18 months prior to BHJJ enrollment was 4.75 while the average number of misdemeanor charges 18 months after BHJJ termination was 1.98.

Figure 49.

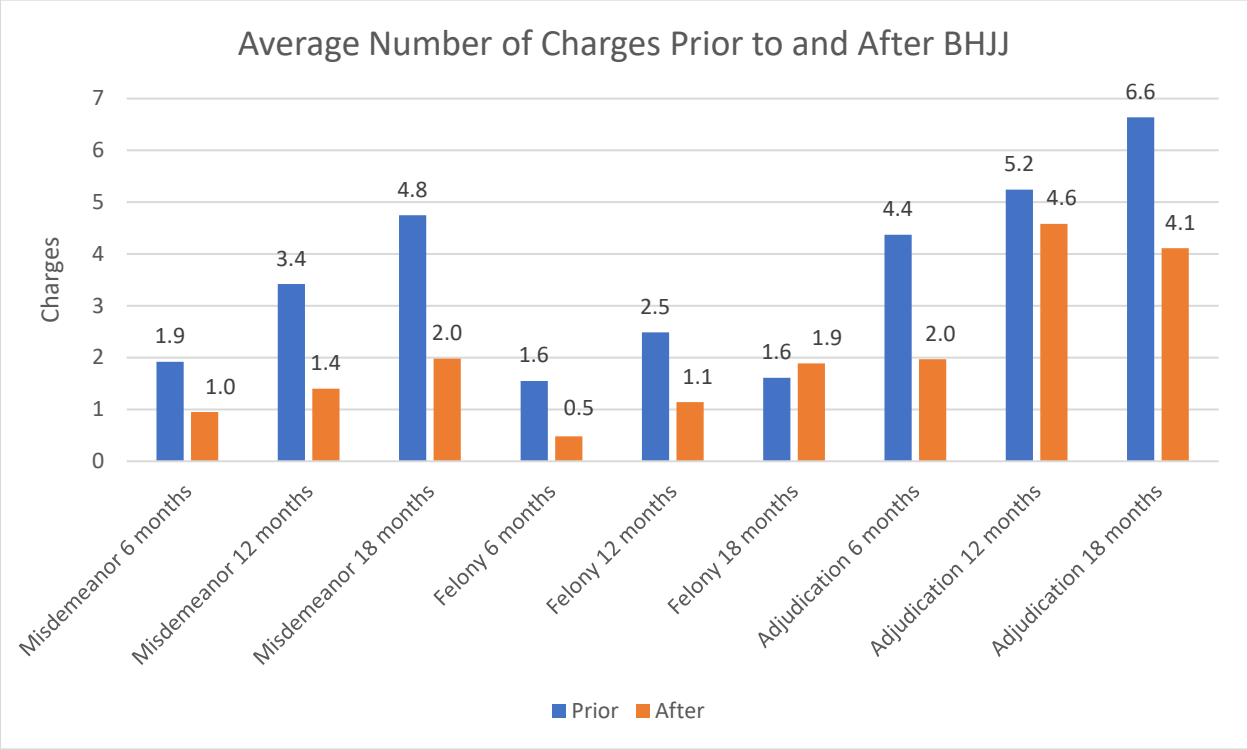


Figure 50 and Figure 51 shows mean differences in charges and adjudications for youth who successfully completed the program and those who did not successfully terminate. To be included in the analysis youth must have data at both time periods. This restricted the sample to 59 youth at 6 months, 46 youth at 12 months, and 34 youth at 18 months for youth who were successfully terminated and 32 youth at 6 months, 25 youth at 12 months, and 21 youth at 18 months for those who terminated unsuccessfully. **For youth who successfully completed, paired samples *t*-tests revealed that there was a significant reduction in the average number of misdemeanor charges in the 12 and 18 month period prior to and after BHJJ and adjudications for each of the time periods we examined.** For example, the average number of delinquent adjudications declined from 6.06 in the 18 months prior to intake to 3.62 after termination. **For youth who terminated unsuccessfully, paired samples *t*-tests revealed that there was a significant reduction in the average number of misdemeanors for each of the time periods we examined.** For example, the average number of misdemeanors was 5.67 in the 18 months prior to intake and 1 in the 18 months after termination.

Figure 50.

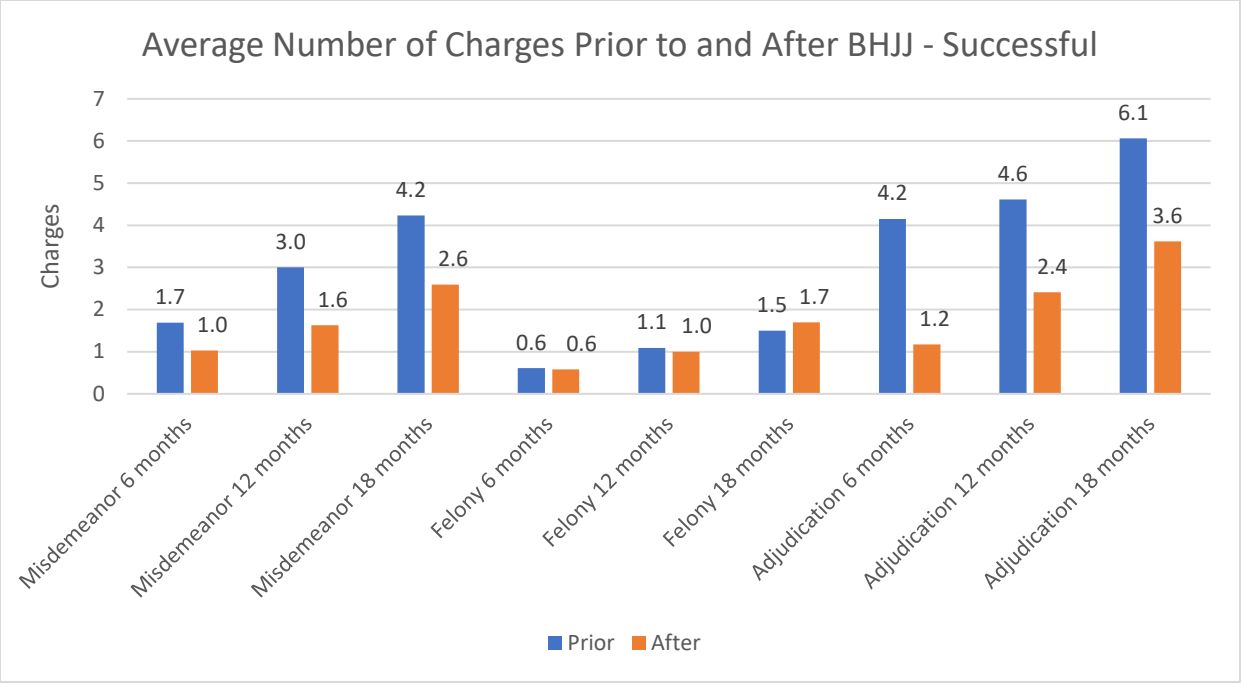
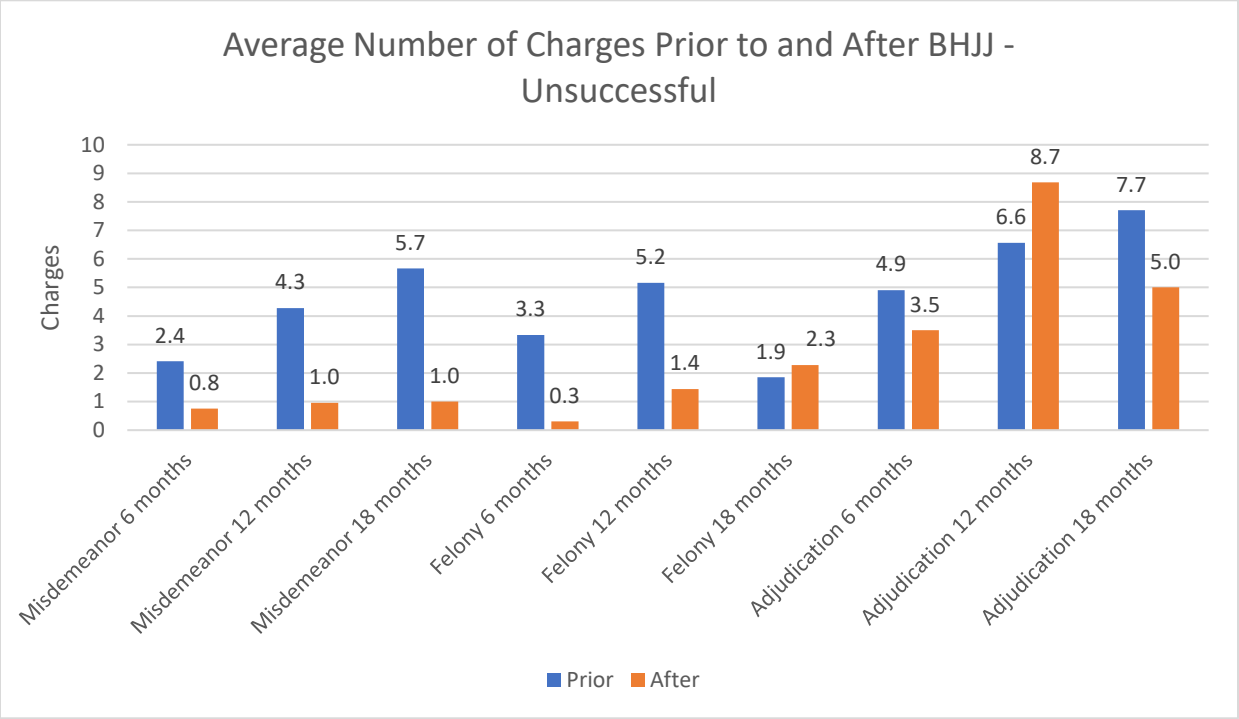


Figure 51.


Average Number of Charges Prior to and After BHJJ - Unsuccessful
Charges
10
9
8
7
6
5
4
3
2
1
0
2.4
0.8
4.3
1.0
5.7
1.0
3.3
0.3
5.2
1.4
1.9
2.3
4.9
3.5
6.6
8.7
7.7
5.0
Misdemeanor 6 months
Misdemeanor 12 months
Misdemeanor 18 months
Felony 6 months
Felony 12 months
Felony 18 months
Adjudication 6 months
Adjudication 12 months
Adjudication 18 months
Prior
After

Franklin

Demographics

As of June 30, 2019, 733 youth were enrolled into the BHJJ program in Franklin County. The average age at enrollment was 15.9 years (SD=1.44). More males (78.9%, n = 568) than females (21.1%, n = 152) have been enrolled. Black youth (56.7%, n = 407), White youth (29.8%, n = 214), and Multiracial youth (10.9%, n = 78) comprised the majority of the total sample.

There were 31 new enrollments in Franklin County during the current reporting period (July 1, 2017 through June 30, 2019). The average age at enrollment was 16.4 (SD = 1.11). Males (93.3%, n = 28) outnumbered females (6.7%, n = 2), and more Black youth (66.7%, n = 20) than White youth (33.3%, n = 10) were enrolled. Over six percent (6.7%, n = 2) of the youth self-identified as Hispanic/Latinx.

Unless otherwise noted, the following sections describe data from the past four years of BHJJ programming from July 1, 2015 through June 30, 2019.

Custody Arrangement and Household Information

At intake, the majority of youth lived with the biological mother (58.5%, n = 69), while 24.6% (n = 29) lived with two biological parents or one biological and one step/adoptive parent (see Table 61). Eighty-seven percent (87.3%, n = 103) of BHJJ youth lived with at least one biological parent at enrollment.

Eighty-six percent (86.1%; n = 99) of the BHJJ caregivers had at least a high school diploma or GED, and 12.1% (n = 14) had a bachelor's degree or higher. Nearly fourteen percent of caregivers (13.9%; n = 16) reported they did not graduate from high school (see Table 62).

Caregivers were asked to report their annual household income (see Table 63). The income range with the highest endorsement was less than $5,000 (23.5%, n = 27). Overall, 63.5% (n = 73) reported a family income of $24,999 or less. When examined by race, 30.0% (n = 9) of White families, 47.1% (n = 33) of Black families, and 58.3% (n = 7) of Multiracial families reported a household income of $14,999 or less. Table 63 displays the reported household income overall and by race.

Table 61. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	24.6% (n = 29)
Biological Mother Only	58.5% (n = 69)
Biological Father Only	4.2% (n = 5)
Adoptive Parent(s)	5.1% (n = 6)
Aunt/Uncle	0.8% (n = 1)
Grandparents	5.9% (n = 7)
Other	0.8% (n = 1)

Table 62. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	13.9% (n = 16)
High School Graduate or G.E.D.	33.9% (n = 39)
Some College or Associate Degree	40.0% (n = 46)
Bachelor's Degree	2.6% (n = 3)
More than a Bachelor's Degree	9.5% (n = 11)

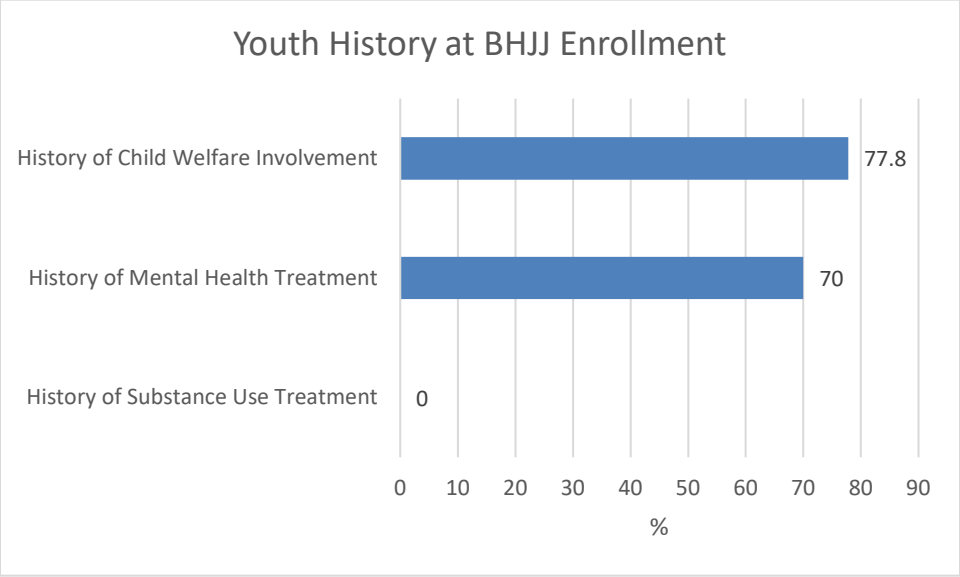
Table 63. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Black	Multiracial
Less than $5,000	23.5% (n = 27)	16.7% (n = 5)	27.1% (n = 19)	16.7% (n = 2)
$5,000 - $9,999	8.7% (n = 10)	6.7% (n = 2)	7.1% (n = 5)	25.0% (n = 3)
$10,000 - $14,999	12.2% (n = 14)	6.7% (n = 2)	12.9% (n = 9)	16.7% (n = 2)
$15,000 - $19,999	8.7% (n = 10)	6.7% (n = 2)	10.0% (n = 7)	8.3% (n = 1)
$20,000 - $24,999	10.4% (n = 12)	3.3% (n = 1)	14.3% (n = 10)	8.3% (n = 1)
$25,000 - $34,999	13.0% (n = 15)	20.0% (n = 6)	10.0% (n = 7)	8.3% (n = 1)
$35,000 - $49,999	11.3% (n = 13)	10.0% (n = 3)	14.3% (n = 10)	NA
$50,000 - $74,999	11.3% (n = 13)	30.0% (n = 9)	2.9% (n = 2)	16.7% (n = 2)
$75,000 or greater	0.9% (n = 1)	NA	1.4% (n = 1)	NA

Youth and Family History

Workers were asked to identify a youth's prior behavioral health and child welfare system involvement (see Figure 52). These three items were new to the past biennium, therefore, data are only available for youth enrolled between July 1, 2017 and June 30, 2019. Over seventy-seven percent (77.8%, n = 7) of youth had a history of child welfare involvement prior to BHJJ enrollment. None of the youth had received substance use treatment in their lifetime prior to BHJJ enrollment and 70.0% (n = 7) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 52.



Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history. Chi-square analyses were conducted to test for gender differences on each item and significant differences are identified in Table 64. A significantly larger proportion of the caregivers of females reported lifetime histories of physical abuse, sexual abuse and taking medication related to their emotional or behavioral symptoms.

Caregivers reported that 11.5% (n = 3) of females and 2.2% (n = 2) of males had a history of being physically abused while 30.8% (n = 8) of females and 3.3% (n = 3) of males had a history of being sexual abused. Caregivers of 23.1% (n = 6) of females and 10.0% (n = 9) of males reported hearing the child talking about committing suicide and 8.0% (n = 2) of females and 4.5% (n = 4) of males had attempted suicide at least once. More than half of the caregivers of females (56.0%, n = 14) and males (55.3%, n = 52) reported a family history of depression.

Table 64. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	11.5% (n = 3)*	2.2% (n = 2)
Has the child ever been sexually abused?	30.8% (n = 8)***	3.3% (n = 3)
Has the child ever run away?	48.0% (n = 12)	31.9% (n = 30)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	42.3% (n = 11)	51.1% (n = 47)
Has the child ever talked about committing suicide?	23.1% (n = 6)	10.0% (n = 9)
Has the child ever attempted suicide?	8.0% (n = 2)	4.5% (n = 4)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	15.4% (n = 4)	20.7% (n = 19)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	56.0% (n = 14)	55.3% (n = 52)
Has anyone in the child's biological family had a mental illness, other than depression?	36.0% (n = 9)	30.0% (n = 27)
Has the child ever lived in a household in which someone was convicted of a crime?	40.0% (n = 10)	32.6% (n = 30)
Has anyone in the child's biological family had a drinking or drug problem?	36.0% (n = 9)	38.0% (n = 35)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	23.1% (n = 6)*	7.9% (n = 7)

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

Problems Leading to Service

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-related problems (66.7% and 94.3% respectively) (see Table 65). Chi-square analysis indicated males had significantly higher rates of conduct/delinquency-related problems. Females had significantly higher rates of problems related to anxiety and depression.

Table 65. Problems Leading to Services

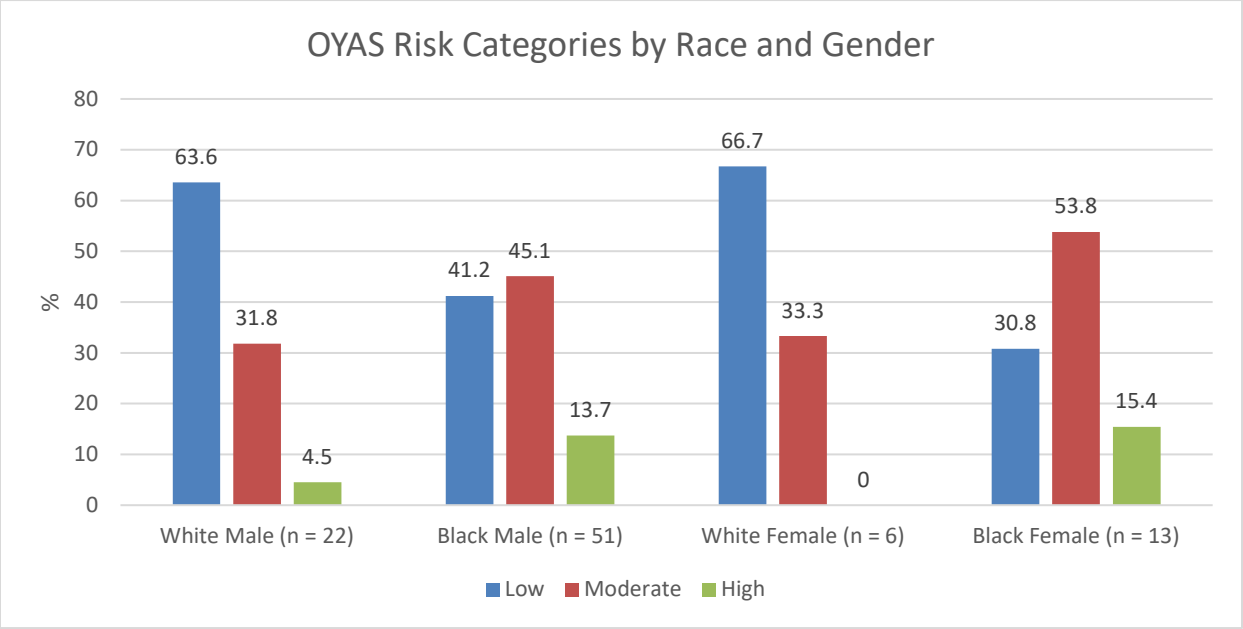
Problems Leading to Services	Females	Males
Adjustment-related problems	4.2% (n = 1)	6.8% (n = 6)
Anxiety-related problems	33.3% (n = 8)***	5.7% (n = 5)
Conduct/delinquency-related problems	66.7% (n = 16)	94.3% (n = 83)***
Depression-related problems	66.7% (n = 16)**	30.7% (n = 27)
Eating disorders	0	0
Hyperactive and attention-related problems	16.7% (n = 4)	36.4% (n = 32)
Learning disabilities	0	8.0% (n = 7)
Pervasive development disabilities	0	0
Psychotic behaviors	0	1.1% (n = 1)
School performance problems not related to learning disabilities	37.5% (n = 9)	22.7% (n = 20)
Specific developmental disabilities	0	1.1% (n = 1)
Substance use, abuse, dependence-related problems	50.0% (n = 12)	50.0% (n = 39)
Suicide-related problems	8.3% (n = 2)	6.8% (n = 6)

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

Ohio Youth Assessment System

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 53 shows the distribution of OYAS risk categories for BHJJ youth by race and gender. In Franklin County, 4.5% (n = 1) of White males and 13.7% (n = 7) of Black males enrolled in the BHJJ program were identified as High risk on the OYAS, while no White females and 15.4% (n = 2) of Black females were identified as High risk.

Figure 53.



DSM Diagnoses

Workers were asked to report any DSM 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 diagnosis for females was Disruptive Behavior Disorder while the most common diagnosis for males were Cannabis-related Disorders (see Table 66).

Chi-square analysis indicated females were significantly more likely than males to be diagnosed with Disruptive Behavior Disorder while males were significantly more likely than females to be diagnosed with Conduct Disorder.

Table 66. Most Common DSM Diagnoses

DSM Diagnosis	Females (n = 23)	Males (n = 86)
Adjustment Disorder	4.3% (n = 1)	7.0% (n = 6)
Alcohol-related Disorders	4.3% (n = 1)	1.2% (n = 1)
Attention Deficit Hyperactivity Disorder	13.0% (n = 3)	25.6% (n = 22)
Bipolar Disorder	0	0
Cannabis-related Disorders	34.8% (n = 8)	**43.0% (n = 37)**
Conduct Disorder	0	19.8% (n = 17)*
Depressive Disorders	30.4% (n = 7)	15.1% (n = 13)
Disruptive Behavior Disorder	**43.5% (n = 10)***	19.8% (n = 17)
Mood Disorder	17.4% (n = 4)*	3.5% (n = 3)
Oppositional Defiant Disorder	13.0% (n = 3)	27.9% (n = 24)
Post-traumatic Stress Disorder	4.3% (n = 1)	2.3% (n = 2)
Trauma and Stressor Related Disorder	0	2.3% (n = 2)
Disruptive Mood Dysregulation Disorder	13.0% (n = 3)	3.5% (n = 3)
Co-Occurring Disorder	34.8% (n = 8)	41.9% (n = 36)

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

Educational Information

Several items focused on educational 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. The wording on some items (e.g. IEP at intake, attendance at intake) was changed from previous versions of the forms. For those items, we present data from only the past biennium (when the new forms were in use). Those items will have smaller sample sizes compared to items that have been consistent for the past four years.

Over sixty-seven percent (67.9%, n = 72) of youth were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in BHJJ treatment BHJJ, 21.7% (n = 18) of the youth were expelled or suspended from school (a 68.0% decrease from intake to termination).

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, 70.0% (n = 7) of youth were currently attending school while at termination, 73.0% (n = 65) 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 67 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 68 displays this information based on completion status. At intake, 29.5% of youth were earning mostly A's and B's, and C's while at termination, 47.6% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 68). For example, at intake, 23.1% of youth who would go on to be unsuccessful completers and 37.5% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 12.0% of unsuccessful completers and 63.0% of successful completers received mostly A's, B's, or C's.

Table 67. Academic Performance

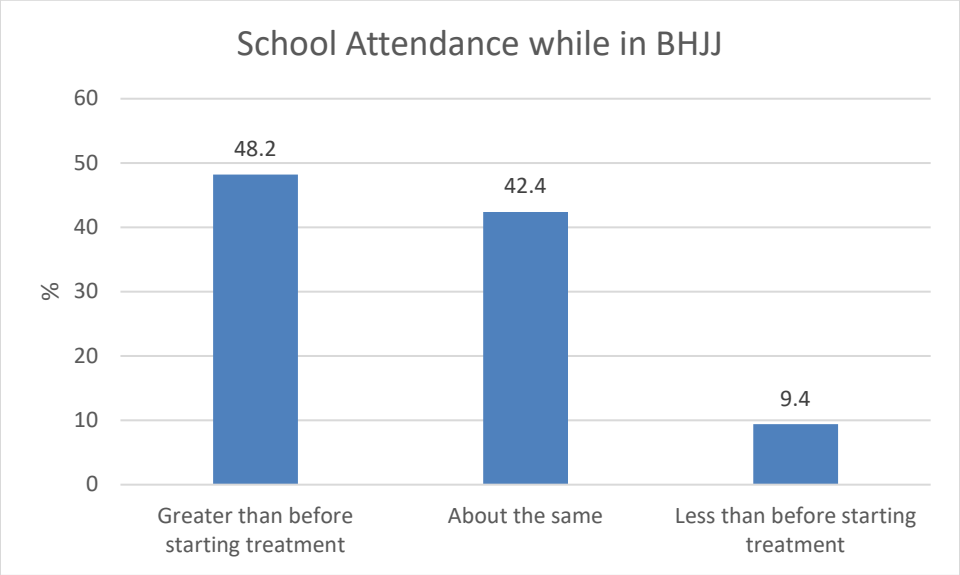
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	6.8% (n = 6)	8.8% (n = 7)
Mostly B's and C's	22.7% (n = 20)	38.8% (n = 31)
Mostly C's and D's	29.5% (n = 26)	27.5% (n = 22)
Mostly D's and F's	40.9% (n = 36)	25.0% (n = 20)

Table 68. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	0	0	10.0% (n = 4)	11.1% (n = 6)
Mostly B's and C's	23.1% (n = 6)	12.0% (n = 3)	27.5% (n = 11)	51.9% (n = 28)
Mostly C's and D's	23.1% (n = 6)	52.0% (n = 13)	35.0% (n = 14)	16.7% (n = 9)
Mostly D's and F's	53.8% (n = 14)	36.0% (n = 9)	27.5% (n = 11)	20.4% (n = 11)

At termination, workers reported that 48.2% (n = 41) of youth were attending school more than before starting treatment and 42.4% (n = 36) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 54). At intake, 50.0% (n = 5) of the youth attending school had Individualized Education Plans (IEPs) while at termination, 33.8% (n = 26) of the youth attending school had Individualized Education Plans (IEPs).

Figure 54.



Ohio Scales

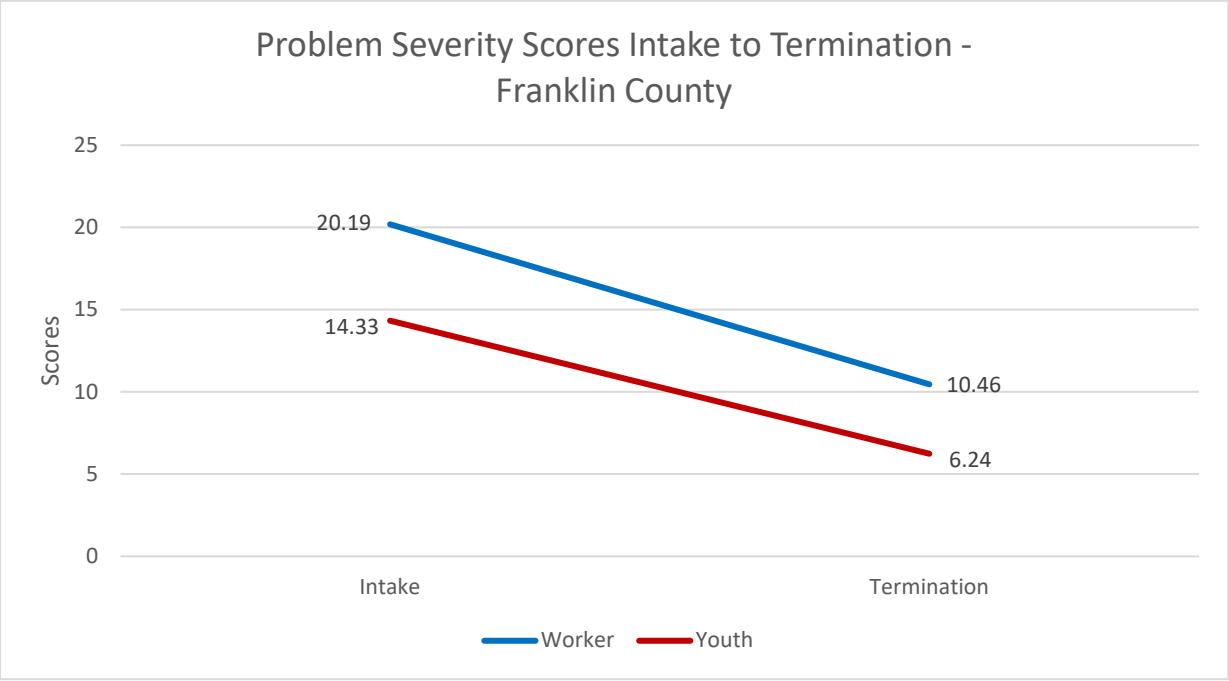
One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum of service, separate charts are included that display the means from intake to termination. Decreases in Problem Severity and increases in Functioning correspond to positive change.

All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Data at termination were available for 1 youth for the caregiver reports. Results for Franklin County will be limited to worker and youth ratings. Paired samples t-tests were used to compare Problem Severity scores at intake to Problem Severity scores at the other assessment periods. A paired samples t-test compares the means of two variables by computing the difference between the two variables for each case and testing to see if the average difference is significantly different from zero. In order for a case to be included in the analyses, the rater must have scores for both assessment periods. For example, a caregiver must supply scores for both the intake and three-month assessment period to be included in the paired samples t-test for that time point. If the caregiver only has an intake score, his or her data is not included in the analysis.

Problem Severity

Overall means for the Problem Severity scale by rater between intake and termination for Franklin County youth are presented in Figure 55.

Figure 55.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Problem Severity at each measurement interval compared to intake (see Table 69). Significant improvements were noted at three months: $t(75) = 4.51$, $p < .001$; six months: $t(37) = 2.43$, $p < .05$; and at termination $t(46) = 6.78$, $p < .001$. A moderate effect was found for the time period between intake and three months. A small effect size was found for the time period between intake to six months. A large effect size was found for the time period between intake to termination.

Table 69. Paired Samples T-Tests for Problem Severity – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	19.78 (SD=10.97; n=76)	13.25 (SD=10.35; n=76)	4.51***	.52
Intake to Six Months	18.10 (SD=10.57; n=38)	12.74 (SD=9.09; n=38)	2.43*	.39
Intake to Nine Months	17.10 (SD=9.71; n=10)	15.90 (SD=9.01; n=10)	.34	.11
Intake to Termination	21.79 (SD=10.05; n=47)	10.49 (SD=7.96; n=47)	6.78***	.99

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvements in Problem Severity at each measurement interval compared to intake (see Table 70). Significant improvements were noted at three months: $t(80) = 2.22$, $p < .05$ and at termination $t(47) = 5.95$, $p < .001$. A small effect size was found for the time period between intake to three months. A large effect size was found for the time period between intake to termination.

Table 70. Paired Samples T-Tests for Problem Severity – Youth

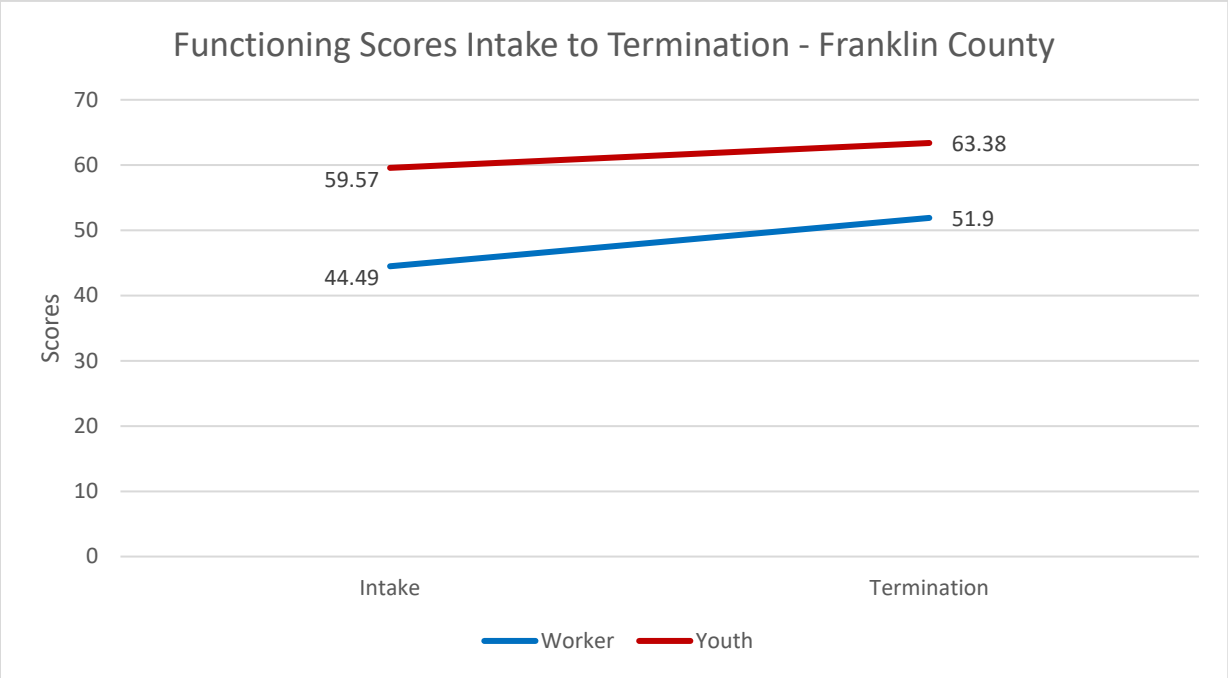
	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	13.23 (SD=10.19; n=81)	10.76 (SD=9.77; n=81)	2.22*	.25
Intake to Six Months	12.14 (SD=7.74; n=39)	8.96 (SD=7.55; n=39)	1.80	.29
Intake to Nine Months	14.13 (SD=8.84; n=10)	11.10 (SD=11.24; n=10)	.84	.26
Intake to Termination	13.94 (SD=8.49; n=48)	6.24 (SD=6.28; n=48)	5.95***	.86

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

Functioning Scores

Overall means for the Functioning scale by rater between intake and termination for Franklin County youth are presented in Figure 56.

Figure 56.



Worker Ratings

For workers, paired samples t-tests indicated significant improvement in Functioning scores from intake to termination $t(46) = -3.71$, $p < .01$ with a moderate effect size (see Table 71).

Table 71. Paired Samples T-Tests for Functioning Scores – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	42.62 (SD=11.44; n=47)	51.81 (SD=15.72; n=47)	-3.71**	.54

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

Youth Ratings

Youth reported Functioning scores indicated no statistically significant improvement from intake to termination (see Table 72).

Table 72. Paired Samples T-Tests for Functioning Scores – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	59.70 (SD=10.51; n=47)	63.19 (SD=16.70; n=47)	-1.58	.23

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

Resilience

As part of the 2017 - 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family.

Figure 57 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were “pretty much true” and “very much true”, we combined these responses. The number of valid responses for these questions was between 6 and 7. Less than half of the respondents indicated that the statements “I can work out my problems”, “I can work with someone who has different opinions than mine”, and “I feel bad when someone gets their feelings hurt” were either pretty much or very much true.

Figure 57.

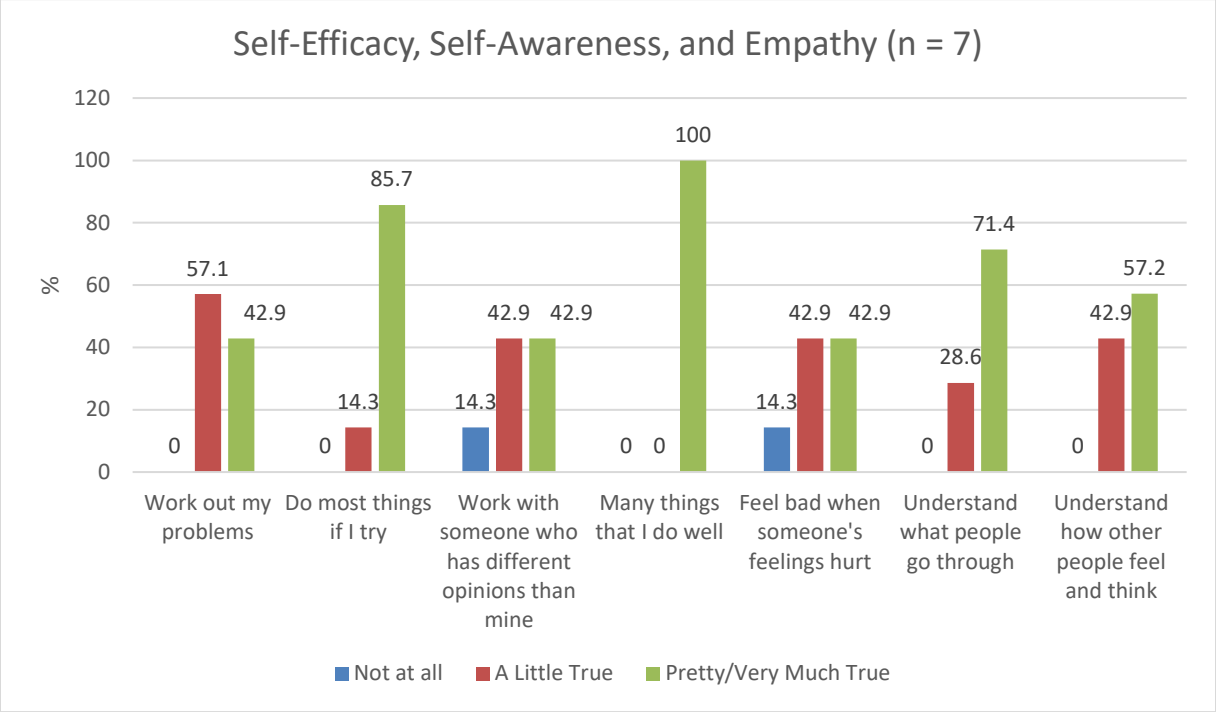


Figure 58 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. The majority of youth identified that each of the statements were either pretty much or very much true.

Figure 58.

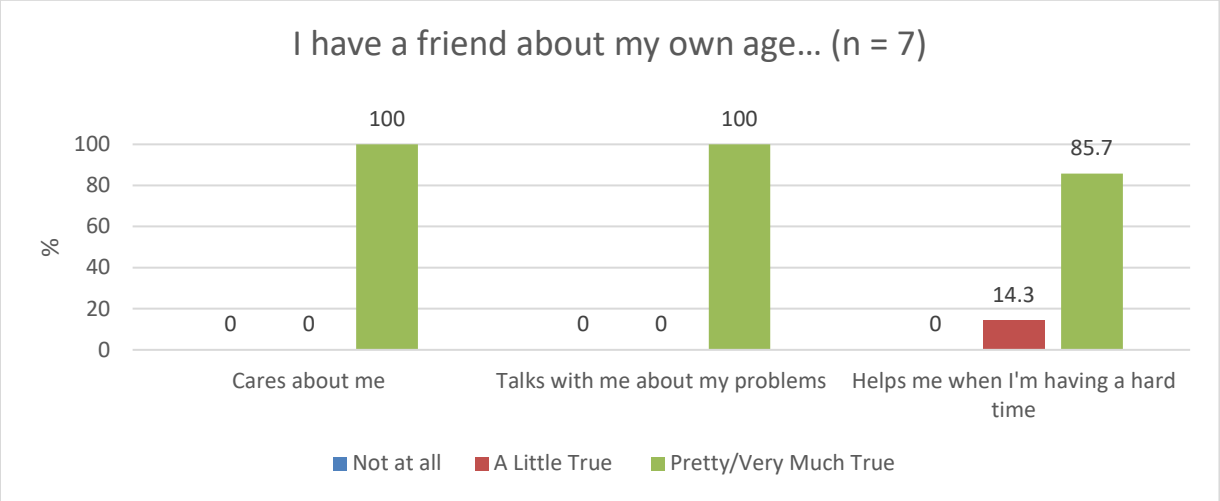
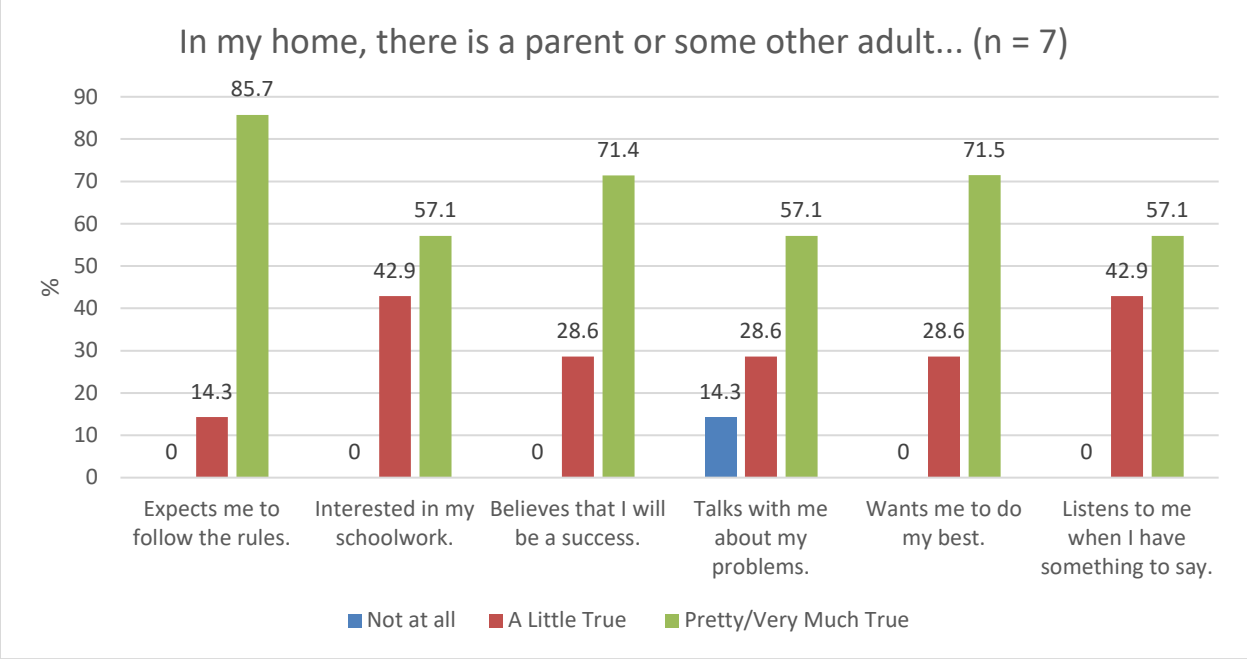


Figure 59 shows intake data on parental or support from other adults in their house. While the majority of youth identified that each of the items were either pretty much or very much true, the three items with the lowest endorsement was “interested in my school work”, “talks with me about my problems”, and “listens to me when I have something to say”.

Figure 59.



TSCC

The TSCC was administered at intake and termination from BHJJ. Paired-samples t-tests were conducted to show whether means at intake and termination on each TSCC subscale differed significantly. Data were analyzed separately for females (see Figure 60) and males (see Figure 61) who had completed the TSCC at both intake and termination in Franklin County.

Research has found that females consistently report more trauma symptoms than males (Singer et al., 1995). We examined trauma symptoms for females and males in the BHJJ sample. Consistent with previous research, BHJJ females from Franklin County reported higher scores on nearly all of the trauma symptom subscale than males. For example, at intake, the average score on the Depression domain was 6.00 for females and 3.14 for males. Paired samples t-tests revealed a significant improvement on the Anger domain at termination for males (see Table 73 and Table 74).

Table 73. TSCC Subscales from Intake to Termination among Females

Females	Intake	Termination	t	d
Anxiety	3.31 (SD = 3.86; n = 13)	2.62 (SD = 3.50; n = 13)	1.35	.37
Depression	4.62 (SD = 4.46; n = 13)	3.54 (SD = 4.82; n = 13)	1.23	.34
Anger	6.00 (SD = 4.76; n = 13)	5.46 (SD = 5.72; n = 13)	.30	.08
Posttraumatic Stress	5.08 (SD = 5.35; n = 13)	4.85 (SD = 6.27; n = 13)	.32	.09
Dissociation	4.46 (SD = 4.61; n = 13)	4.15 (SD = 5.40; n = 13)	.46	.13
Sexual Concerns	2.31 (SD = 2.72; n = 13)	1.38 (SD = 1.94; n = 13)	1.16	.32

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

Figure 60.

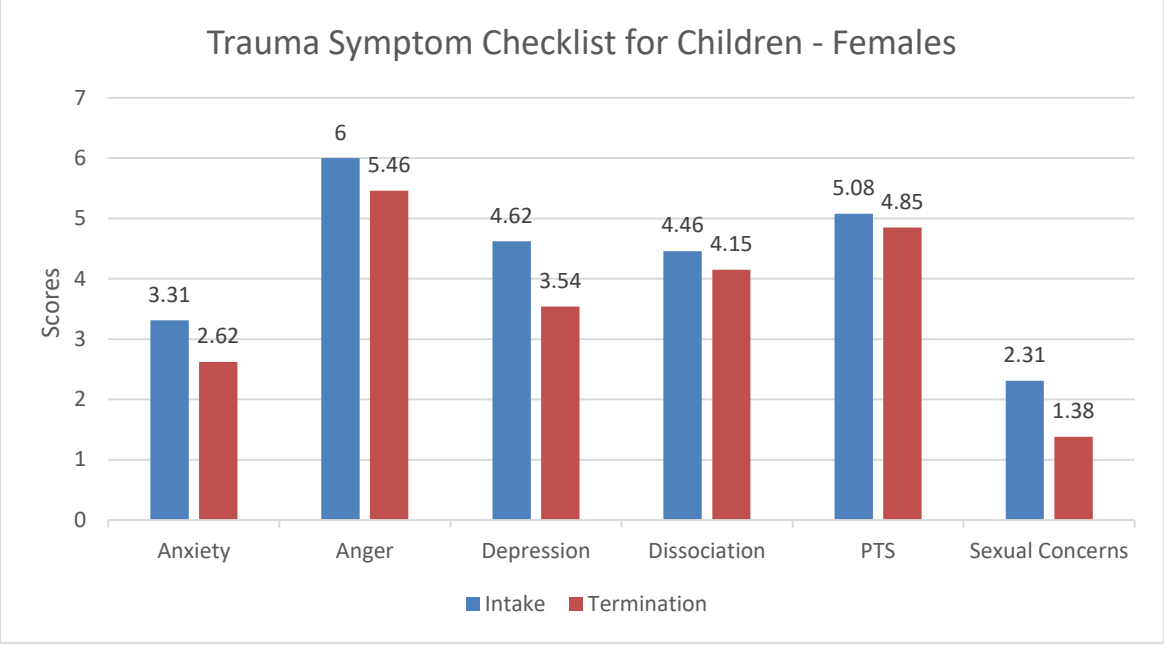
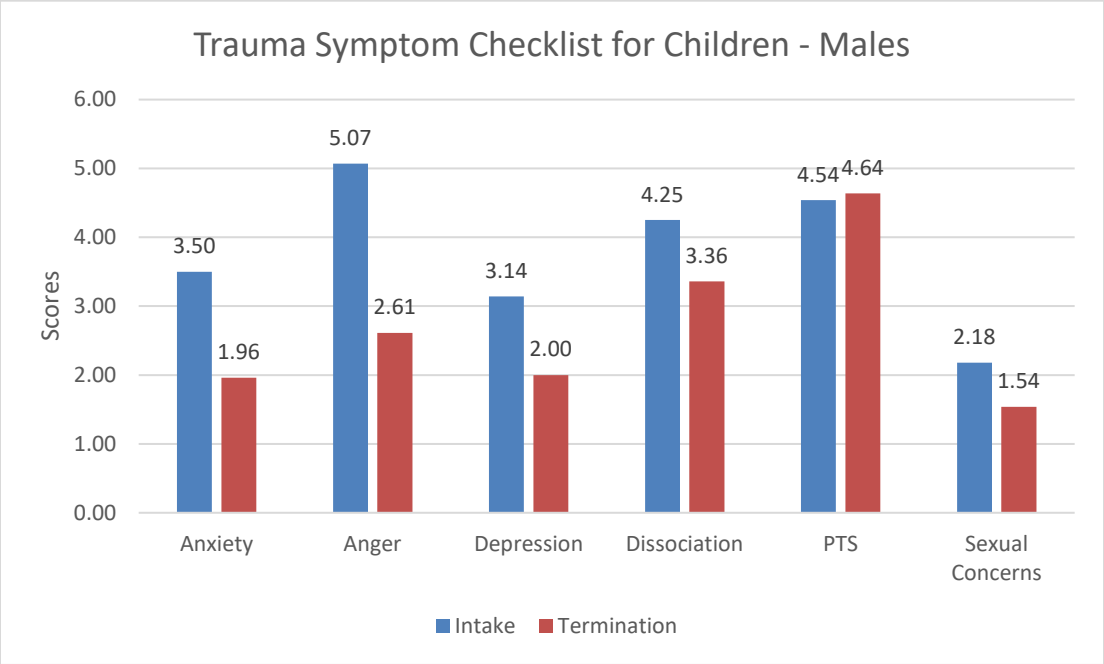


Table 74. TSCC Subscales from Intake to Termination for Males

Males	Intake	Termination	t	d
Anxiety	3.50 (SD = 4.21; n = 28)	1.96 (SD = 2.03; n = 28)	1.98	.38
Depression	3.14 (SD = 3.18; n = 28)	2.00 (SD = 1.92; n = 28)	1.97	.37
Anger	5.07 (SD = 4.47; n = 28	2.61 (SD = 2.38; n = 28)	2.96**	.56
Posttraumatic Stress	4.54 (SD = 5.04; n = 28)	4.64 (SD = 4.06; n = 28)	-.09	.02
Dissociation	4.25 (SD = 3.88; n = 28)	3.36 (SD = 3.06; n = 28)	1.19	.22
Sexual Concerns	2.18 (SD = 2.42; n = 28)	1.54 (SD = 1.60; n = 28)	1.23	.23

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

Figure 61.



Substance Use Survey

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 75 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use in Franklin County. Tobacco and cannabis were the two most commonly reported substances.

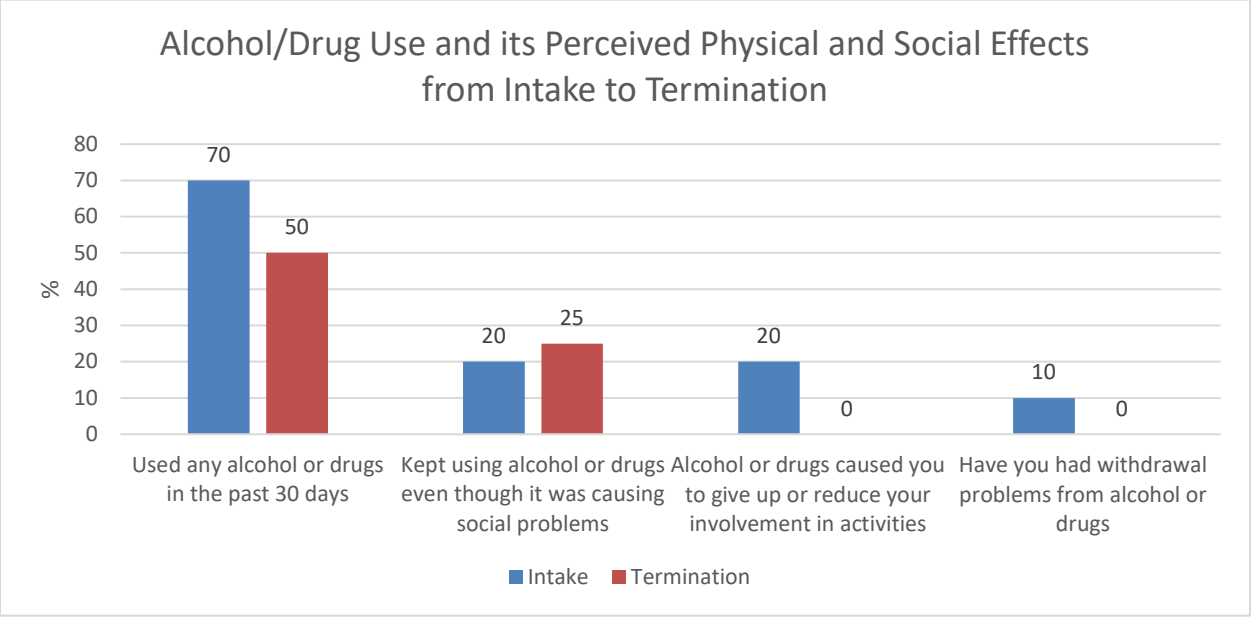
Table 75. Self-Reported Substance Use at Intake – Franklin County

	% Ever Used	Age of First Use
Alcohol	22.2% (n = 2)	12.00 (SD = 4.24)
Tobacco	55.6% (n = 5)	14.40 (SD = 1.67)
Cannabis	90.0% (n = 9)	13.44 (SD = 2.07)
Hallucinogens	10.0% (n = 1)	17.00[a]
Inhalants	0.0% (n = 0)	
Opioids	0.0% (n = 0)	
Sedatives	10.0% (n = 1)	15.00[a]
Caffeine	0.0% (n = 0)	
Stimulants	0.0% (n = 0)	
Over the counter medications	10.0% (n = 1)	12.00[a]
Other prescription drugs	0.0% (n = 0)	
Herbs/Flowers	0.0% (n = 0)	

[a] No Standard Deviations are calculated.

In addition to questions pertaining to the use of specific substances, youth were asked questions around general alcohol/drug use and its perceived effects on physical health and social functioning. For each of the items, there were 10 valid responses at intake and four at termination. The proportion of youth who indicated that they had used any alcohol or drugs in the past 30 days decreased from 70% at intake to 50% at termination (see Figure 62). From intake to termination, the proportion of youth who indicated that they had continued to use alcohol/drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people at least sometimes increased slightly while the proportion of youth who indicated having withdrawal problems from alcohol or drugs and those who indicated that alcohol/drugs caused them to give up or reduce involvement in activities at work, school, home, and social events decreased from intake to termination.

Figure 62.



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.

Between July 1, 2015 and June 30, 2019, there have been 93 youth terminated from the BHJJ program in Franklin County. Sixty-six percent (65.6%, n = 61) of the youth terminated from the BHJJ program were identified as successful treatment completers. Slightly over five percent (5.4%, n = 5) were terminated from the program due to some level of incarceration. Table 76 presents all of the reasons for termination from BHJJ and displays reasons for termination for White and Black participants.

Table 76. Reasons for Termination from BHJJ

Termination Reason	All Youth Enrolled between July 2015 and June 2019	White Youth Enrolled between July 2015 and June 2019	Black Youth Enrolled between July 2015 and June 2019
Successfully Completed Services	65.6% (n = 61)	75.0% (n = 21)	60.8% (n = 31)
Client Did Not Return/Rejected Services	3.2% (n = 3)	3.6% (n = 1)	3.9% (n = 2)
Out of Home Placement	10.8% (n = 10)	7.1% (n = 2)	13.7% (n = 7)
Client/Family Moved	1.1% (n = 1)	0	2.0% (n = 1)
Client Withdrawn	0	0	0
Client AWOL	6.5% (n = 6)	7.1% (n = 2)	3.9% (n = 2)
Client Incarcerated	5.4% (n = 5)	0	7.8% (n = 4)
Other	7.5% (n = 7)	7.1% (n = 2)	7.8% (n = 4)

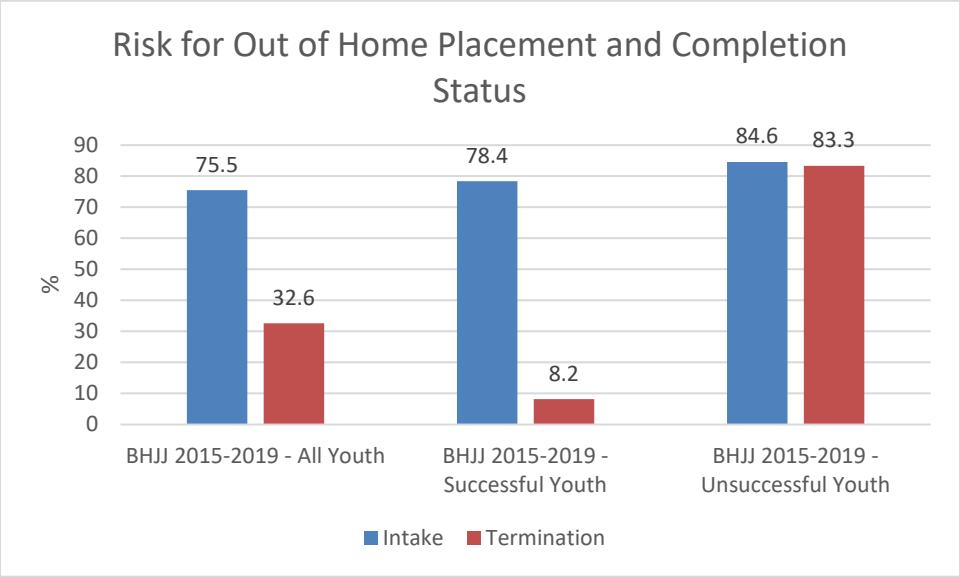
Average Length of Stay

Since the start of BHJJ, the average length of stay (ALOS) in the program was 208.5 days. For youth identified as successful treatment completers, the ALOS was 215.2 days while for unsuccessful treatment completers, the ALOS was 196.3 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, 75.5% of the youth (n = 77) were at risk for out of home placement. At termination, 32.6% (n = 30) of youth were at risk for out of home placement (see Figure 63). Of those youth who successfully completed BHJJ treatment, 8.2% (n = 5) were at risk for out of home placement at termination while 83.3% (n = 25) of youth who completed unsuccessfully were at risk for out of home placement (see Figure 63).

Figure 63.



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 services through BHJJ. Workers reported that police contacts had been reduced for 67.4% (n = 62) of the youth and had stayed the same for 9.8% (n= 9) of the youth. Police contacts increased for 20.7% (n = 19) of the youth and the worker was unable to estimate for 2.2% of youth (n = 2).

Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve months prior to the end of the data collection period for inclusion in the analysis. These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 62.8% (n = 71) of BHJJ youth in Franklin county enrolled between July 1, 2015 and June 30, 2019 had a misdemeanor charge, 70.8% (n = 80) had a felony charge, and 94.7% (n = 107) had been adjudicated delinquent in the 12 months prior to enrollment (see Table 77). Previous juvenile court information was similar for youth regardless of their completion status (successful vs. unsuccessful). In the 12 months prior to enrollment in BHJJ, 68.9% (n = 42) of successful completers and 68.8% (n = 22) of unsuccessful completers were charged with felonies (see Table 78 and Table 79). Chi-square analyses revealed no statistically significant differences based on completion status.

Table 77. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 113)	45.1% (n = 51)	52.2% (n = 59)	90.3% (n = 102)
12 months (n = 113)	62.8% (n = 71)	70.8% (n = 80)	94.7% (n = 107)
18 months (n = 113)	69.9% (n = 79)	75.2% (n = 85)	95.6% (n = 108)

Table 78. Charges Prior to BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 61)	50.8% (n = 31)	47.5% (n = 29)	90.2% (n = 55)
12 months (n = 61)	63.9% (n = 39)	68.9% (n = 42)	93.4% (n = 57)
18 months (n = 61)	72.1% (n = 44)	72.1% (n = 44)	95.1% (n = 58)

Table 79. Charges Prior to BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 32)	37.5% (n = 12)	53.1% (n = 17)	90.6% (n = 29)
12 months (n = 32)	65.6% (n = 21)	68.8% (n = 22)	93.8% (n = 30)
18 months (n = 32)	71.9% (n = 23)	75.0% (n = 24)	93.8% (n = 30)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 80). In the 12 months after enrollment in BHJJ, 44.3% (n = 35) of participants were charged with at least one new misdemeanor and 25.3% (n = 20) were charged with at least one new felony, and 57.0% (n = 45) of youth were adjudicated delinquent.

Table 80. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 95)	32.6% (n = 31)	16.8% (n = 16)	35.8% (n = 34)
12 months (n = 79)	44.3% (n = 35)	25.3% (n = 20)	57.0% (n = 45)
18 months (n = 58)	55.2% (n = 32)	34.5% (n = 20)	63.8% (n = 37)

In the 12 months after enrollment in BHJJ, 41.5% (n = 17) of successful completers were charged with at least one new misdemeanor, 22.0% (n = 9) were charged with at least one new felony, and 48.8% (n = 20) were adjudicated delinquent (see Table 81). Of the youth who completed unsuccessfully, 40.6% (n = 13) were charged with at least one new misdemeanor, 39.1% (n = 9) were charged with at least one new felony, and 69.6% (n = 16) were adjudicated delinquent in the 12 months after their enrollment in BHJJ (see Table 82). Chi-square analyses revealed that no statistically significant differences based on termination status. However, this may due to low sample sizes, particularly among the unsuccessful treatment completion group.

Table 81. Recidivism after BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 50)	34.0% (n = 17)	18.0% (n = 9)	36.0% (n = 18)
12 months (n = 41)	41.5% (n = 17)	22.0% (n = 9)	48.8% (n = 20)
18 months (n = 36)	50.0% (n = 18)	36.1% (n = 13)	61.1% (n = 22)

Table 82. Recidivism after BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 26)	38.5% (n = 10)	23.1% (n = 6)	42.3% (n = 11)
12 months (n = 23)	40.6% (n = 13)	39.1% (n = 9)	69.6% (n = 16)
18 months (n = 13)	61.5% (n = 8)	30.8% (n = 4)	76.9% (n = 10)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 83). In the 12 months after termination from BHJJ, 38.8% (n = 19) of youth were charged with at least one new misdemeanor and 22.4% (n = 11) were charged with at least one new felony, and 38.8% (n = 19) were adjudicated delinquent in the 12 months following their termination from BHJJ.

Table 83. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 60)	18.3% (n = 11)	10.0% (n = 6)	25.0% (n = 15)
12 months (n = 49)	38.8% (n = 19)	22.4% (n = 11)	38.8% (n = 19)
18 months (n = 37)	48.6% (n = 18)	27.0% (n = 10)	56.8% (n = 21)

In the 12 months following their termination from BHJJ, 34.3% (n = 12) of successful completers were charged with at least one new misdemeanor, 22.9% (n = 8) were charged with at least one new felony, and 31.4% (n = 35) were adjudicated delinquent (see Table 84). Of the youth who completed unsuccessfully, 50.0% (n = 7) were charged with at least one new misdemeanor, 43.8% (n = 14) were charged with at least one new felony, and 57.1% (n = 8) were adjudicated delinquent in the 12 months after their termination from BHJJ (see Table 85). Chi-square analyses showed no statistically significant differences.

Table 84. Recidivism after BHJJ Termination for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 38)	18.4% (n = 7)	10.5% (n = 4)	18.4% (n = 7)
12 months (n = 35)	34.3% (n = 12)	22.9% (n = 8)	31.4% (n = 35)
18 months (n = 27)	40.7% (n = 11)	25.9% (n = 7)	48.1% (n = 13)

Table 85. Recidivism after BHJJ Termination for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 21)	19.0% (n = 4)	9.5% (n = 2)	38.1% (n = 8)
12 months (n = 14)	50.0% (n = 7)	43.8% (n = 14)	57.1% (n = 8)
18 months (n = 10)	70.0% (n = 7)	30.0% (n = 3)	80.0% (n = 8)

ODYS Commitments

Among a total of 113 youth who enrolled since July 1, 2015, 2.7% (n = 3) were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ. **Conversely, 97.3% of youth participating in BHJJ were not admitted to an ODYS facility at any point after enrollment.**

Average Numbers of Charges and Adjudications

In addition to whether a youth was charged or adjudicated delinquent, we examined whether there were differences in the average number of charges and adjudications in equivalent periods of time prior to enrollment and after termination. We conducted paired samples *t*-tests to examine whether there were statistically significant differences in the mean number of charges and adjudications at each time period prior to and after BHJJ participation. Figure 64 shows the average number of charges for youth who had data at both time periods. This restriction resulted in a sample of 60 youth at 6 months, 49 youth at 12 months, and 37 youth at 18 months. **Paired samples *t*-tests revealed a statistically significant decline in the average number of felony charges and adjudications for each time period.** For example, the average number of felony charges 18 months prior to BHJJ enrollment was 1.46 while the average number of felony charges 18 months after BHJJ termination was 0.59.

Figure 64.

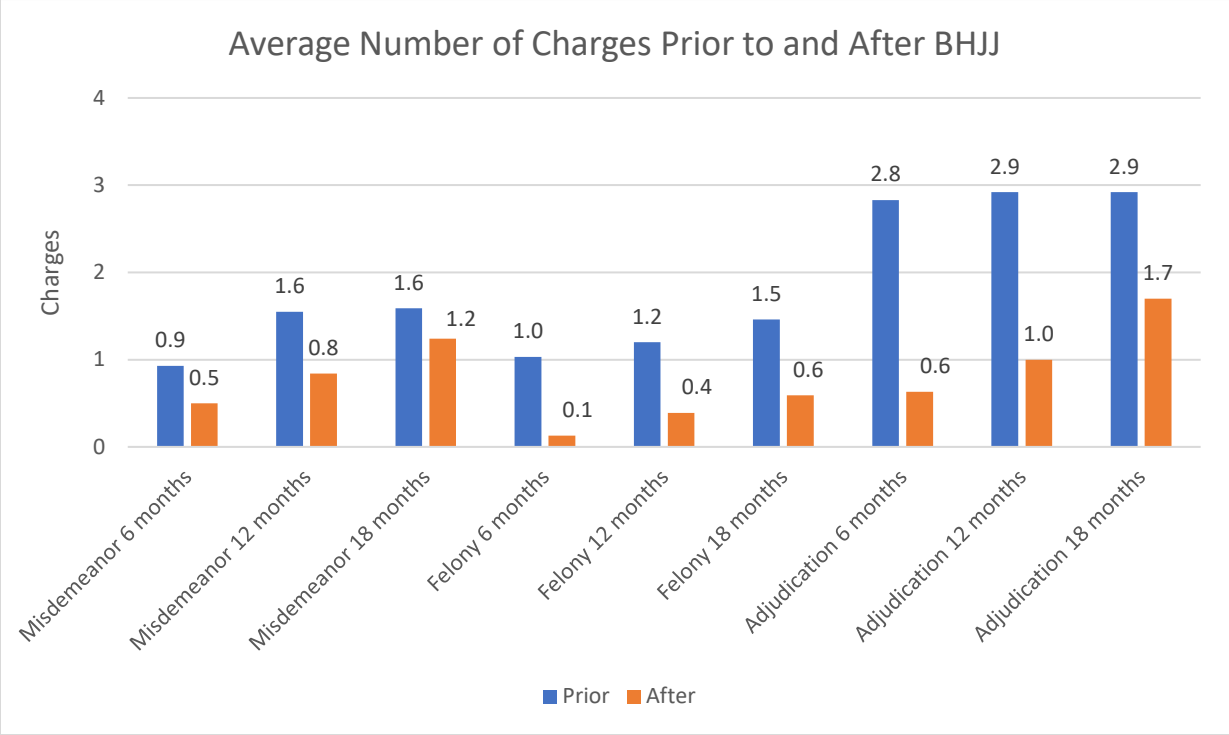


Figure 65 and Figure 66 shows mean differences in charges and adjudications for youth who successfully completed the program and those who did not successfully terminate. To be included in the analysis youth must have data at both time periods. This restricted the sample to 38 youth at 6 months, 35 youth at 12 months, and 27 youth at 18 months for youth who were successfully terminated and 21 youth at 6 months, 14 youth at 12 months, and 10 youth at 18 months for those who terminated unsuccessfully. **For youth who successfully completed, paired samples *t*-tests revealed that there was a significant reduction in the average number of misdemeanor charges, felony charges, and adjudications in each of the time periods we examined.** For example, the average number of felony charges declined from 1.06 in the 12 months prior to intake to 0.37 after termination. **For youth who terminated unsuccessfully, paired samples *t*-tests revealed that there was a significant reduction in the average number of felony charges and adjudications in the 6 months prior to intake and after termination.** For example, the average number of adjudications was 3.09 in the 6 months prior to intake and 1.24 in the 6 months after termination.

Figure 65.

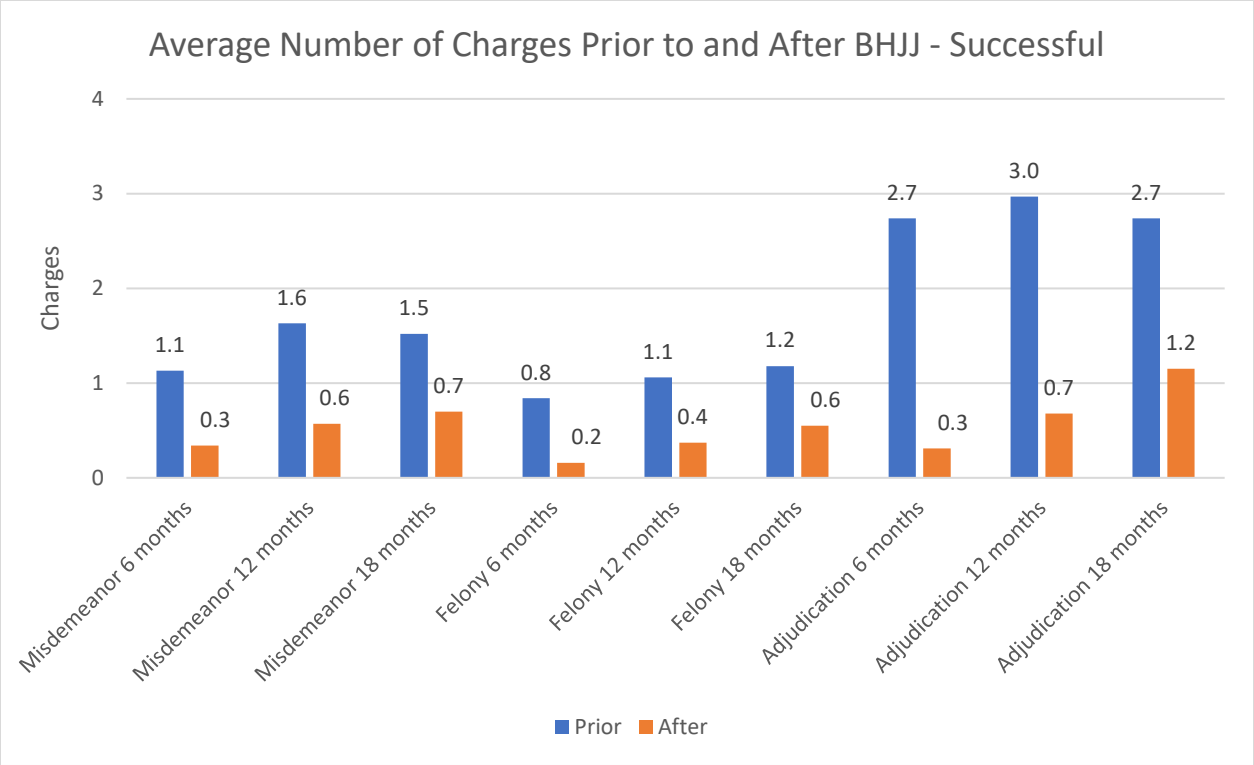
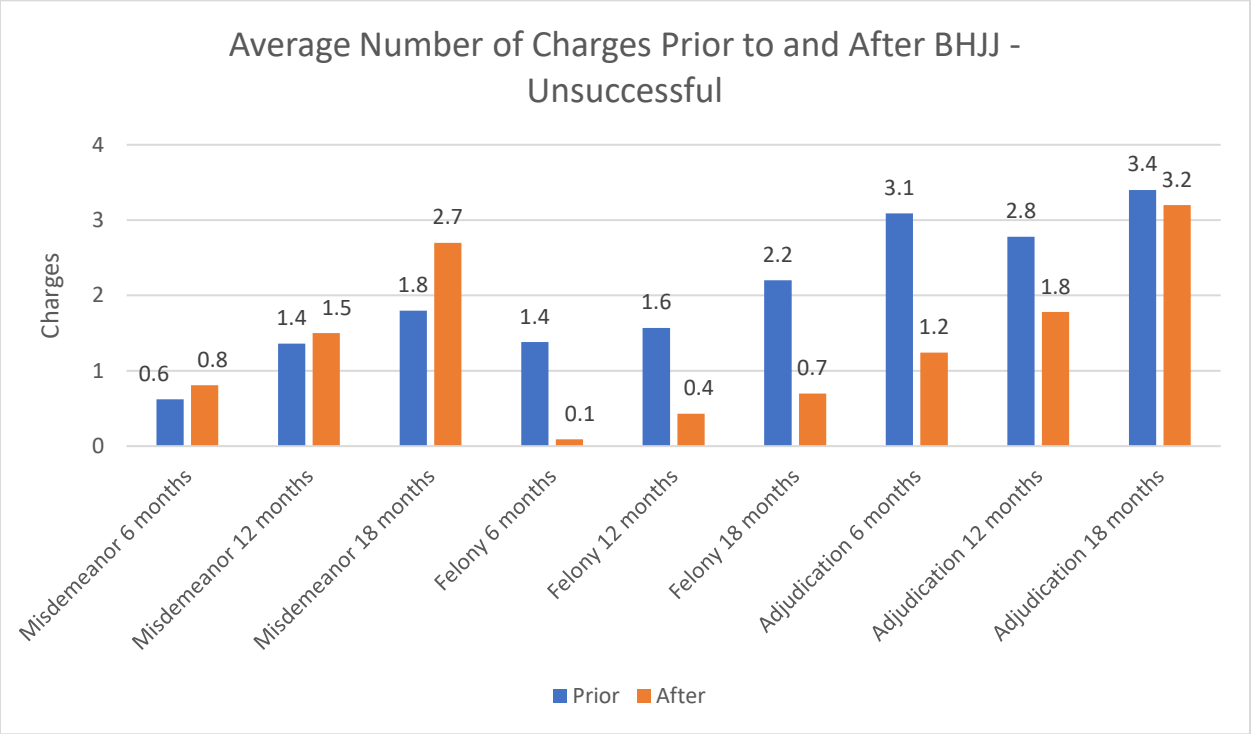


Figure 66.


Average Number of Charges Prior to and After BHJJ - Unsuccessful
Charges
0
1
2
3
4
0.6
0.8
1.4
1.5
1.8
2.7
1.4
0.1
1.6
0.4
2.2
0.7
3.1
1.2
2.8
1.8
3.4
3.2
Misdemeanor 6 months
Misdemeanor 12 months
Misdemeanor 18 months
Felony 6 months
Felony 12 months
Felony 18 months
Adjudication 6 months
Adjudication 12 months
Adjudication 18 months
Prior
After

Montgomery

Demographics

As of June 30, 2019, 2,155 youth were enrolled into the BHJJ program in Montgomery County. The average age at enrollment was 15.4 years (SD=1.74). More males (54.6%, n = 1,168) than females (45.4%, n = 970) have been enrolled. White youth (51.2%, n = 1,093), Black youth (39.1%, n = 835), and Multiracial youth (8.7%, n = 186) comprised the majority of the total sample.

There were 190 new enrollments in Montgomery County during the current reporting period (July 1, 2017 through June 30, 2019). The average age at enrollment was 14.8 (SD = 2.27). Males (62.1%, n = 118) outnumbered females (37.9%, n = 72), and more White youth (56.3%, n = 107) than Black youth (33.7%, n = 64) were enrolled. Two percent (2.1%, n = 4) of the youth self-identified as Hispanic/Latinx.

Unless otherwise noted, the following sections describe data from the past four years of BHJJ programming from July 1, 2015 through June 30, 2019.

Custody Arrangement and Household Information

At intake, the majority of youth lived with the biological mother (50.3%, n = 246), while 19.6% (n = 96) lived with two biological parents or one biological and one step/adoptive parent (see Table 86). Seventy-five percent (75.5%, n = 369) of BHJJ youth lived with at least one biological parent at enrollment.

Eighty-nine percent (89.3%; n = 425) of the BHJJ caregivers had at least a high school diploma or GED, and 14.9% (n = 71) had a bachelor's degree or higher. Over ten percent of caregivers (10.7%; n = 51) reported they did not graduate from high school (see Table 87).

Caregivers were asked to report their annual household income (see Table 88). The income range with the highest endorsement was $20,000 - $24,999 (14.6%, n = 67). Overall, 55.9% (n = 256) reported a family income of $24,999 or less. When examined by race, 27.4% (n = 68) of White families, 41.9% (n = 67) of Black families, and 36.2% (n = 17) of Multiracial families reported a household income of $14,999 or less. Table 88 displays the reported household income overall and by race.

Table 86. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	19.6% (n = 96)
Biological Mother Only	50.3% (n = 246)
Biological Father Only	5.5% (n = 27)
Adoptive Parent(s)	5.7% (n = 28)
Aunt/Uncle	3.5% (n = 17)
Grandparents	12.5% (n = 61)
Other	2.8% (n = 14)

Table 87. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	10.7% (n = 51)
High School Graduate or G.E.D.	30.3% (n = 144)
Some College or Associate Degree	44.1% (n = 210)
Bachelor's Degree	8.6% (n = 41)
More than a Bachelor's Degree	6.3% (n = 30)

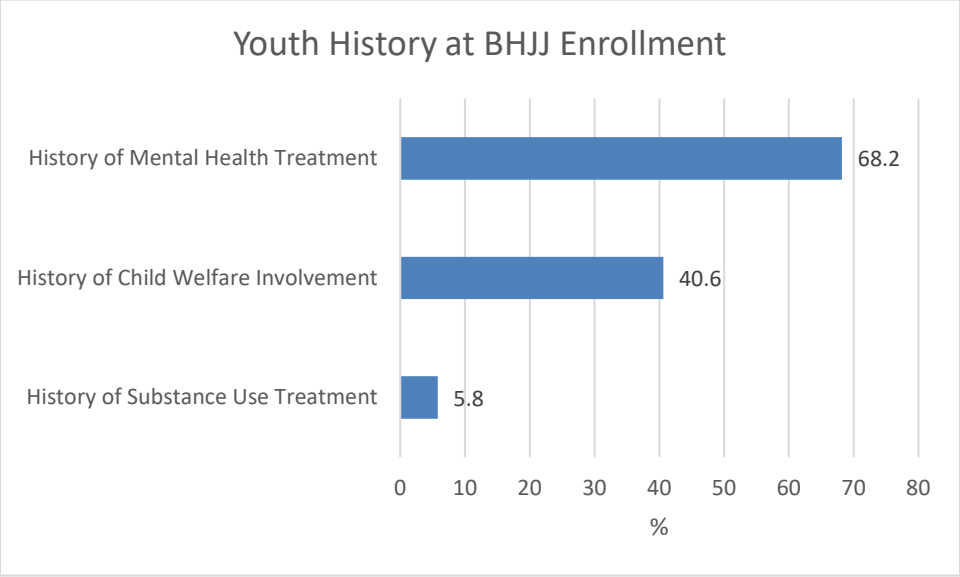
Table 88. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Black	Multiracial
Less than $5,000	13.8% (n = 63)	7.3% (n = 18)	23.8% (n = 38)	14.9% (n = 7)
$5,000 - $9,999	5.5% (n = 25)	5.2% (n = 13)	4.4% (n = 7)	8.5% (n = 4)
$10,000 - $14,999	14.4% (n = 66)	14.9% (n = 37)	13.8% (n = 22)	12.8% (n = 6)
$15,000 - $19,999	7.6% (n = 35)	6.5% (n = 16)	8.1% (n = 13)	12.8% (n = 6)
$20,000 - $24,999	14.6% (n = 67)	14.9% (n = 37)	14.4% (n = 23)	14.9% (n = 7)
$25,000 - $34,999	10.9% (n = 50)	10.1% (n = 25)	12.5% (n = 20)	10.6% (n = 5)
$35,000 - $49,999	14.0% (n = 64)	15.7% (n = 39)	11.3% (n = 18)	14.9% (n = 7)
$50,000 - $74,999	12.0% (n = 55)	14.9% (n = 37)	8.8% (n = 14)	8.5% (n = 4)
$75,000 or greater	7.2% (n = 33)	10.4% (n = 26)	3.2% (n = 5)	2.1% (n = 1)

Youth and Family History

Workers were asked to identify a youth's prior behavioral health and child welfare system involvement (see Figure 67). These three items were new to the past biennium, therefore, data are only available for youth enrolled between July 1, 2017 and June 30, 2019. Over forty percent (40.6%, n = 54) of youth had a history of child welfare involvement prior to BHJJ enrollment. Nearly six percent (5.8%, n = 8) of youth had received substance use treatment in their lifetime prior to BHJJ enrollment and 68.2% (n = 90) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 67.



Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history. Chi-square analyses were conducted on each item to test for gender differences and significant differences are identified in Table 89. A significantly larger proportion of the caregivers of females reported lifetime histories of running away, talking about suicide, and attempting suicide.

Caregivers reported that 17.5% (n = 32) of females and 15.7% (n = 46) of males had a history of being physically abused while 13.5% (n = 24) of females and 7.9% (n = 23) of males had a history of being sexual abused. Caregivers of 43.3% (n = 81) of females and 50.2% (n = 150) of males reported hearing the child talking about committing suicide and 21.4% (n = 39) of females and 8.4% (n = 25) of males had attempted suicide at least once. A majority of the caregivers of females (63.1%, n = 118) and males (68.4%, n = 201) reported a family history of depression. More than half of the caregivers of females (56.4%, n = 106) and males (53.6%, n = 156) reported a family history of problems with substance use.

Table 89. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	17.5% (n = 32)	15.7% (n = 46)
Has the child ever been sexually abused?	13.5% (n = 24)	7.9% (n = 23)
Has the child ever run away?	56.7% (n = 106)*	46.0% (n = 138)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	43.3% (n = 81)	50.2% (n = 150)
Has the child ever talked about committing suicide?	48.4% (n = 90)**	35.6% (n = 106)
Has the child ever attempted suicide?	21.4% (n = 39)***	8.4% (n = 25)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	32.1% (n = 60)	38.5% (n = 114)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	63.1% (n = 118)	68.4% (n = 201)
Has anyone in the child's biological family had a mental illness, other than depression?	54.1% (n = 100)	54.2% (n = 156)
Has the child ever lived in a household in which someone was convicted of a crime?	39.2% (n = 73)	35.6% (n = 104)
Has anyone in the child's biological family had a drinking or drug problem?	56.4% (n = 106)	53.6% (n = 156)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	37.4% (n = 70)	35.4% (n = 104)

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

Problems Leading to Service

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-related related problems (84.7% and 83.7% respectively) (see Table 90). Chi-square analyses indicated females had significantly higher rates of problems related to anxiety and depression. Males had significantly higher rates of hyperactive and attention-related problems.

Table 90. Problems Leading to Services

Problems Leading to Services	Females	Males
Adjustment-related problems	7.1% (n = 13)	7.8% (n = 23)
Anxiety-related problems	30.6% (n = 56)**	18.4% (n = 54)
Conduct/delinquency-related problems	84.7% (n = 155)	83.7% (n = 246)
Depression-related problems	39.3% (n = 72)**	24.8% (n = 73)
Eating disorders	1.1% (n = 2)	0
Hyperactive and attention-related problems	21.3% (n = 39)	43.9% (n = 129)***
Learning disabilities	4.4% (n = 8)	4.8% (n = 14)
Pervasive development disabilities	2.2% (n = 4)	3.1% (n = 9)
Psychotic behaviors	0	1.0% (n = 3)
School performance problems not related to learning disabilities	8.2% (n = 15)	11.9% (n = 35)
Specific developmental disabilities	2.7% (n = 5)	3.1% (n = 9)
Substance use, abuse, dependence-related problems	29.4% (n = 40)	37.8% (n = 82)
Suicide-related problems	4.4% (n = 8)	2.7% (n = 8)

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

DSM Diagnoses

Workers were asked to report any DSM 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 diagnosis for females was Oppositional Defiant Disorder while the most common diagnosis for males was Attention Deficit Hyperactivity Disorder (see Table 91).

Chi-square analysis indicated females were significantly more likely than males to be diagnosed with Bipolar Disorder, Depressive Disorders, and Post-traumatic Stress Disorder while males were significantly more likely than females to be diagnosed with Conduct Disorder, Attention Deficit Hyperactivity Disorder, and Cannabis-related Disorders.

Table 91. Most Common DSM Diagnoses

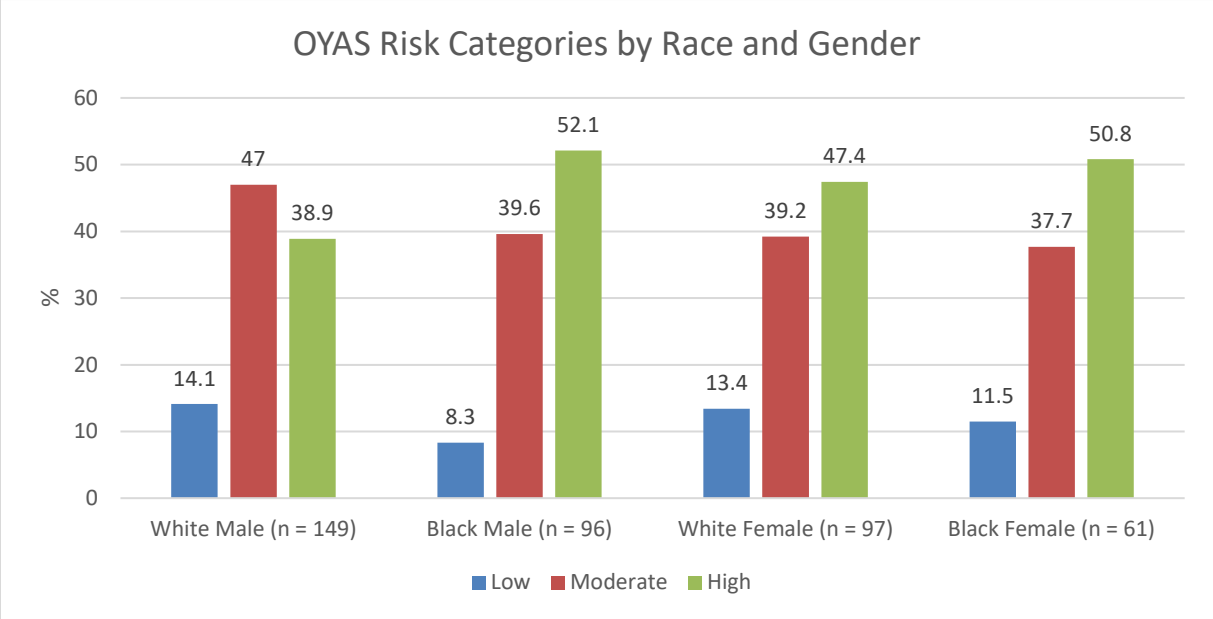
DSM Diagnosis	Females (n = 168)	Males (n = 272)
Adjustment Disorder	4.8% (n = 8)	4.4% (n = 12)
Alcohol-related Disorders	6.5% (n = 11)	4.4% (n = 12)
Attention Deficit Hyperactivity Disorder	28.0% (n = 47)	**50.7% (n = 138)*** **
Bipolar Disorder	5.4% (n = 9)*	1.8% (n = 5)
Cannabis-related Disorders	26.2% (n = 44)	36.8% (n = 100)*
Conduct Disorder	5.4% (n = 9)	15.4% (n = 42)***
Depressive Disorders	25.0% (n = 42)***	12.5% (n = 34)
Disruptive Behavior Disorder	0.6% (n = 1)	0.4% (n = 1)
Mood Disorder	10.7% (n = 18)	3.5% (n = 3)
Oppositional Defiant Disorder	**45.8% (n = 77)**	44.1% (n = 120)
Post-traumatic Stress Disorder	13.7% (n = 23)**	5.1% (n = 14)
Trauma and Stressor Related Disorder	0	0
Disruptive Mood Dysregulation Disorder	14.8% (n = 8)	8.1% (n = 22)
Co-Occurring Disorder	28.0% (n = 47)	34.2% (n = 93)

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

Ohio Youth Assessment System

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 68 shows the distribution of OYAS risk categories for BHJJ youth by race and gender. In Montgomery County, 38.9% (n = 58) of White males and 52.1% (n = 50) of Black males enrolled in the BHJJ program were identified as High risk on the OYAS, while 47.4% (n = 46) of White females and 50.8% (n = 31) of Black females were identified as High risk.

Figure 68.



Educational Information

Several items focused on educational 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. The wording on some items (e.g. IEP at intake, attendance at intake) was changed from previous versions of the forms. For those items, we present data from only the past biennium (when the new forms were in use). Those items will have smaller sample sizes compared to items that have been consistent for the past four years.

Over fifty-nine percent (59.7%, n = 280) of youth were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in BHJJ treatment BHJJ, 30.3% (n = 110) of the youth were expelled or suspended from school (a 49.2% decrease from intake to termination).

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, 91.1% (n = 92) of youth were currently attending school while at termination, 77.4% (n = 267) 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 92 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 93 displays this information based on completion status. At intake, 40.5% of youth were earning mostly A's and B's, and C's while at termination, 48.3% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 93). For example, at intake, 29.7% of youth who would go on to be unsuccessful completers and 44.6% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 32.8% of unsuccessful completers and 57.8% of successful completers received mostly A's, B's, or C's.

Table 92. Academic Performance

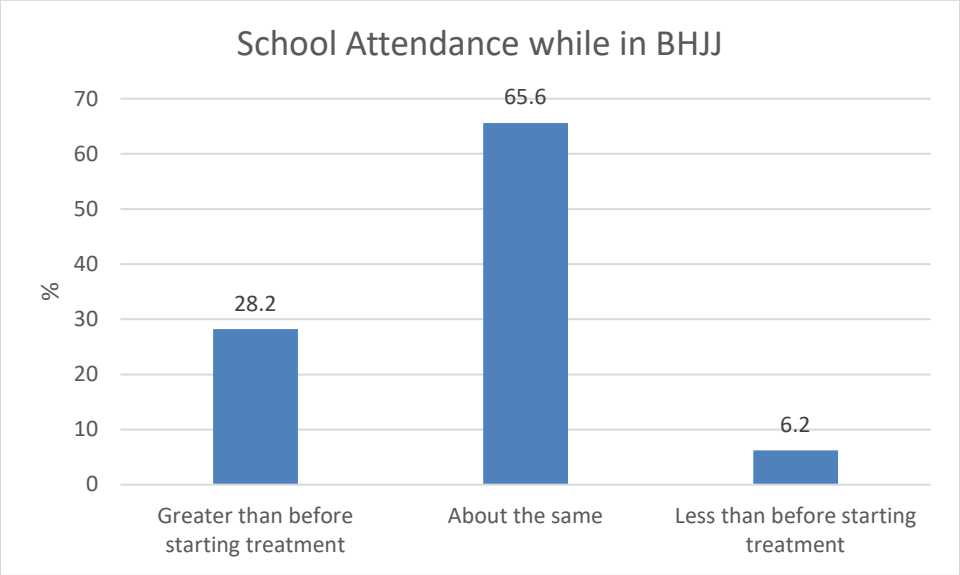
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	17.7% (n = 79)	18.9% (n = 63)
Mostly B's and C's	22.8% (n = 102)	29.4% (n = 98)
Mostly C's and D's	30.2% (n = 135)	35.1% (n = 117)
Mostly D's and F's	29.3% (n = 131)	16.5% (n = 55)

Table 93. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	15.3% (n = 18)	9.6% (n = 12)	19.6% (n = 40)	24.8% (n = 51)
Mostly B's and C's	14.4% (n = 17)	23.2% (n = 29)	25.0% (n = 51)	33.0% (n = 68)
Mostly C's and D's	28.8% (n = 34)	36.0% (n = 45)	28.9% (n = 59)	34.5% (n = 71)
Mostly D's and F's	41.5% (n = 49)	31.2% (n = 39)	26.5% (n = 54)	7.8% (n = 16)

At termination, workers reported that 28.2% (n = 95) of youth were attending school more than before starting treatment and 65.6% (n = 221) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 69). At intake, 34.2% (n = 39) of the youth attending school had Individualized Education Plans (IEPs) while at termination, 34.2% (n = 121) of the youth attending school had Individualized Education Plans (IEPs).

Figure 69.



Ohio Scales

One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum of service, separate charts are included that display the means from intake to termination. Decreases in Problem Severity and increases in Functioning correspond to positive change.

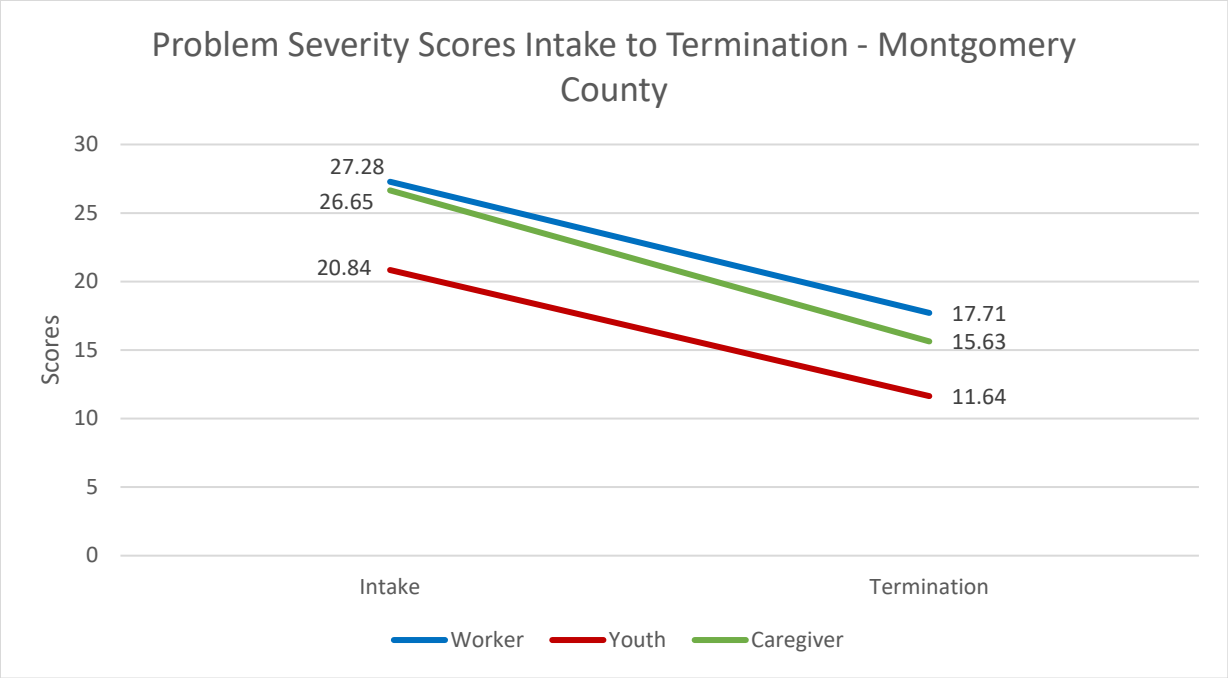
All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Results for Montgomery County will be limited to intake and termination data.

Paired samples t-tests were used to compare Problem Severity scores at intake to Problem Severity scores at termination. 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 termination to be included in the analysis. If the caregiver only has an intake score, his or her data is not included.

Problem Severity

Overall means for the Problem Severity scale by rater between intake and termination for Montgomery County youth are presented in Figure 70.

Figure 70.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Problem Severity from intake to termination $t(353) = 11.82$, $p < .001$ with a moderate effect size (see Table 94).

Table 94. Paired Samples T-Tests for Problem Severity – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	27.63 (SD=14.83; n=354)	17.89 (SD=13.96; n=354)	11.82***	.63

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvements in Problem Severity from intake to termination $t(218) = 9.80$, $p < .001$ with a moderate effect size (see Table 95).

Table 95. Paired Samples T-Tests for Problem Severity – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	19.11 (SD=13.46; n=219)	11.53 (SD=10.44; n=219)	9.80***	.66

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Problem Severity from intake to termination $t(217) = 9.01$, $p < .001$ with a moderate effect size (see Table 96).

Table 96. Paired Samples T-Tests for Problem Severity – Caregiver

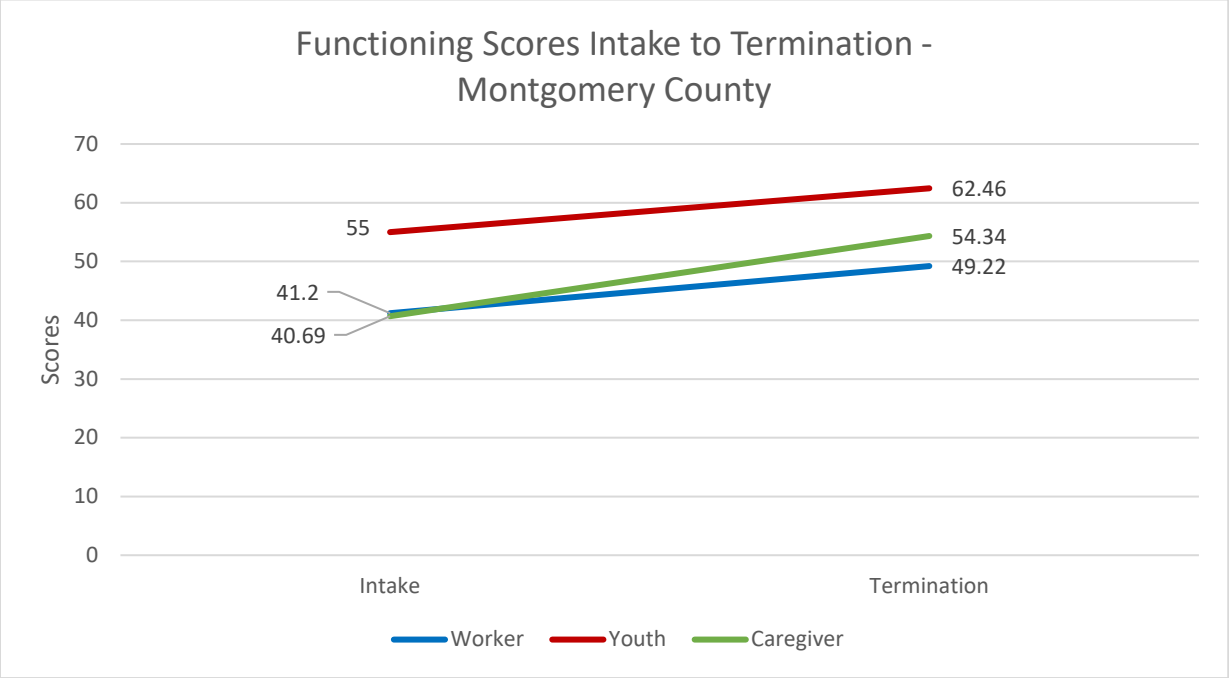
	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	24.05 (SD=16.61; n=218)	14.96 (SD=14.43; n=218)	9.01***	.61

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

Functioning Scores

Overall means for the Functioning scale by rater between intake and termination for Montgomery County youth are presented in Figure 71.

Figure 71.



Worker Ratings

For workers, paired samples t-tests indicated significant improvement in Functioning scores from intake to termination $t(351) = -9.34$, $p < .001$ with a moderate effect size (see Table 97).

Table 97. Paired Samples T-Tests for Functioning Scores – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	41.07 (SD=11.97; n=352)	49.01 (SD=15.42; n=352)	-9.34***	.50

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvement in Functioning scores from intake to termination $t(218) = -8.13$, $p < .001$ with a moderate effect size (see Table 98).

Table 98. Paired Samples T-Tests for Functioning Scores – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	55.78 (SD=12.90; n=219)	62.54 (SD=13.44; n=219)	-8.13***	.55

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements Functioning scores from intake to termination $t(217) = -10.66$, $p < .001$ with a moderate effect size (see Table 99).

Table 99. Paired Samples T-Tests for Functioning Scores – Caregiver

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	43.23 (SD=16.06; n=218)	54.82 (SD=18.09; n=218)	-10.66***	.72

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

Violence and Delinquency Questionnaire

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey composed of three general domains: exposure to violence, violence perpetration, and peer delinquency. The VDQ is offered at intake and termination into the BHJJ program. At intake, each item prompts the youth to answer within the context of the past year. At termination, youth are directed to answer "since the last time you answered these questions".

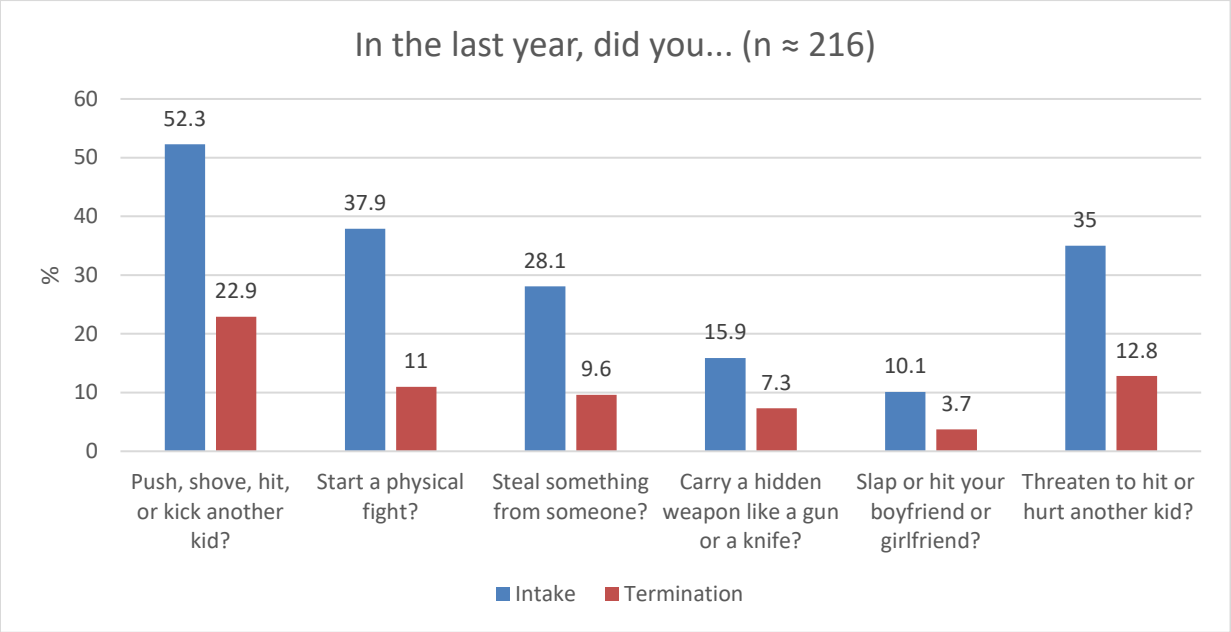
This section will be divided into three distinct parts that examine the prevalence of violence exposure as either a victim or witness, self-reported delinquent behavior from intake to termination, and delinquent behavior by peers from intake to termination. Table 100 provides the percentage of those who had experienced violence as either a victim or witness in the past year.

Table 100. Violence Exposure

	% Yes BHJJ Sample (n = 488)
In the last year, did someone threaten to hurt you when you thought they might really do it?	38.4%
In the last year, have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?	10.5%
In the last year, did a boyfriend or girlfriend or anyone you went on a date with slap or hit you?	9.4%
In the last year, did anyone steal anything from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?	43.6%
Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	14.4%
In the last year, did anyone hit or attack you WITHOUT using an object or weapon?	35.3%
In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?	25.8%
In the last year, did a grown-up touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?	4.8%
Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. In the last year, did another child or teen make you do sexual things?	4.3%
In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	12.2%
In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	23.7%
In the last year, in real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt them?	35.9%
In the last year, was anyone close to you murdered, like a friend, neighbor, or someone in your family?	20.5%
In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	34.6%
Not including spanking on your bottom, did a grown-up in your life hit, beat, kick or physically hurt you in any way?	22.5%
When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. In the last year, were you neglected?	12.1%

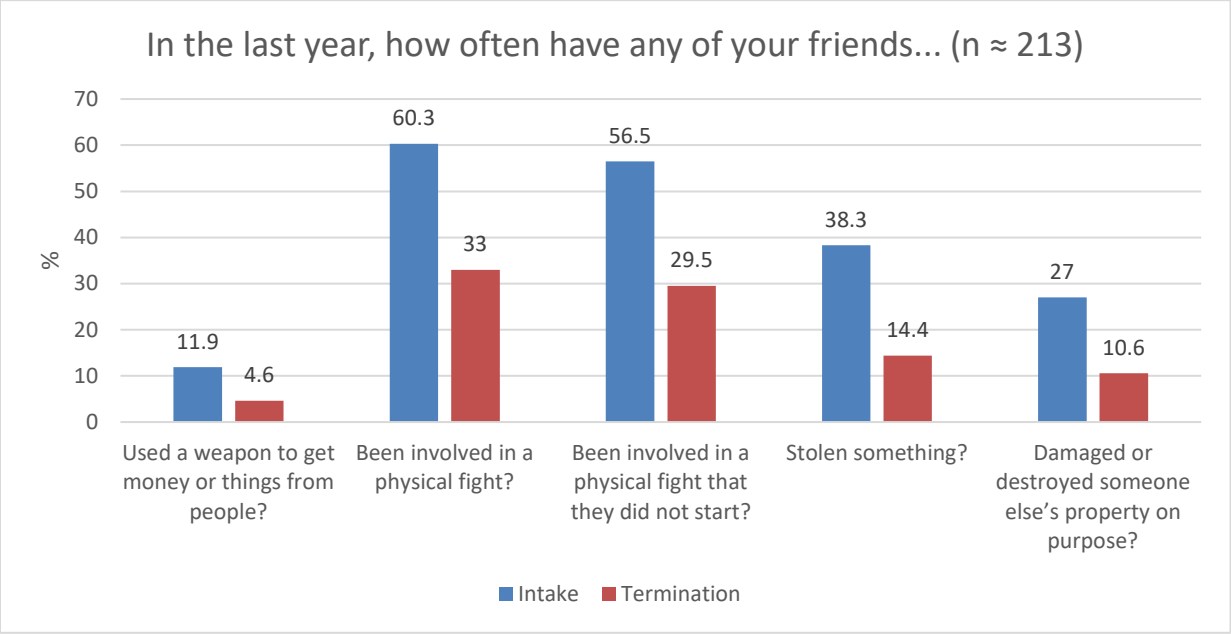
Delinquent behaviors were measured as self-report items of violent and weapon carrying behaviors as well as stealing. At intake, youth were asked how often they engaged in each behavior in the last year while at termination, youth were asked how often they engaged in the behavior since the last time they were asked. Figure 72 presents the percentage of youth who identified that they had engaged in each type of behavior at least once. Depending on the item, data were available for a range between 213 and 217 matched pairs (Mode = 216). McNemar's tests revealed statistically significant improvements from intake to termination for five items: push, shove, hit, or kick another kid, start a physical fight, steal something from someone, slap or hit your boyfriend or girlfriend, and threaten to hit or hurt another kid.

Figure 72.



Self-reported peer delinquency was also measured at intake (how often in the last year) and at termination (how often since the last time they were asked). Figure 73 presents the percentage of youth who identified how often their friends had engaged in delinquent behavior at intake and termination. Depending on the item, data were available for a range between 212 and 215 matched pairs (Mode = 213). Statistically significant differences were found for each of the items between intake and termination.

Figure 73.



Resilience

As part of the 2017 - 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family.

Figure 74 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were “pretty much true” and “very much true”, we combined these responses. The number of valid responses for these questions was between 141 and 142. Generally, the majority of youth indicated high levels of endorsement for each one of these items. It is important to note, that the largest proportion of youth responding “not at all” or “a little true” were for two of the three items that measure empathy including “I feel bad when someone gets their feelings hurt” and “I try to understand how other people feel and think”.

Figure 74.

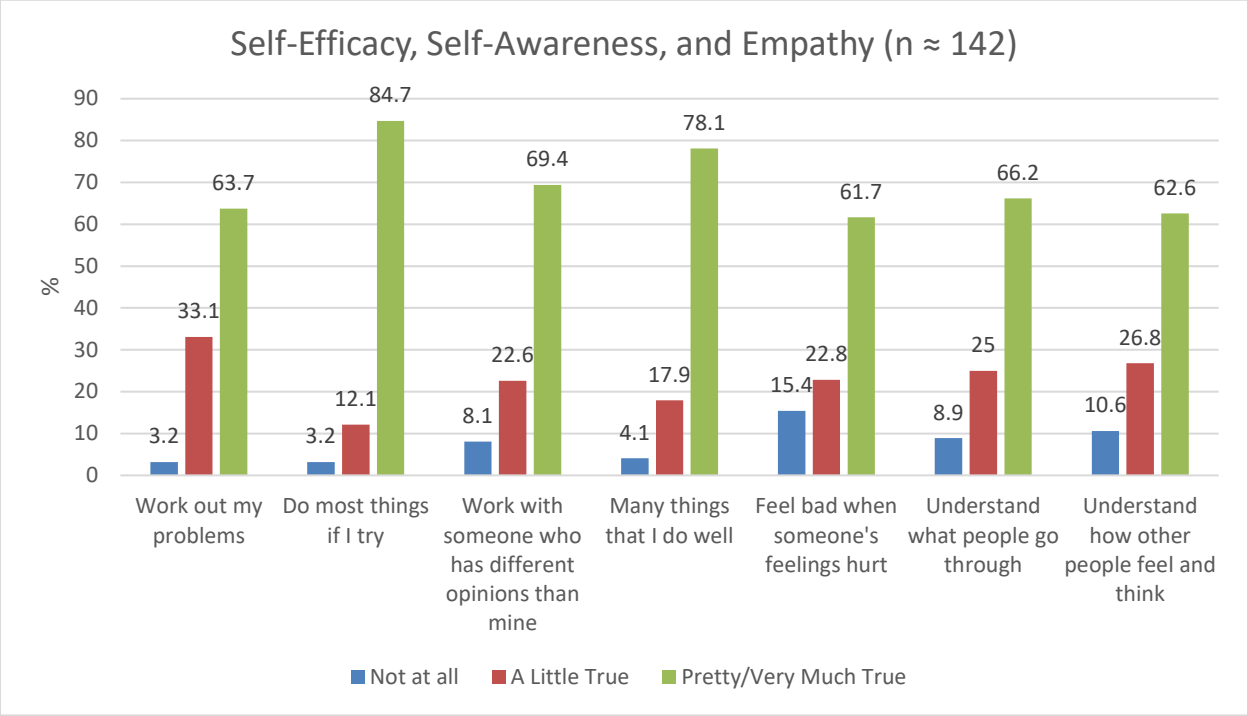


Figure 75 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. There were 141 valid responses for the three items. The majority of youth identified that each of the statements were either pretty much or very much true.

Figure 75.

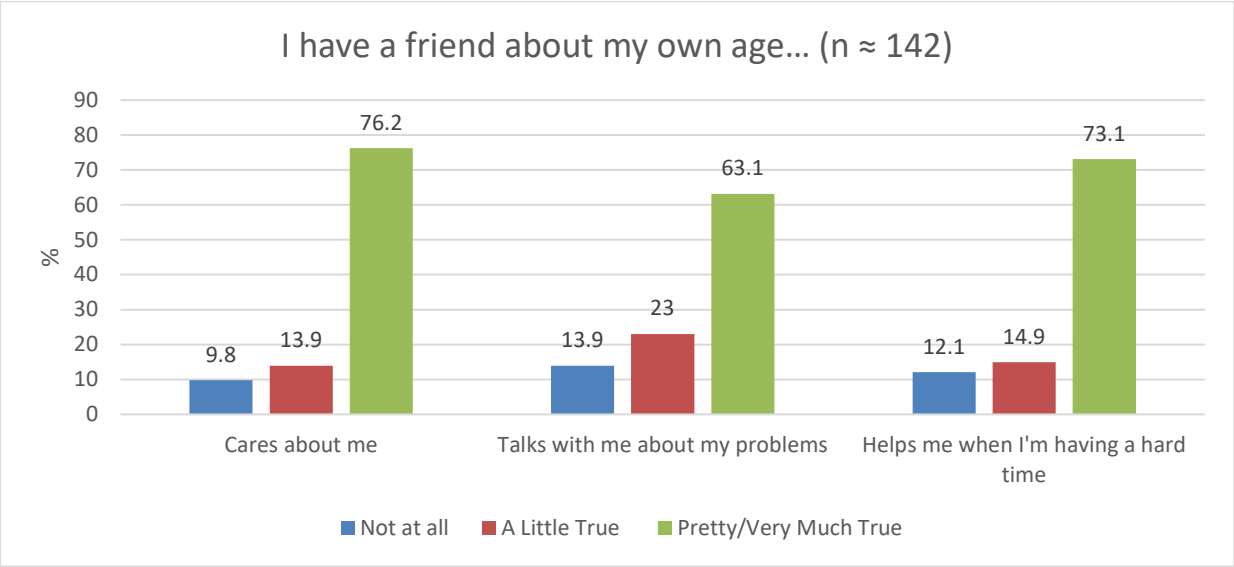
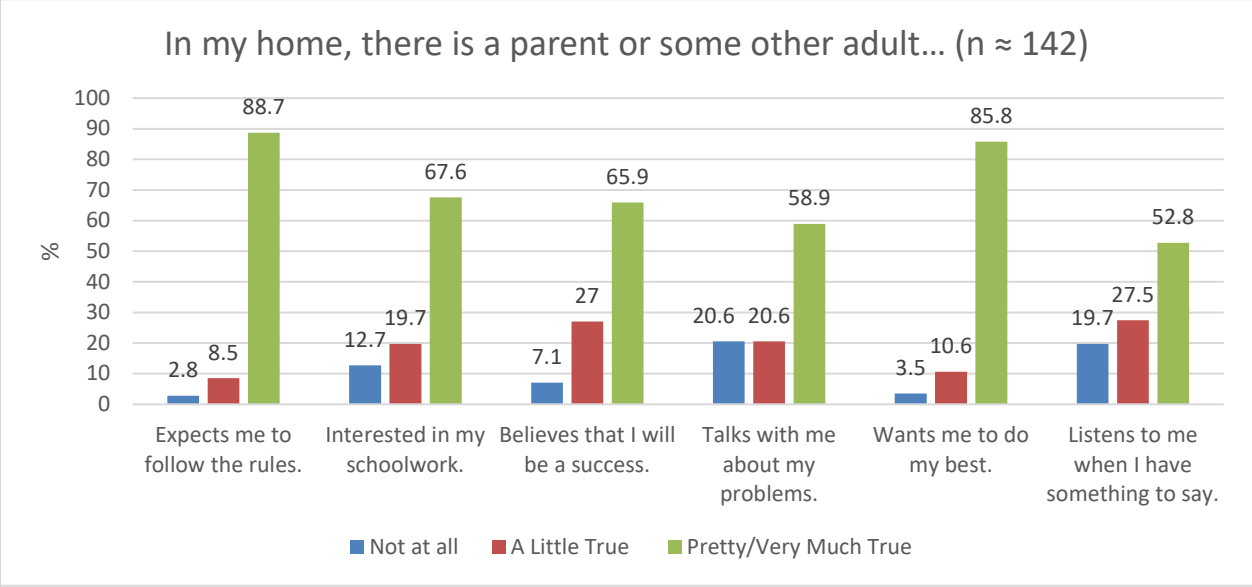


Figure 76 shows intake data on parental or support from other adults in their house. The number of valid responses at intake ranged between 141 and 142. While the majority of youth identified that each of the items were either pretty much or very much true, the two items with the lowest endorsement was “talks with me about my problems” and “listens to me when I have something to say”.

Figure 76.



In addition to intake data, Figure 77 through Figure 79 show the proportion of youth who identified that each of the statements were either pretty much or very much true from intake to termination. Due to sample size restrictions, McNemar's tests were not conducted. Figure 77 shows differences from intake to termination for the items measuring self-efficacy, self-awareness, and empathy. The number of valid responses was 42 for each of the items. Youth exhibited either an improvement or no change in items measuring self-efficacy, self-awareness, and empathy except "there are many things that I do well. For example, 66.7% (n = 28) at intake and 85.7% (n = 36) indicated that the item "I can work out my problems" was either pretty much or very much true.

Figure 77.

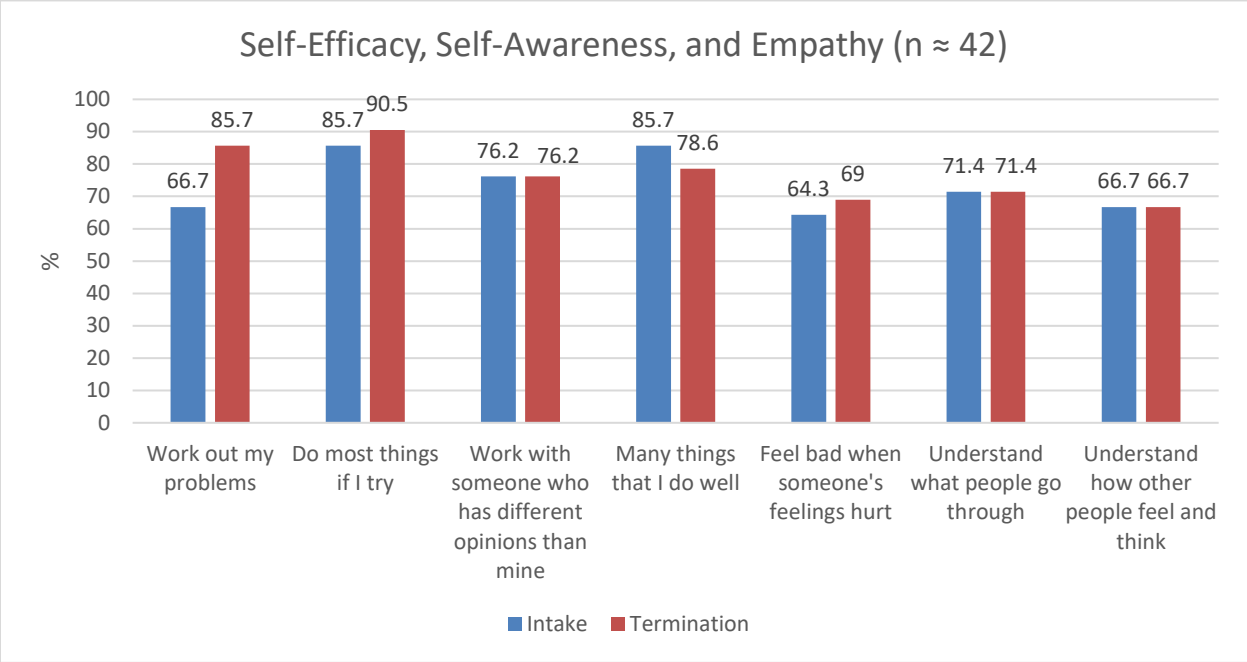


Figure 78 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring peer support. The number of valid responses was between 41 and 42. A slightly lower proportion of youth at termination compared to at intake reported that the items “I have a friend about my own age who really cares about me” and “I have a friend about my own age who helps me when I’m having a hard time” were either pretty much or very much true.

Figure 78.

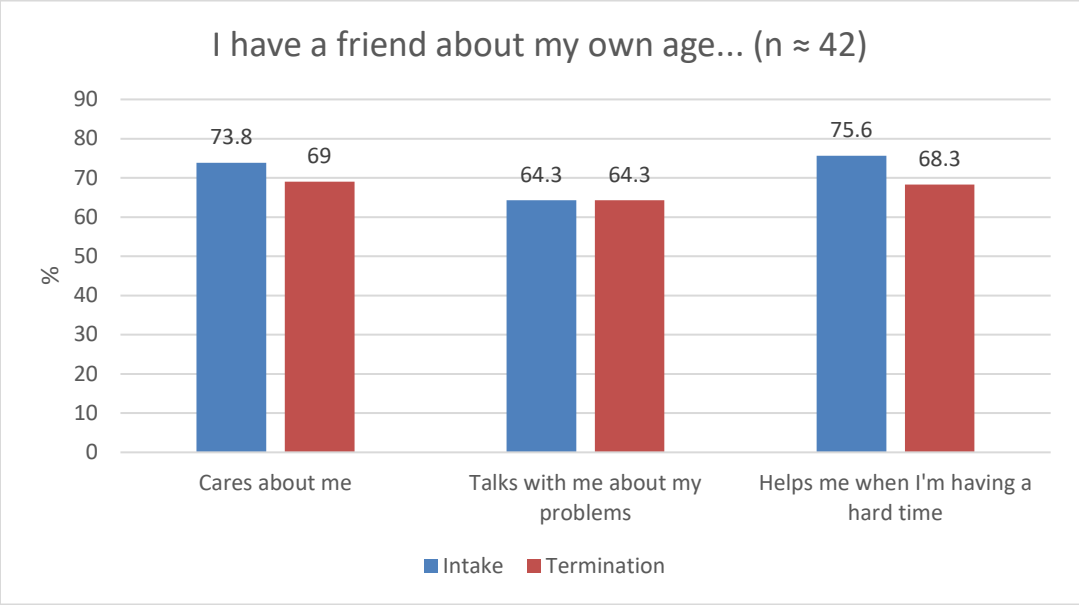
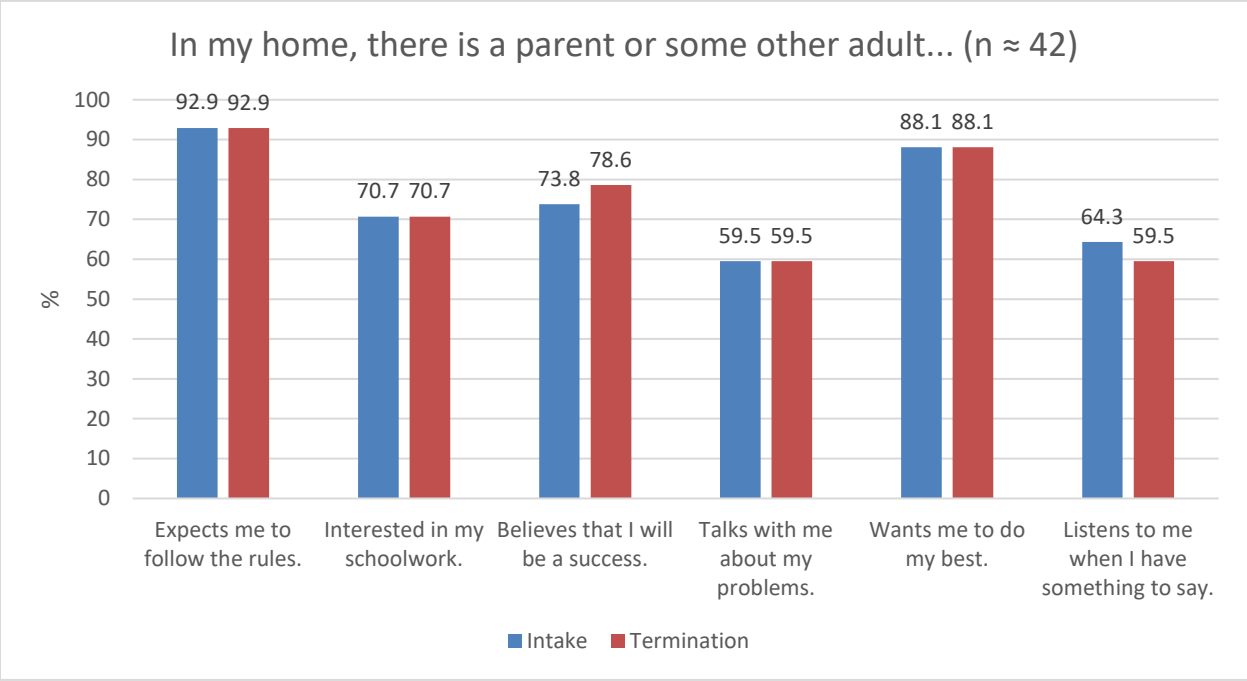


Figure 79 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring parental support or support from other adults in the home. Valid responses to these 6 items ranged between 41 and 42. The proportion of positive responses increased slightly for the item “believes that I will be a success”.

Figure 79.



TSCC

The TSCC was administered at intake and termination from BHJJ. Paired-samples t-tests were conducted to show whether means at intake and termination on each TSCC subscale differed significantly. Data were analyzed separately for females (see Figure 80) and males (see Figure 81) who had completed the TSCC at both intake and termination in Montgomery County.

Research has found that females consistently report more trauma symptoms than males (Singer et al., 1995). We examined trauma symptoms for females and males in the BHJJ sample. Consistent with previous research, BHJJ females in Montgomery County reported higher scores on each trauma symptom subscale than males. For example, at intake, the average score on the Depression domain was 6.22 for females and 4.12 for males. Paired samples t-tests revealed significant improvements in trauma symptoms for Anxiety, Depression, and Anger domains for females and each domain except Sexual Concerns for males (see Table 101 and Table 102).

Table 101. TSCC Subscales from Intake to Termination among Females

Females	Intake	Termination	t	d
Anxiety	3.99 (SD = 3.45; n = 81)	2.80 (SD = 3.11; n = 81)	3.11**	.35
Depression	6.22 (SD = 4.57; n = 81)	4.12 (SD = 4.39; n = 81)	3.97***	.44
Anger	7.25 (SD = 5.26; n = 81)	4.47 (SD = 4.89; n = 81)	4.43***	.49
Posttraumatic Stress	5.53 (SD = 5.36; n = 81)	4.35 (SD = 5.34; n = 81)	1.72	.19
Dissociation	5.15 (SD = 4.56; n = 81)	4.23 (SD = 4.70; n = 81)	1.68	.19
Sexual Concerns	2.78 (SD = 3.02; n = 81)	2.14 (SD = 3.43; n = 81)	1.80	.20

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

Figure 80.

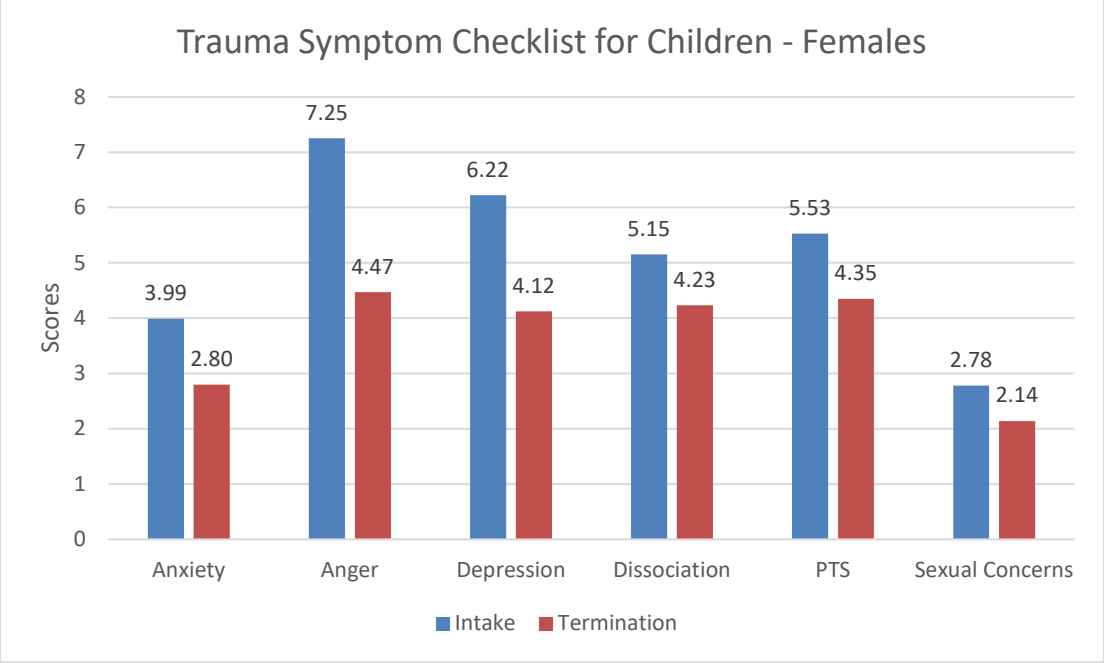
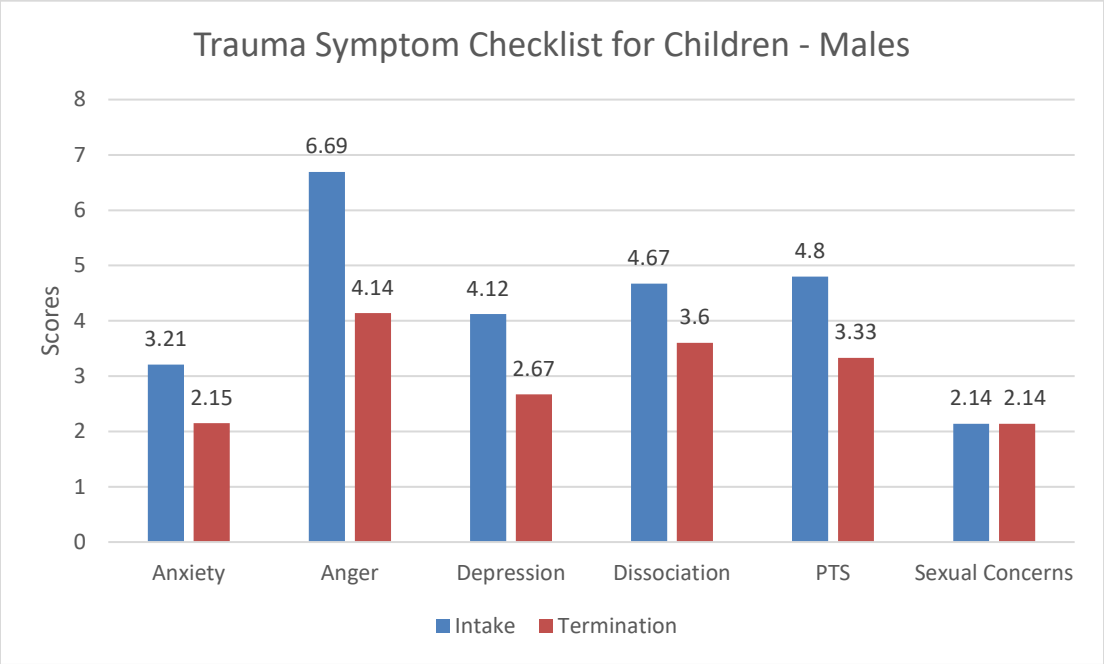


Table 102. TSCC Subscales from Intake to Termination for Males

Males	Intake	Termination	t	d
Anxiety	3.21 (SD = 4.00; n = 123)	2.15 (SD = 3.29; n = 123)	3.75***	.34
Depression	4.12 (SD = 4.94; n = 123)	2.67 (SD = 4.23; n = 123)	3.64***	.33
Anger	6.69 (SD = 5.46; n = 123)	4.14 (SD = 5.12; n = 123)	5.60***	.50
Posttraumatic Stress	4.80 (SD = 5.24; n = 123)	3.33 (SD = 4.63; n = 123)	4.38***	.40
Dissociation	4.67 (SD = 4.98; n = 123)	3.60 (SD = 4.53; n = 123)	2.91**	.26
Sexual Concerns	2.14 (SD = 3.27; n = 123)	2.14 (SD = 3.45; n = 123)	.56	.05

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

Figure 81.



Substance Use Survey

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 103 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use by gender in Montgomery County. For both females and males, alcohol, tobacco, marijuana, and caffeine were the most commonly used substances. Chi-squared tests revealed that a significantly higher proportion of males reported ever having used tobacco than females ($\chi^2(1) = 5.30$, $p < .05$).

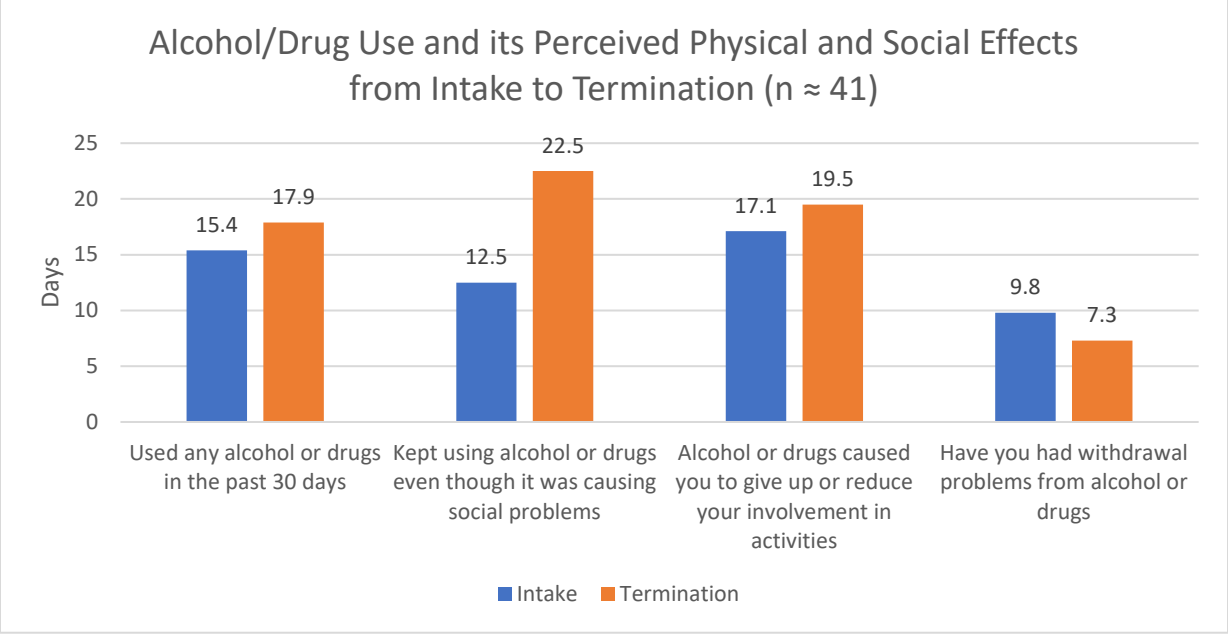
Table 103. Self-Reported Substance Use at Intake by Gender – Montgomery County

	Male		Female	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	41.7% (n = 35)	12.69 (SD = 3.50)	37.5% (n = 21)	12.90 (SD = 3.63)
Tobacco	**40.0% (n = 34)**	**12.50 (SD = 3.04)**	**21.4% (n = 12)**	**12.17 (SD = 1.75)**
Cannabis	57.1% (n = 48)	12.53 (SD = 2.95)	48.2% (n = 27)	13.08 (SD = 1.52)
Hallucinogens	10.6% (n = 9)	14.56 (SD = 2.07)	5.4% (n = 3)	13.67 (SD = 3.21)
Inhalants	3.5% (n = 3)	15.00[a]	0.0% (n = 0)	
Opioids	3.5% (n = 3)	13.33 (SD = 1.53)	3.6% (n = 2)	15.00 (SD = .00)
Sedatives	8.2% (n = 7)	14.29 (SD = 1.98)	10.7% (n = 6)	15.00 (SD = 1.58)
Caffeine	31.8% (n = 27)	9.17 (SD = 3.87)	28.6% (n = 16)	10.70 (SD = 3.62)
Stimulants	7.1% (n = 6)	15.17 (SD = 1.33)	7.3% (n = 4)	15.00 (SD = 1.00)
Over the counter medications	5.9% (n = 5)	14.60 (SD = .55)	1.8% (n = 1)	8.00[a]
Other prescription drugs	4.8% (n = 4)	11.00 (SD = 4.36)	5.4% (n = 3)	13.67 (SD = 3.51)
Herbs/Flowers	1.2% (n = 1)	15.00[a]	1.8% (n = 1)	

[a] No Standard Deviations are calculated.

In addition to questions pertaining to the use of specific substances, youth were asked questions around general alcohol/drug use and its perceived effects on physical health and social functioning. The proportion of youth who indicated that they had used any alcohol or drugs in the past 30 days increased slightly from 15.4% at intake to 17.9% at termination. From intake to termination, the proportion of youth who indicated that they had continued to use alcohol/drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people at least sometimes and the proportion of youth who indicated that alcohol/drugs caused them to give up or reduce involvement in activities at work, school, home, and social events increased from intake to termination (see Figure 82). The proportion of youth who indicated that they had withdrawal problems from alcohol or drugs decreased. None of these differences were statistically significant.

Figure 82.



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.

Between July 1, 2015 and June 30, 2019, there have been 362 youth terminated from the BHJJ program in Montgomery County. Sixty-two percent (61.9%, n = 224) of the youth terminated from the BHJJ program were identified as successful treatment completers. Eight percent (8.0%, n = 29) were terminated from the program due to some type of out of home placement. Table 104 presents all of the reasons for termination from BHJJ and displays reasons for termination for White and Black participants.

Table 104. Reasons for Termination from BHJJ

Termination Reason	All Youth Enrolled between July 2015 and June 2019	White Youth Enrolled between July 2015 and June 2019	Black Youth Enrolled between July 2015 and June 2019
Successfully Completed Services	61.9% (n = 224)	66.3% (n = 132)	58.9% (n = 76)
Client Did Not Return/Rejected Services	5.5% (n = 20)	2.5% (n = 5)	8.5% (n = 11)
Out of Home Placement	8.0% (n = 29)	9.0% (n = 18)	7.8% (n = 10)
Client/Family Moved	3.3% (n = 12)	3.5% (n = 7)	3.1% (n = 4)
Client Withdrawn	12.2% (n = 44)	11.1% (n = 22)	12.4% (n = 16)
Client AWOL	1.9% (n = 7)	3.0% (n = 6)	0.8% (n = 1)
Client Incarcerated	0	0	0
Other	7.2% (n = 26)	4.5% (n = 9)	8.5% (n = 11)

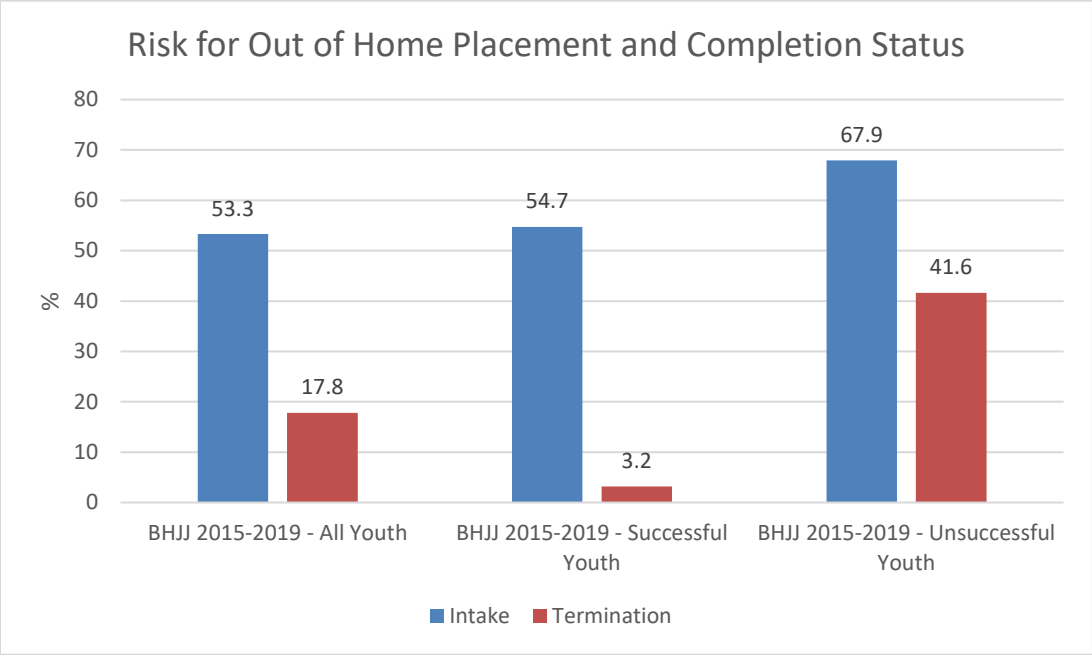
Average Length of Stay

Since the start of BHJJ, the average length of stay (ALOS) in the program was 131.4 days. For youth identified as successful treatment completers, the ALOS was 142.4 days while for unsuccessful treatment completers, the ALOS was 114.2 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, 53.3% of the youth (n = 245) were at risk for out of home placement. At termination, 17.8% (n = 64) of youth were at risk for out of home placement (see Figure 83). Of those youth who successfully completed BHJJ treatment, 3.2% (n = 7) were at risk for out of home placement at termination while 41.6% (n = 57) of youth who completed unsuccessfully were at risk for out of home placement.

Figure 83.



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 services through BHJJ. Workers reported that police contacts had been reduced for 72.3% (n = 261) of the youth and had stayed the same for 17.7% (n= 64) of the youth. Police contacts increased for 5.3% (n = 19) of the youth and the worker was unable to estimate for 4.7% of youth (n = 17).

YSSF

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the services they received through the BHJJ program in Montgomery County as well as how services impacted their children and family. At termination from the BHJJ program, 94.7% (n =217) of caregivers either strongly agreed or agreed that BHJJ staff were sensitive to their cultural/ethnic background and 97.8% (n =225) either strongly agreed or agreed that the location of the services was convenient (see Figure 84). Over seventy-eight percent (78.6%, n = 177) of caregivers reported that as a result of the services their child/family received, their child gets along better with family members and 74.2% (n = 170) reported their child is better able to do the things they want to do (see Figure 85).

Figure 84.

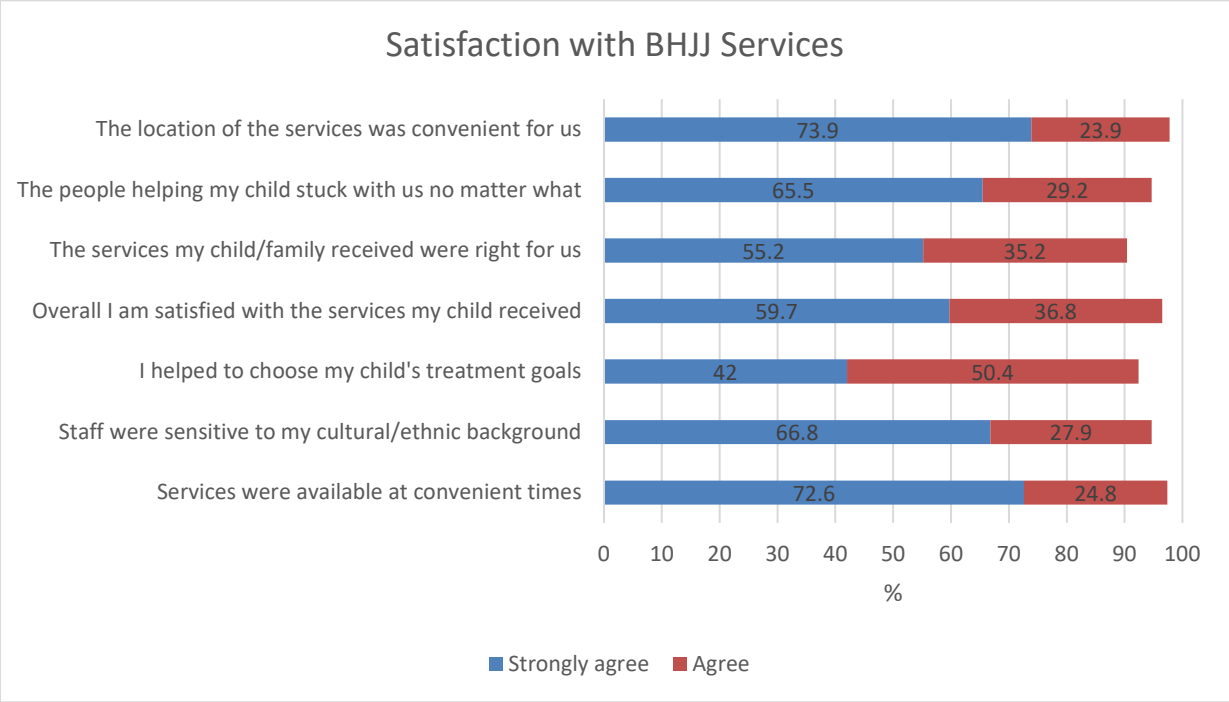
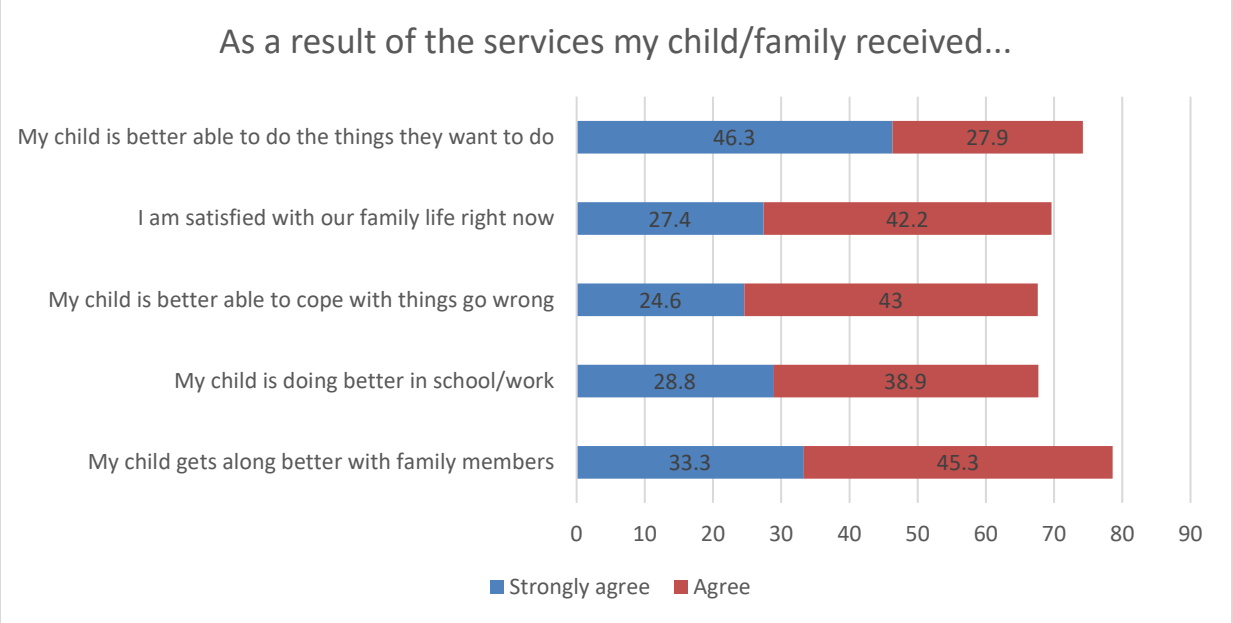


Figure 85.



Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve months prior to the end of the data collection period for inclusion in the analysis. These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 69.0% (n = 325) of BHJJ youth in Montgomery county enrolled between July 1, 2015 and June 30, 2019 had a misdemeanor charge, 16.3% (n = 77) had a felony charge, and 51.4% (n = 242) had been adjudicated delinquent in the 12 months prior to enrollment (see Table 105). Previous juvenile court information was similar for youth regardless of their completion status (successful vs. unsuccessful). In the 12 months prior to enrollment in BHJJ, 71.8% (n = 155) of successful completers and 68.4% (n = 93) of unsuccessful completers were charged with at least one misdemeanor (see Table 106 and Table 107). A slightly higher proportion of unsuccessful completers had an adjudication in the 12 months prior to

enrollment (50.5%; n = 109) than successful completers (54.4%; n = 74). Chi-square analyses revealed that a significantly larger proportion of youth who completed the program unsuccessfully had at least one felony charge in the 18 months prior to intake.

Table 105. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 471)	58.2% (n = 274)	9.8% (n = 46)	43.5% (n = 205)
12 months (n = 471)	69.0% (n = 325)	16.3% (n = 77)	51.4% (n = 242)
18 months (n = 471)	72.8% (n = 343)	18.3% (n = 86)	53.1% (n = 250)

Table 106. Charges Prior to BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 216)	63.9% (n = 138)	8.3% (n = 18)	44.0% (n = 95)
12 months (n = 216)	71.8% (n = 155)	13.4% (n = 29)	50.5% (n = 109)
18 months (n = 216)	73.1% (n = 158)	13.9% (n = 30)	51.4% (n = 111)

Table 107. Charges Prior to BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 136)	54.4% (n = 74)	10.3% (n = 14)	44.1% (n = 60)
12 months (n = 136)	68.4% (n = 93)	18.4% (n = 25)	54.4% (n = 74)
18 months (n = 136)	73.5% (n = 100)	22.1% (n = 30)	55.1% (n = 75)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 108). In the 12 months after enrollment in BHJJ, 40.3% (n = 153) of participants were charged with at least one new misdemeanor, 14.7% (n = 56) were charged with at least one new felony, and 39.2% (n = 149) of the youth were adjudicated delinquent.

Table 108. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 435)	27.8% (n = 121)	9.0% (n = 39)	26.0% (n = 113)
12 months (n = 380)	40.3% (n = 153)	14.7% (n = 56)	39.2% (n = 149)
18 months (n = 328)	45.4% (n = 149)	17.4% (n = 57)	43.9% (n = 144)

In the 12 months after enrollment in BHJJ, 33.3% (n = 58) of successful completers were charged with at least one new misdemeanor, 9.8% (n = 17) were charged with at least one new felony, and 30.5% (n = 53) were adjudicated delinquent (see Table 109). Of the youth who completed unsuccessfully, 52.7% (n = 59) were charged with at least one new misdemeanor, 18.8% (n = 21) were charged with at least one new felony, and 50.9% (n = 57) were adjudicated delinquent in the 12 months after their enrollment in BHJJ (see Table 110). Chi-square analyses revealed that **a significantly higher percentage of unsuccessful completers were charged with at least one misdemeanor, felony, and had at least one adjudication than successful completers at each of the time points we examined after enrollment.**

Table 109. Recidivism after BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 200)	19.5% (n = 39)	4.0% (n = 8)	17.5% (n = 35)
12 months (n = 174)	33.3% (n = 58)	9.8% (n = 17)	30.5% (n = 53)
18 months (n = 147)	38.1% (n = 56)	11.6% (n = 17)	36.1% (n = 53)

Table 110. Recidivism after BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 126)	41.3% (n = 52)	12.7% (n = 16)	36.5% (n = 46)
12 months (n = 112)	52.7% (n = 59)	18.8% (n = 21)	50.9% (n = 57)
18 months (n = 100)	58.0% (n = 58)	22.0% (n = 22)	53.0% (n = 53)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 111). In the 12 months after termination from BHJJ, 34.5% (n = 89) of youth were charged with at least one new misdemeanor and 11.6% (n = 30) were charged with at least one new felony, and 29.5% (n = 76) were adjudicated delinquent.

Table 111. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 294)	24.1% (n = 71)	6.8% (n = 20)	24.8% (n = 73)
12 months (n = 258)	34.5% (n = 89)	11.6% (n = 30)	29.5% (n = 76)
18 months (n = 213)	40.8% (n = 87)	13.1% (n = 28)	32.9% (n = 70)

In the 12 months following their termination from BHJJ, 30.3% (n = 46) of successful completers were charged with at least one new misdemeanor, 11.2% (n = 17) were charged with at least one new felony, and 25.0% (n = 38) were adjudicated delinquent (see Table 112). Of the youth who completed unsuccessfully, 40.6% (n = 43) were charged with at least one new misdemeanor, 12.3% (n = 13) were charged with at least one new felony, and 35.8% (n = 38) were adjudicated delinquent in the 12 months after their termination from BHJJ (see Table 113). **A significantly larger proportion of unsuccessful youth were charged with at least one misdemeanor in the 18 months after termination and at least one adjudication in the 6 months after termination.**

Table 112. Recidivism after BHJJ Termination for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 176)	20.5% (n = 36)	5.7% (n = 10)	19.9% (n = 35)
12 months (n = 152)	30.3% (n = 46)	11.2% (n = 17)	25.0% (n = 38)
18 months (n = 121)	33.9% (n = 41)	11.6% (n = 14)	28.1% (n = 34)

Table 113. Recidivism after BHJJ Termination for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 118)	29.7% (n = 35)	8.5% (n = 10)	32.2% (n = 38)
12 months (n = 106)	40.6% (n = 43)	12.3% (n = 13)	35.8% (n = 38)
18 months (n = 92)	50.0% (n = 46)	15.2% (n = 14)	39.1% (n = 36)

Average Numbers of Charges and Adjudications

In addition to whether a youth was charged or adjudicated delinquent, we examined whether there were differences in the average number of charges and adjudications in equivalent periods of time prior to enrollment and after termination. We conducted paired samples *t*-tests to examine whether there were statistically significant differences in the mean number of charges and adjudications at each time period prior to and after BHJJ participation. Figure 86 shows the average number of charges for youth who had data at both time periods. This restriction resulted in a sample of 294 youth at 6 months, 258 youth at 12 months, and 213 youth at 18 months. **Paired samples *t*-tests revealed a statistically significant decline in the average number of misdemeanors for each time period and adjudications at 6 and 12 months.** For example, the average number of misdemeanor charges 18 months prior to BHJJ enrollment was 1.78 while the average number of misdemeanor charges 18 months after BHJJ termination was 1.14.

Figure 86.

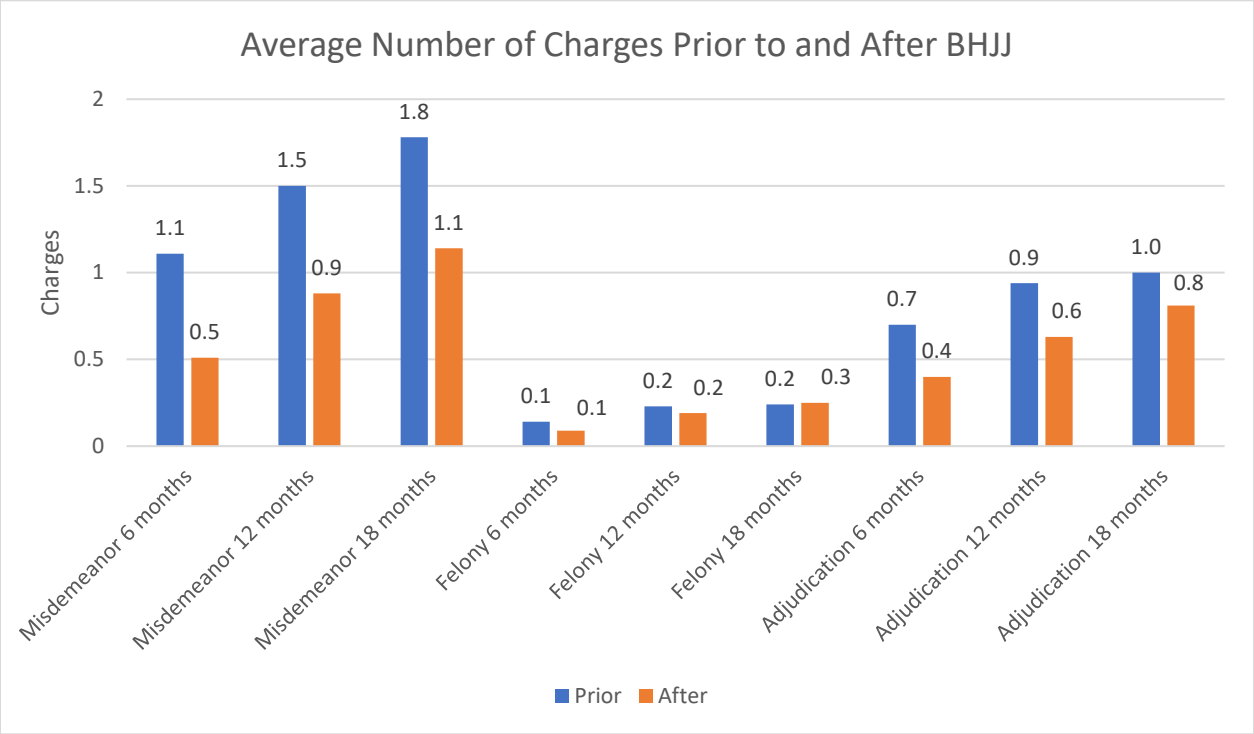


Figure 87 and Figure 88 shows mean differences in charges and adjudications for youth who successfully completed the program and those who did not successfully terminate. To be included in the analysis youth must have data at both time periods. This restricted the sample to 178 youth at 6 months, 152 youth at 12 months, and 121 youth at 18 months for youth who were successfully terminated and 118 youth at 6 months, 106 youth at 12 months, and 92 youth at 18 months for those who terminated unsuccessfully. **For youth who successfully completed, paired samples *t*-tests revealed that there was a significant reduction in the average number of misdemeanor charges in each of the time periods we examined and adjudications for 6 and 12 months.** For example, the average number of misdemeanor charges declined from 1.43 in the 12 months prior to intake to 0.7 in the 12 months after termination. **For youth who terminated unsuccessfully, paired samples *t*-tests revealed that there was a significant reduction in the average number of misdemeanor charges at 6 months.** For example, the average number of misdemeanors was 1.18 in the 6 months prior to intake and 0.71 in the 6 months after termination.

Figure 87.

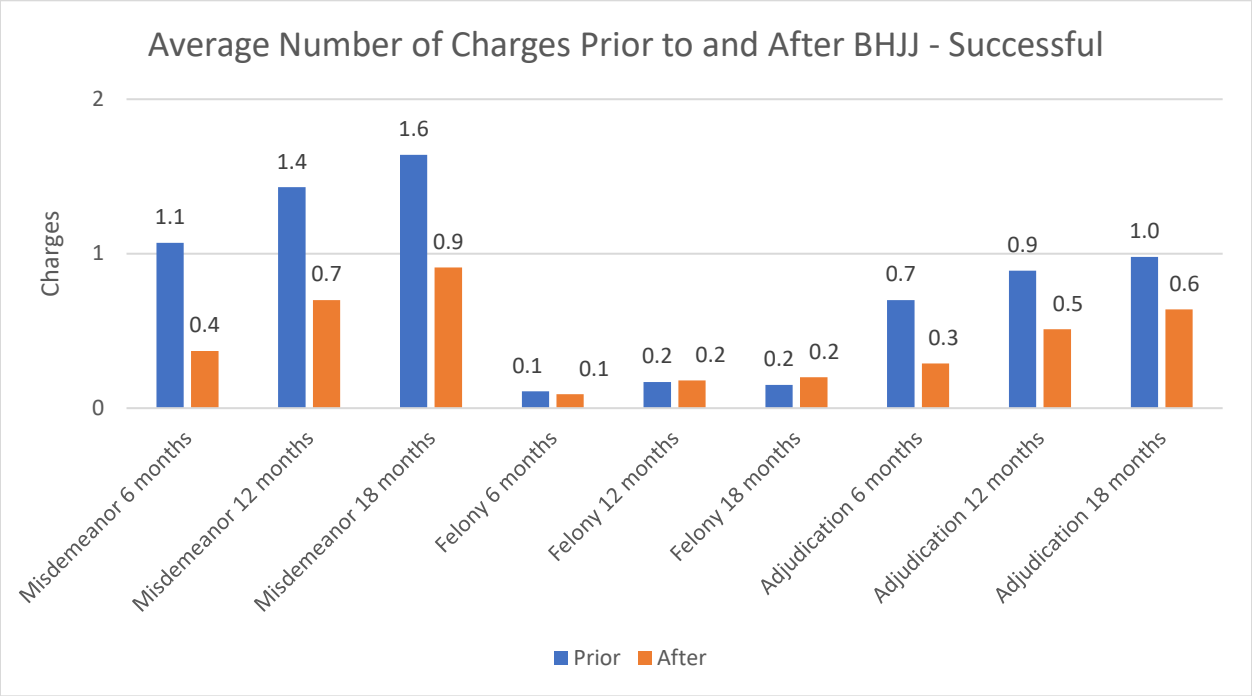
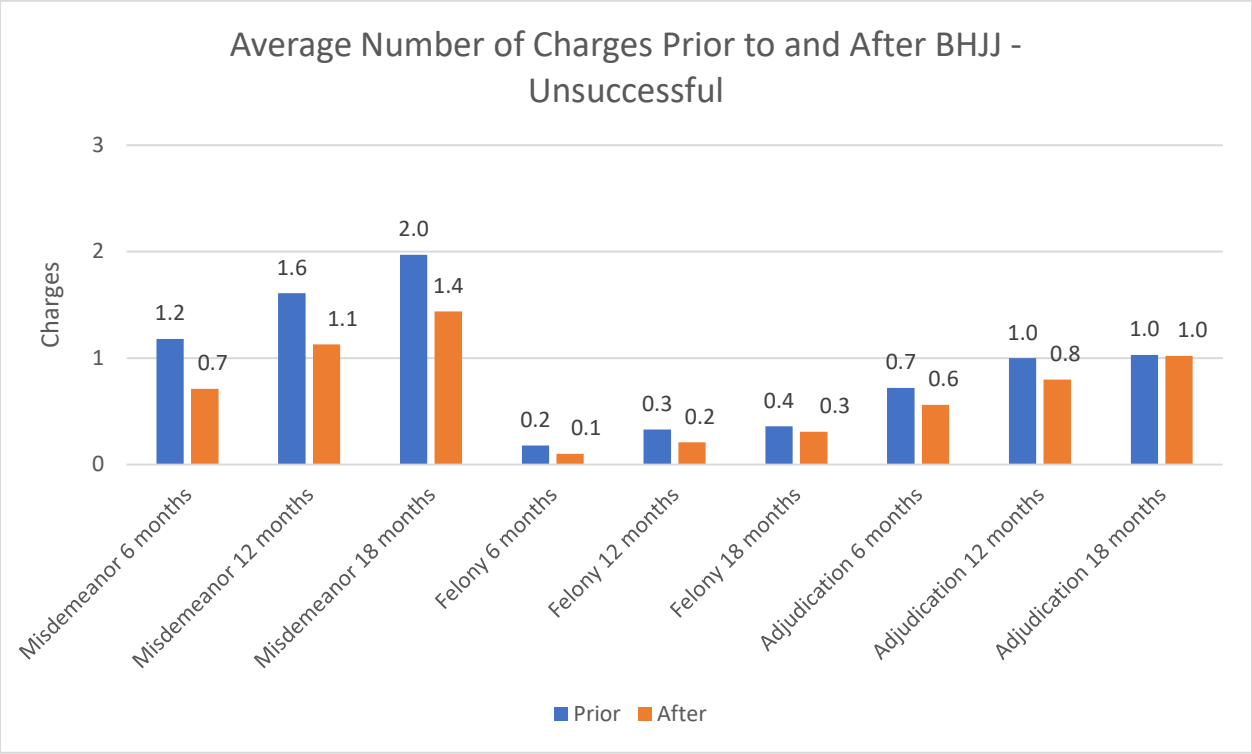


Figure 88.



Hamilton

Demographics

As of June 30, 2019, 411 youth were enrolled into the BHJJ program in Hamilton County. The average age at enrollment was 15.2 years (SD=1.40). More males (74.2%, n = 305) than females (25.8%, n = 106) have been enrolled. Black youth (54.3%, n = 222), White youth (38.4%, n = 157), and Multiracial youth (6.1%, n = 25) comprised the majority of the total sample.

There were 75 new enrollments in Hamilton County during the current reporting period (July 1, 2017 through June 30, 2019). The average age at enrollment was 15.4 (SD = 1.32). Males (82.7%, n = 62) outnumbered females (17.3%, n = 13), and more Black youth (57.3%, n = 43) than White youth (34.7%, n = 26) were enrolled. Nearly three percent (2.7%, n = 2) of the youth self-identified as Hispanic/Latinx.

Unless otherwise noted, the following sections describe data from the past four years of BHJJ programming from July 1, 2015 through June 30, 2019.

Custody Arrangement and Household Information

At intake, the majority of youth lived with the biological mother (65.1%, n = 95), while 17.1% (n = 25) lived with two biological parents or one biological and one step/adoptive parent (see Table 114). Over eighty-five percent (85.6%, n = 125) of BHJJ youth lived with at least one biological parent at enrollment.

Eighty-two percent (82.4%; n = 117) of the BHJJ caregivers had at least a high school diploma or GED, and 14.1% (n = 20) had a bachelor's degree or higher. Over seventeen percent of caregivers (17.6%; n = 25) reported they did not graduate from high school (see Table 115).

Caregivers were asked to report their annual household income (see Table 116). The income range with the highest endorsement was less than $5,000 (23.6%, n = 34). Overall, 66.0% (n = 95) reported a family income of $24,999 or less. When examined by race, 27.5% (n = 14) of White families, 54.7% (n = 47) of Black families, and 50.0% (n = 3) of Multiracial families reported a household income of $14,999 or less. Table 116 displays the reported household income overall and by race.

Table 114. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	17.1% (n = 25)
Biological Mother Only	65.1% (n = 95)
Biological Father Only	3.4% (n = 5)
Adoptive Parent(s)	2.7% (n = 4)
Aunt/Uncle	2.7% (n = 4)
Grandparents	7.5% (n = 11)
Other	1.4% (n = 2)

Table 115. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	17.6% (n = 25)
High School Graduate or G.E.D.	34.5% (n = 49)
Some College or Associate Degree	33.8% (n = 48)
Bachelor's Degree	9.9% (n = 14)
More than a Bachelor's Degree	4.2% (n = 6)

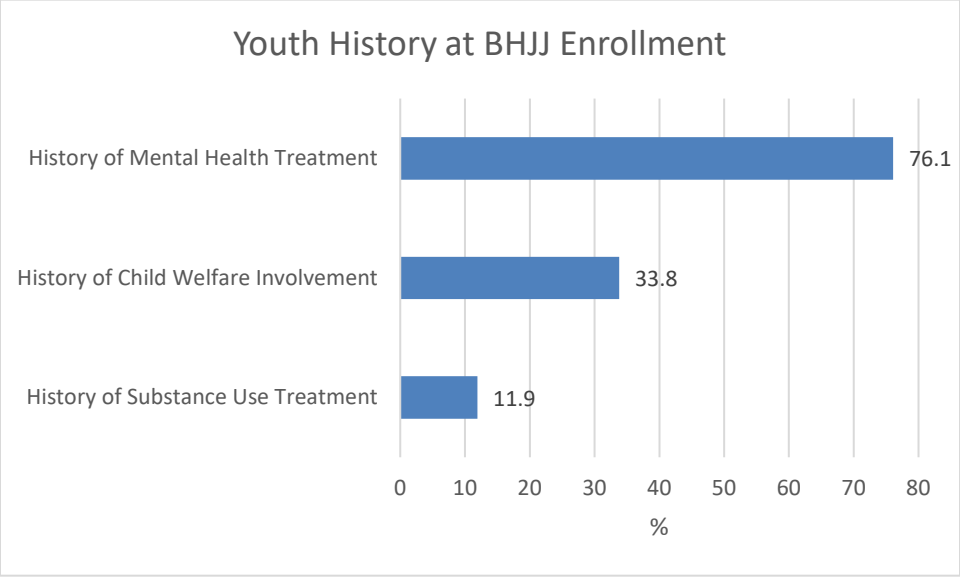
Table 116. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Black	Multiracial
Less than $5,000	23.6% (n = 34)	11.8% (n = 6)	31.4% (n = 27)	16.7% (n = 1)
$5,000 - $9,999	7.6% (n = 11)	9.8% (n = 5)	7.0% (n = 6)	NA
$10,000 - $14,999	13.2% (n = 19)	5.9% (n = 3)	16.3% (n = 14)	33.3% (n = 2)
$15,000 - $19,999	4.9% (n = 7)	2.0% (n = 1)	7.0% (n = 6)	NA
$20,000 - $24,999	16.7% (n = 24)	13.7% (n = 7)	19.8% (n = 17)	NA
$25,000 - $34,999	6.3% (n = 9)	3.9% (n = 2)	4.7% (n = 4)	33.3% (n = 2)
$35,000 - $49,999	13.9% (n = 20)	19.6% (n = 10)	10.5% (n = 9)	16.7% (n = 1)
$50,000 - $74,999	10.4% (n = 15)	23.5% (n = 12)	3.5% (n = 3)	NA
$75,000 or greater	3.5% (n = 5)	9.8% (n = 5)	NA	NA

Youth and Family History

Workers were asked to identify a youth's prior behavioral health and child welfare system involvement (see Figure 89). These three items were new to the past biennium, therefore, data are only available for youth enrolled between July 1, 2017 and June 30, 2019. Over a third of youth (33.8%, n = 23) had a history of child welfare involvement prior to BHJJ enrollment. Nearly twelve percent (11.9%, n = 8) of youth had received substance use treatment in their lifetime prior to BHJJ enrollment and 76.1% (n = 51) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 89.



Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history. Chi-square analysis to test for gender differences was conducted on each item and significant differences are identified in Table 117. A significant larger proportion of the caregivers of females reported lifetime histories of talking about suicide, attempting suicide, and a family history of mental illness other than depression. Caregivers reported that a significant larger proportion of males than females had a lifetime history of exposure to domestic violence.

Caregivers reported that 10.3% (n = 3) of females and 11.1% (n = 13) of males had a history of being physically abused while 21.4% (n = 6) of females and 9.1% (n = 10) of males had a history of being sexual abused. Caregivers of 75.9% (n = 22) of females and 39.3% (n = 46) of males reported hearing the child talking about committing suicide and 37.0% (n = 10) of females and 12.9% (n = 15) of males had attempted suicide at least once. A majority of the caregivers of females (71.4%, n = 20) and males (63.5%, n = 73) reported a family history of depression.

Table 117. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	10.3% (n = 3)	11.1% (n = 13)
Has the child ever been sexually abused?	21.4% (n = 6)	9.1% (n = 10)
Has the child ever run away?	58.6% (n = 17)	48.3% (n = 56)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	55.2% (n = 16)	57.8% (n = 67)
Has the child ever talked about committing suicide?	75.9% (n = 22)***	39.3% (n = 46)
Has the child ever attempted suicide?	37.0% (n = 10)**	12.9% (n = 15)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	13.8% (n = 4)	36.4% (n = 43)*
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	71.4% (n = 20)	63.5% (n = 73)
Has anyone in the child's biological family had a mental illness, other than depression?	73.1% (n = 19)*	50.0% (n = 56)
Has the child ever lived in a household in which someone was convicted of a crime?	29.6% (n = 8)	35.7% (n = 41)
Has anyone in the child's biological family had a drinking or drug problem?	35.7% (n = 10)	39.1% (n = 45)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	53.8% (n = 14)	40.9% (n = 47)

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

Problems Leading to Service

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-related problems (62.5% and 81.0% respectively) (see Table 118). Chi-square analysis indicated females had significantly higher rates of problems related to anxiety and depression. Males had significantly higher rates of hyperactive and attention-related problems.

Table 118. Problems Leading to Services

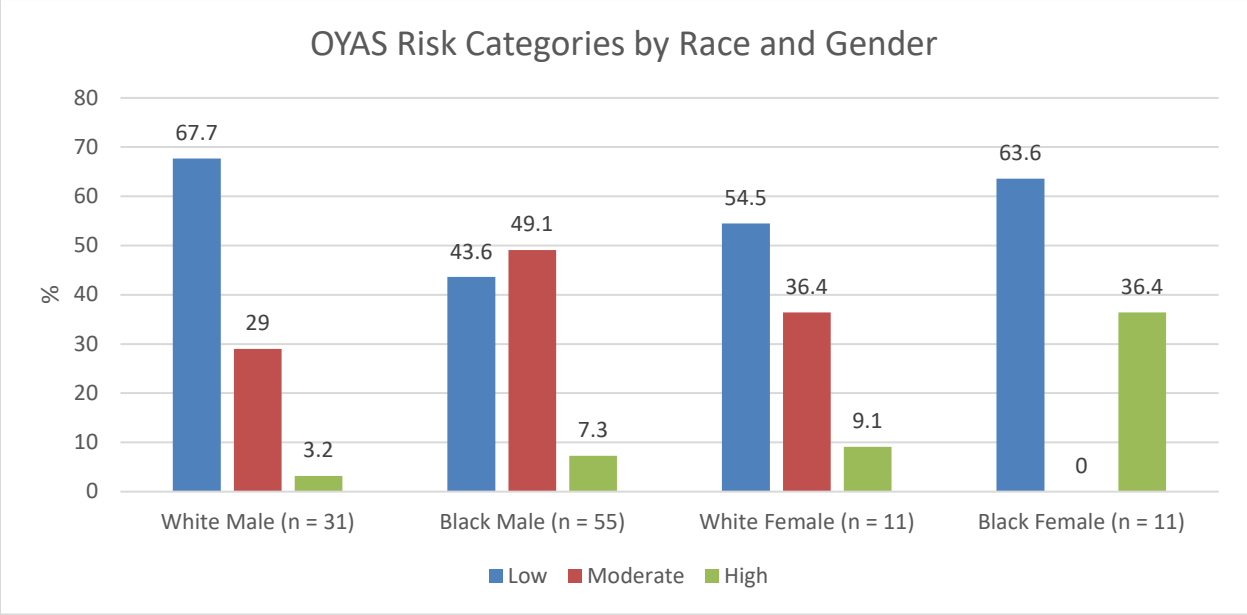
Problems Leading to Services	Females	Males
Adjustment-related problems	12.5% (n = 3)	10.5% (n = 11)
Anxiety-related problems	54.2% (n = 13)***	12.4% (n = 13)
Conduct/delinquency-related problems	62.5% (n = 15)	81.0% (n = 85)
Depression-related problems	83.3% (n = 20)**	48.6% (n = 51)
Eating disorders	0	0
Hyperactive and attention-related problems	25.0% (n = 6)	54.3% (n = 57)*
Learning disabilities	16.7% (n = 4)	13.3% (n = 14)
Pervasive development disabilities	0	2.9% (n = 3)
Psychotic behaviors	4.2% (n = 1)	2.9% (n = 3)
School performance problems not related to learning disabilities	50.0% (n = 12)	46.7% (n = 49)
Specific developmental disabilities	0	0
Substance use, abuse, dependence-related problems	27.3% (n = 3)	49.0% (n = 24)
Suicide-related problems	16.7% (n = 4)	9.5% (n = 10)

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

Ohio Youth Assessment System

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 90 shows the distribution of OYAS risk categories for BHJJ youth by race and gender. In Hamilton County, 3.2% (n = 1) of White males and 7.3% (n = 4) of Black males enrolled in the BHJJ program were identified as High risk on the OYAS, while 9.1% (n = 1) of White females and 36.4% (n = 4) of Black females were identified as High risk.

Figure 90.



DSM Diagnoses

Workers were asked to report any DSM 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 diagnosis for females were Depressive Disorders while the most common diagnosis for males was Cannabis-related Disorder (see Table 119).

Chi-square analysis indicated females were significantly more likely than males to be diagnosed with Bipolar Disorder and Post-traumatic Stress Disorder while males were significantly more likely than females to be diagnosed with Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Cannabis-related Disorders, and co-occurring disorders (both a DSM mental health diagnosis and a substance use diagnosis).

Table 119. Most Common DSM Diagnoses

DSM Diagnosis	Females (n = 25)	Males (n = 103)
Adjustment Disorder	0	6.8% (n = 7)
Alcohol-related Disorders	4.0% (n = 1)	4.9% (n = 5)
Attention Deficit Hyperactivity Disorder	16.0% (n = 4)	52.4% (n = 54)**
Bipolar Disorder	20.0% (n = 5)**	2.9% (n = 3)
Cannabis-related Disorders	24.0% (n = 6)	**56.3% (n = 58)****
Conduct Disorder	12.0% (n = 3)	21.4% (n = 22)
Depressive Disorders	**40.0% (n = 10)**	35.9% (n = 37)
Disruptive Behavior Disorder	0	3.9% (n = 4)
Unspecified Mood Disorder	8.0% (n = 2)	5.8% (n = 6)
Oppositional Defiant Disorder	16.0% (n = 4)	35.9% (n = 37)*
Post-traumatic Stress Disorder	24.0% (n = 6)*	7.8% (n = 8)
Unspecified Trauma and Stressor Related Disorder	4.0% (n = 1)	2.9% (n = 3)
Disruptive Mood Dysregulation Disorder	8.0% (n = 2)	8.7% (n = 9)
Co-Occurring Disorder	24.0% (n = 6)	56.3% (n = 58)**

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

Educational Information

Several items focused on educational 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. The wording on some items (e.g. IEP at intake, attendance at intake) was changed from previous versions of the forms. For those items, we present data from only the past biennium (when the new forms were in use). Those items will have smaller sample sizes compared to items that have been consistent for the past four years.

Over sixty-six percent (66.1%, n = 82) of youth were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in BHJJ treatment BHJJ, 44.6% (n = 37) of the youth were expelled or suspended from school (a 32.5% decrease from intake to termination).

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, 62.5% (n = 35) of youth were currently attending school while at termination, 89.2% (n = 74) 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 120 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 121 displays this information based on completion status. At intake, 29.4% of youth were earning mostly A's and B's, and C's while at termination, 57.5% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 121). For example, at intake, 30.8% of youth who would go on to be unsuccessful completers and 40.5% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 44.4% of unsuccessful completers and 66.0% of successful completers received mostly A's, B's, or C's.

Table 120. Academic Performance

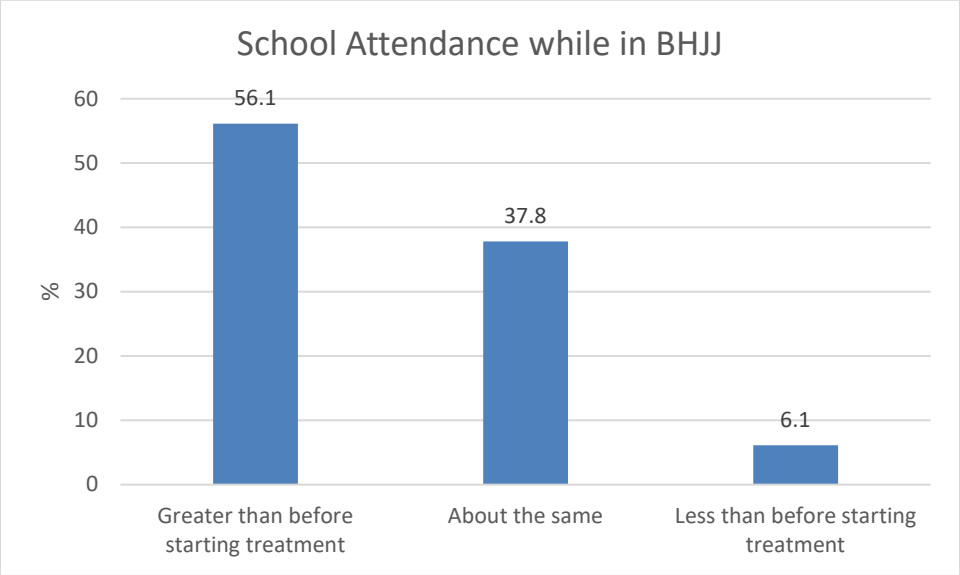
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	10.1% (n = 12)	17.5% (n = 14)
Mostly B's and C's	19.3% (n = 23)	40.0% (n = 32)
Mostly C's and D's	27.7% (n = 33)	25.0% (n = 20)
Mostly D's and F's	42.9% (n = 51)	17.5% (n = 14)

Table 121. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	7.7% (n = 2)	7.4% (n = 2)	18.9% (n = 7)	24.0% (n = 12)
Mostly B's and C's	23.1% (n = 6)	37.0% (n = 10)	21.6% (n = 8)	42.0% (n = 21)
Mostly C's and D's	26.9% (n = 7)	25.9% (n = 7)	35.1% (n = 13)	24.0% (n = 12)
Mostly D's and F's	42.3% (n = 11)	29.6% (n = 8)	24.3% (n = 9)	10.0% (n = 5)

At termination, workers reported that 56.1% (n = 46) of youth were attending school more than before starting treatment and 37.8% (n = 31) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 91). At intake, 58.7% (n = 37) of the youth attending school had Individualized Education Plans (IEPs) while at termination, 66.3% (n = 53) of the youth attending school had Individualized Education Plans (IEPs).

Figure 91.



Ohio Scales

One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum of service, separate charts are included that display the means from intake to termination. Decreases in Problem Severity and increases in Functioning correspond to positive change.

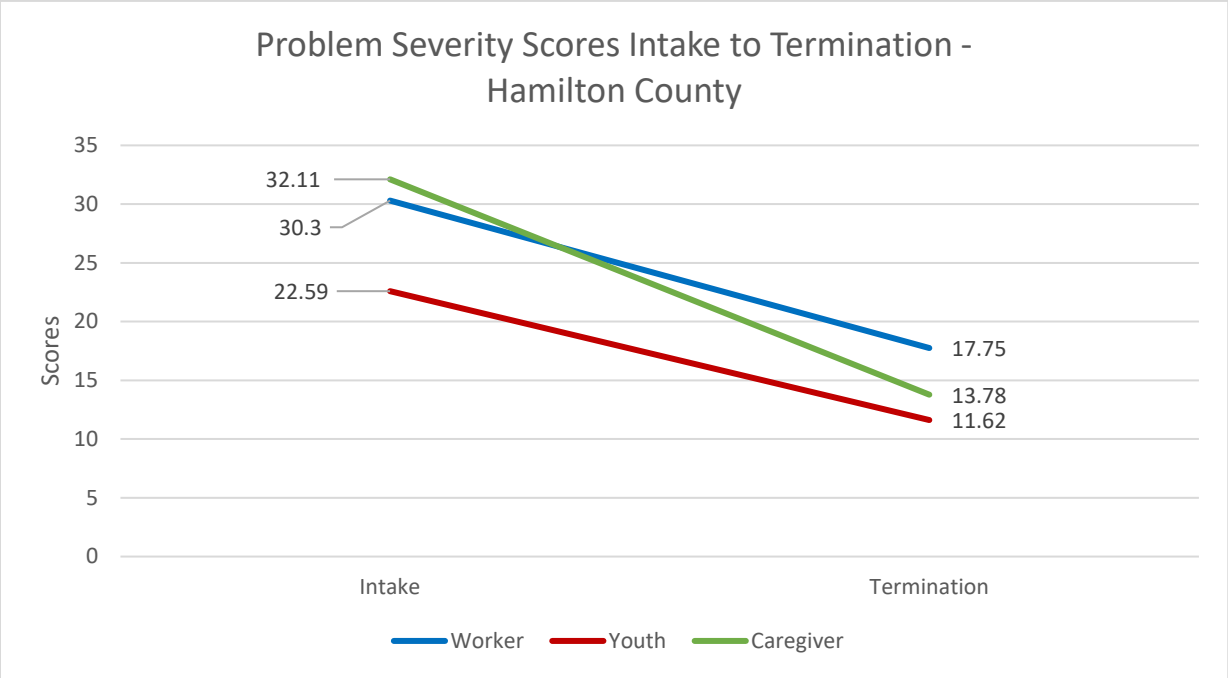
All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Results for Hamilton County will be limited to intake and termination data.

Paired samples t-tests were used to compare Problem Severity scores at intake to Problem Severity scores at termination. 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 termination to be included in the analysis. If the caregiver only has an intake score, his or her data is not included.

Problem Severity

Overall means for the Problem Severity scale by rater between intake and termination for Hamilton County youth are presented in Figure 92.

Figure 92.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Problem Severity from intake to termination $t(74) = 6.59$, $p < .001$ with a moderate effect size (see Table 122).

Table 122. Paired Samples T-Tests for Problem Severity – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	28.58 (SD=15.23; n=75)	17.41 (SD=12.50; n=75)	6.59***	.76

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvements in Problem Severity from intake to termination $t(73) = 6.20$, $p < .001$ with a moderate effect size (see Table 123).

Table 123. Paired Samples T-Tests for Problem Severity – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	20.71 (SD=14.53; n=74)	11.58 (SD=12.08; n=74)	6.20***	.72

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Problem Severity from intake to termination $t(70) = 7.40$, $p < .001$ with a large effect size (see Table 124).

Table 124. Paired Samples T-Tests for Problem Severity – Caregiver

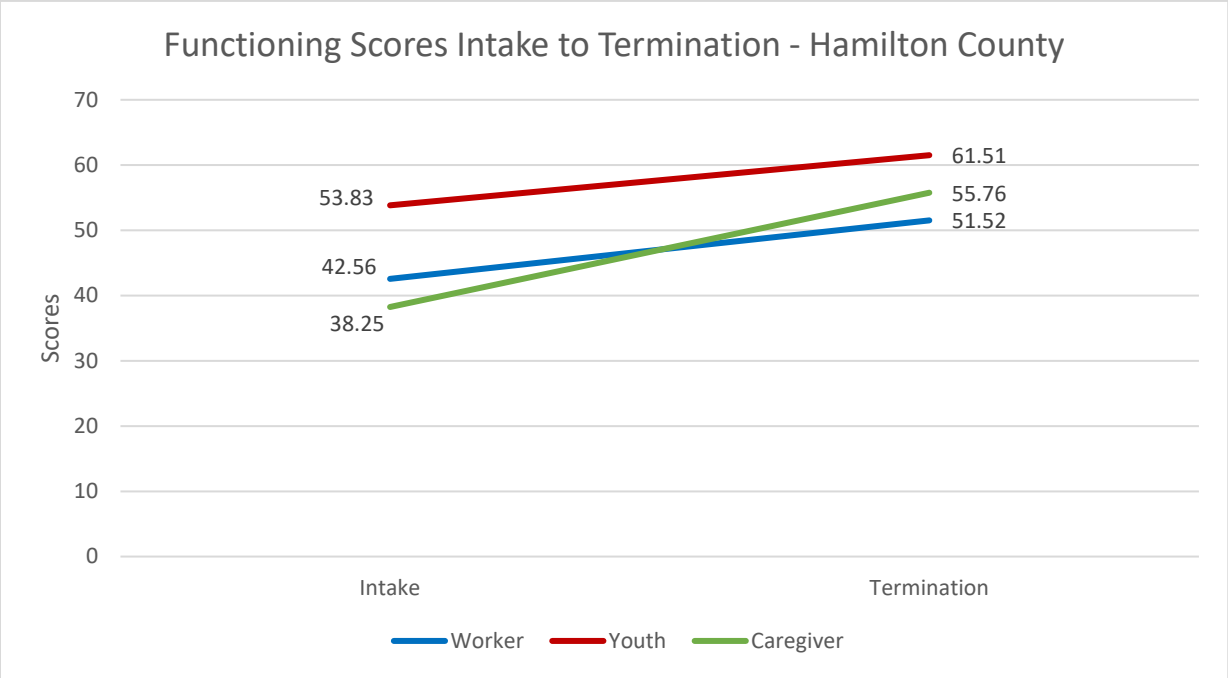
	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	29.57 (SD=20.78; n=71)	13.58 (SD=13.02; n=71)	7.40***	.88

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

Functioning Scores

Overall means for the Functioning scale by rater between intake and termination for Hamilton County youth are presented in Figure 93.

Figure 93.



Worker Ratings

For workers, paired samples t-tests indicated significant improvement in Functioning scores from intake to termination $t(73) = -4.30$, $p < .001$ with a moderate effect size (see Table 125).

Table 125. Paired Samples T-Tests for Functioning Scores – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	42.81 (SD=13.60; n=74)	51.20 (SD=15.44; n=74)	-4.30***	.50

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

Youth Ratings

Paired samples t-tests conducted on the youth reported Functioning scores indicated significant improvement from intake to termination $t(73) = -3.71$, $p < .001$ with a small effect size (see Table 126).

Table 126. Paired Samples T-Tests for Functioning Scores – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	55.08 (SD=13.41; n=74)	61.61 (SD=12.88; n=74)	-3.71***	.43

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvement in Functioning scores from intake to termination $t(70) = -6.92$, $p < .001$ with a large effect size (see Table 127).

Table 127. Paired Samples T-Tests for Functioning Scores – Caregiver

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	40.34 (SD=19.28; n=71)	55.82 (SD=17.59; n=71)	-6.92***	.82

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

Violence and Delinquency Questionnaire

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey composed of three general domains: exposure to violence, violence perpetration, and peer delinquency. The VDQ is offered at intake and termination into the BHJJ program. At intake, each item prompts the youth to answer within the context of the past year. At termination, youth are directed to answer "since the last time you answered these questions".

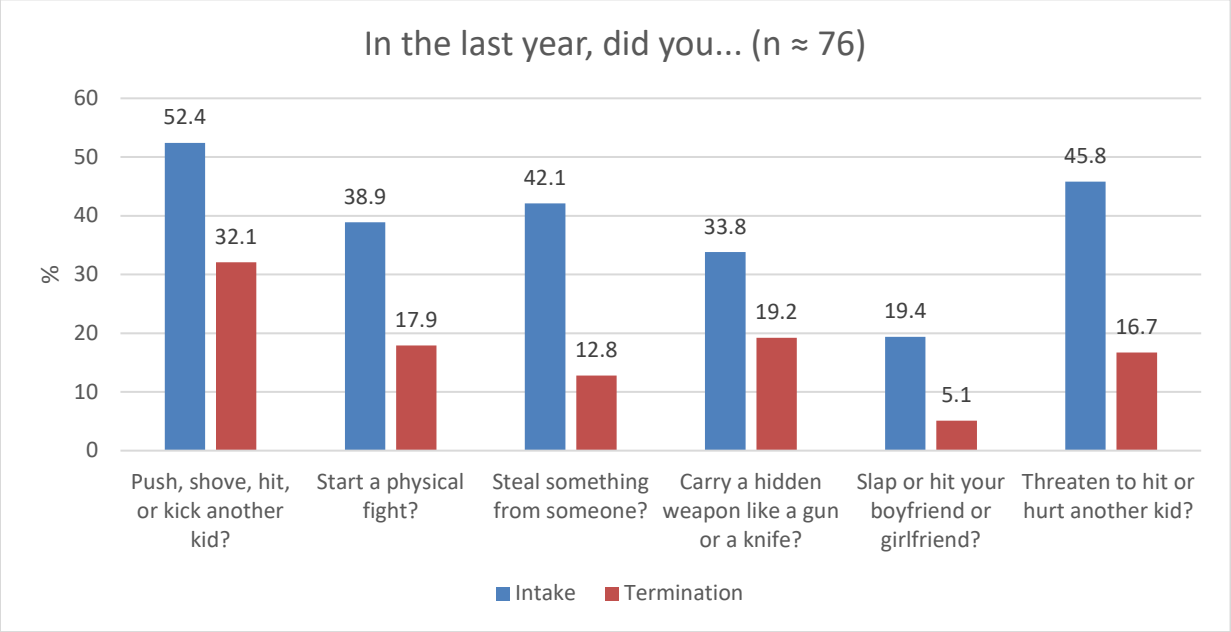
This section will be divided into three distinct parts that examine the prevalence of violence exposure as either a victim or witness, self-reported delinquent behavior from intake to termination, and delinquent behavior by peers from intake to termination. Table 128 provides the percentage of those who had experienced violence as either a victim or witness in the past year.

Table 128. Violence Exposure

	% Yes BHJJ Sample (n = 146)
In the last year, did someone threaten to hurt you when you thought they might really do it?	36.3%
In the last year, have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?	10.3%
In the last year, did a boyfriend or girlfriend or anyone you went on a date with slap or hit you?	21.4%
In the last year, did anyone steal anything from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?	41.1%
Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	17.8%
In the last year, did anyone hit or attack you WITHOUT using an object or weapon?	39.7%
In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?	21.9%
In the last year, did a grown-up touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?	3.4%
Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. In the last year, did another child or teen make you do sexual things?	6.8%
In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	13.0%
In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	33.6%
In the last year, in real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt them?	49.7%
In the last year, was anyone close to you murdered, like a friend, neighbor, or someone in your family?	34.5%
In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	24.8%
Not including spanking on your bottom, did a grown-up in your life hit, beat, kick or physically hurt you in any way?	23.1%
When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. In the last year, were you neglected?	8.3%

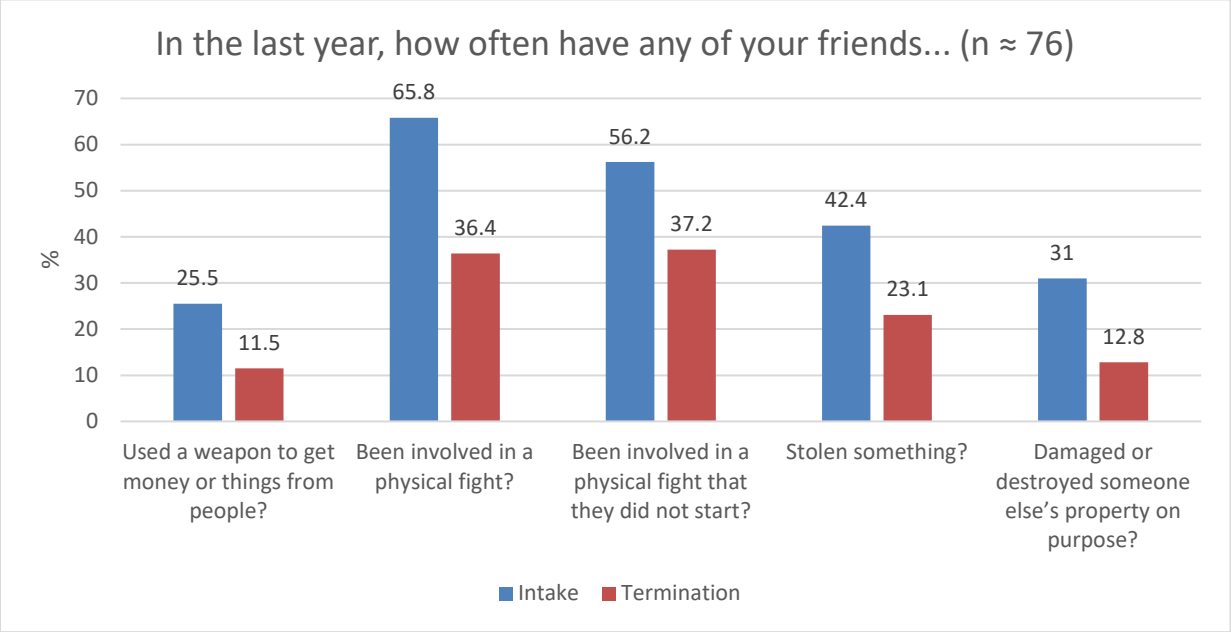
Delinquent behaviors were measured as self-report items of violent and weapon carrying behaviors as well as stealing. At intake, youth were asked how often they engaged in each behavior in the last year while at termination, youth were asked how often they engaged in the behavior since the last time they were asked. Figure 94 presents the percentage of youth who identified that they had engaged in each type of behavior at least once. Depending on the item, data were available for a range between 74 and 76 matched pairs (Mode = 76). McNemar's tests revealed statistically significant improvements from intake to termination for five items: push, shove, hit, or kick another kid, start a physical fight, steal something from someone, slap or hit your boyfriend or girlfriend, and threaten to hit or hurt another kid.

Figure 94.



Self-reported peer delinquency was also measured at intake (how often in the last year) and at termination (how often since the last time they were asked). Figure 95 presents the percentage of youth who identified how often their friends had engaged in delinquent behavior at intake and termination. Depending on the item, data were available for a range between 75 and 76 matched pairs (Mode = 76). Statistically significant improvements were found for each of the items between intake and termination.

Figure 95.



Resilience

As part of the 2017 - 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family.

Figure 96 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were “pretty much true” and “very much true”, we combined these responses. Generally, the majority of youth indicated high levels of endorsement for each one of these items. It is important to note, that the largest proportion of youth responding “not at all” or “a little true” were for two of the three items that measure empathy including “I feel bad when someone gets their feelings hurt” and “I try to understand how other people feel and think”.

Figure 96.

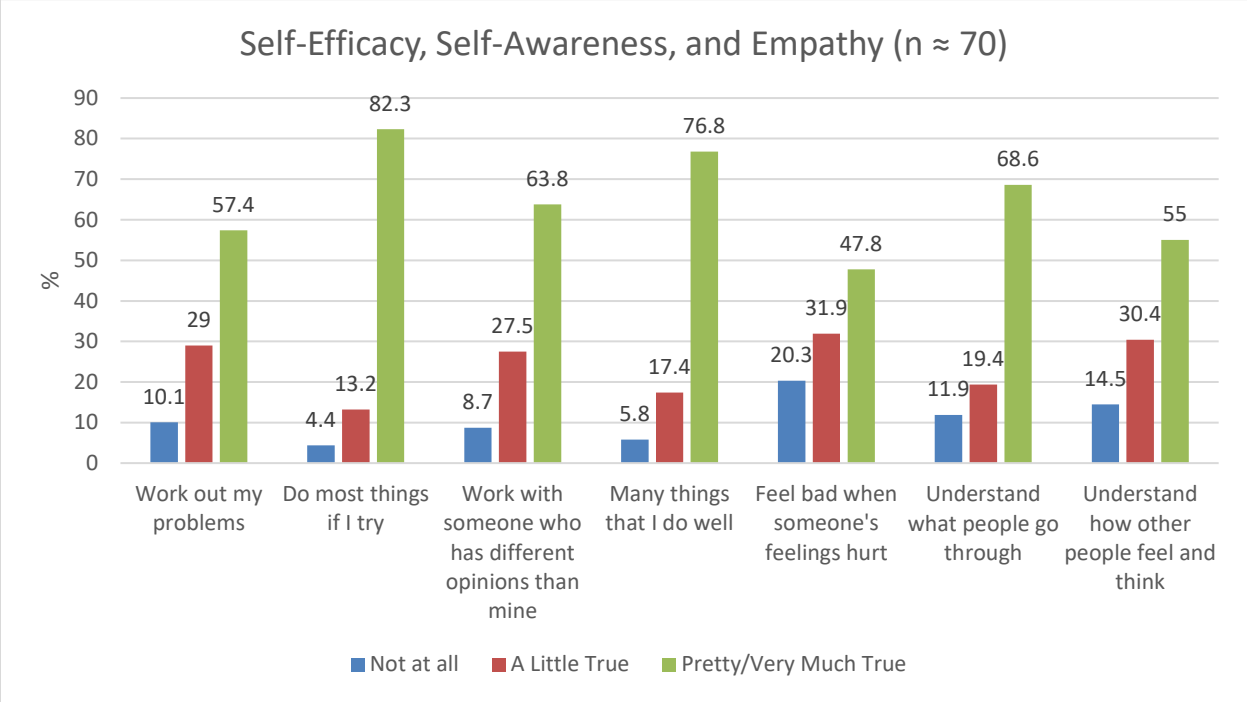


Figure 97 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. The majority of youth identified that each of the statements were either pretty much or very much true.

Figure 97.

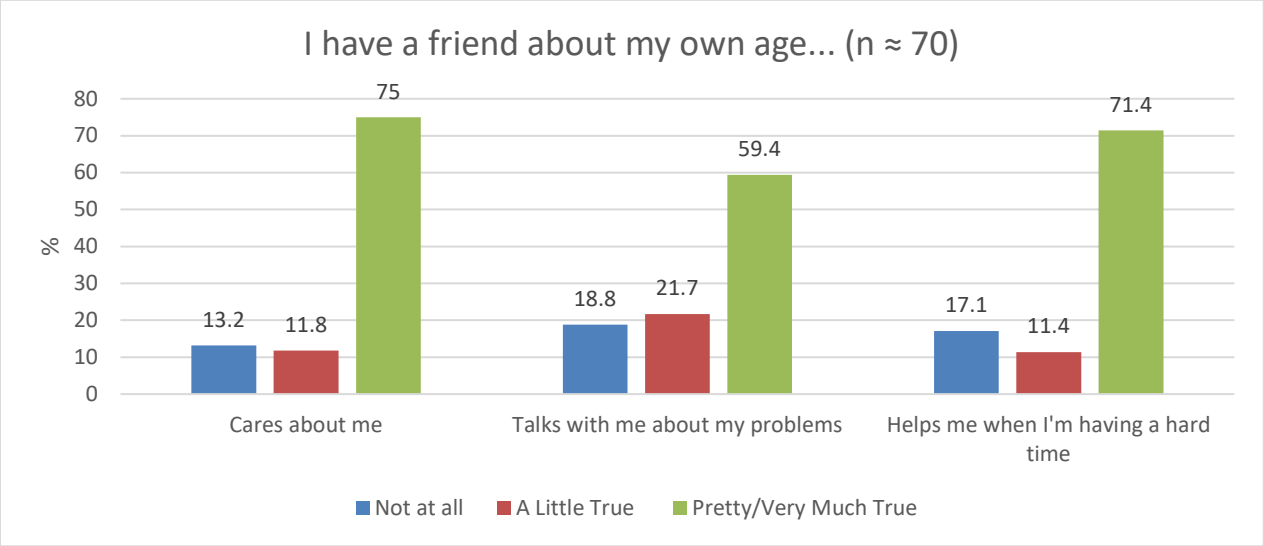
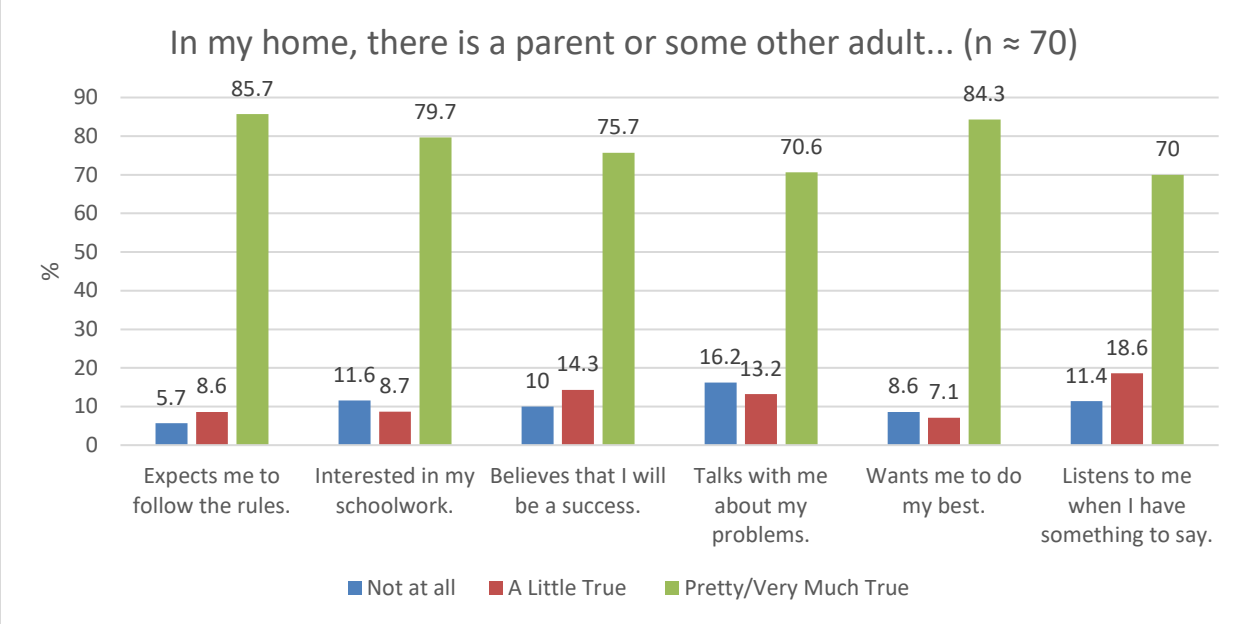


Figure 98 shows intake data on parental or support from other adults in their house. At least 70% of youth positively endorsed each of the items.

Figure 98.



In addition to intake data, Figure 99 through Figure 101 show the proportion of youth who identified that each of the statements were either pretty much or very much true from intake to termination. Due to sample size restrictions, McNemar's tests were not conducted. Figure 99 shows differences from intake to termination for the items measuring self-efficacy, self-awareness, and empathy. Youth exhibited either an improvement or no change in each of the items.

Figure 99.

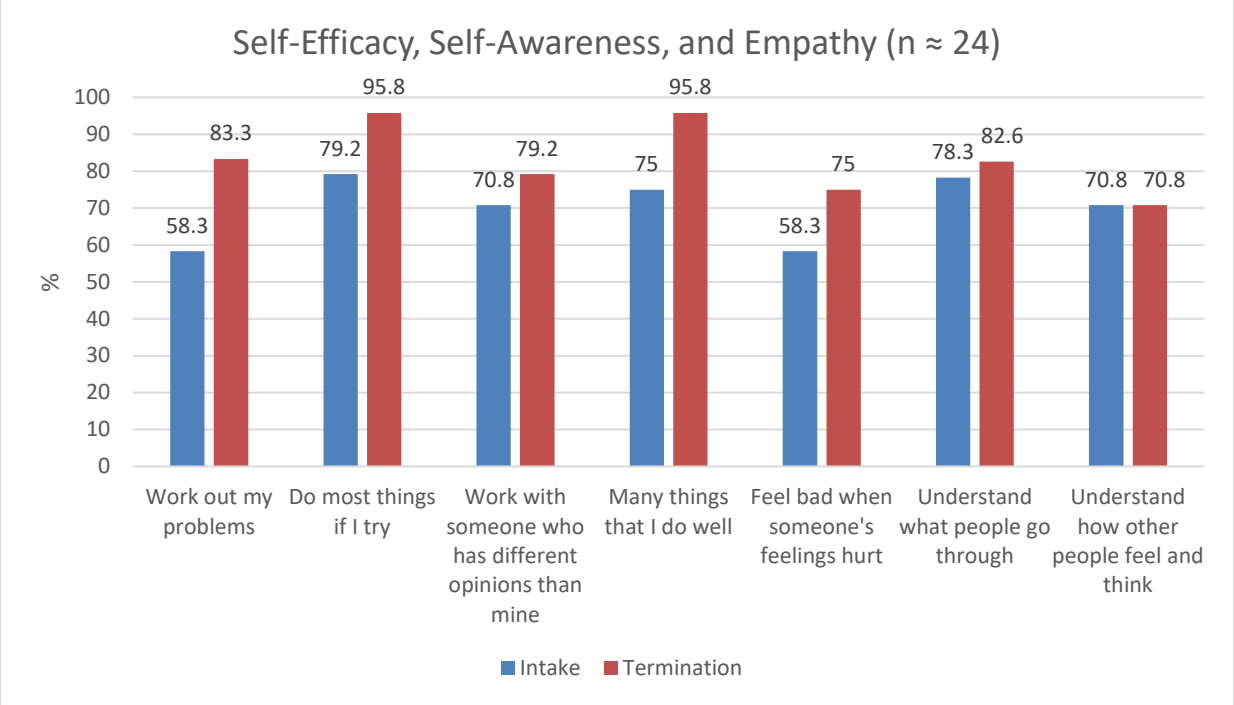


Figure 100 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring peer support. The number of valid responses was between 22 and 24. A slightly higher proportion of youth at termination responded positively to each of the items.

Figure 100.

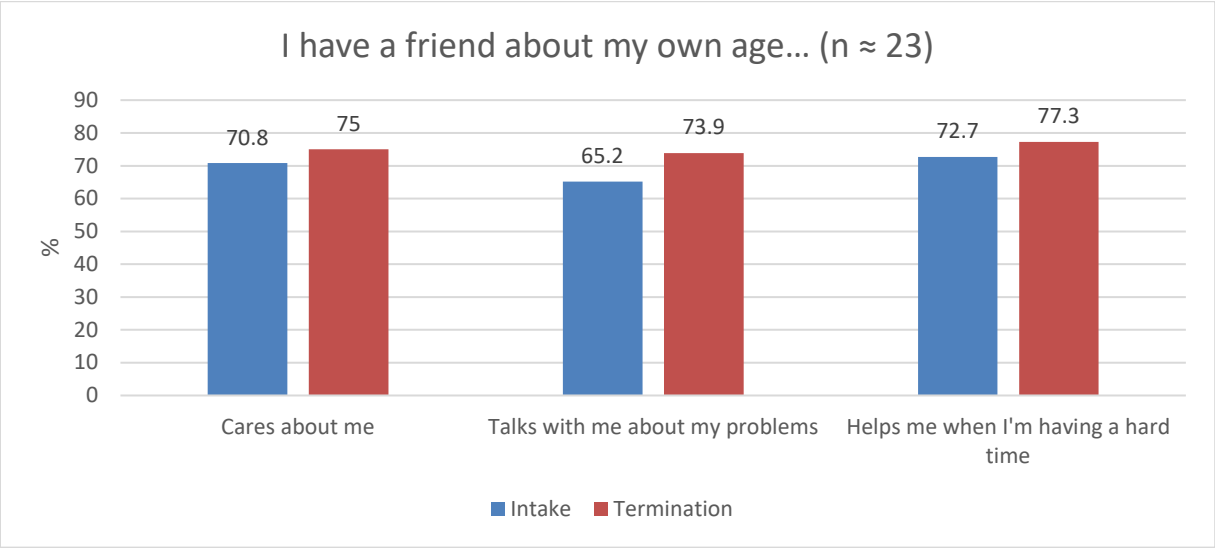
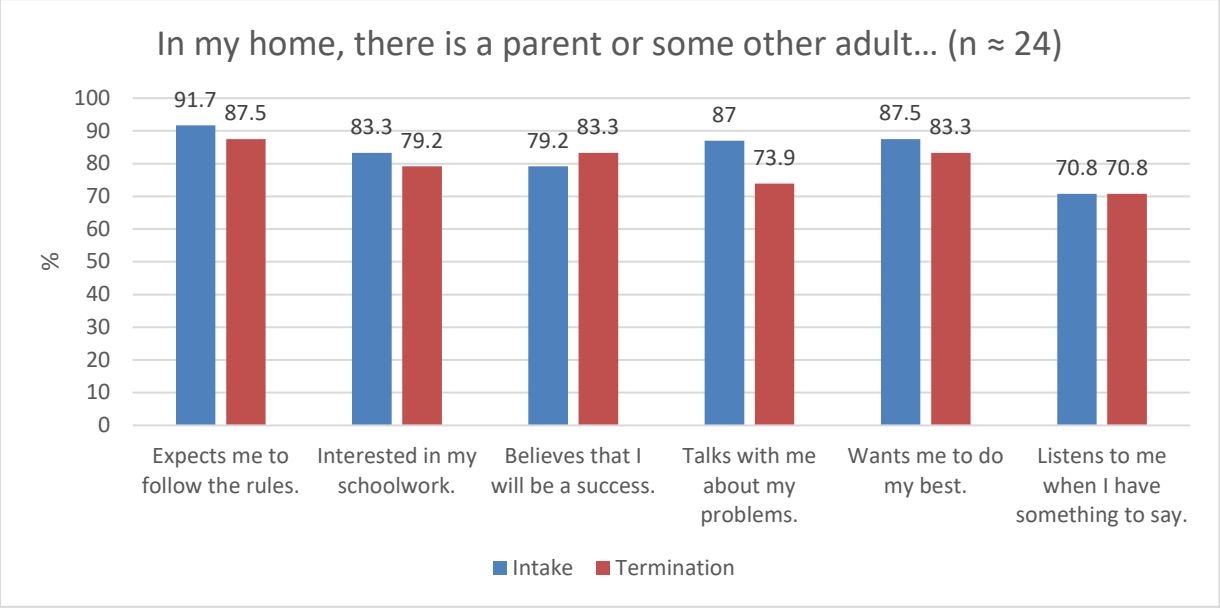


Figure 101 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring parental support or support from other adults in the home. Valid responses to these 6 items ranged between 23 and 24. The proportion of positive responses increased slightly for the item “believes that I will be a success”.

Figure 101.



TSCC

The TSCC was administered at intake and termination from BHJJ. Paired-samples t-tests were conducted to show whether means at intake and termination on each TSCC subscale differed significantly. Data were analyzed separately for females (see Figure 102) and males (see Figure 103) who had completed the TSCC at both intake and termination in Hamilton County.

Research has found that females consistently report more trauma symptoms than males (Singer et al., 1995). We examined trauma symptoms for females and males in the BHJJ sample. Consistent with previous research, BHJJ females in Hamilton County reported higher scores on each trauma symptom subscale than males. For example, at intake, the average score on the Anxiety domain was 9.50 for females and 2.84 for males. Paired samples t-tests revealed significant improvements in trauma symptoms for each domain except Anger for females and the Anger Domain for males (see Table 129 and Table 130).

Table 129. TSCC Subscales from Intake to Termination among Females

Females	Intake	Termination	t	d
Anxiety	9.50 (SD = 6.63; n = 12)	4.92 (SD = 5.05; n = 12)	2.71*	.82
Depression	11.42 (SD = 6.17; n = 12)	5.17 (SD = 4.41; n = 12)	3.35**	.97
Anger	10.17 (SD = 5.37; n = 12)	5.92 (SD = 6.65; n = 12)	2.09	.60
Posttraumatic Stress	10.75 (SD = 6.97; n = 12)	6.92 (SD = 6.91; n = 12)	2.53*	.73
Dissociation	11.58 (SD = 7.93; n = 12)	6.25 (SD = 5.59; n = 12)	2.80*	.81
Sexual Concerns	6.92 (SD = 4.72; n = 12)	3.25 (SD = 3.28; n = 12)	2.58*	.75

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

Figure 102.

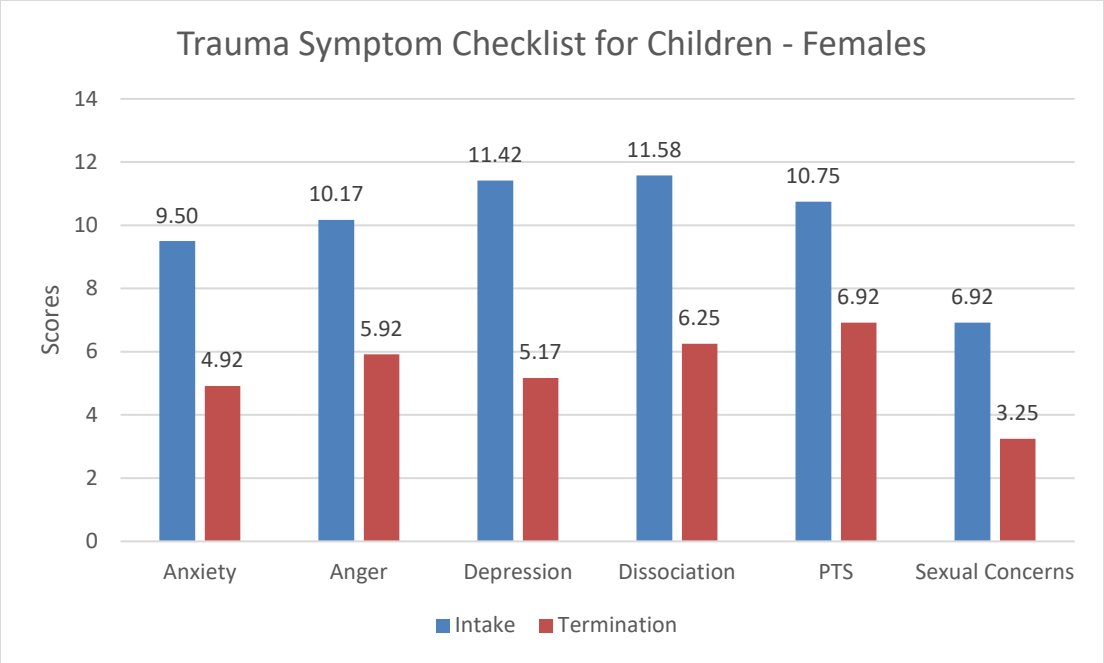
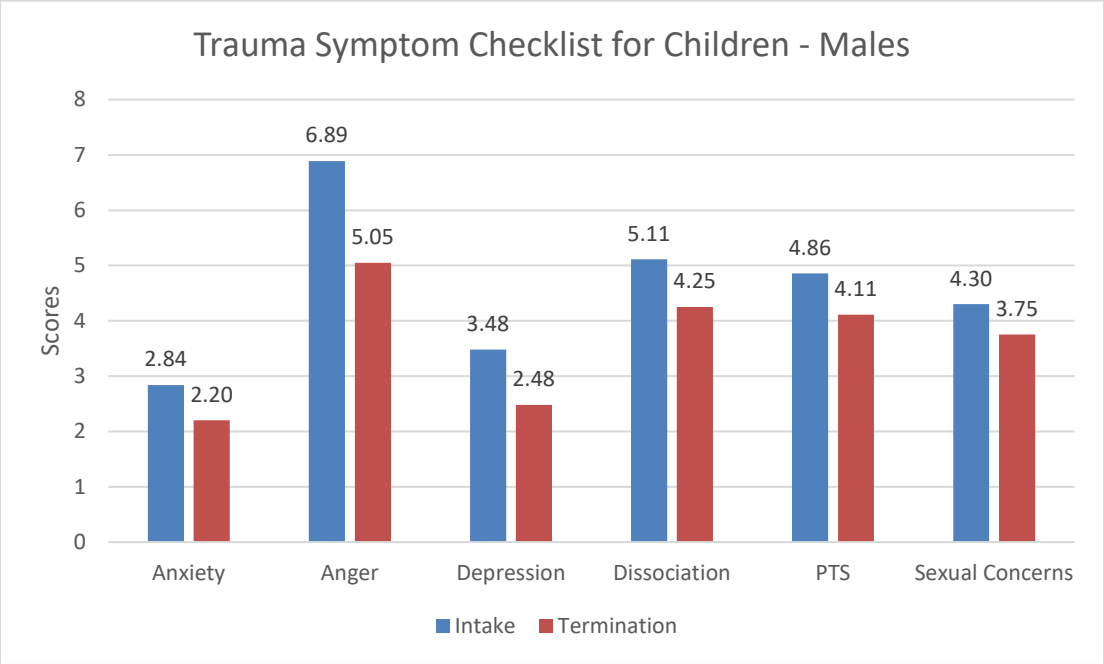


Table 130. TSCC Subscales from Intake to Termination for Males

Males	Intake	Termination	t	d
Anxiety	2.84 (SD = 3.48; n = 44)	2.20 (SD = 2.79; n = 44)	1.26	.19
Depression	3.48 (SD = 3.34; n = 44)	2.48 (SD = 3.32; n = 44)	1.77	.27
Anger	6.89 (SD = 5.47; n = 44)	5.05 (SD = 6.03; n = 44)	2.05*	.31
Posttraumatic Stress	4.86 (SD = 4.71; n = 44)	4.11 (SD = 4.91; n = 44)	.94	.14
Dissociation	5.11 (SD = 3.81; n = 44)	4.25 (SD = 4.40; n = 44)	1.19	.18
Sexual Concerns	4.30 (SD = 4.62; n = 44)	3.75 (SD = 3.81; n = 44)	.87	.14

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

Figure 103.



Substance Use Survey

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 131 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use by gender in Hamilton County. For both females and males, alcohol, tobacco, cannabis, and caffeine were the most commonly used substances. Chi-squared tests revealed that a significantly higher proportion of females reported ever having used alcohol than males ($\chi^2(1) = 7.02$, $p < .01$).

Table 131. Self-Reported Substance Use at Intake by Gender – Hamilton County

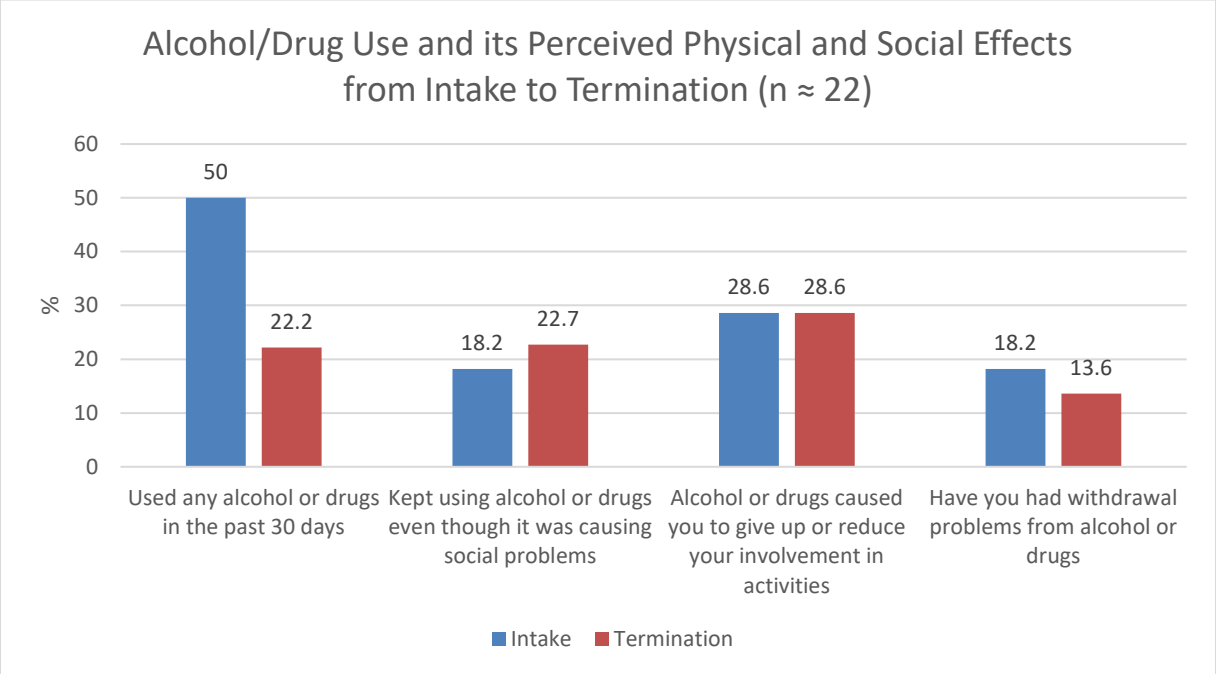
	Male		Female	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	**36.4% (n = 20)**	**12.45 (SD = 2.19)**	**76.9% (n = 10)**	**13.50 (SD = 1.18)**
Tobacco	41.8% (n = 23)	12.91 (SD = 2.50)	61.5% (n = 8)	12.63 (SD = 2.33)
Cannabis	59.3% (n = 32)	13.16 (SD = 2.37)	76.9% (n = 10)	12.70 (SD = 1.49)
Hallucinogens	5.6% (n = 3)	13.67 (SD = 1.53)	7.7% (n = 1)	15.00[a]
Inhalants	1.9% (n = 1)	11.00[a]	0.0% (n = 0)	
Opioids	5.6% (n = 3)	14.33 (SD = 1.15)	0.0% (n = 0)	
Sedatives	5.6% (n = 3)	14.33 (SD = 1.15)	8.3% (n = 1)	17.00[a]
Caffeine	40.7% (n = 22)	8.37 (SD = 4.11)	46.2% (n = 6)	10.50 (SD = 4.93)
Stimulants	1.9% (n = 1)	13.00[a]	8.3% (n = 1)	15.00[a]
Over the counter medications	9.3% (n = 5)	13.60 (SD = 0.89)	8.3% (n = 1)	14.00[a]
Other prescription drugs	5.6% (n = 3)	12.67 (SD = 3.21)	0.0% (n = 0)	
Herbs/Flowers	0.0% (n = 0)		0.0% (n = 0)	

[a] No Standard Deviations are calculated.

In addition to questions pertaining to the use of specific substances, youth were asked questions around general alcohol/drug use and its perceived effects on physical health and social functioning. The proportion of youth who indicated that they had used any alcohol or drugs in the past 30 days decreased from 50.0% at intake to 22.2% at termination. It is important to note here that the percentage of youth who indicated that they had used in the past 30 days in this more general question seems lower than the percentage who indicated past 30-day use in the questions that asked about specific substances. Percentages in Figure 104 included only those who had indicated they had ever used the specific substance. Further, we suspect that when asked a general question about alcohol or drugs, many of the youth may not consider a substance to be a drug and therefore may answer no to a general question about alcohol/drugs.

From intake to termination, the proportion of youth who indicated that they had continued to use alcohol/drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people at least sometimes increased slightly from intake to termination. The proportion of those who indicated that alcohol or drugs caused them to give up or reduce their involvement in activities stayed the same and the proportion of youth who indicated that they had withdrawal problems from alcohol or drugs declined from intake to termination. While none of these differences were statistically significant, it is likely a function of low cell sizes.

Figure 104.



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.

Between July 1, 2015 and June 30, 2019, there have been 83 youth terminated from the BHJJ program in Hamilton County. Sixty-four percent (63.9%, n = 53) of the youth terminated from the BHJJ program were identified as successful treatment completers. Five percent (4.8%, n = 4) were terminated from the program due to some type of incarceration. Table 132 presents all of the reasons for termination from BHJJ and displays reasons for termination for White and Black participants.

Table 132. Reasons for Termination from BHJJ

Termination Reason	All Youth Enrolled between July 2015 and June 2019	White Youth Enrolled between July 2015 and June 2019	Black Youth Enrolled between July 2015 and June 2019
Successfully Completed Services	63.9% (n = 53)	81.5% (n = 22)	54.9% (n = 28)
Client Did Not Return/Rejected Services	4.8% (n = 4)	11.1% (n = 3)	2.0% (n = 1)
Out of Home Placement	8.4% (n = 7)	0	11.8% (n = 6)
Client/Family Moved	3.6% (n = 3)	0	5.9% (n = 3)
Client Withdrawn	9.6% (n = 8)	7.4% (n = 2)	9.8% (n = 5)
Client AWOL	2.4% (n = 2)	0	3.9% (n = 2)
Client Incarcerated	4.8% (n = 4)	0	7.8% (n = 4)
Other	2.4% (n = 2)	0	3.9% (n = 2)

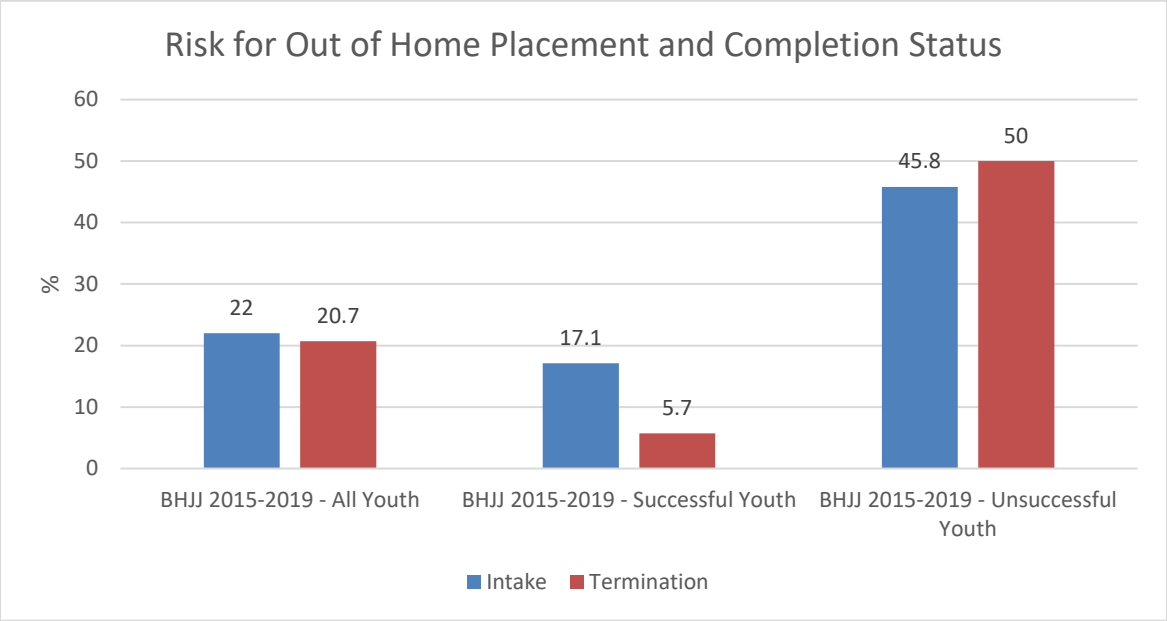
Average Length of Stay

Since the start of BHJJ, the average length of stay (ALOS) in the program was 213.1 days. For youth identified as successful treatment completers, the ALOS was 223.9 days while for unsuccessful treatment completers, the ALOS was 188.9 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, 22.0% of the youth (n = 24) were at risk for out of home placement. At termination, 20.7% (n = 17) of youth were at risk for out of home placement (see Figure 105). Of those youth who successfully completed BHJJ treatment, 5.7% (n = 3) were at risk for out of home placement at termination while 50.0% (n = 14) of youth who completed unsuccessfully were at risk for out of home placement (see Figure 105).

Figure 105.



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 services through BHJJ. Workers reported that police contacts had been reduced for 66.7% (n = 56) of the youth and had stayed the same for 26.2% (n= 22) of the youth. Police contacts increased for 4.8% (n = 4) of the youth and the worker was unable to estimate for 2.4% of youth (n = 2).

YSSF

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the services they received through the BHJJ program in Hamilton County as well as how services impacted their children and family. At termination from the BHJJ program, 91.2% (n =31) of caregivers either strongly agreed or agreed that BHJJ staff were sensitive to their cultural/ethnic background and 100% (n =34) either strongly agreed or agreed that the location of the services was convenient (see Figure 106). Over seventy-three percent (73.5%, n = 25) of caregivers reported that as a result of the services their

child/family received, their child gets along better with family members and 73.5% (n = 25) reported their child is better able to do the things they want to do (see Figure 107).

Figure 106.

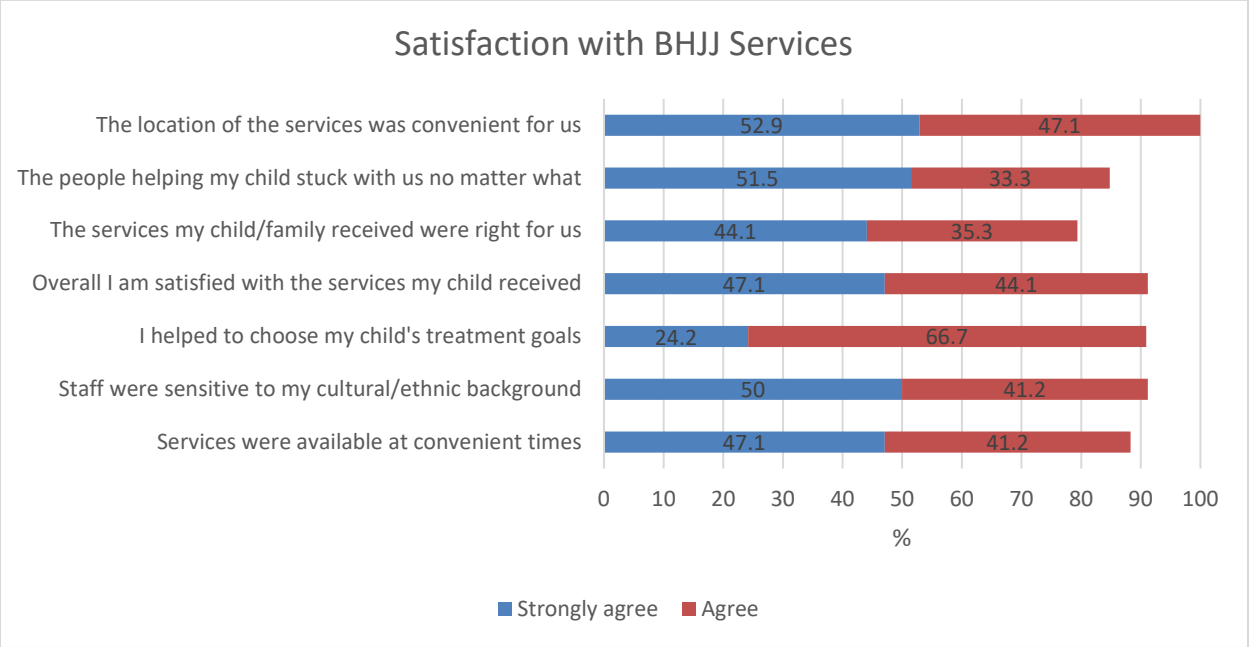
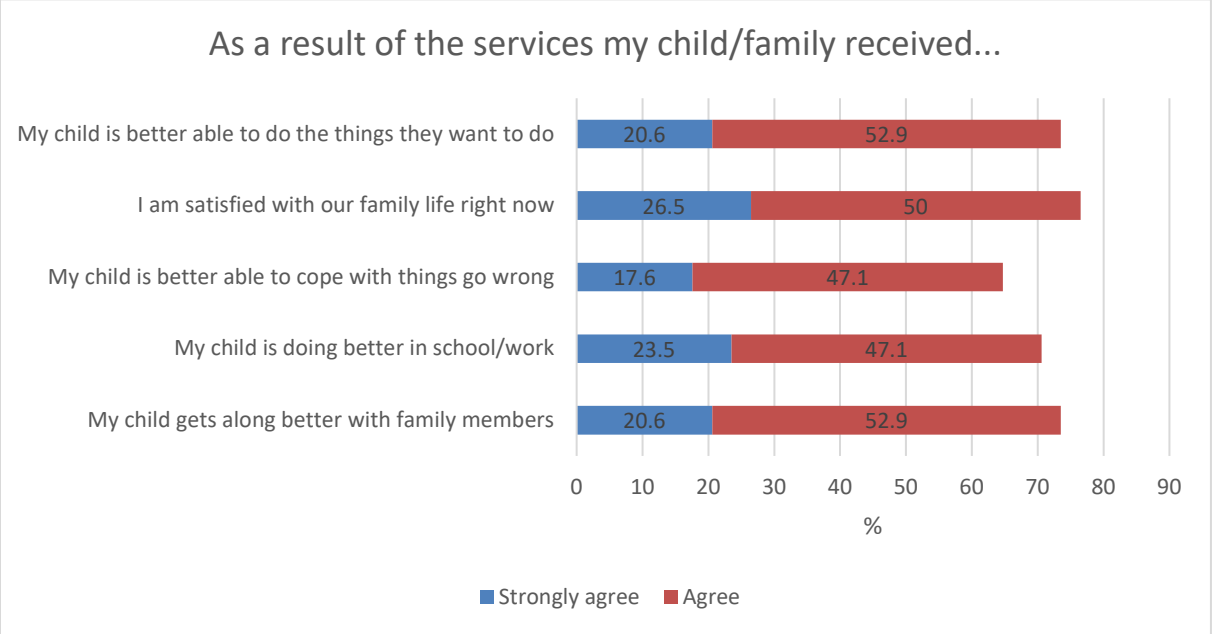


Figure 107.



Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve months prior to the end of the data collection period for inclusion in the analysis. These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 69.0% (n = 325) of BHJJ youth in Hamilton county enrolled between July 1, 2015 and June 30, 2019 had a misdemeanor charge, 41.0% (n = 55) had a felony charge, and 86.6% (n = 116) had been adjudicated delinquent in the 12 months prior to enrollment (see Table 133). There were some differences in the previous levels of juvenile court involvement based on completion status (successful vs. unsuccessful). For example, in the 12 months prior to enrollment in BHJJ, 65.4% (n = 34) of successful completers and 86.2% (n = 25) of unsuccessful completers had a misdemeanor charge (see Table 134

and Table 135). Chi-square analyses revealed that a higher proportion of youth who were terminated unsuccessfully had a misdemeanor charge in the 12 months and 18 months prior to intake compared to those who completed successfully.

Table 133. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 134)	63.4% (n = 85)	28.4% (n = 38)	80.6% (n = 108)
12 months (n = 134)	69.0% (n = 325)	41.0% (n = 55)	86.6% (n = 116)
18 months (n = 134)	77.6% (n = 104)	44.8% (n = 60)	87.3% (n = 117)

Table 134. Charges Prior to BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 52)	55.8% (n = 29)	30.8% (n = 16)	88.5% (n = 46)
12 months (n = 52)	65.4% (n = 34)	42.3% (n = 22)	90.4% (n = 47)
18 months (n = 52)	71.2% (n = 37)	44.2% (n = 23)	90.4% (n = 47)

Table 135. Charges Prior to BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 29)	72.4% (n = 21)	27.6% (n = 8)	86.2% (n = 25)
12 months (n = 29)	86.2% (n = 25)	34.5% (n = 10)	93.1% (n = 27)
18 months (n = 29)	96.6% (n = 28)	37.9% (n = 11)	93.1% (n = 27)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 136). In the 12 months after enrollment in BHJJ, 52.6% (n = 61) of participants were charged with at least one new misdemeanor and 27.6% (n = 32) were charged with at least one new felony. More than 80% (81.0%; n = 94) of the youth were adjudicated delinquent in the 12 months after their enrollment in BHJJ.

Table 136. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 127)	38.6% (n = 49)	17.3% (n = 22)	63.0% (n = 80)
12 months (n = 116)	52.6% (n = 61)	27.6% (n = 32)	81.0% (n = 94)
18 months (n = 101)	66.3% (n = 67)	33.7% (n = 34)	86.1% (n = 87)

In the 12 months after enrollment in BHJJ, 39.0% (n = 16) of successful completers were charged with at least one new misdemeanor, 17.1% (n=7) were charged with at least one new felony, and 75.6% (n=31) were adjudicated delinquent (see Table 137). Of the youth who completed unsuccessfully, 65.4% (n = 17) were charged with at least one new misdemeanor, 46.2% (n = 12) were charged with at least one new felony, and 96.2% (n = 25) were adjudicated delinquent in the 12 months after their enrollment in BHJJ (see Table 138). Chi-square analyses revealed that **a significantly higher percentage of unsuccessful completers were charged with at least one misdemeanor charge at 12 months, felony charges at 12 and 18 months after intake and were adjudicated delinquent in the 6 and 12 months after intake.**

Table 137. Recidivism after BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 46)	32.6% (n = 15)	13.0% (n = 6)	56.5% (n = 26)
12 months (n = 41)	39.0% (n = 16)	17.1% (n = 7)	75.6% (n = 31)
18 months (n = 37)	56.8% (n = 21)	21.6% (n = 8)	83.8% (n = 31)

Table 138. Recidivism after BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 28)	50.0% (n = 14)	28.6% (n = 8)	85.7% (n = 24)
12 months (n = 26)	65.4% (n = 17)	46.2% (n = 12)	96.2% (n = 25)
18 months (n = 24)	75.0% (n = 16)	50.0% (n = 12)	95.8% (n = 23)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 139). In the 12 months after termination from BHJJ, 37.9% (n = 22) of youth were charged with at least one new misdemeanor and 13.8% (n = 8) were charged with at least one new felony, and 60.3% (n = 35) were adjudicated delinquent.

Table 139. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 66)	16.7% (n = 11)	6.1% (n = 4)	47.0% (n = 31)
12 months (n = 58)	37.9% (n = 22)	13.8% (n = 8)	60.3% (n = 35)
18 months (n = 21)	45.7% (n = 21)	23.9% (n = 11)	69.6% (n = 32)

In the 12 months following their termination from BHJJ, 33.3% (n = 11) of successful completers were charged with at least one new misdemeanor, 9.1% (n = 3) were charged with at least one new felony, and 54.5% (n = 27) were adjudicated delinquent (see Table 140). Of the youth who completed unsuccessfully, 45.8% (n = 11) were charged with at least one new misdemeanor, 16.7% (n = 4) were charged with at least one new felony, and 66.7% (n = 16) were adjudicated delinquent in the 12 months after their termination from BHJJ (see Table 141). **Chi-square analyses revealed that a higher proportion of youth who were unsuccessfully terminated were adjudication delinquent in the 6 and 18 months after termination.**

Table 140. Recidivism after BHJJ Termination for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 38)	13.2% (n = 5)	2.6% (n = 1)	34.2% (n = 13)
12 months (n = 33)	33.3% (n = 11)	9.1% (n = 3)	54.5% (n = 18)
18 months (n = 22)	40.9% (n = 9)	13.6% (n = 3)	54.5% (n = 12)

Table 141. Recidivism after BHJJ Termination for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 26)	23.1% (n = 6)	7.7% (n = 2)	61.5% (n = 16)
12 months (n = 24)	45.8% (n = 11)	16.7% (n = 4)	66.7% (n = 16)
18 months (n = 23)	52.2% (n = 12)	30.4% (n = 7)	82.6% (n = 19)

ODYS Commitments

Among a total of 134 youth who enrolled since July 1, 2015, 3.7% (n = 5) were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ. **Conversely, 96.3% of youth participating in BHJJ were not admitted to an ODYS facility at any point after enrollment.**

Average Numbers of Charges and Adjudications

In addition to whether a youth was charged or adjudicated delinquent, we examined whether there were differences in the average number of charges and adjudications in equivalent periods of time prior to enrollment and after termination. We conducted paired samples *t*-tests to examine whether there were statistically significant differences in the mean number of charges and adjudications at each time period prior to and after BHJJ participation. Figure 108 shows the average number of charges for youth who had data at both time periods. This restriction resulted in a sample of 66 youth at 6 months, 58 youth at 12 months, and 46 youth at 18 months. **Paired samples *t*-tests revealed a statistically significant decline in the average number of misdemeanors for each time period, felony charges at 6 and 12 months, and adjudications at each time period.** For example, the average number of misdemeanor charges 18 months prior to BHJJ enrollment was 2.63 while the average number of misdemeanor charges 18 months after BHJJ termination was 1.06.

Figure 108.

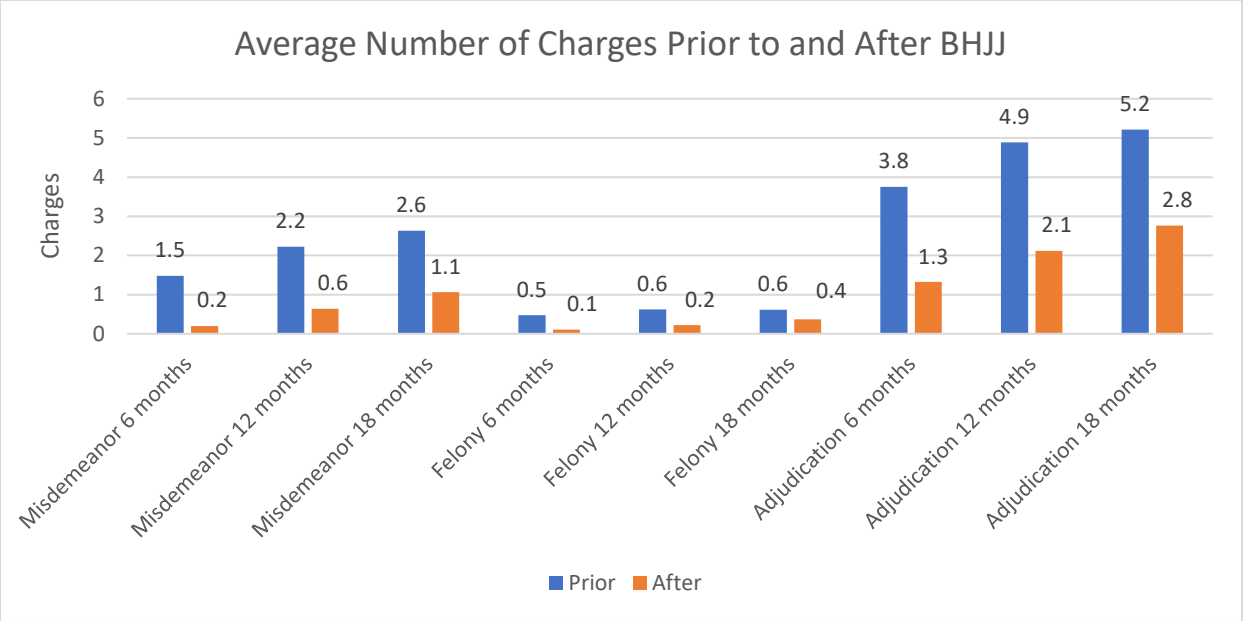


Figure 109 and Figure 110 shows mean differences in charges and adjudications for youth who successfully completed the program and those who did not successfully terminate. To be included in the analysis youth must have data at both time periods. This restricted the sample to 38 youth at 6 months, 33 youth at 12 months, and 22 youth at 18 months for youth who were successfully terminated and 26 youth at 6 months, 24 youth at 12 months, and 23 youth at 18 months for those who terminated unsuccessfully. **For youth who successfully completed, paired samples *t*-tests revealed that there was a significant reduction in the average number of misdemeanor charges a each time period prior to and after BHJJ, felony charges at 6 months and adjudications for each of the time periods we examined.** For example, the average number of felony charges at 12 months went from 0.73 prior to intake to 0.18 after termination. **Similarly, for youth who terminated unsuccessfully, paired samples *t*-tests revealed that there was a significant reduction in the average number of misdemeanors for each of the time periods we examined, felony charges at 6 months, and adjudications for each time period.** For example, the average number of adjudications went from 6.37 in the 12 months prior to intake to 2.71 after termination.

Figure 109.

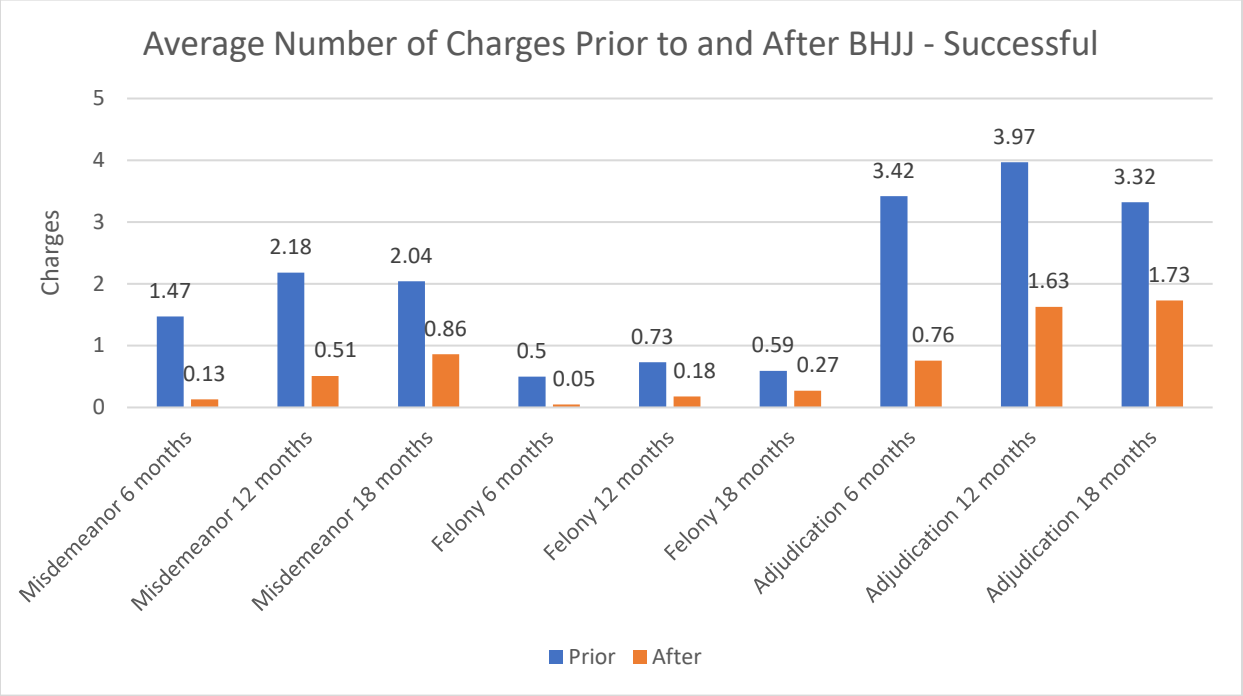
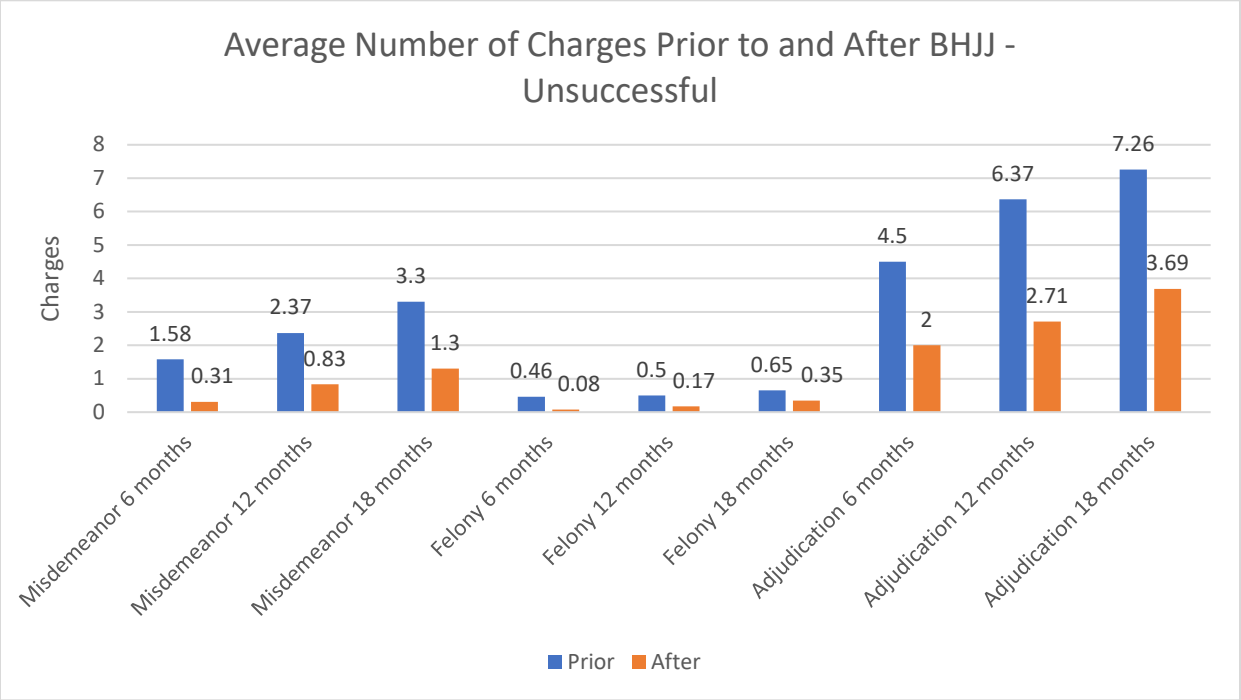


Figure 110.


Average Number of Charges Prior to and After BHJJ - Unsuccessful
Charges
8
7
6
5
4
3
2
1
0
1.58
0.31
2.37
0.83
3.3
1.3
0.46
0.08
0.5
0.17
0.65
0.35
4.5
2
6.37
2.71
7.26
3.69
Misdemeanor 6 months
Misdemeanor 12 months
Misdemeanor 18 months
Felony 6 months
Felony 12 months
Felony 18 months
Adjudication 6 months
Adjudication 12 months
Adjudication 18 months
Prior
After

Lucas

Demographics

As of June 30, 2019, 360 youth were enrolled into the BHJJ program in Lucas County. The average age at enrollment was 15.2 years (SD=1.43). More males (78.2%, n = 280) than females (21.8%, n = 78) have been enrolled. Black youth (51.1%, n = 182), White youth (36.2%, n = 129), and Multiracial youth (10.7%, n = 38) comprised the majority of the total sample.

There were 66 new enrollments in Lucas County during the current reporting period (July 1, 2017 through June 30, 2019). The average age at enrollment was 15.0 (SD = 1.70). Males (77.3%, n = 51) outnumbered females (22.7%, n = 15), and more Black youth (48.5%, n = 32) than White youth (42.4%, n = 28) were enrolled. Over thirteen percent (13.6%, n = 9) of the youth self-identified as Hispanic/Latinx.

Unless otherwise noted, the following sections describe data from the past four years of BHJJ programming from July 1, 2015 through June 30, 2019.

Custody Arrangement and Household Information

At intake, the majority of youth lived with the biological mother (54.2%, n = 52), while 24.0% (n = 23) lived with two biological parents or one biological and one step/adoptive parent (see Table 142). Over eighty percent (80.2%, n = 77) of BHJJ youth lived with at least one biological at enrollment.

Seventy-seven percent (77.4%; n = 72) of the BHJJ caregivers had at least a high school diploma or GED, and 14.0% (n = 13) had a bachelor's degree or higher. Over twenty-two percent of caregivers (22.6%; n = 21) reported they did not graduate from high school (see Table 143).

Caregivers were asked to report their annual household income (see Table 144). The income range with the highest endorsement was less than $5,000 (27.4%, n = 26). Overall, 65.3% (n = 62) reported a family income of $24,999 or less. When examined by race, 32.4% (n = 12) of White families, 54.2% (n = 7) of Black families, and 66.7% (n = 6) of Multiracial families reported a household income of $14,999 or less. Table 144 displays the reported household income overall and by race.

Table 142. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	24.0% (n = 23)
Biological Mother Only	54.2% (n = 52)
Biological Father Only	2.1% (n = 2)
Adoptive Parent(s)	8.3% (n = 8)
Aunt/Uncle	3.1% (n = 3)
Grandparents	6.3% (n = 6)
Other	2.1% (n = 2)

Table 143. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	22.6% (n = 21)
High School Graduate or G.E.D.	32.3% (n = 30)
Some College or Associate Degree	31.2% (n = 29)
Bachelor's Degree	7.5% (n = 7)
More than a Bachelor's Degree	6.5% (n = 6)

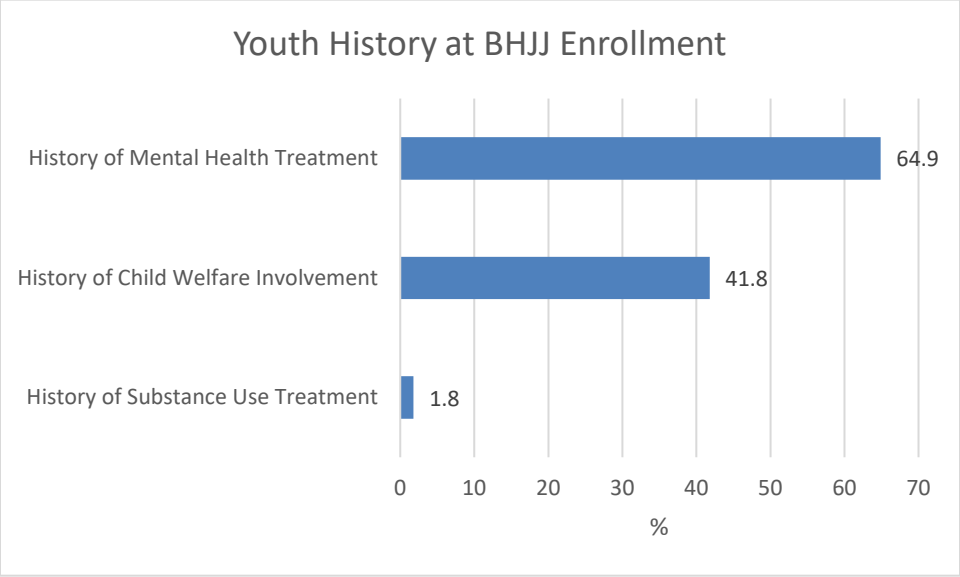
Table 144. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Black	Multiracial
Less than $5,000	27.4% (n = 26)	10.8% (n = 4)	37.5% (n = 18)	44.4% (n = 4)
$5,000 - $9,999	6.3% (n = 6)	10.8% (n = 4)	2.1% (n = 1)	NA
$10,000 - $14,999	13.7% (n = 13)	10.8% (n = 4)	14.6% (n = 7)	22.2% (n = 2)
$15,000 - $19,999	7.4% (n = 7)	2.7% (n = 1)	12.5% (n = 6)	NA
$20,000 - $24,999	10.5% (n = 10)	13.5% (n = 5)	8.3% (n = 4)	11.1% (n = 1)
$25,000 - $34,999	8.4% (n = 8)	8.1% (n = 3)	8.3% (n = 4)	11.1% (n = 1)
$35,000 - $49,999	7.4% (n = 7)	8.1% (n = 3)	8.3% (n = 4)	NA
$50,000 - $74,999	8.4% (n = 8)	13.5% (n = 5)	6.3% (n = 3)	NA
$75,000 or greater	10.5% (n = 10)	21.6% (n = 8)	2.1% (n = 1)	11.1% (n = 1)

Youth and Family History

Workers were asked to identify a youth's prior behavioral health and child welfare system involvement (see Figure 111). These three items were new to the past biennium, therefore, data are only available for youth enrolled between July 1, 2017 and June 30, 2019. Over forty-one percent (41.8%, n = 23) of youth had a history of child welfare involvement prior to BHJJ enrollment. Under two percent (1.8%, n = 1) of youth had received substance use treatment in their lifetime prior to BHJJ enrollment and 64.9% (n = 37) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 111.



Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history. Chi-square analyses were conducted on each item to test for gender differences and significant differences are identified in Table 145. A significantly larger proportion of the caregivers of females reported lifetime histories of running away. A significantly higher proportion of the caregivers of males reported a history of substance abuse.

Caregivers reported that 11.1% (n = 2) of females and 12.7% (n = 10) of males had a history of being physically abused while 27.8% (n = 5) of females and 12.0% (n = 9) of males had a history of being sexual abused. Caregivers of 33.3% (n = 6) of females and 46.8% (n = 37) of males reported hearing the child talking about committing suicide and 27.8% (n = 5) of females and 19.0% (n = 15) of males had attempted suicide at least once. A majority of the caregivers of females (64.7%, n = 11) and males (59.0%, n = 46) reported a family history of depression.

Table 145. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	11.1% (n = 2)	12.7% (n = 10)
Has the child ever been sexually abused?	27.8% (n = 5)	12.0% (n = 9)
Has the child ever run away?	83.3% (n = 15)*	55.7% (n = 44)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	23.5% (n = 4)	59.2% (n = 45)**
Has the child ever talked about committing suicide?	33.3% (n = 6)	46.8% (n = 37)
Has the child ever attempted suicide?	27.8% (n = 5)	19.0% (n = 15)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	38.9% (n = 7)	36.7% (n = 29)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	64.7% (n = 11)	59.0% (n = 46)
Has anyone in the child's biological family had a mental illness, other than depression?	61.1% (n = 11)	57.7% (n = 41)
Has the child ever lived in a household in which someone was convicted of a crime?	43.8% (n = 7)	45.5% (n = 35)
Has anyone in the child's biological family had a drinking or drug problem?	38.9% (n = 7)	57.0% (n = 45)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	55.6% (n = 10)	45.5% (n = 35)

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

Problems Leading to Service

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-related problems (94.4% and 87.5% respectively) (see Table 146).

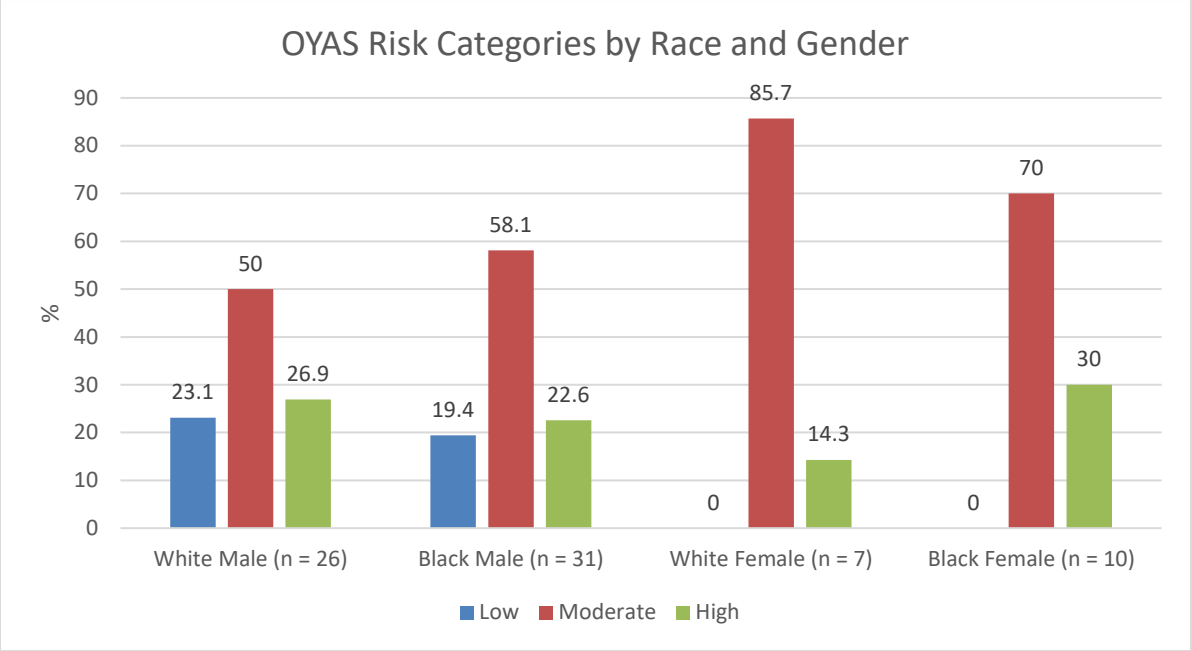
Table 146. Problems Leading to Services

Problems Leading to Services	Females	Males
Adjustment-related problems	5.6% (n = 1)	2.5% (n = 2)
Anxiety-related problems	0	11.3% (n = 9)
Conduct/delinquency-related problems	94.4% (n = 17)	87.5% (n = 70)
Depression-related problems	22.2% (n = 4)	17.5% (n = 14)
Eating disorders	0	1.3% (n = 1)
Hyperactive and attention-related problems	22.2% (n = 4)	31.3% (n = 25)
Learning disabilities	0	8.8% (n = 7)
Pervasive development disabilities	0	2.5% (n = 2)
Psychotic behaviors	5.6% (n = 1)	1.3% (n = 1)
School performance problems not related to learning disabilities	16.7% (n = 3)	41.3% (n = 33)
Specific developmental disabilities	0	2.5% (n = 2)
Substance use, abuse, dependence-related problems	0	32.5% (n = 13)
Suicide-related problems	0	7.5% (n = 6)

Ohio Youth Assessment System

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 112 shows the distribution of OYAS risk categories for BHJJ youth by race and gender. In Lucas County, 26.9% (n = 7) of White males and 22.6% (n = 7) of Black males enrolled in the BHJJ program were identified as High risk on the OYAS, while 14.3% (n = 1) of White females and 30.0% (n = 3) of Black females were identified as High risk.

Figure 112.



DSM Diagnoses

Workers were asked to report any DSM 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 diagnosis for females and males was Oppositional Defiant Disorder (see Table 147). Chi-square analysis indicated males were significantly more likely than females to be diagnosed with Attention Deficit Hyperactivity Disorder.

Table 147. Most Common DSM Diagnoses

DSM Diagnosis	Females (n = 18)	Males (n = 78)
Adjustment Disorder	11.1% (n = 2)	1.3% (n = 1)
Alcohol-related Disorders	0	1.3% (n = 1)
Attention Deficit Hyperactivity Disorder	16.7% (n = 3)	39.7% (n = 31)*
Bipolar Disorder	5.6% (n = 1)	3.8% (n = 3)
Cannabis-related Disorders	11.1% (n = 2)	12.8% (n = 10)
Conduct Disorder	0	9.0% (n = 7)
Depressive Disorders	22.2% (n = 4)	15.4% (n = 12)
Disruptive Behavior Disorder	0	2.6% (n = 2)
Unspecified Mood Disorder	0	0
Oppositional Defiant Disorder	**72.2% (n = 13)**	**74.4% (n = 58)**
Post-traumatic Stress Disorder	16.7% (n = 3)	10.3% (n = 8)
Unspecified Trauma and Stressor Related Disorder	5.6% (n = 1)	2.6% (n = 2)
Disruptive Mood Dysregulation Disorder	0	0
Co-Occurring Disorder	11.1% (n = 2)	12.8% (n = 10)

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

Educational Information

Several items focused on educational 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. The wording on some items (e.g. IEP at intake, attendance at intake) was changed from previous versions of the forms. For those items, we present data from only the past biennium (when the new forms were in use). Those items will have smaller sample sizes compared to items that have been consistent for the past four years.

Over fifty-nine percent (59.7%, n = 52) of youth were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in BHJJ treatment BHJJ, 32.1% (n = 17) of the youth were expelled or suspended from school (a 46.3% decrease from intake to termination).

Educational data were analyzed for youth who were eligible for inclusion (youth on summer break or who had graduated at the time of the survey were not included in the analyses). At intake, 100% (n = 51) of youth were currently attending school while at termination, 70.4% (n = 31) 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 148 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 149 displays this information based on completion status. At intake, 52.8% of youth were earning mostly A's and B's, and C's while at termination, 53.1% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 149). For example, at intake, 28.6% of youth who would go on to be unsuccessful completers and 52.5% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 14.3% of unsuccessful completers and 59.5% of successful completers received mostly A's, B's, or C's.

Table 148. Academic Performance

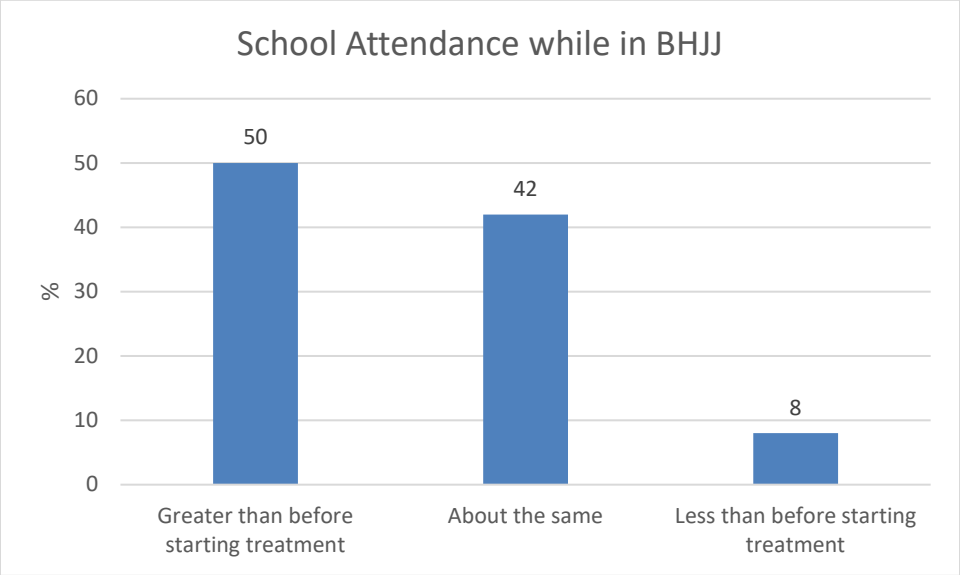
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	25.8% (n = 23)	18.4% (n = 9)
Mostly B's and C's	27.0% (n = 24)	34.7% (n = 17)
Mostly C's and D's	23.6% (n = 21)	28.6% (n = 14)
Mostly D's and F's	23.6% (n = 21)	18.4% (n = 9)

Table 149. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	28.6% (n = 2)	14.3% (n = 1)	25.0% (n = 8)	19.0% (n = 8)
Mostly B's and C's	0	0	27.5% (n = 11)	40.5% (n = 17)
Mostly C's and D's	42.9% (n = 3)	57.1% (n = 4)	27.5% (n = 11)	23.8% (n = 10)
Mostly D's and F's	28.6% (n = 3)	28.6% (n = 2)	20.0% (n = 8)	16.7% (n = 7)

At termination, workers reported that 50.0% (n = 25) of youth were attending school more than before starting treatment and 42.0% (n = 21) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 113). At intake, 44.2% (n = 23) of the youth attending school had Individualized Education Plans (IEPs) while at termination, 52.0% (n = 26) of the youth attending school had Individualized Education Plans (IEPs).

Figure 113.



Ohio Scales

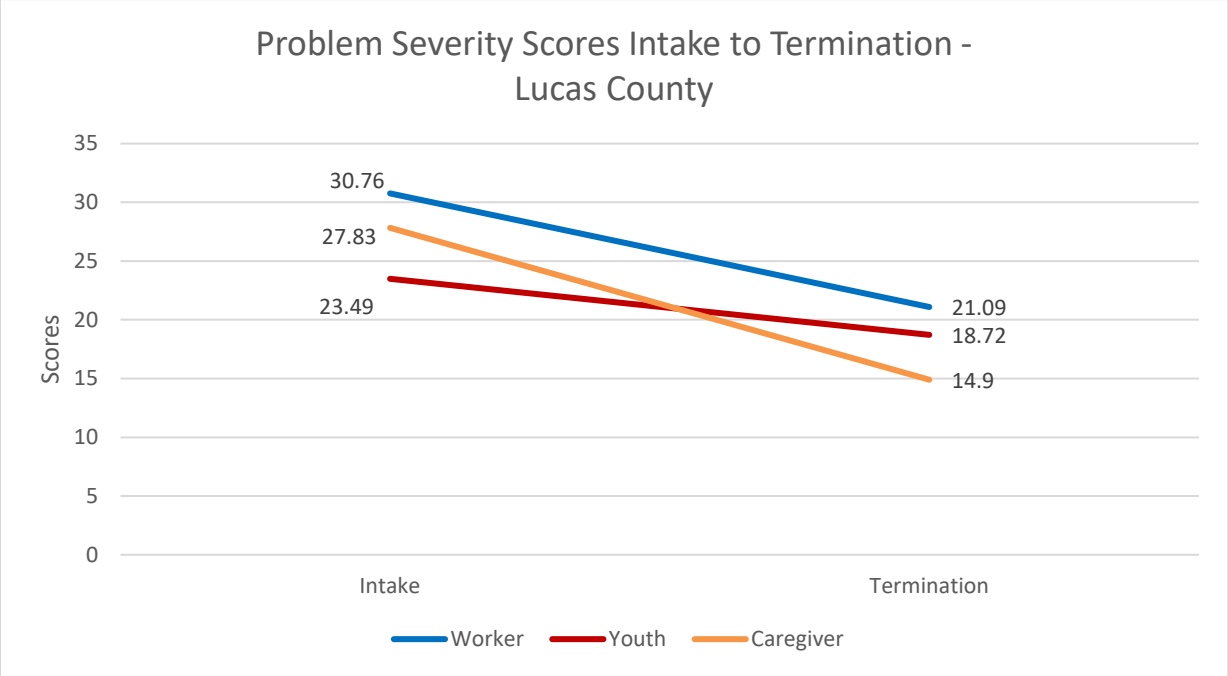
One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum of service, separate charts are included that display the means from intake to termination. Decreases in Problem Severity and increases in Functioning correspond to positive change.

All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Paired samples t-tests were used to compare Problem Severity scores at intake to Problem Severity scores at the other assessment periods. A paired samples t-test compares the means of two variables by computing the difference between the two variables for each case and testing to see if the average difference is significantly different from zero. In order for a case to be included in the analyses, the rater must have scores for both assessment periods. For example, a caregiver must supply scores for both the intake and three-month assessment period to be included in the paired samples t-test for that time point. If the caregiver only has an intake score, his or her data is not included in the analysis.

Problem Severity

Overall means for the Problem Severity scale by rater between intake and termination for Lucas County youth are presented in Figure 114.

Figure 114.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Problem Severity at both measurement intervals compared to intake (see Table 150). Significant improvements were noted at three months: $t(25) = 3.64$, $p < .01$; and at termination $t(51) = 3.65$, $p < .01$ with moderate effect sizes.

Table 150. Paired Samples T-Tests for Problem Severity – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	27.35 (SD=11.78; n=26)	20.74 (SD=10.84; n=26)	3.64**	.71
Intake to Termination	29.52 (SD=12.65; n=52)	21.15 (SD=12.88; n=52)	3.65**	.50

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvements in Problem Severity at both measurement intervals compared to intake (see Table 151). Significant improvements were noted at three months: $t(24) = 2.57$, $p < .05$ with a moderate effect size; and at termination $t(40) = 2.78$, $p < .01$ with a small effect size.

Table 151. Paired Samples T-Tests for Problem Severity – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	20.52 (SD=10.12; n=25)	16.64 (SD=11.28; n=25)	2.57*	.51
Intake to Termination	26.53 (SD=19.41; n=41)	18.50 (SD=14.17; n=41)	2.78**	.43

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Problem Severity from intake to termination $t(11) = 2.51$, $p < .05$ with a moderate effect size (see Table 152).

Table 152. Paired Samples T-Tests for Problem Severity – Caregiver

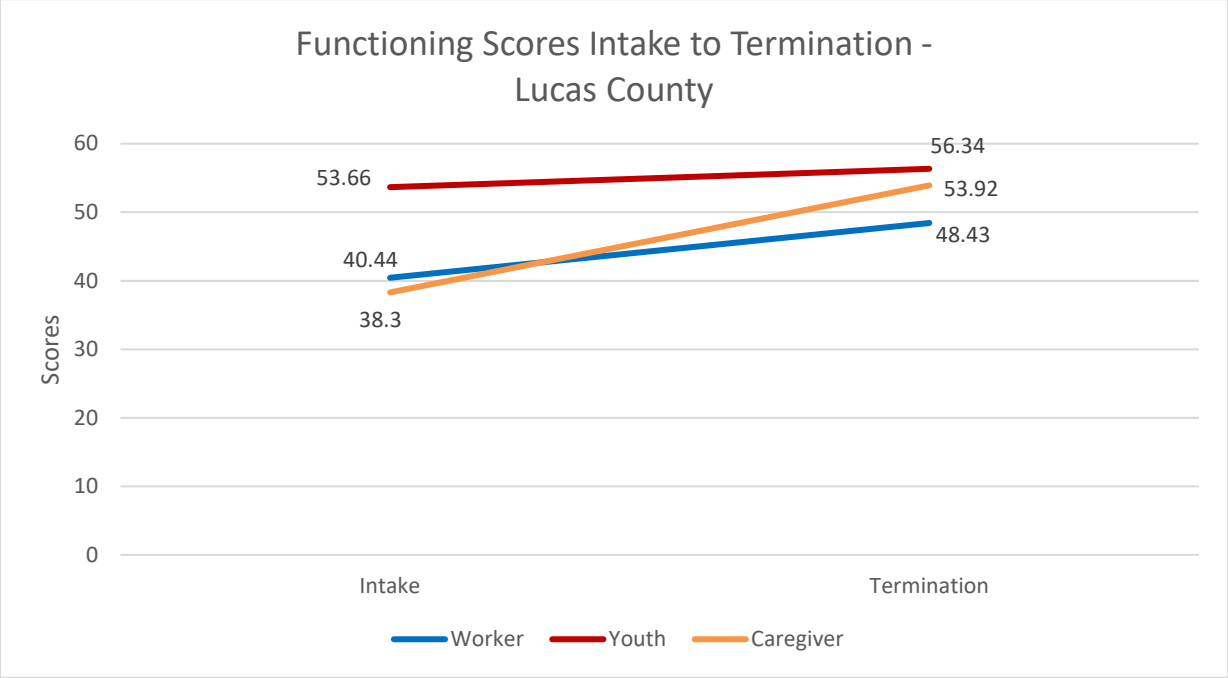
	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	23.80 (SD=15.99; n=15)	19.33 (SD=15.94; n=15)	1.70	.44
Intake to Termination	23.33 (SD=14.44; n=12)	14.90 (SD=13.42; n=12)	2.51*	.72

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

Functioning Scores

Overall means for the Functioning scale by rater between intake and termination for Lucas County youth are presented in Figure 115.

Figure 115.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Functioning scores at both measurement intervals compared to intake (see Table 153). Significant improvements were noted at three months: $t(25) = -3.00$, $p < .01$ with a moderate effect size; and at termination $t(51) = -3.12$, $p < .01$ with a small effect size.

Table 153. Paired Samples T-Tests for Functioning Scores – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	43.31 (SD=8.27; n=26)	51.27 (SD=13.72; n=26)	-3.00**	.59
Intake to Termination	41.56 (SD=12.07; n=52)	48.31 (SD=14.22; n=52)	-3.12**	.43

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated no statistically significant improvements in Functioning scores at both measurement intervals compared to intake (see Table 154).

Table 154. Paired Samples T-Tests for Functioning Scores – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	57.60 (SD=10.27; n=25)	61.76 (SD=7.89; n=25)	-2.04	.41
Intake to Termination	53.24 (SD=12.78; n=41)	56.22 (SD=13.05; n=41)	-1.54	.24

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Functioning scores at both measurement intervals compared to intake (see Table 155). Significant improvements were noted at three months: $t(14) = -2.38$, $p < .05$ with a moderate effect size; and at termination $t(11) = -4.19$, $p < .01$ with a large effect size.

Table 155. Paired Samples T-Tests for Functioning Scores – Caregiver

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	39.73 (SD=16.93; n=15)	46.60 (SD=16.16; n=15)	-2.38*	.61
Intake to Termination	38.83 (SD=17.75; n=12)	53.92 (SD=16.86; n=12)	-4.19**	1.21

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

Violence and Delinquency Questionnaire

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey composed of three general domains: exposure to violence, violence perpetration, and peer delinquency. The VDQ is offered at intake and termination into the BHJJ program. At intake, each item prompts the youth to answer within the context of the past year. At termination, youth are directed to answer "since the last time you answered these questions".

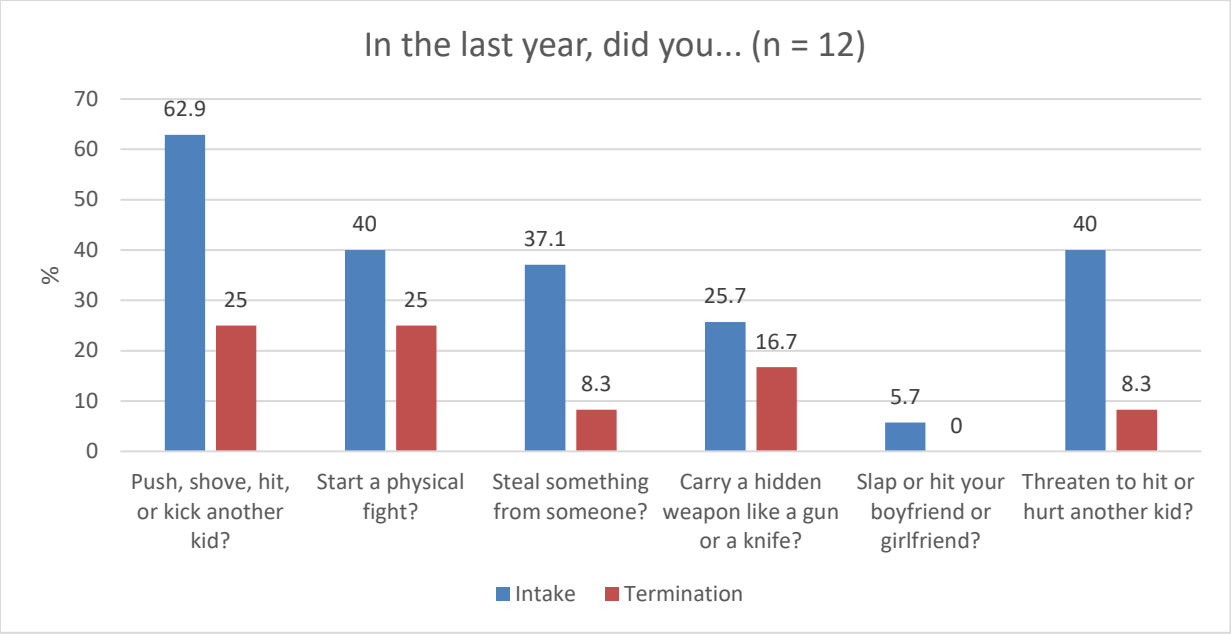
This section will be divided into three distinct parts that examine the prevalence of violence exposure as either a victim or witness, self-reported delinquent behavior from intake to termination, and delinquent behavior by peers from intake to termination. Table 156 provides the percentage of those who had experienced violence as either a victim or witness in the past year.

Table 156. Violence Exposure

	% Yes BHJJ Sample (n = 35)
In the last year, did someone threaten to hurt you when you thought they might really do it?	40.0%
In the last year, have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?	17.1%
In the last year, did a boyfriend or girlfriend or anyone you went on a date with slap or hit you?	5.7%
In the last year, did anyone steal anything from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?	51.4%
Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	28.6%
In the last year, did anyone hit or attack you WITHOUT using an object or weapon?	51.4%
In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?	34.3%
In the last year, did a grown-up touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?	0
Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. In the last year, did another child or teen make you do sexual things?	0
In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	14.3%
In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	25.7%
In the last year, in real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt them?	45.7%
In the last year, was anyone close to you murdered, like a friend, neighbor, or someone in your family?	28.6%
In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	45.7%
Not including spanking on your bottom, did a grown-up in your life hit, beat, kick or physically hurt you in any way?	45.7%
When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. In the last year, were you neglected?	17.1%

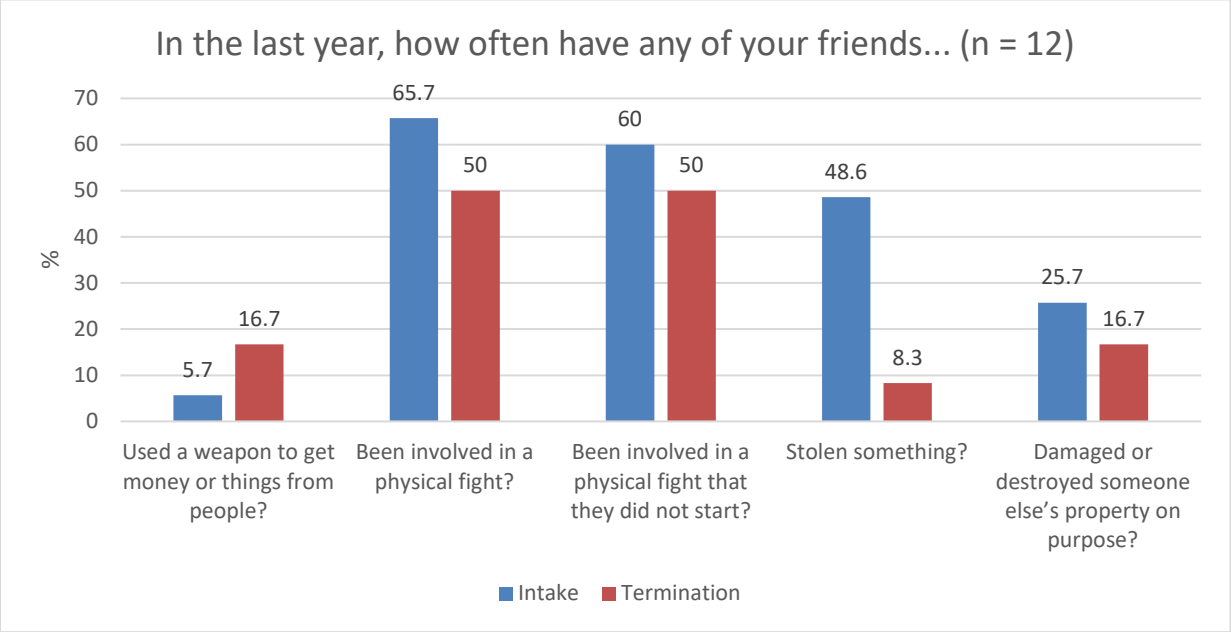
Delinquent behaviors were measured as self-report items of violent and weapon carrying behaviors as well as stealing. At intake, youth were asked how often they engaged in each behavior in the last year while at termination, youth were asked how often they engaged in the behavior since the last time they were asked. Figure 116 presents the percentage of youth who identified that they had engaged in each type of behavior at least once. McNemar's tests revealed no statistically significant improvements from intake to termination on any item.

Figure 116.



Self-reported peer delinquency was also measured at intake (how often in the last year) and at termination (how often since the last time they were asked). Figure 117 presents the percentage of youth who identified how often their friends had engaged in delinquent behavior at intake and termination. McNemar's tests revealed statistically significant improvements from intake to termination for one item: stolen something.

Figure 117.



Resilience

As part of the 2017 - 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family.

Figure 118 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were “pretty much true” and “very much true”, we combined these responses.. Generally, the majority of youth indicated high levels of endorsement for each one of these items. However, less than 50% (49.1%, n = 28) of youth gave a positive response to the item “I can work with someone who has different opinions than mine”.

Figure 118.

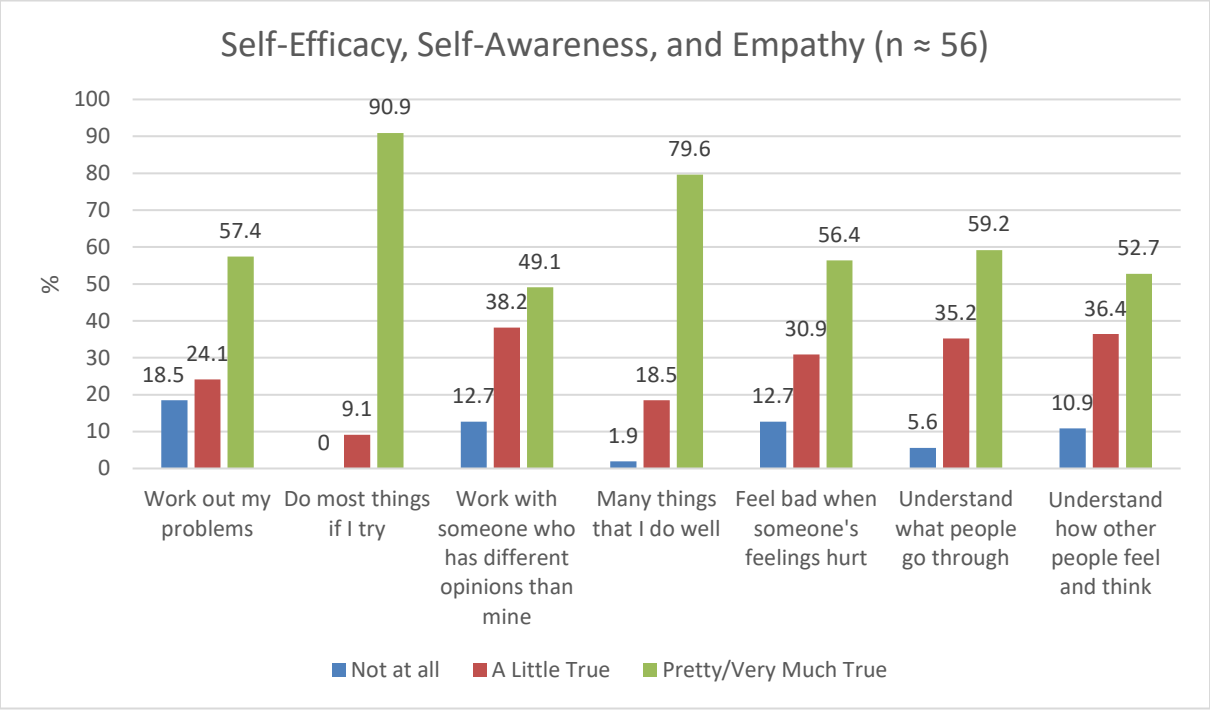


Figure 119 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. The majority of youth identified that each of the statements were either pretty much or very much true.

Figure 119.

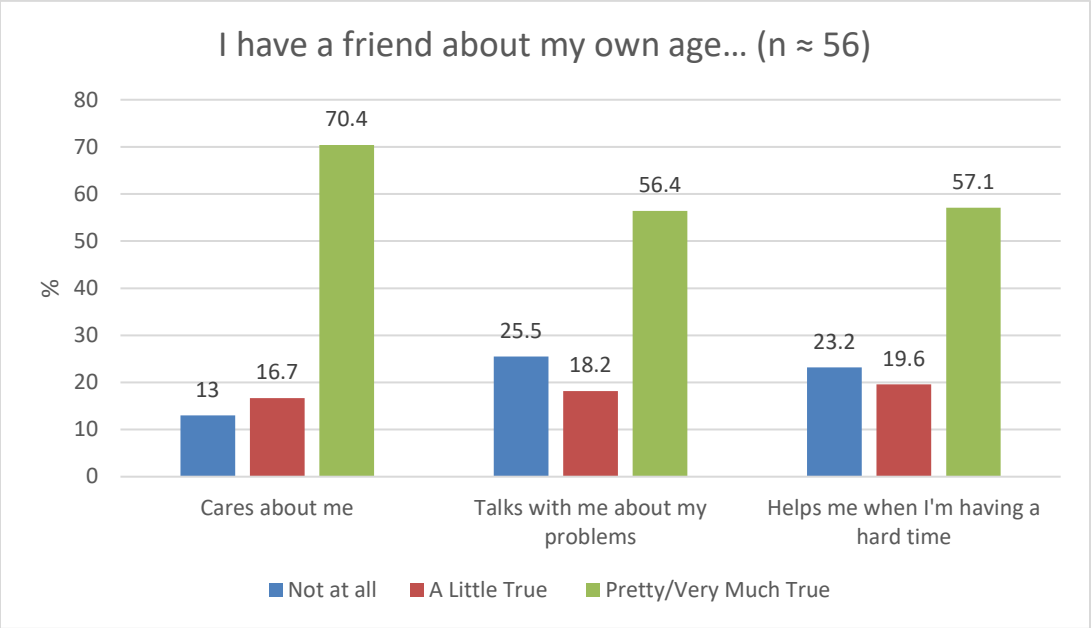
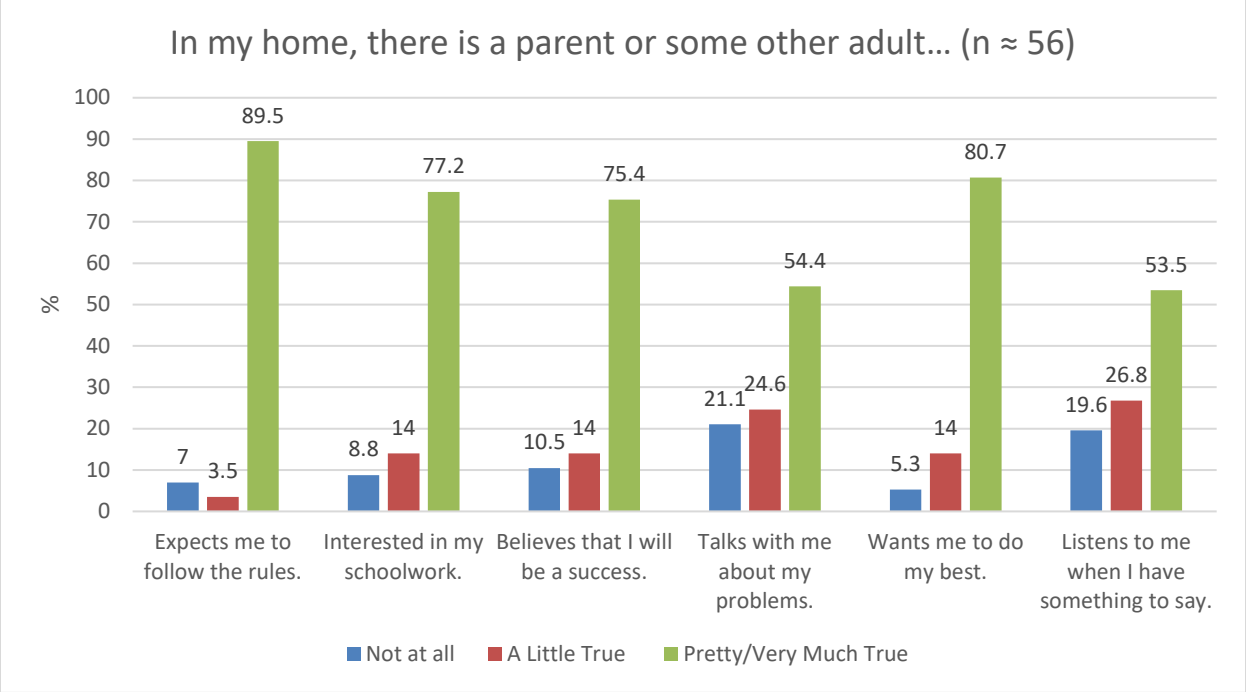


Figure 120 shows intake data on parental or support from other adults in their house. While the majority of youth identified that each of the items were either pretty much or very much true, the two items with the lowest endorsement was “talks with me about my problems” and “listens to me when I have something to say”.

Figure 120.



In addition to intake data, Figure 121 through Figure 123 show the proportion of youth who identified that each of the statements were either pretty much or very much true from intake to termination. Due to sample size restrictions, McNemar's tests were not conducted. Figure 121 shows differences from intake to termination for the items measuring self-efficacy, self-awareness, and empathy. Youth exhibited improvements from intake to termination in the items "I can work out my problems", "There are many things that I do well", and "I try to understand how other people feel and think".

Figure 121.

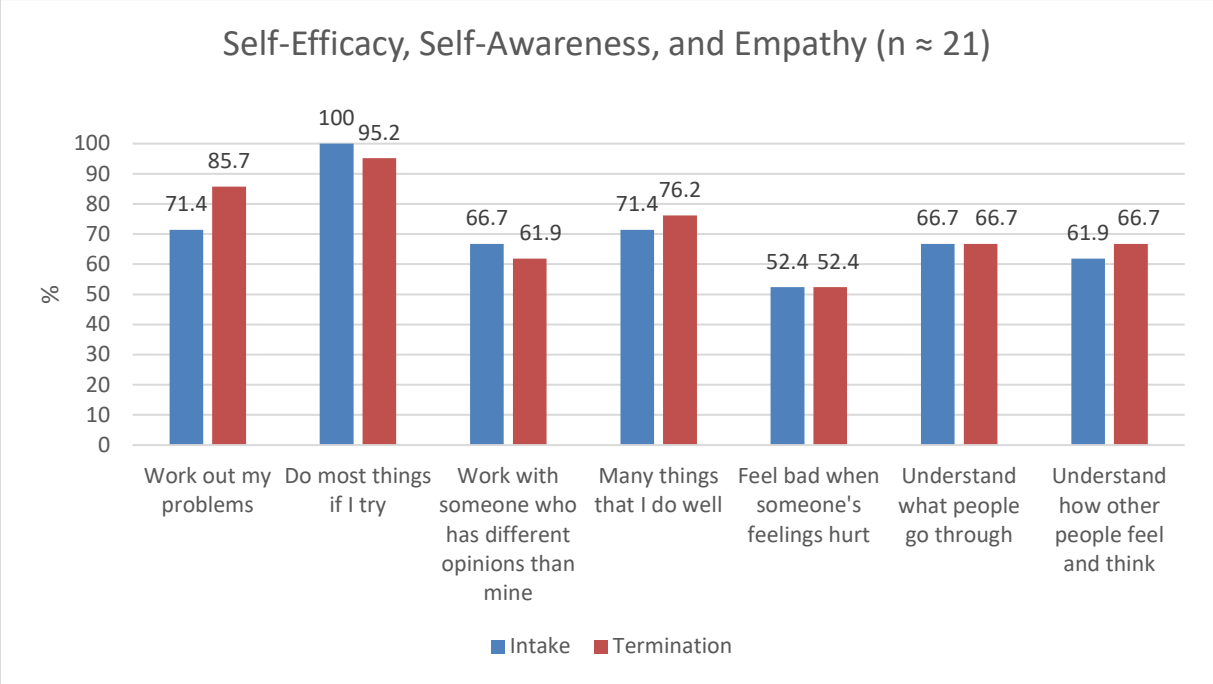


Figure 122 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring peer support. Youth exhibited improvements from intake to termination on "talks with me about my problems" and "helps me when I'm having a hard time".

Figure 122.

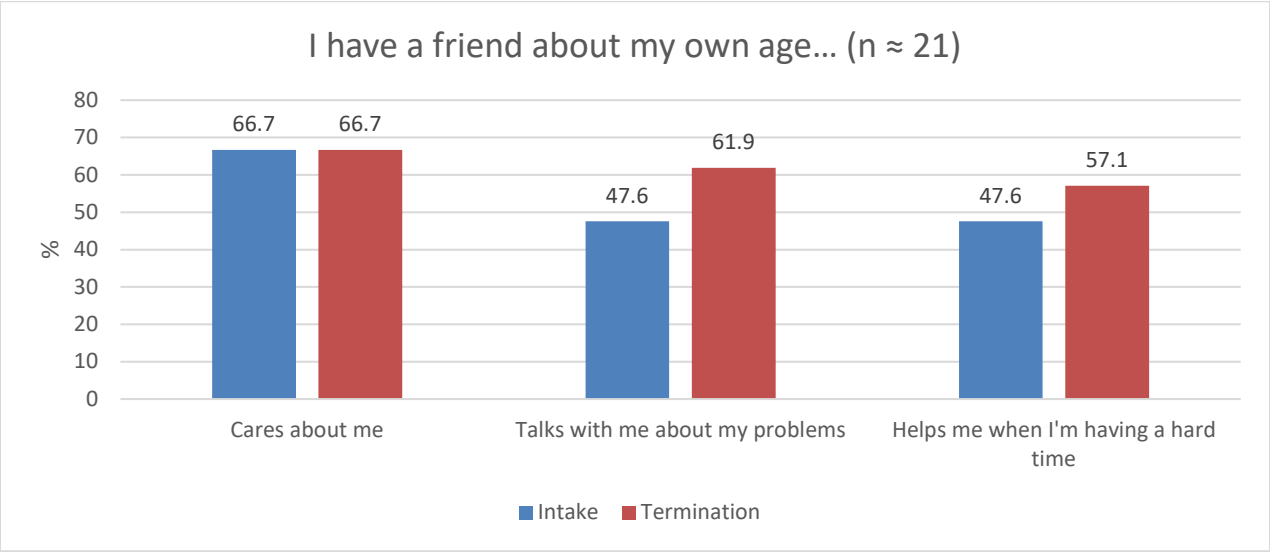
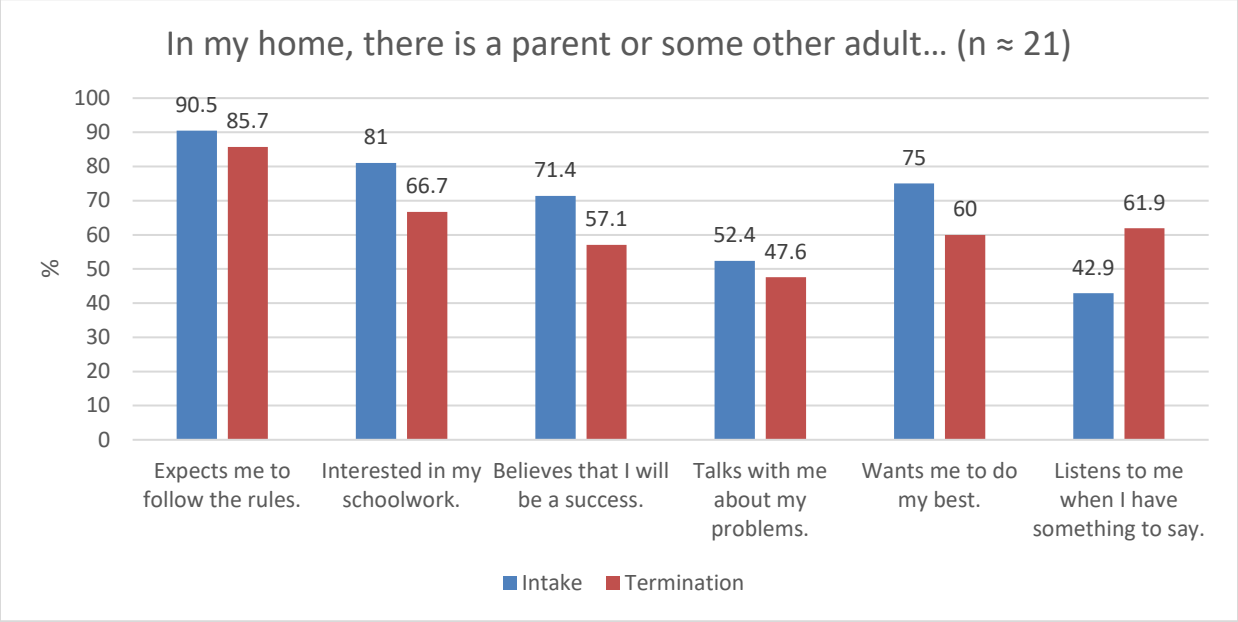


Figure 123 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring parental support or support from other adults in the home. The proportion of responses that were either pretty or very much true decreased for each of the items except "who listens to me when I have something to say".

Figure 123.



TSCC

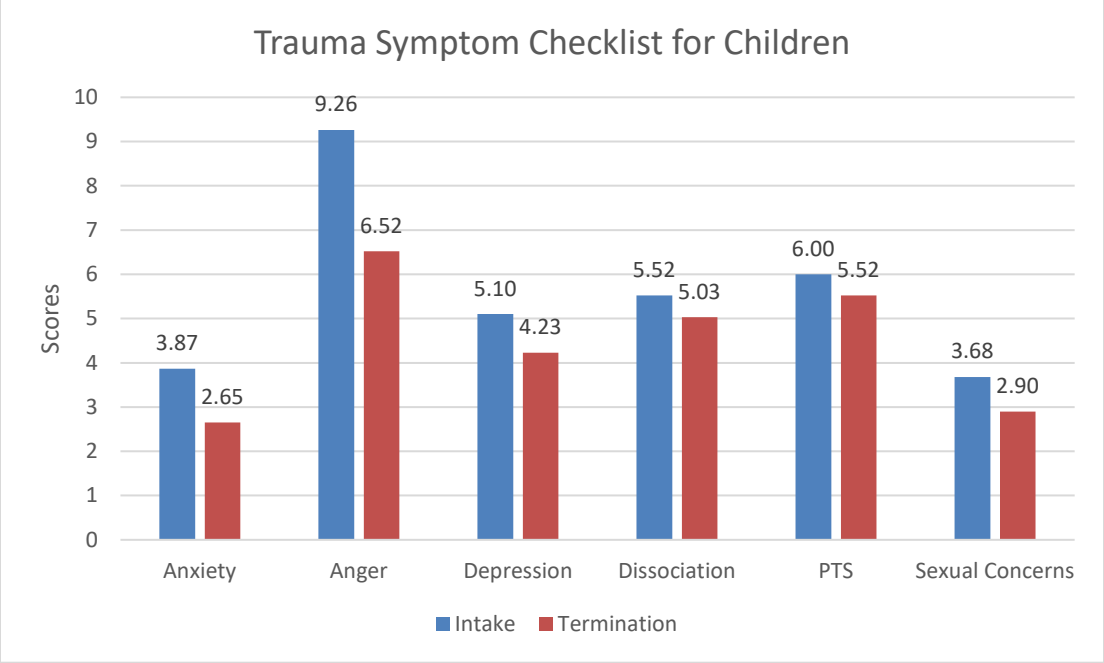
The TSCC was administered at intake and termination from BHJJ. Paired-samples t-tests were conducted to determine whether means at intake and termination on each TSCC subscale differed significantly. We were unable to examine gender effects due to the low sample size of females (n = 5). Paired samples t-tests revealed significant improvements for the Anger domain from intake to termination (see Table 157).

Table 157. TSCC Subscales from Intake to Termination among all Participants

	Intake	Termination	t	d
Anxiety	3.87 (SD = 3.48; n = 31)	2.65 (SD = 3.27; n = 31)	1.83	.33
Depression	5.10 (SD = 4.64; n = 31)	4.23 (SD = 4.42; n = 31)	1.29	.23
Anger	9.26 (SD = 6.64; n = 31)	6.52 (SD = 5.98; n = 31)	2.80**	.50
Posttraumatic Stress	6.00 (SD = 4.65; n = 31)	5.52 (SD = 5.17; n = 31)	.59	.11
Dissociation	5.52 (SD = 4.21; n = 31)	5.03 (SD = 4.15; n = 31)	.69	.13
Sexual Concerns	3.68 (SD = 4.09; n = 31)	2.90 (SD = 3.00; n = 31)	1.29	.23

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

Figure 124.



Substance Use Survey

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 158 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use by gender in Lucas County. For both females and males, alcohol, tobacco, cannabis, and caffeine were the most commonly used substances. Chi-squared tests revealed no significant differences.

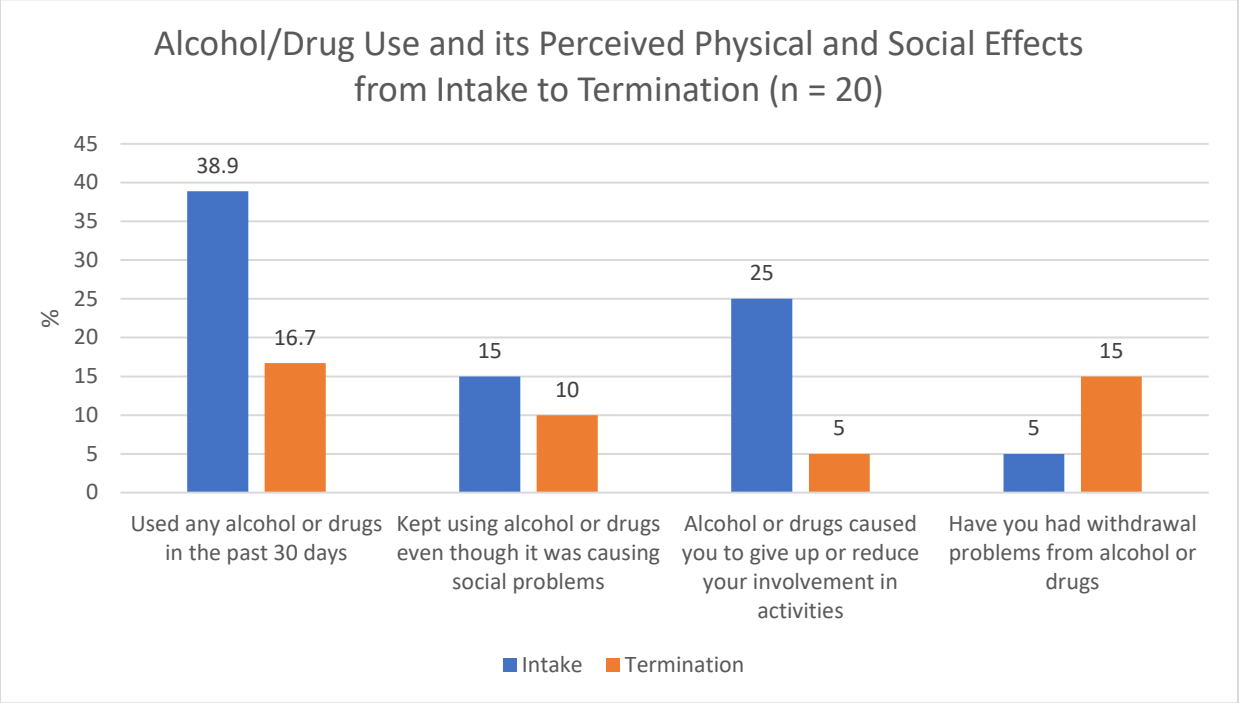
Table 158. Self-Reported Substance Use at Intake by Gender – Lucas County

	Male		Female	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	42.9% (n = 18)	13.00 (SD = 2.99)	50.0% (n = 7)	13.00 (SD = 1.63)
Tobacco	38.1% (n = 16)	13.31 (SD = 2.77)	35.7% (n = 5)	11.20 (SD = 2.95)
Cannabis	64.3% (n = 27)	12.81 (SD = 2.64)	69.2% (n = 9)	13.33 (SD = 1.94)
Hallucinogens	0.0% (n = 0)		0.0% (n = 0)	
Inhalants	0.0% (n = 0)		7.1% (n = 1)	8.00[a]
Opioids	7.1% (n = 3)	13.00[a]	0.0% (n = 0)	
Sedatives	9.8% (n = 4)	13.50 (SD = 2.65)	14.3% (n = 2)	13.00[a]
Caffeine	41.5% (n = 17)	12.53 (SD = 4.24)	57.1% (n = 8)	7.13 (SD = 5.08)
Stimulants	2.4% (n = 1)	13.00[a]	0.0% (n = 0)	
Over the counter medications	9.8% (n = 4)	12.50 (SD = 0.71)	21.4% (n = 3)	11.67 (SD = 5.13)
Other prescription drugs	12.2% (n = 5)	11.50 (SD = 4.43)	7.1% (n = 1)	13.00[a]
Herbs/Flowers	0.0% (n = 0)		0.0% (n = 0)	

[a] No Standard Deviations are calculated.

In addition to questions pertaining to the use of specific substances, youth were asked questions around general alcohol/drug use and its perceived effects on physical health and social functioning. The proportion of youth who indicated that they had used any alcohol or drugs in the past 30 days decreased from 38.9% at intake to 16.7% at termination (see Figure 125). From intake to termination, the proportion of youth who indicated that they had continued to use alcohol/drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people at least sometimes and the proportion of those who indicated that alcohol or drugs had caused them to give up or reduce their involvement in activities declined from intake to termination. The proportion of youth who indicated that they had withdrawal problems from alcohol or drugs increased from intake to termination. While none of these differences were statistically significant, it is likely a function of low cell sizes.

Figure 125.



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.

Between July 1, 2015 and June 30, 2019, there have been 54 youth terminated from the BHJJ program in Lucas County. Eighty percent (79.6%, n = 43) of the youth terminated from the BHJJ program were identified as successful treatment completers. Two percent (1.9%, n = 1) were terminated from the program due to some type of incarceration. Table 159 presents all of the reasons for termination from BHJJ and displays reasons for termination for White and Black participants.

Table 159. Reasons for Termination from BHJJ

Termination Reason	All Youth Enrolled between July 2015 and June 2019	White Youth Enrolled between July 2015 and June 2019	Black Youth Enrolled between July 2015 and June 2019
Successfully Completed Services	79.6% (n = 43)	92.9% (n = 26)	65.2% (n = 15)
Client Did Not Return/Rejected Services	1.9% (n = 1)	0	4.3% (n = 1)
Out of Home Placement	5.6% (n = 3)	0	13.0% (n = 3)
Client/Family Moved	5.6% (n = 3)	7.1% (n = 2)	0
Client Withdrawn	0	0	0
Client AWOL	0	0	0
Client Incarcerated	1.9% (n = 1)	0	4.3% (n = 1)
Other	5.6% (n = 3)	0	13.0% (n = 3)

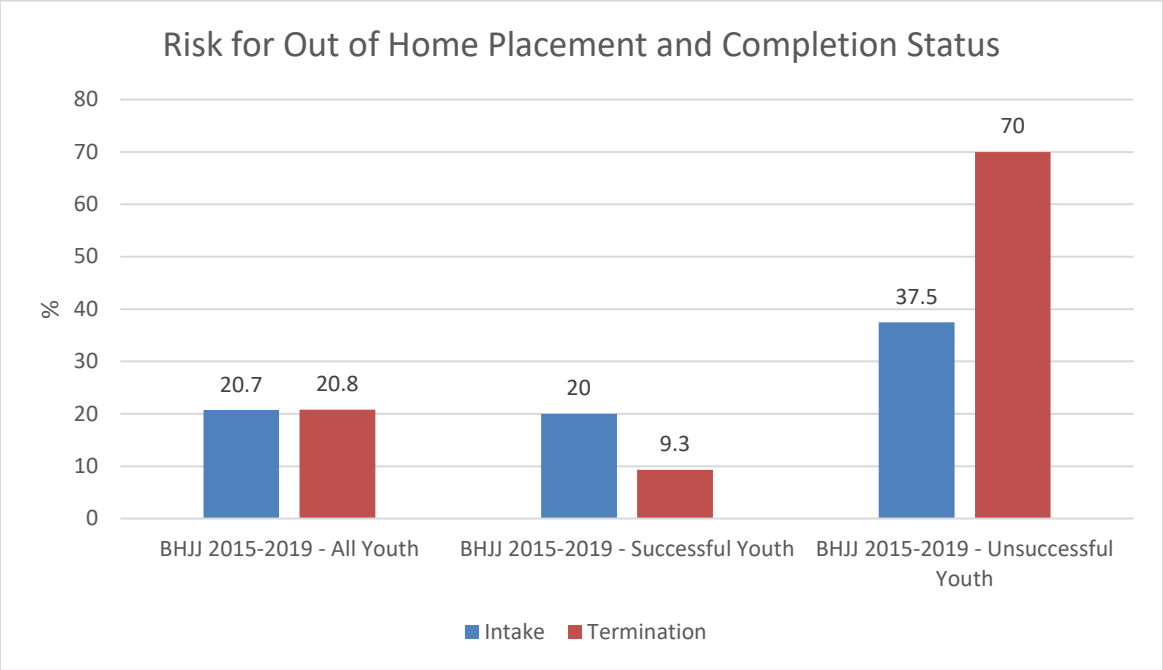
Average Length of Stay

Since the start of BHJJ, the average length of stay (ALOS) in the program was 127.6 days. For youth identified as successful treatment completers, the ALOS was 133.5 days while for unsuccessful treatment completers, the ALOS was 105.0 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, 20.7% of the youth (n = 18) were at risk for out of home placement. At termination, 20.8% (n = 11) of youth were at risk for out of home placement (see Figure 126). Of those youth who successfully completed BHJJ treatment, 9.3% (n = 4) were at risk for out of home placement at termination while 70.0% (n = 7) of youth who completed unsuccessfully were at risk for out of home placement (see Figure 126).

Figure 126.



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 services through BHJJ. Workers reported that police contacts had been reduced for 72.2% (n = 39) of the youth and had stayed the same for 18.5% (n= 10) of the youth. Police contacts increased for 7.4% (n = 4) of the youth and the worker was unable to estimate for 1.9% of youth (n = 1).

YSSF

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the services they received through the BHJJ program in Lucas County as well as how services impacted their children and family. At termination from the BHJJ program, 100% (n =13) of caregivers either strongly agreed or agreed that BHJJ staff were sensitive to their cultural/ethnic background and 100% (n =13) either strongly agreed or agreed that the location of the services was convenient (see Figure 127). Over seventy-six percent (76.9%, n = 10) of caregivers reported that as a result of the services their child/family received, their child gets along better with family members and 77.0% (n = 10) reported their child is better able to cope when things go wrong (see Figure 128).

Figure 127.

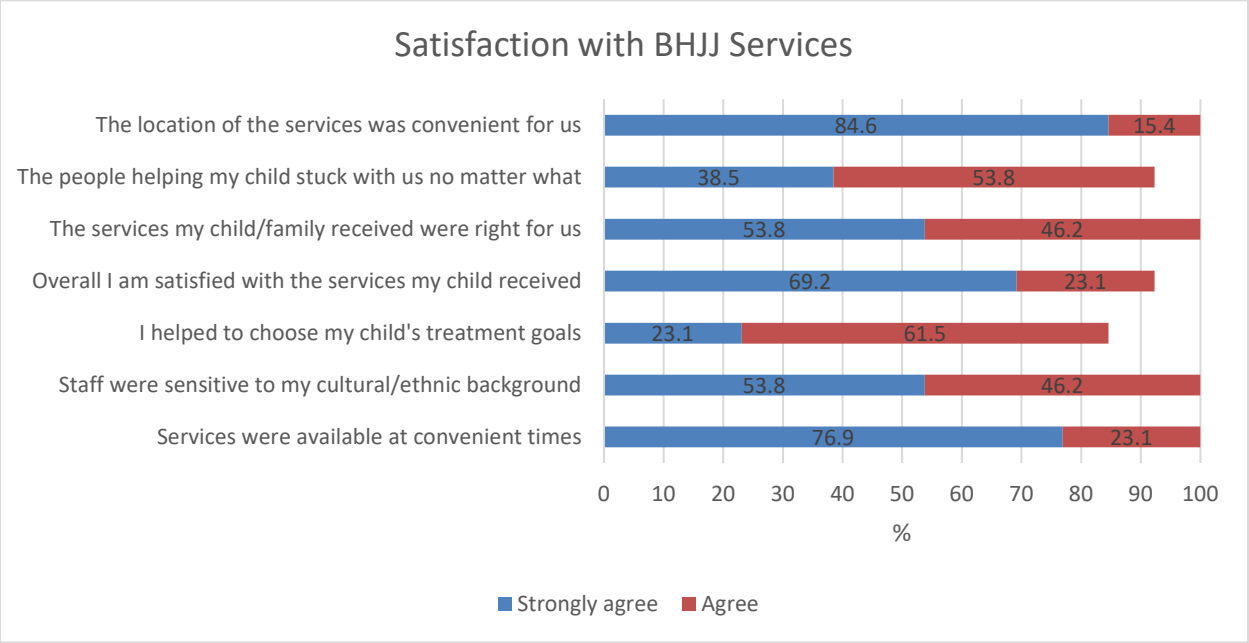
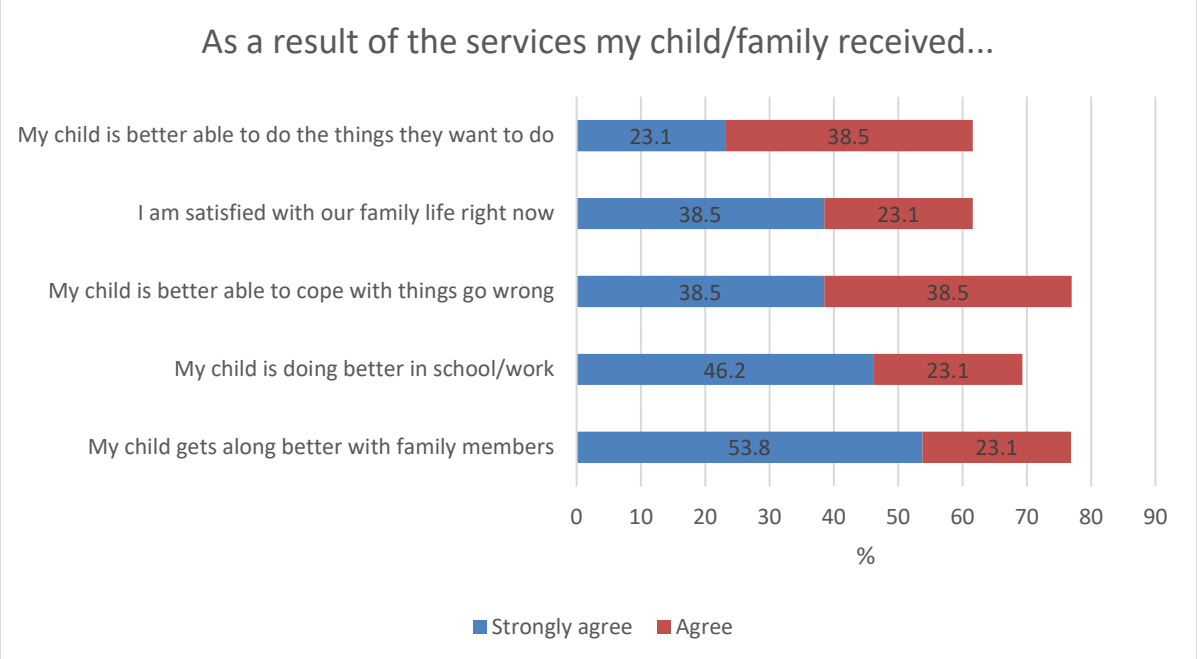


Figure 128.



Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve months prior to the end of the data collection period for inclusion in the analysis. Due to a small number of youth who terminated unsuccessfully, we were not able to separate out these data by completion status. These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 91.8% (n = 78) of BHJJ youth in Lucas county enrolled between July 1, 2015 and June 30, 2019 had a misdemeanor charge, 32.9% (n = 28) a felony charge, and 81.2% (n = 69) had been adjudicated delinquent in the 12 months prior to enrollment (see Table 160).

Table 160. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 85)	84.7% (n = 72)	30.6% (n = 26)	80.6% (n = 108)
12 months (n = 85)	91.8% (n = 78)	32.9% (n = 28)	81.2% (n = 69)
18 months (n = 85)	95.3% (n = 81)	44.8% (n = 60)	83.5% (n = 71)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 161). In the 12 months after enrollment in BHJJ, 57.9% (n = 44) of participants were charged with at least one new misdemeanor, 19.7% (n = 15) were charged with at least one new felony, and 76.3% (n = 58) were adjudicated delinquent.

Table 161. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 83)	50.6% (n = 41)	10.8% (n = 9)	71.1% (n = 59)
12 months (n = 76)	57.9% (n = 44)	19.7% (n = 15)	76.3% (n = 58)
18 months (n = 63)	60.3% (n = 63)	23.8% (n = 15)	76.2% (n = 48)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 162). In the 12 months after termination from BHJJ, 42.9% (n = 15) of youth were charged with at least one new misdemeanor and 28.6% (n = 10) were charged with at least one new felony, and 45.7% (n = 16) were adjudicated delinquent in the 12 months following their termination from BHJJ.

Table 162. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 40)	40.0% (n = 16)	20.0% (n = 8)	45.0% (n = 18)
12 months (n = 35)	42.9% (n = 15)	28.6% (n = 10)	45.7% (n = 16)
18 months (n = 29)	44.8% (n = 13)	34.5% (n = 10)	41.4% (n = 12)

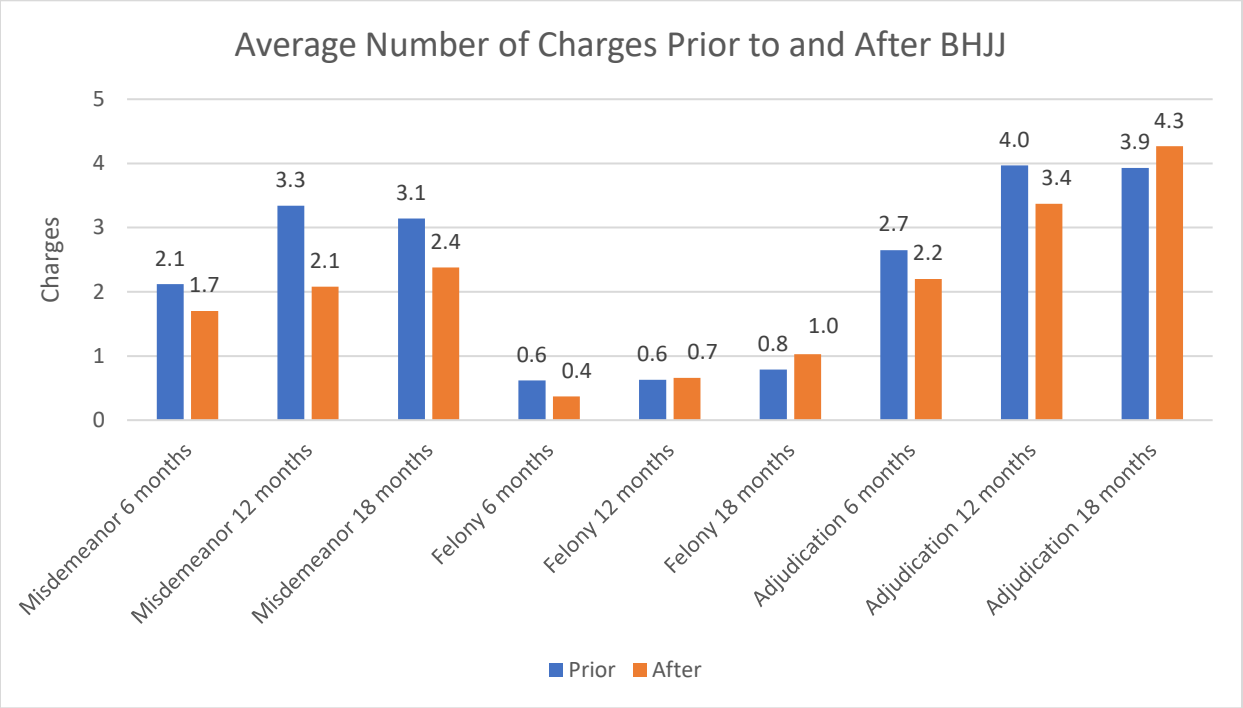
ODYS Commitments

Among a total of 85 youth who enrolled since July 1, 2015, 1.2% (n = 1) were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ. **Conversely, 98.8% of youth participating in BHJJ were not admitted to an ODYS facility at any point after enrollment.**

Average Numbers of Charges and Adjudications

In addition to whether a youth was charged or adjudicated delinquent, we examined whether there were differences in the average number of charges and adjudications in equivalent periods of time prior to enrollment and after termination. We conducted paired samples *t*-tests to examine whether there were statistically significant differences in the mean number of charges and adjudications at each time period prior to and after BHJJ participation. Figure 129 shows the average number of charges for youth who had data at both time periods. This restriction resulted in a sample of 40 youth at 6 months, 35 youth at 12 months, and 29 youth at 18 months. **Paired samples *t*-tests revealed no statistically significant differences for any of the time periods we examined.** However, there were some slight declines worth noting. The average number of misdemeanor charges 12 months prior to BHJJ enrollment was 3.34 while the average number of misdemeanor charges 12 months after BHJJ termination was 2.08.

Figure 129.


Average Number of Charges Prior to and After BHJJ
Charges
5
4
3
2
1
0
2.1
1.7
3.3
2.1
3.1
2.4
0.6
0.4
0.6
0.7
0.8
1.0
2.7
2.2
4.0
3.4
3.9
4.3
Misdemeanor 6 months
Misdemeanor 12 months
Misdemeanor 18 months
Felony 6 months
Felony 12 months
Felony 18 months
Adjudication 6 months
Adjudication 12 months
Adjudication 18 months
Prior
After

Summit

Demographics

As of June 30, 2019, 368 youth were enrolled into the BHJJ program in Summit County. The average age at enrollment was 15.9 years (SD=1.29). More males (79.8%, n = 293) than females (20.2%, n = 74) have been enrolled. Black youth (70.2%, n = 257), White youth (20.2%, n = 74), and Multiracial youth (8.5%, n = 31) comprised the majority of the total sample.

There were 66 new enrollments in Summit County during the current reporting period (July 1, 2017 through June 30, 2019). The average age at enrollment was 15.9 (SD = 1.21). Males (83.3%, n = 55) outnumbered females (16.7%, n = 11), and more Black youth (89.4%, n = 59) than White youth (6.1%, n = 4) were enrolled. One youth (1.5%) self-identified as Hispanic/Latinx.

Unless otherwise noted, the following sections describe data from the past four years of BHJJ programming from July 1, 2015 through June 30, 2019.

Custody Arrangement and Household Information

At intake, the majority of youth lived with the biological mother (63.2%, n = 74), while 11.1% (n = 13) lived with two biological parents or one biological and one step/adoptive parent (see Table 163). Over eighty-one percent (81.2%, n = 95) of BHJJ youth lived with at least one biological at enrollment.

Over eighty-five percent (85.3%; n = 99) of the BHJJ caregivers had at least a high school diploma or GED, and 6.8% (n = 8) had a bachelor's degree or higher. Over fourteen percent of caregivers (14.7%; n = 17) reported they did not graduate from high school (see Table 164).

Caregivers were asked to report their annual household income (see Table 165). The income range with the highest endorsement was less than $5,000 (31.0%, n = 35). Overall, 80.5% (n = 91) reported a family income of $24,999 or less. When examined by race, 46.7% (n = 7) of White families, 61.3% (n = 57) of Black families, and 50.0% (n = 2) of Multiracial families reported a household income of $14,999 or less. Table 165 displays the reported household income overall and by race.

Table 163. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	11.1% (n = 13)
Biological Mother Only	63.2% (n = 74)
Biological Father Only	6.8% (n = 8)
Adoptive Parent(s)	3.4% (n = 4)
Aunt/Uncle	5.1% (n = 6)
Grandparents	8.5% (n = 10)
Other	1.7% (n = 2)

Table 164. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	14.7% (n = 17)
High School Graduate or G.E.D.	44.8% (n = 52)
Some College or Associate Degree	33.6% (n = 39)
Bachelor's Degree	3.4% (n = 4)
More than a Bachelor's Degree	3.4% (n = 4)

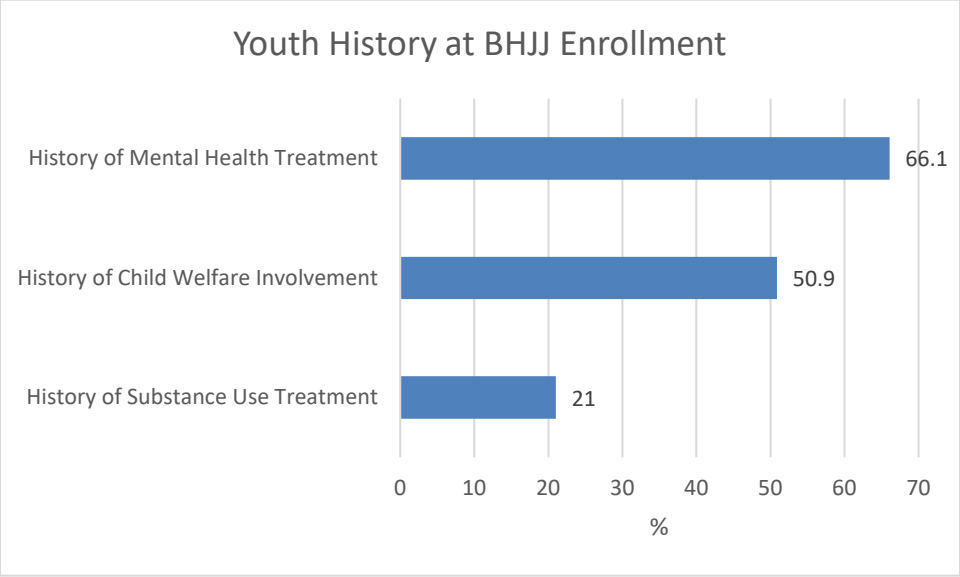
Table 165. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Black	Multiracial
Less than $5,000	31.0% (n = 35)	26.7% (n = 4)	31.2% (n = 29)	50.0% (n = 2)
$5,000 - $9,999	6.2% (n = 7)	6.7% (n = 1)	5.4% (n = 5)	NA
$10,000 - $14,999	22.1% (n = 25)	13.3% (n = 2)	24.7% (n = 23)	NA
$15,000 - $19,999	7.1% (n = 8)	6.7% (n = 1)	7.5% (n = 7)	NA
$20,000 - $24,999	14.2% (n = 16)	6.7% (n = 1)	16.1% (n = 15)	NA
$25,000 - $34,999	8.8% (n = 10)	20.0% (n = 3)	7.5% (n = 7)	NA
$35,000 - $49,999	7.1% (n = 8)	6.7% (n = 1)	6.5% (n = 6)	25.0% (n = 1)
$50,000 - $74,999	1.8% (n = 2)	NA	1.1% (n = 1)	25.0% (n = 1)
$75,000 or greater	1.8% (n = 2)	13.3% (n = 2)	NA	NA

Youth and Family History

Workers were asked to identify a youth's prior behavioral health and child welfare system involvement (see Figure 130). These three items were new to the past biennium, therefore, data are only available for youth enrolled between July 1, 2017 and June 30, 2019. Over half the youth (50.9%, n = 29) had a history of child welfare involvement prior to BHJJ enrollment. Twenty-one percent (21.0%, n = 13) of youth had received substance use treatment in their lifetime prior to BHJJ enrollment and 66.1% (n = 41) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 130.



Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history. Chi-square analyses were conducted on each item to test for gender differences and significant differences are identified in Table 166. A significantly larger proportion of the caregivers of females reported lifetime histories of sexual abuse.

Caregivers reported that 10.5% (n = 2) of females and 8.5% (n = 8) of males had a history of being physically abused while 21.1% (n = 4) of females and 1.1% (n = 1) of males had a history of being sexual abused. Caregivers of 19.0% (n = 4) of females and 14.7% (n = 14) of males reported hearing the child talking about committing suicide and 5.0% (n = 1) of females and 5.4% (n = 5) of males had attempted suicide at least once. More than half of the caregivers of females (54.5%, n = 12) and males (55.8%, n = 48) reported a family history of depression. Nearly half of the caregivers of females (52.4%, n = 11) and males (47.8%, n = 44) reported a family history of problems with substance use.

Table 166. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	10.5% (n = 2)	8.5% (n = 8)
Has the child ever been sexually abused?	21.1% (n = 4)***	1.1% (n = 1)
Has the child ever run away?	55.0% (n = 11)	42.6% (n = 40)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	33.3% (n = 7)	67.0% (n = 65)**
Has the child ever talked about committing suicide?	19.0% (n = 4)	14.7% (n = 14)
Has the child ever attempted suicide?	5.0% (n = 1)	5.4% (n = 5)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	27.3% (n = 6)	28.7% (n = 27)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	54.5% (n = 12)	55.8% (n = 48)
Has anyone in the child's biological family had a mental illness, other than depression?	28.6% (n = 6)	30.7% (n = 27)
Has the child ever lived in a household in which someone was convicted of a crime?	35.0% (n = 7)	46.6% (n = 41)
Has anyone in the child's biological family had a drinking or drug problem?	52.4% (n = 11)	47.8% (n = 44)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	25.0% (n = 5)	17.2% (n = 15)

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

Problems Leading to Service

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-related problems (66.7% and 61.2% respectively) (see Table 167). Chi-square analyses indicated females had significantly higher rates of problems related to anxiety.

Table 167. Problems Leading to Services

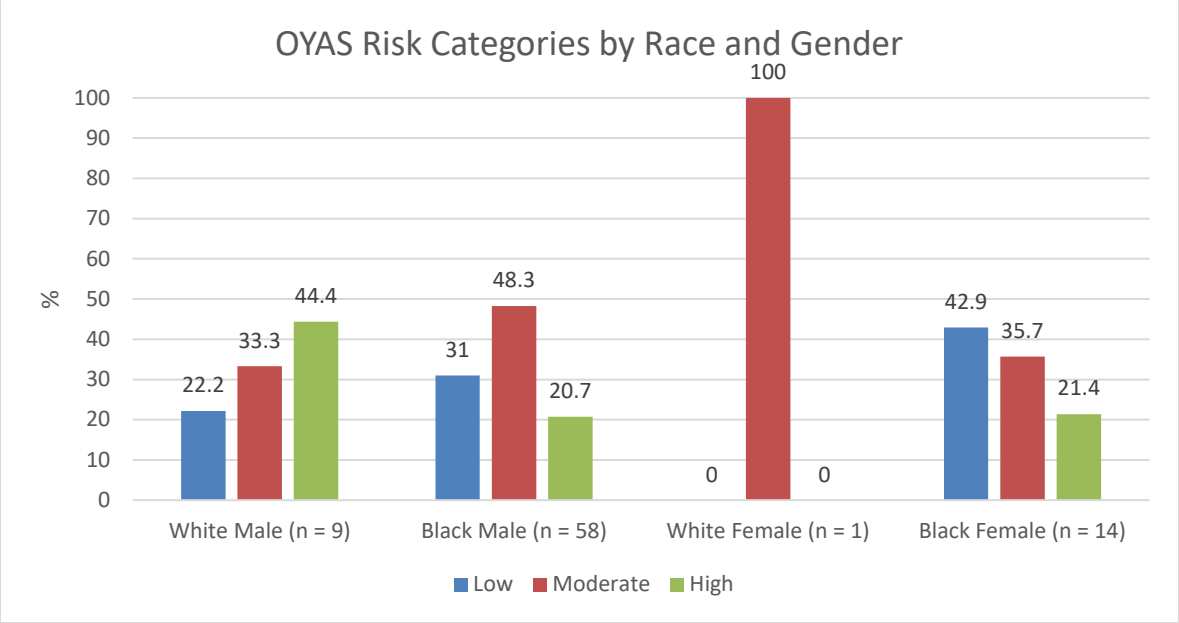
Problems Leading to Services	Females	Males
Adjustment-related problems	16.7% (n = 3)	20.4% (n = 20)
Anxiety-related problems	27.8% (n = 5)**	36.7% (n = 36)
Conduct/delinquency-related problems	66.7% (n = 12)	61.2% (n = 60)
Depression-related problems	38.9% (n = 7)	33.7% (n = 33)
Eating disorders	0	0
Hyperactive and attention-related problems	11.1% (n = 2)	21.4% (n = 21)
Learning disabilities	11.1% (n = 2)	12.2% (n = 12)
Pervasive development disabilities	0	0
Psychotic behaviors	0	0
School performance problems not related to learning disabilities	22.2% (n = 4)	34.7% (n = 34)
Specific developmental disabilities	0	1.0% (n = 1)
Substance use, abuse, dependence-related problems	33.3% (n = 3)	62.3% (n = 33)
Suicide-related problems	5.6% (n = 1)	1.0% (n = 1)

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

Ohio Youth Assessment System

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 131 shows the distribution of OYAS risk categories for BHJJ youth by race and gender. In Summit County, 44.4% (n = 4) of White males and 20.7% (n = 12) of Black males enrolled in the BHJJ program were identified as High risk on the OYAS, while no White females and 21.4% (n = 3) of Black females were identified as High risk.

Figure 131.



DSM Diagnoses

Workers were asked to report any DSM 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 diagnosis for females and males were Cannabis-related Disorders (see Table 168). Chi-square analysis indicated females were significantly more likely than males to be diagnosed with Oppositional Defiant Disorder.

Table 168. Most Common DSM Diagnoses

DSM Diagnosis	Females (n = 17)	Males (n = 93)
Adjustment Disorder	17.6% (n = 3)	11.8% (n = 11)
Alcohol-related Disorders	0	0
Attention Deficit Hyperactivity Disorder	29.4% (n = 5)	35.5% (n = 33)
Bipolar Disorder	0	0
Cannabis-related Disorders	**35.3% (n = 6)**	**54.8% (n = 51)**
Conduct Disorder	11.8% (n = 2)	23.7% (n = 22)
Depressive Disorders	29.4% (n = 5)	25.8% (n = 24)
Disruptive Behavior Disorder	0	0
Unspecified Mood Disorder	0	0
Oppositional Defiant Disorder	23.5% (n = 4)*	5.4% (n = 5)
Post-traumatic Stress Disorder	5.9% (n = 1)	8.6% (n = 8)
Unspecified Trauma and Stressor Related Disorder	11.8% (n = 2)	12.9% (n = 12)
Disruptive Mood Dysregulation Disorder	0	1.1% (n = 1)
Co-Occurring Disorder	35.3% (n = 6)	59.1% (n = 58)

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

Educational Information

Several items focused on educational 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. The wording on some items (e.g. IEP at intake, attendance at intake) was changed from previous versions of the forms. For those items, we present data from only the past biennium (when the new forms were in use). Those items will have smaller sample sizes compared to items that have been consistent for the past four years.

Forty-nine percent (49.0%, n = 51) of youth were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in BHJJ treatment BHJJ, 33.3% (n = 20) of the youth were expelled or suspended from school (a 32.0% decrease from intake to termination).

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, 70.0% (n = 28) of youth were currently attending school while at termination, 69.6% (n = 39) 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 169 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 170 displays this information based on completion status. At intake, 26.9% of youth were earning mostly A's and B's, and C's while at termination, 22.9% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 170). For example, at intake, 14.3% of youth who would go on to be unsuccessful completers and 35% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 0% of unsuccessful completers and 31.5% of successful completers received mostly A's, B's, or C's.

Table 169. Academic Performance

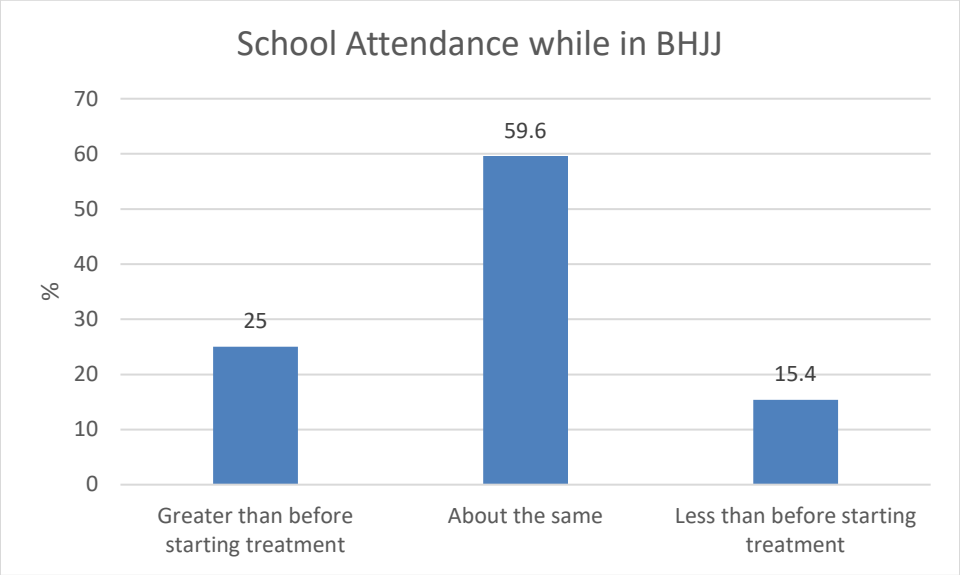
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	9.6% (n = 10)	1.8% (n = 1)
Mostly B's and C's	17.3% (n = 18)	21.1% (n = 12)
Mostly C's and D's	29.8% (n = 31)	31.6% (n = 18)
Mostly D's and F's	43.3% (n = 45)	45.6% (n = 26)

Table 170. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	0	0	11.1% (n = 4)	2.6% (n = 1)
Mostly B's and C's	14.3% (n = 2)	0	23.9% (n = 5)	28.9% (n = 11)
Mostly C's and D's	21.4% (n = 3)	29.4% (n = 5)	30.6% (n = 11)	31.6% (n = 12)
Mostly D's and F's	64.3% (n = 9)	70.6% (n = 12)	44.4% (n = 16)	36.8% (n = 14)

At termination, workers reported that 25.0% (n = 46) of youth were attending school more than before starting treatment and 59.6% (n = 31) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 132). At intake, 44.2% (n = 23) of the youth attending school had Individualized Education Plans (IEPs) while at termination, 46.2% (n = 24) of the youth attending school had Individualized Education Plans (IEPs).

Figure 132.



Ohio Scales

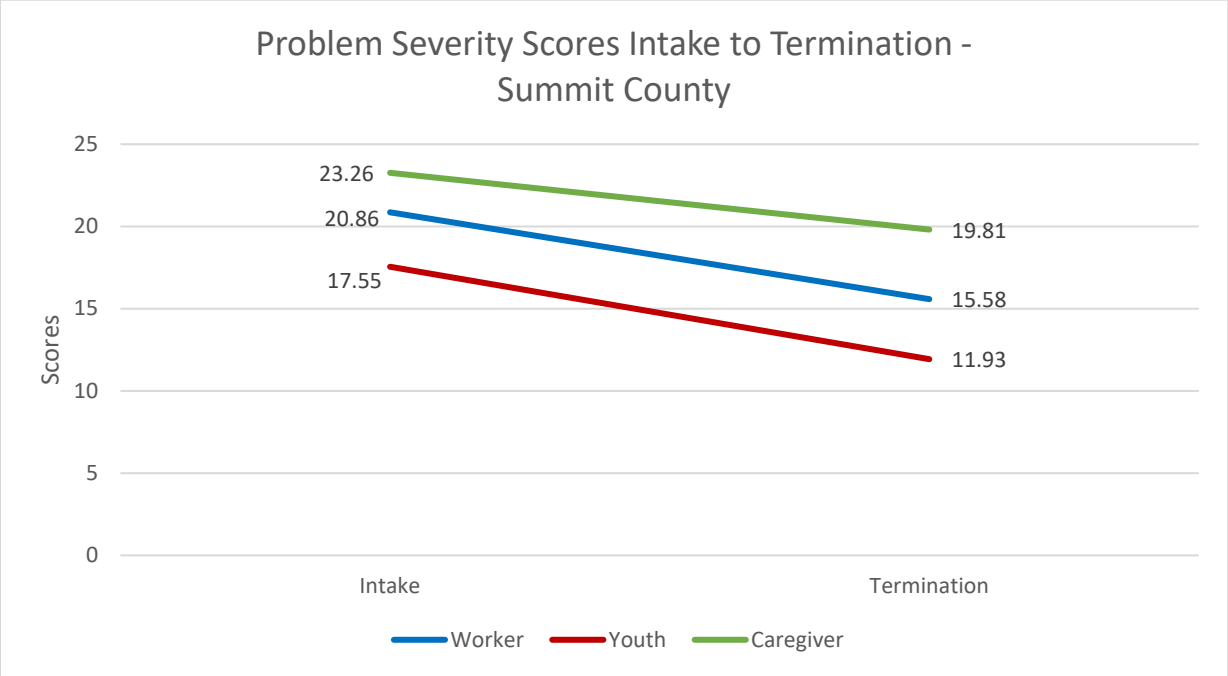
One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum of service, separate charts are included that display the means from intake to termination. Decreases in Problem Severity and increases in Functioning correspond to positive change.

All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Paired samples t-tests were used to compare Problem Severity scores at intake to Problem Severity scores at the other assessment periods. A paired samples t-test compares the means of two variables by computing the difference between the two variables for each case and testing to see if the average difference is significantly different from zero. In order for a case to be included in the analyses, the rater must have scores for both assessment periods. For example, a caregiver must supply scores for both the intake and three-month assessment period to be included in the paired samples t-test for that time point. If the caregiver only has an intake score, his or her data is not included in the analysis.

Problem Severity

Overall means for the Problem Severity scale by rater between intake and termination for Summit County youth are presented in Figure 133.

Figure 133.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Problem Severity at both measurement intervals compared to intake (see Table 171). Significant improvements were noted at three months: $t(17) = 3.19$, $p < .01$ with a moderate effect size; and at termination $t(58) = 3.74$, $p < .001$ with a small effect size.

Table 171. Paired Samples T-Tests for Problem Severity – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	23.11 (SD=10.55; n=18)	14.93 (SD=9.35; n=18)	3.19**	.75
Intake to Termination	20.45 (SD=10.25; n=59)	15.35 (SD=9.99; n=59)	3.74***	.49

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvements in Problem Severity from intake to termination $t(50) = 3.37$, $p < .01$ with a small effect size (see Table 172).

Table 172. Paired Samples T-Tests for Problem Severity – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	17.10 (SD=14.03; n=17)	9.74 (SD=8.71; n=17)	1.98	.48
Intake to Termination	18.02 (SD=13.96; n=51)	11.30 (SD=8.91; n=51)	3.37**	.47

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Problem Severity from intake to termination $t(21) = 2.25$, $p < .05$ with a small effect size (see Table 173).

Table 173. Paired Samples T-Tests for Problem Severity – Caregiver

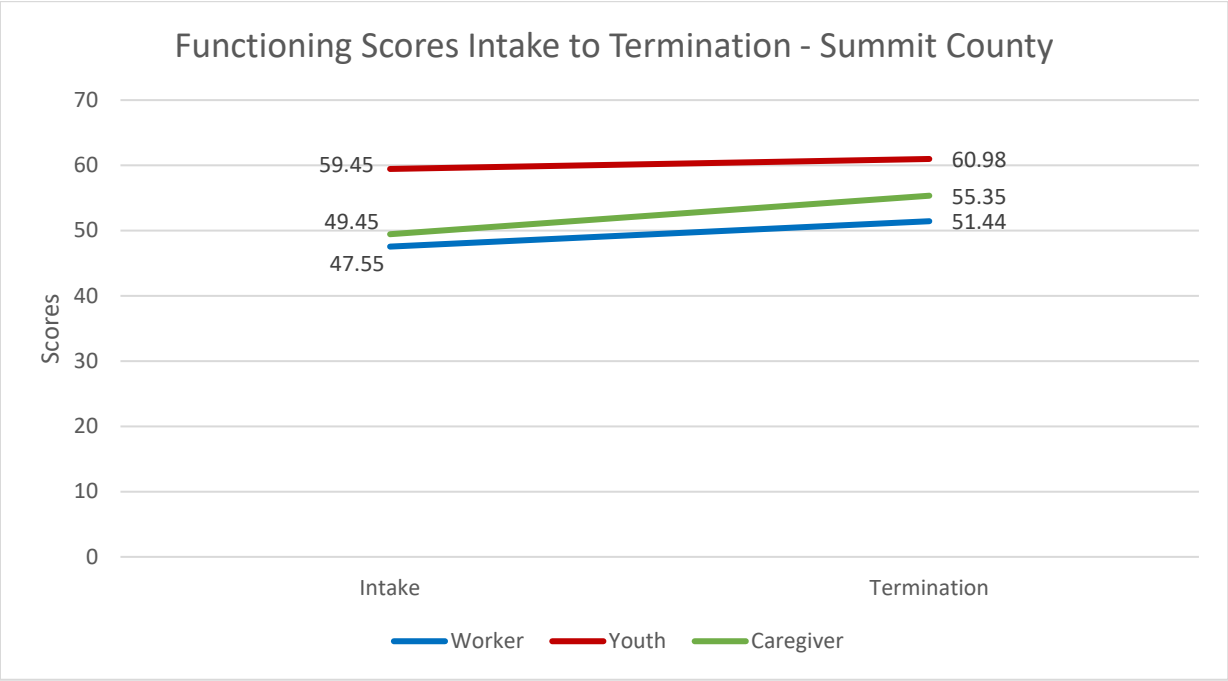
	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	26.98 (SD=16.32; n=16)	20.94 (SD=17.05; n=16)	1.96	.49
Intake to Termination	27.75 (SD=14.98; n=22)	20.11 (SD=13.55; n=22)	2.25*	.48

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

Functioning Scores

Overall means for the Functioning scale by rater between intake and termination for Summit County youth are presented in Figure 134.

Figure 134.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Functioning scores at both measurement intervals compared to intake (see Table 174). Significant improvements were noted at three months: $t(17) = -4.51$, $p < .001$ with a large effect size; and at termination $t(59) = -3.40$, $p < .01$ with a small effect size.

Table 174. Paired Samples T-Tests for Functioning Scores – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	46.44 (SD=7.82; n=18)	54.67 (SD=8.71; n=18)	-4.51***	1.06
Intake to Termination	46.47 (SD=8.65; n=60)	51.32 (SD=9.42; n=60)	-3.40**	.44

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated no statistically significant improvements in Functioning scores from intake to three months and to termination $t(52) = -.29$ (see Table 175).

Table 175. Paired Samples T-Tests for Functioning Scores – Youth

	Mean Time 1	Mean Time 2	t	d
Intake to Three Months	63.29 (SD=11.85; n=17)	68.24 (SD=10.35; n=17)	-1.76	.43
Intake to Termination	59.94 (SD=14.42; n=53)	60.58 (SD=14.92; n=53)	-.29	.04

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Functioning scores from intake to termination $t(20) = -2.08$, $p < .05$ with a small effect size (see Table 176).

Table 176. Paired Samples T-Tests for Functioning Scores – Caregiver

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	44.80 (SD=18.00; n=15)	51.47 (SD=15.66; n=15)	-1.94	.50
Intake to Termination	46.95 (SD=17.95; n=21)	55.67 (SD=13.16; n=21)	-2.08*	.46

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

Violence and Delinquency Questionnaire

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey composed of three general domains: exposure to violence, violence perpetration, and peer delinquency. The VDQ is offered at intake and termination into the BHJJ program. At intake, each item prompts the youth to answer within the context of the past year. At termination, youth are directed to answer "since the last time you answered these questions".

This section will be divided into three distinct parts that examine the prevalence of violence exposure as either a victim or witness, self-reported delinquent behavior from intake to termination, and delinquent

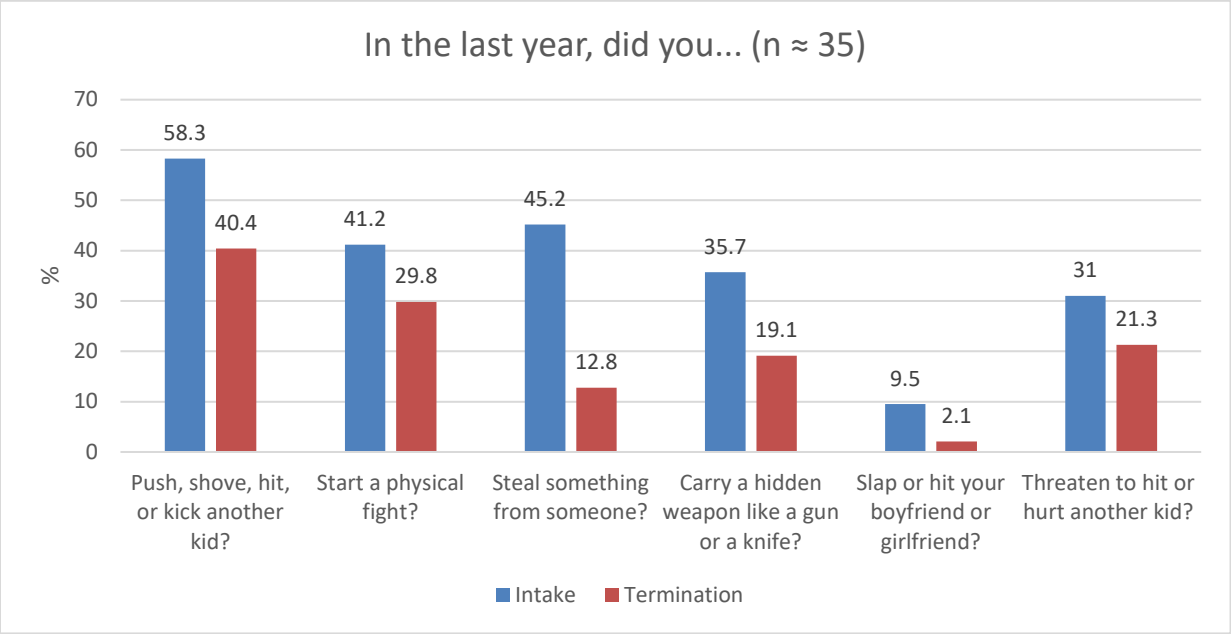
behavior by peers from intake to termination. Table 177 provides the percentage of those who had experienced violence as either a victim or witness in the past year.

Table 177. Violence Exposure

	% Yes BHJJ Sample (n = 86)
In the last year, did someone threaten to hurt you when you thought they might really do it?	40.0%
In the last year, have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?	8.3%
In the last year, did a boyfriend or girlfriend or anyone you went on a date with slap or hit you?	17.6%
In the last year, did anyone steal anything from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?	52.4%
Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street?	18.6%
In the last year, did anyone hit or attack you WITHOUT using an object or weapon?	45.3%
In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?	17.6%
In the last year, did a grown-up touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?	1.2%
Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother/sister. In the last year, did another child or teen make you do sexual things?	1.2%
In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	9.4%
In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	41.2%
In the last year, in real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt them?	57.6%
In the last year, was anyone close to you murdered, like a friend, neighbor, or someone in your family?	33.7%
In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	18.8%
Not including spanking on your bottom, did a grown-up in your life hit, beat, kick or physically hurt you in any way?	11.8%
When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. In the last year, were you neglected?	11.9%

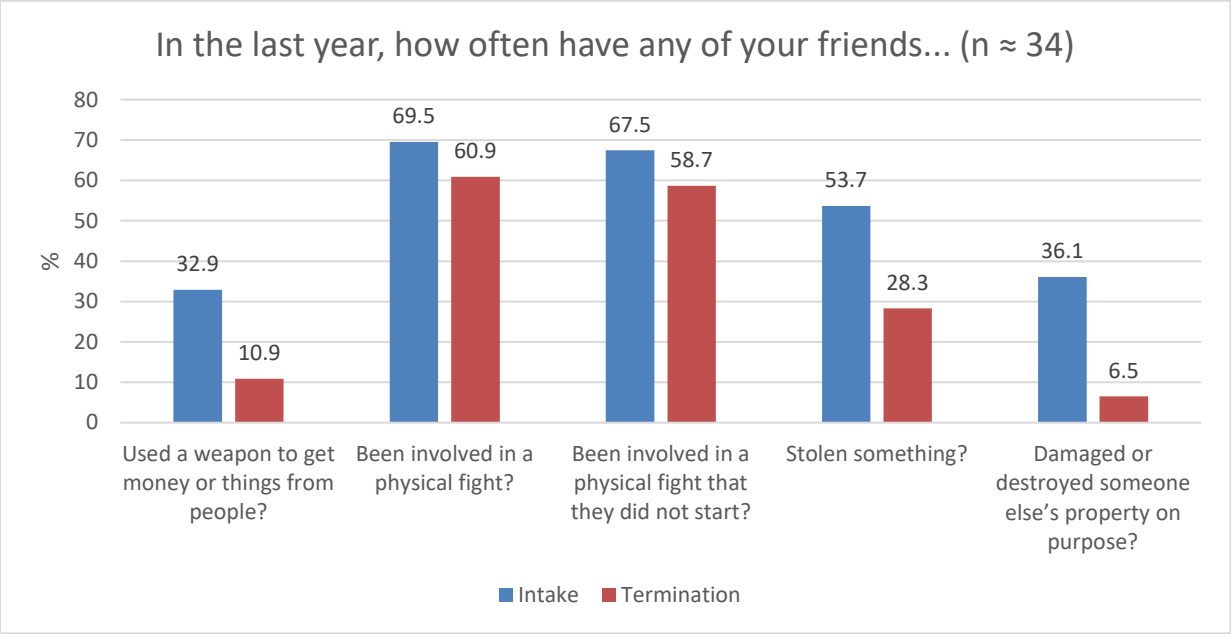
Delinquent behaviors were measured as self-report items of violent and weapon carrying behaviors as well as stealing. At intake, youth were asked how often they engaged in each behavior in the last year while at termination, youth were asked how often they engaged in the behavior since the last time they were asked. Figure 135 presents the percentage of youth who identified that they had engaged in each type of behavior at least once. Depending on the item, data were available for a range between 35 and 36 matched pairs (Mode = 35). McNemar's tests revealed statistically significant improvements from intake to termination for one item: steal something from someone.

Figure 135.



Self-reported peer delinquency was also measured at intake (how often in the last year) and at termination (how often since the last time they were asked). Figure 136 presents the percentage of youth who identified how often their friends had engaged in delinquent behavior at intake and termination. Depending on the item, data were available for a range between 33 and 34 matched pairs (Mode = 34). McNemar's tests revealed statistically significant improvements from intake to termination for three items: used a weapon to get money or things from people, stolen something, and damaged or destroyed someone else's property on purpose.

Figure 136.



Resilience

As part of the 2017 - 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family. Figure 137 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were "pretty much true" and "very much true", we combined these responses. Generally, the majority of youth indicated high levels of endorsement for each one of these items. It is important to note, that the largest proportion of youth responding "not at all" or "a little true" were for the three items that measure empathy including "I feel bad when someone gets their feelings hurt", "I try to understand how other people feel and think", and "I try to understand how other people feel and think".

Figure 137.

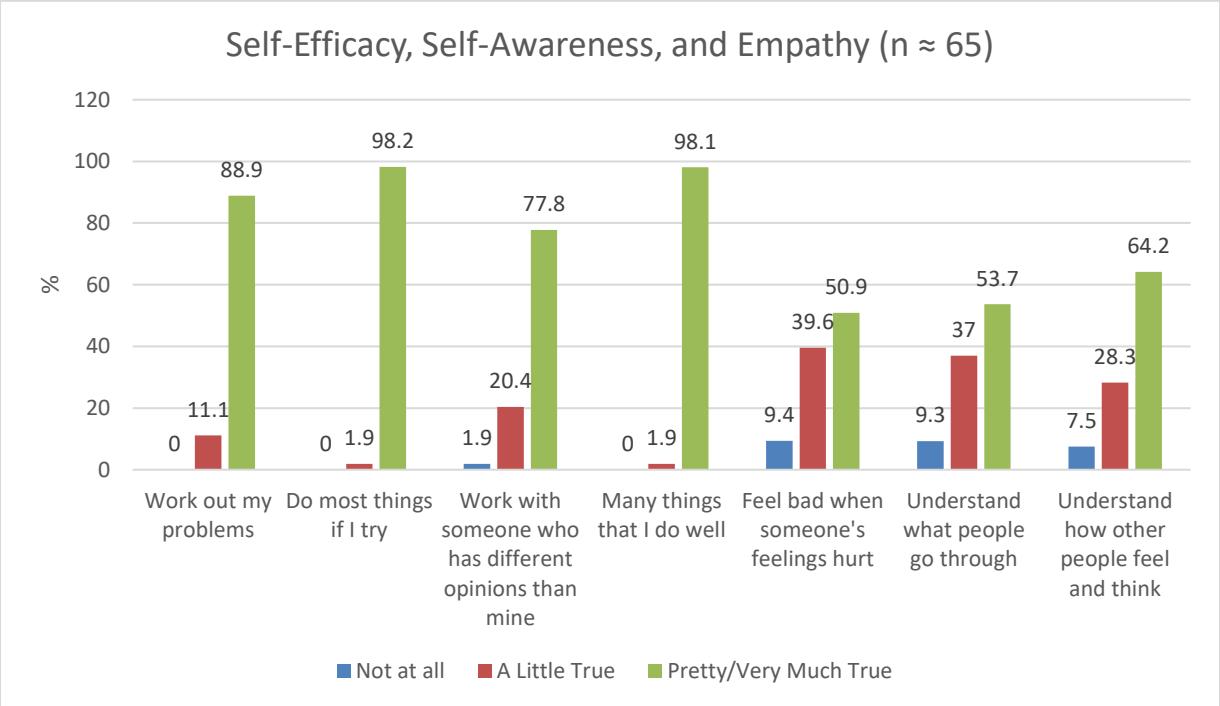


Figure 138 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. The majority of youth identified that each of the statements were either pretty much or very much true.

Figure 138.

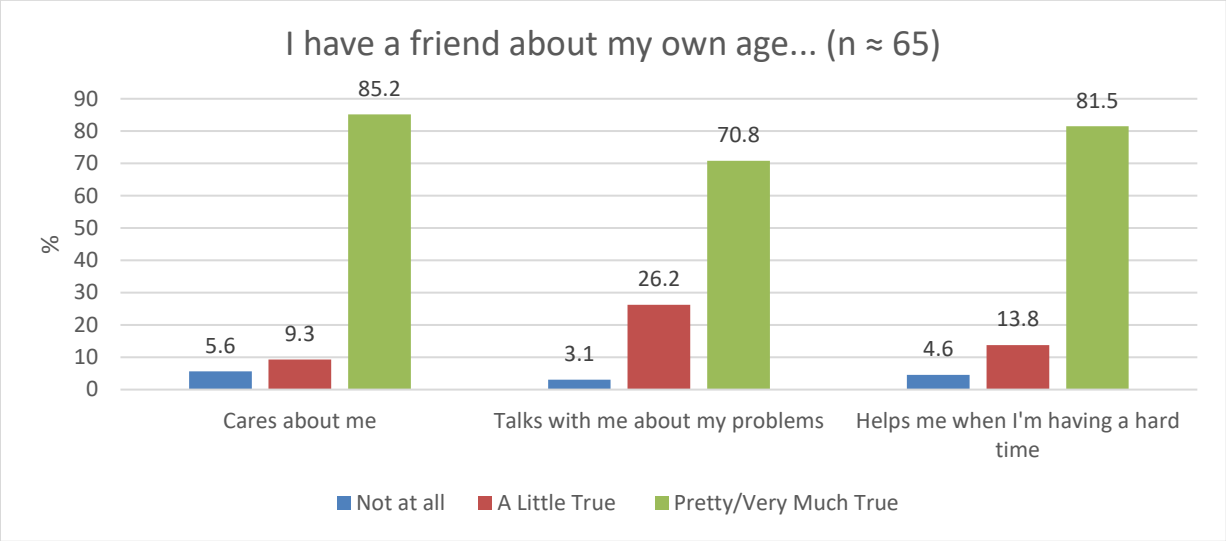
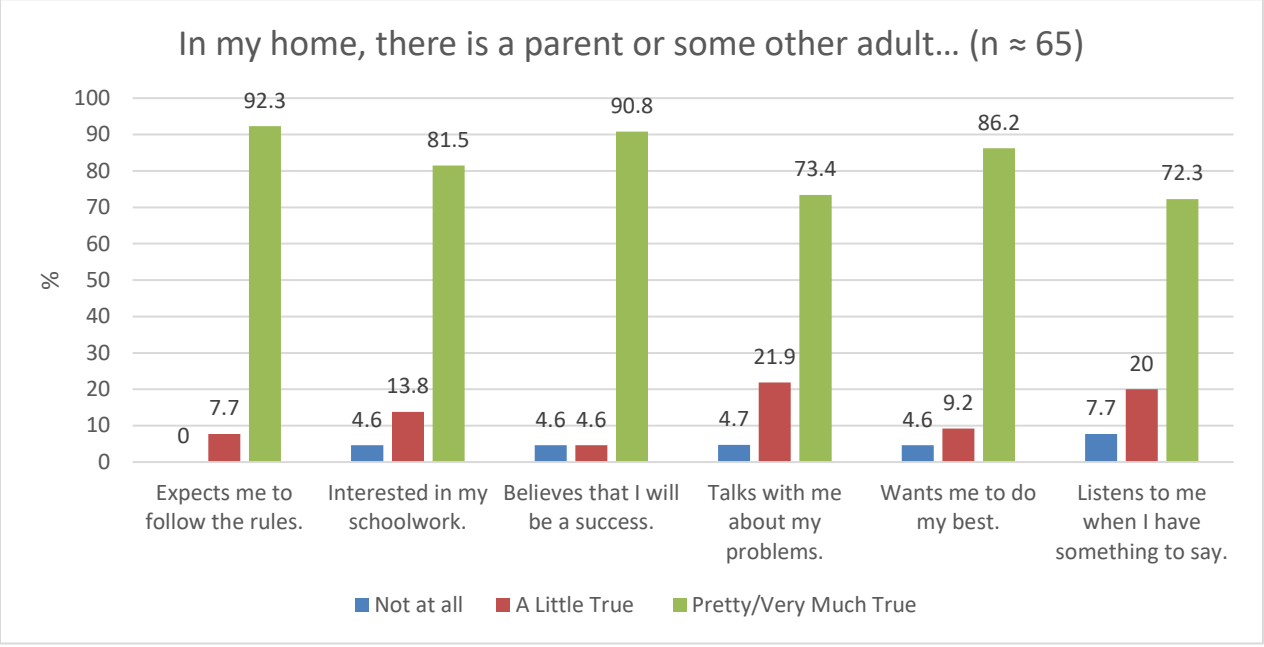


Figure 139 shows intake data on parental or support from other adults in their house. For each of the items measuring support from a parent or other adult, the majority identified that the items were either pretty or very much true.

Figure 139.



In addition to intake data, Figure 140 through Figure 142 show the proportion of youth who identified that each of the statements were either pretty much or very much true from intake to termination. Due to sample size restrictions, McNemar's tests were not conducted. Figure 140 shows differences from intake to termination for the items measuring self-efficacy, self-awareness, and empathy. Youth exhibited an improvement in two of the three items measuring empathy including "I feel bad when someone gets their feelings hurt" and "I try to understand what other people go through".

Figure 140.

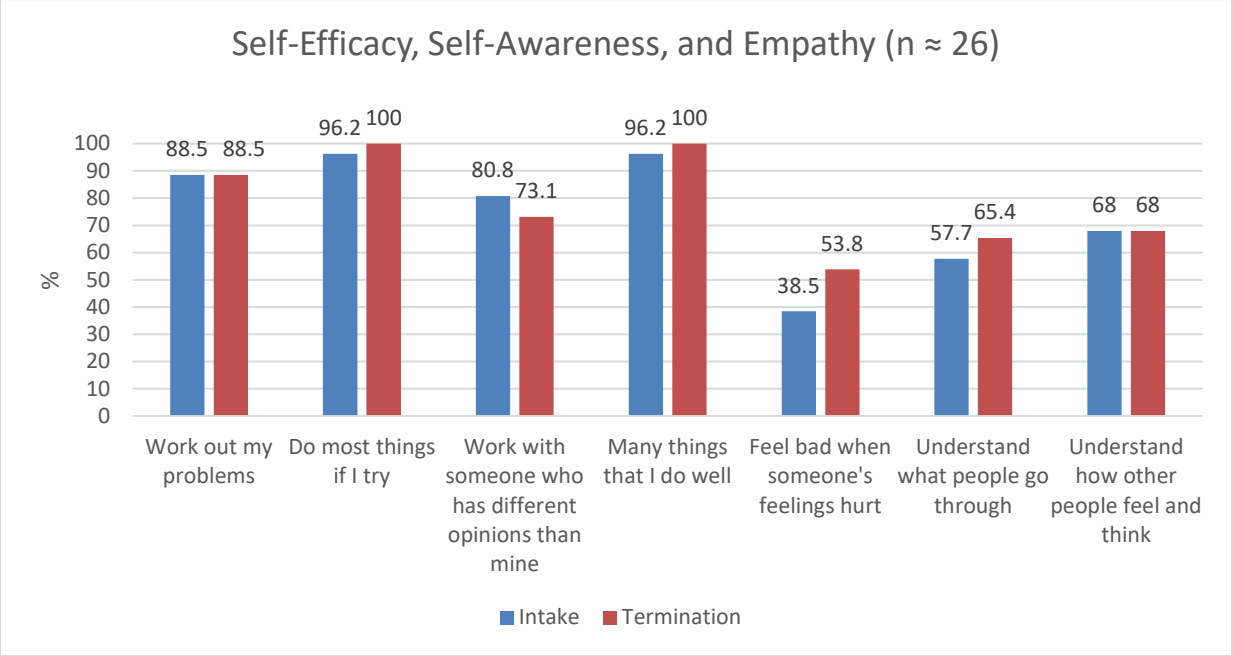


Figure 141 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring peer support. A slightly lower proportion of youth at termination compared to at intake reported that “I have a friend about my own age who helps me when I’m having a hard time”.

Figure 141.

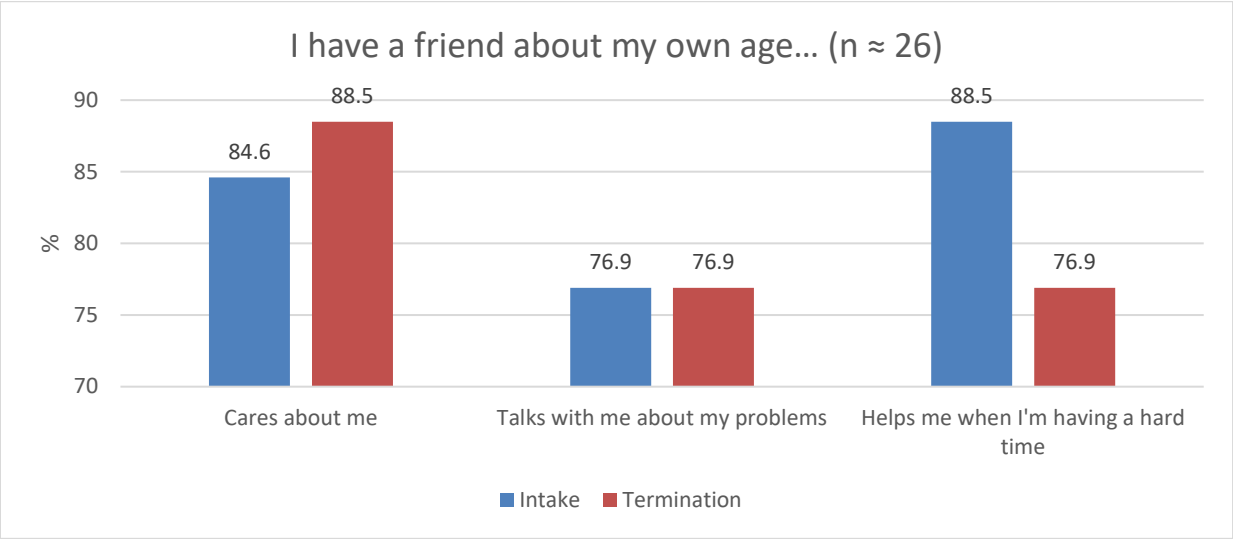
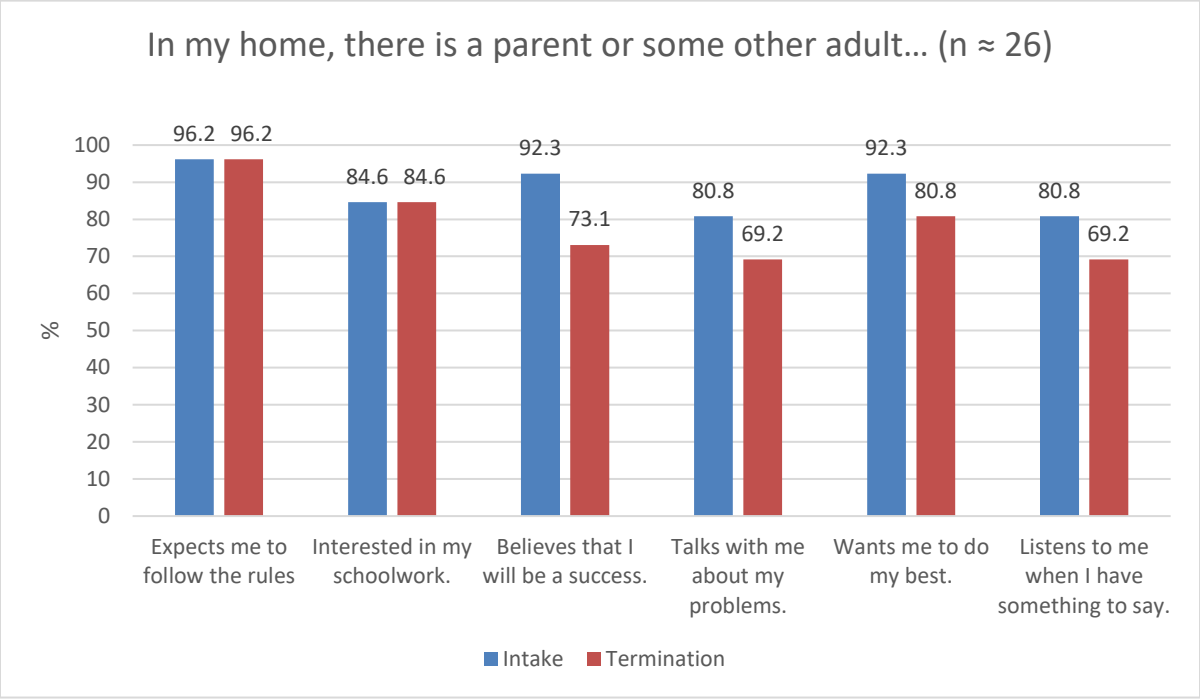


Figure 142 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring parental support or support from other adults in the home. The proportion of positive responses decreased for four of the six items from intake to termination.

Figure 142.



TSCC

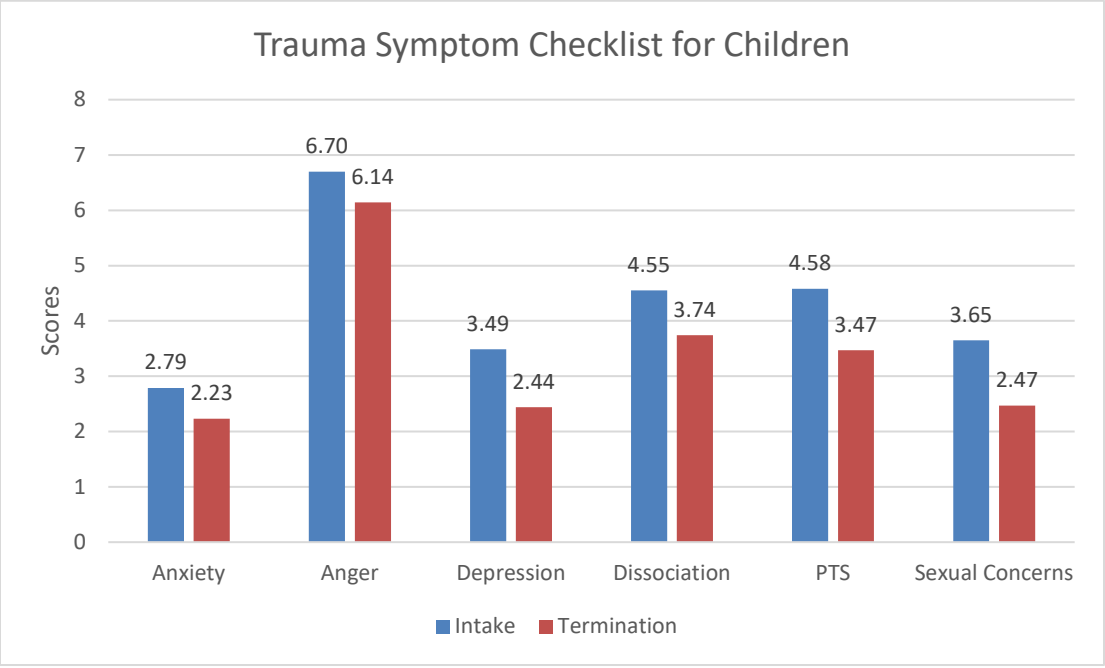
The TSCC was administered at intake and termination from BHJJ. Paired-samples t-tests were conducted to show whether means at intake and termination on each TSCC subscale differed significantly. We were unable to examine gender effects due to the low sample size of females (n = 5). Paired samples t-tests revealed significant improvements on the Depression and Sexual Concerns domain from intake to termination (see Table 178).

Table 178. TSCC Subscales from Intake to Termination among All Participants

	Intake	Termination	t	d
Anxiety	2.79 (SD = 2.56; n = 43)	2.23 (SD = 2.57; n = 43)	1.21	.19
Depression	3.49 (SD = 3.02; n = 43)	2.44 (SD = 2.52; n = 43)	2.18*	.33
Anger	6.70 (SD = 4.54; n = 43)	6.14 (SD = 4.66; n = 43)	.790	.12
Posttraumatic Stress	4.58 (SD = 3.87; n = 43)	3.47 (SD = 4.29; n = 43)	1.62	.25
Dissociation	4.55 (SD = 4.20; n = 43)	3.74 (SD = 4.24; n = 43)	1.27	.20
Sexual Concerns	3.65 (SD = 3.75; n = 43)	2.47 (SD = 2.72; n = 43)	2.24*	.34

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

Figure 143.



Substance Use Survey

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 179 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use by gender in Summit County. For both females and males, alcohol, tobacco, and cannabis were the most commonly used substances. Chi-squared tests revealed no significant differences based on gender.

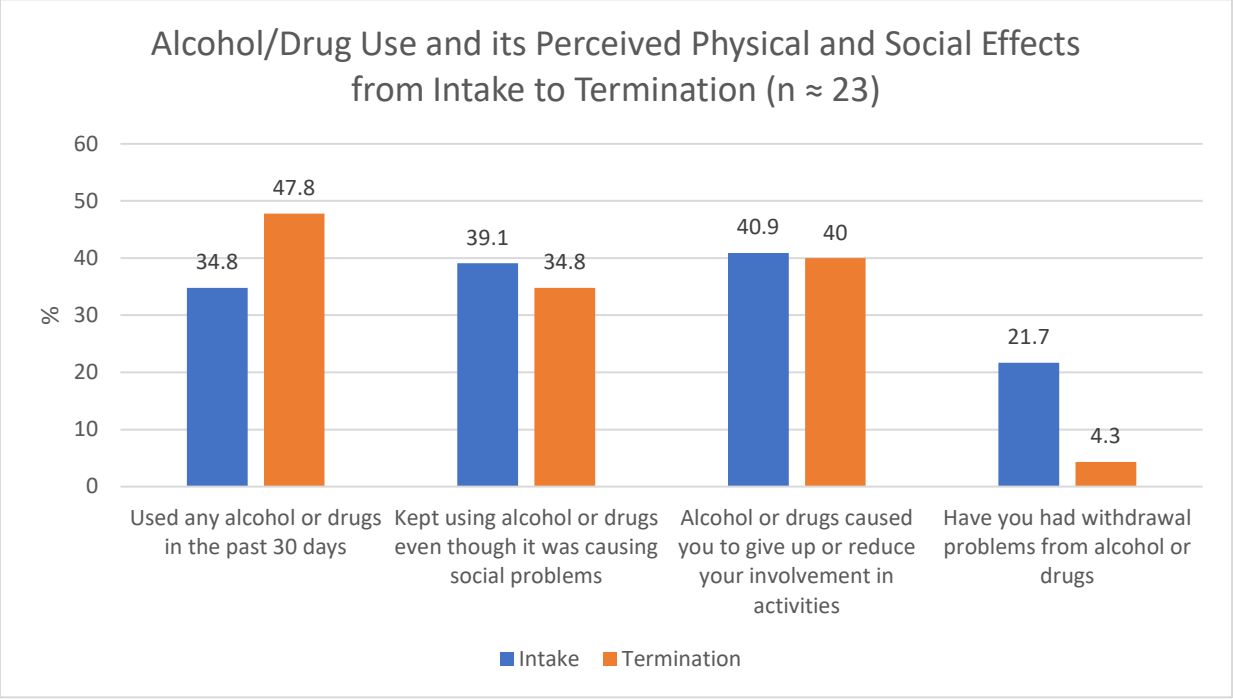
Table 179. Self-Reported Substance Use at Intake by Gender – Summit County

	Male		Female	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	76.4% (n = 42)	13.39 (SD = 2.08)	81.8% (n = 9)	14.50 (SD = 1.60)
Tobacco	72.7% (n = 40)	13.23 (SD = 1.80)	72.7% (n = 8)	13.86 (SD = 1.07)
Cannabis	92.6% (n = 50)	12.67 (SD = 2.56)	100.0% (n = 11)	13.73 (SD = 1.27)
Hallucinogens	7.4% (n = 4)	15.00 (SD = 0.82)	0.0% (n = 0)	
Inhalants	0.0% (n = 0)		0.0% (n = 0)	
Opioids	10.9% (n = 6)	14.20 (SD = 1.64)	11.1% (n = 1)	16.00[a]
Sedatives	18.2% (n = 10)	14.20 (SD = 0.92)	0.0% (n = 0)	
Caffeine	20.4% (n = 11)	7.43 (SD = 3.55)	0.0% (n = 0)	
Stimulants	11.1% (n = 6)	15.20 (SD = 0.84)	0.0% (n = 0)	
Over the counter medications	16.7% (n = 9)	13.67 (SD = 1.32)	0.0% (n = 0)	
Other prescription drugs	1.9% (n = 1)	14.00[a]	0.0% (n = 0)	
Herbs/Flowers	0.0% (n = 0)		0.0% (n = 0)	

[a] No Standard Deviations are calculated.

In addition to questions pertaining to the use of specific substances, youth were asked questions around general alcohol/drug use and its perceived effects on physical health and social functioning. The proportion of youth who indicated that they had used any alcohol or drugs in the past 30 days increased from 34.8% at intake to 47.8% at termination (see Figure 144). From intake to termination, the proportion of youth who indicated that they had continued to use alcohol/drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people at least sometimes and the proportion of those who indicated that alcohol or drugs had caused them to give up or reduce their involvement in activities declined from intake to termination. The proportion of youth who indicated that they had withdrawal problems from alcohol or drugs increased from intake to termination. While none of these differences were statistically significant, it is likely a function of low cell sizes.

Figure 144.



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.

Between July 1, 2015 and June 30, 2019, there have been 58 youth terminated from the BHJJ program in Summit County. Sixty-nine percent (69.0%, n = 40) of the youth terminated from the BHJJ program were identified as successful treatment completers. Nearly nine percent (8.6%, n = 5) were terminated from the program due to some type of incarceration. Table 180 presents all of the reasons for termination from BHJJ and displays reasons for termination for White and Black participants.

Table 180. Reasons for Termination from BHJJ

Termination Reason	All Youth Enrolled between July 2015 and June 2019	White Youth Enrolled between July 2015 and June 2019	Black Youth Enrolled between July 2015 and June 2019
Successfully Completed Services	69.0% (n = 40)	83.3% (n = 5)	66.0% (n = 33)
Client Did Not Return/Rejected Services	5.2% (n = 3)	0	6.0% (n = 3)
Out of Home Placement	3.4% (n = 2)	0	4.0% (n = 2)
Client/Family Moved	1.7% (n = 1)	0	2.0 (n = 1)
Client Withdrawn	3.4% (n = 2)	0	4.0% (n = 2)
Client AWOL	5.2% (n = 3)	16.7% (n = 1)	4.0% (n = 2)
Client Incarcerated	8.6% (n = 5)	0	10.0% (n = 5)
Other	3.4% (n = 2)	0	4.0% (n = 2)

Average Length of Stay

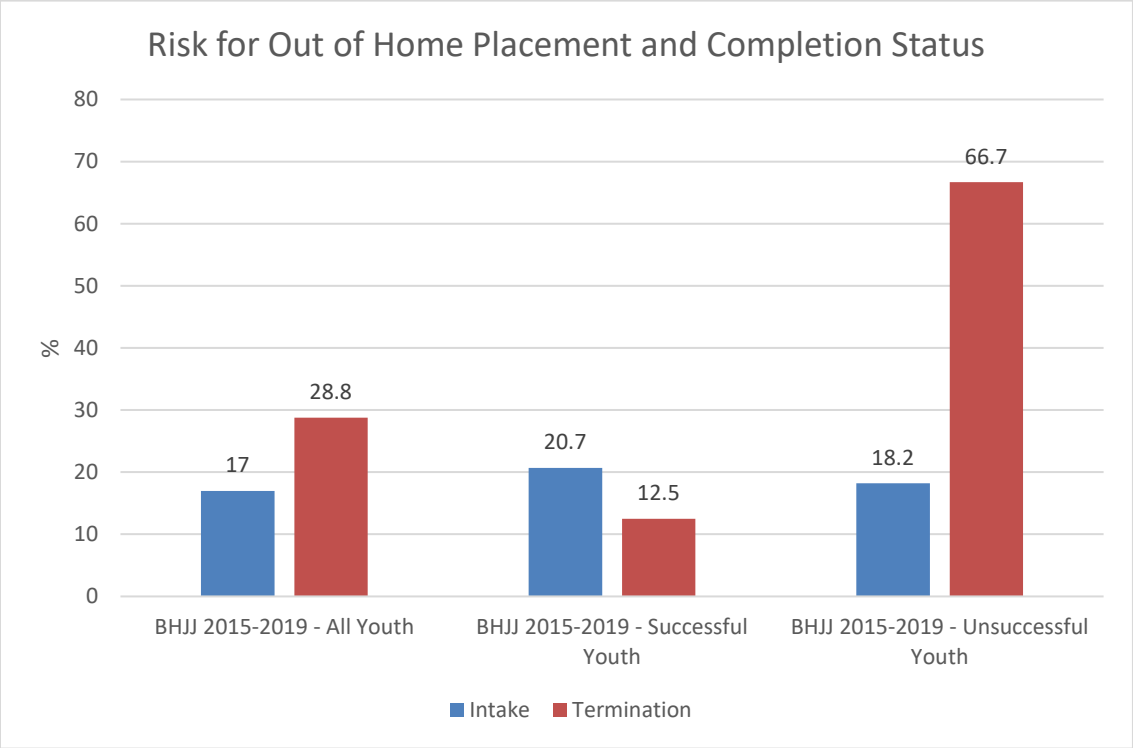
Since the start of BHJJ, the average length of stay (ALOS) in the program was 165.6 days. For youth identified as successful treatment completers, the ALOS was 183.1 days while for unsuccessful treatment completers, the ALOS was 120.8 days.

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, 17.0% of the youth (n = 16) were at risk for out of home placement. At termination, 28.8% (n = 17) of youth were at risk for out of home placement (see Figure 145). Of those youth who successfully completed BHJJ treatment, 12.5% (n = 5) were at risk

for out of home placement at termination while 66.7% (n = 12) of youth who completed unsuccessfully were at risk for out of home placement (see Figure 145).

Figure 145.



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 services through BHJJ. Workers reported that police contacts had been reduced for 79.7% (n = 47) of the youth and had stayed the same for 8.5% (n= 5) of the youth. Police contacts increased for 6.8% (n = 4) of the youth and the worker was unable to estimate for 5.1% of youth (n = 3).

YSSF

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the services they received through the BHJJ program in Summit County as well as how services impacted their children and family. At termination from the BHJJ program, 95.5% (n =21) of caregivers either strongly agreed or agreed that BHJJ staff were sensitive to their cultural/ethnic background and 96.9% (n =23) either strongly agreed or agreed that the location of the services was convenient (see Figure 146). Over seventy-six percent (70.8%, n = 17) of caregivers reported that as a result of the services their child/family received, their child gets along better with family members and 62.5% (n = 15) reported their child is better able to cope when things go wrong (see Figure 147).

Figure 146.

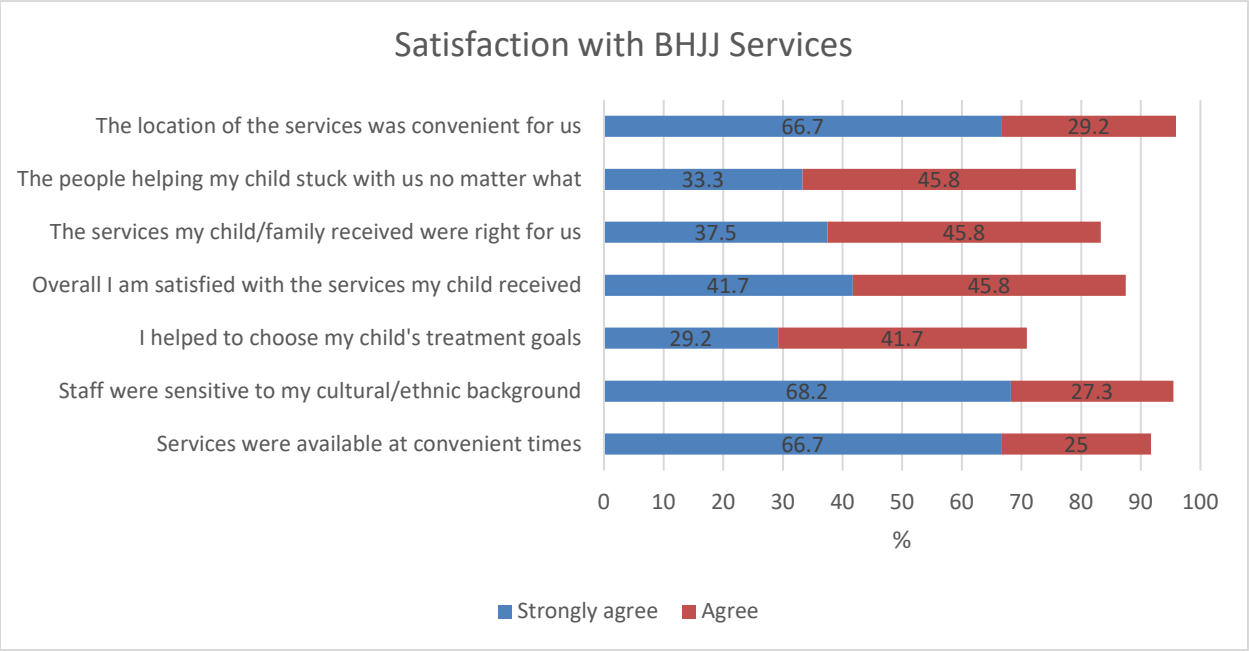
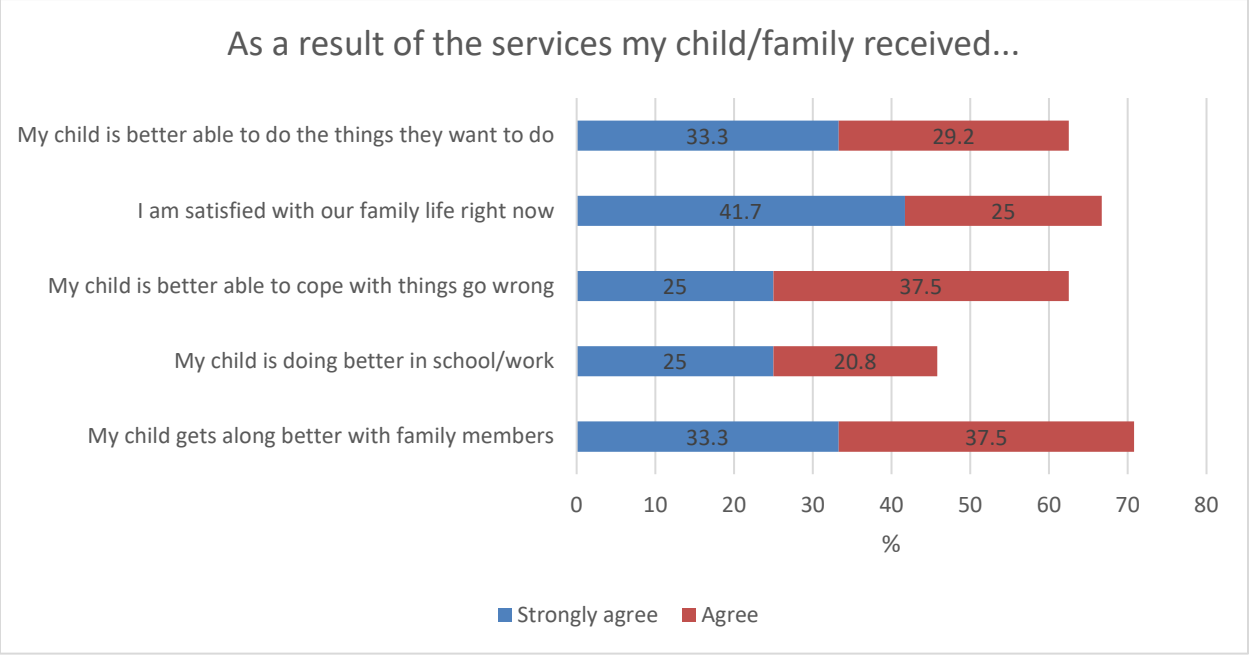


Figure 147.



Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve months prior to the end of the data collection period for inclusion in the analysis. These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 81.4% (n = 70) of BHJJ youth in Summit County enrolled between July 1, 2015 and June 30, 2019 had a misdemeanor charge, 96.5% (n = 83) or a felony charge, and 98.8% (n = 85) had been adjudicated delinquent in the 12 months prior to enrollment (see Table 181). Previous juvenile court information was similar for youth regardless of their completion status (successful vs. unsuccessful). In the 12 months prior to enrollment in BHJJ, 96.3% (n = 26) of successful completers and 90.9% (n = 10) of

unsuccessful completers were charged with at least one felony (see Table 182 and Table 183). Chi-square analyses revealed no statistically significant differences based on completion status.

Table 181. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 86)	67.4% (n = 58)	88.4% (n = 76)	95.3% (n = 82)
12 months (n = 86)	81.4% (n = 70)	96.5% (n = 83)	98.8% (n = 85)
18 months (n = 86)	87.2% (n = 75)	98.8% (n = 85)	100.0% (n = 86)

Table 182. Charges Prior to BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 27)	74.1% (n = 20)	92.6% (n = 25)	100.0% (n = 27)
12 months (n = 27)	88.9% (n = 24)	96.3% (n = 26)	100.0% (n = 27)
18 months (n = 27)	88.9% (n = 24)	100.0% (n = 27)	100.0% (n = 27)

Table 183. Charges Prior to BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 11)	81.8% (n = 9)	90.9% (n = 10)	90.9% (n = 10)
12 months (n = 11)	90.9% (n = 10)	90.9% (n = 10)	100.0% (n = 11)
18 months (n = 11)	90.9% (n = 10)	100.0% (n = 11)	100.0% (n = 11)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 184). In the 12 months after enrollment in BHJJ, 61.6% (n = 45) of participants were charged with at least one new misdemeanor and 53.4% (n = 39) were charged with at least one new felony. Nearly two-thirds (65.8%; n = 48) of the youth were adjudicated delinquent.

Table 184. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 81)	50.6% (n = 41)	39.5% (n = 32)	49.4% (n = 40)
12 months (n = 73)	61.6% (n = 45)	53.4% (n = 39)	65.8% (n = 48)
18 months (n = 59)	71.2% (n = 42)	59.3% (n = 35)	72.9% (n = 43)

In the 12 months after enrollment in BHJJ, 64.0% (n = 16) of successful completers were charged with at least one new misdemeanor, 52.0% (n = 13) were charged with at least one new felony, and 72.0% (n = 18) were adjudicated delinquent (see Table 185). Of the youth who completed unsuccessfully, 40.0% (n = 4) were charged with at least one new misdemeanor, 70.0% (n = 7) were charged with at least one new felony, and 60.0% (n = 6) were adjudicated delinquent in the 12 months after their enrollment in BHJJ (see Table 186). Chi-square analyses did not reveal any significant differences by completion status.

Table 185. Recidivism after BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 26)	53.8% (n = 14)	38.5% (n = 10)	61.5% (n = 16)
12 months (n = 25)	64.0% (n = 16)	52.0% (n = 13)	72.0% (n = 18)
18 months (n = 18)	88.9% (n = 16)	61.1% (n = 11)	88.9% (n = 16)

Table 186. Recidivism after BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 11)	36.4% (n = 4)	54.5% (n = 6)	45.5% (n = 5)
12 months (n = 10)	40.0% (n = 4)	70.0% (n = 7)	60.0% (n = 6)
18 months (n = 10)	60.0% (n = 6)	80.0% (n = 8)	70.0% (n = 7)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 187). In the 12 months after termination from BHJJ, 56.7% (n = 17) of youth were charged with at least one new misdemeanor and 50.0% (n = 15) were charged with at least one new felony, and 53.3% (n = 16) were adjudicated delinquent.

Table 187. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 35)	31.4% (n = 11)	31.4% (n = 11)	34.3% (n = 12)
12 months (n = 30)	56.7% (n = 17)	50.0% (n = 15)	53.3% (n = 16)
18 months (n = 25)	60.0% (n = 15)	64.0% (n = 16)	68.0% (n = 17)

In the 12 months following their termination from BHJJ, 52.6% (n = 10) of successful completers were charged with at least one new misdemeanor, 47.4% (n = 9) were charged with at least one new felony, and 52.6% (n = 10) were adjudicated delinquent (see Table 188). Of the youth who completed unsuccessfully, 60.0% (n = 6) were charged with at least one new misdemeanor, 50.0% (n = 5) were charged with at least one new felony, and 50.0% (n = 5) were adjudicated delinquent in the 12 months after their termination from BHJJ (see Table 189). Chi-square analyses showed no statistically significant differences.

Table 188. Recidivism after BHJJ Termination for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 24)	33.3% (n = 8)	37.5% (n = 9)	33.3% (n = 8)
12 months (n = 19)	52.6% (n = 10)	47.4% (n = 9)	52.6% (n = 10)
18 months (n = 15)	60.0% (n = 9)	66.7% (n = 10)	66.7% (n = 10)

Table 189. Recidivism after BHJJ Termination for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 10)	20.0% (n = 2)	10.0% (n = 1)	30.0% (n = 3)
12 months (n = 10)	60.0% (n = 6)	50.0% (n = 5)	50.0% (n = 5)
18 months (n = 9)	55.6% (n = 5)	55.6% (n = 5)	66.7% (n = 6)

ODYS Commitments

Among a total of 86 youth who enrolled since July 1, 2015, 4.7% (n = 4) were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ. **Conversely, 95.3% of youth participating in BHJJ were not admitted to an ODYS facility at any point after enrollment.**

Average Numbers of Charges and Adjudications

In addition to whether a youth was charged or adjudicated delinquent, we examined whether there were differences in the average number of charges and adjudications in equivalent periods of time prior to enrollment and after termination. We conducted paired samples *t*-tests to examine whether there were statistically significant differences in the mean number of charges and adjudications at each time

period prior to and after BHJJ participation. Figure 148 shows the average number of charges for youth who had data at both time periods. This restriction resulted in a sample of 35 youth at 6 months, 30 youth at 12 months, and 25 youth at 18 months. **Paired samples *t*-tests revealed a statistically significant decline in the average number of misdemeanor charges and delinquent adjudications at each of the time periods we examined.** For example, the average number of misdemeanor charges 18 months prior to BHJJ enrollment was 4.24 while the average number of misdemeanor charges 18 months after BHJJ termination was 2.04.

Figure 148.

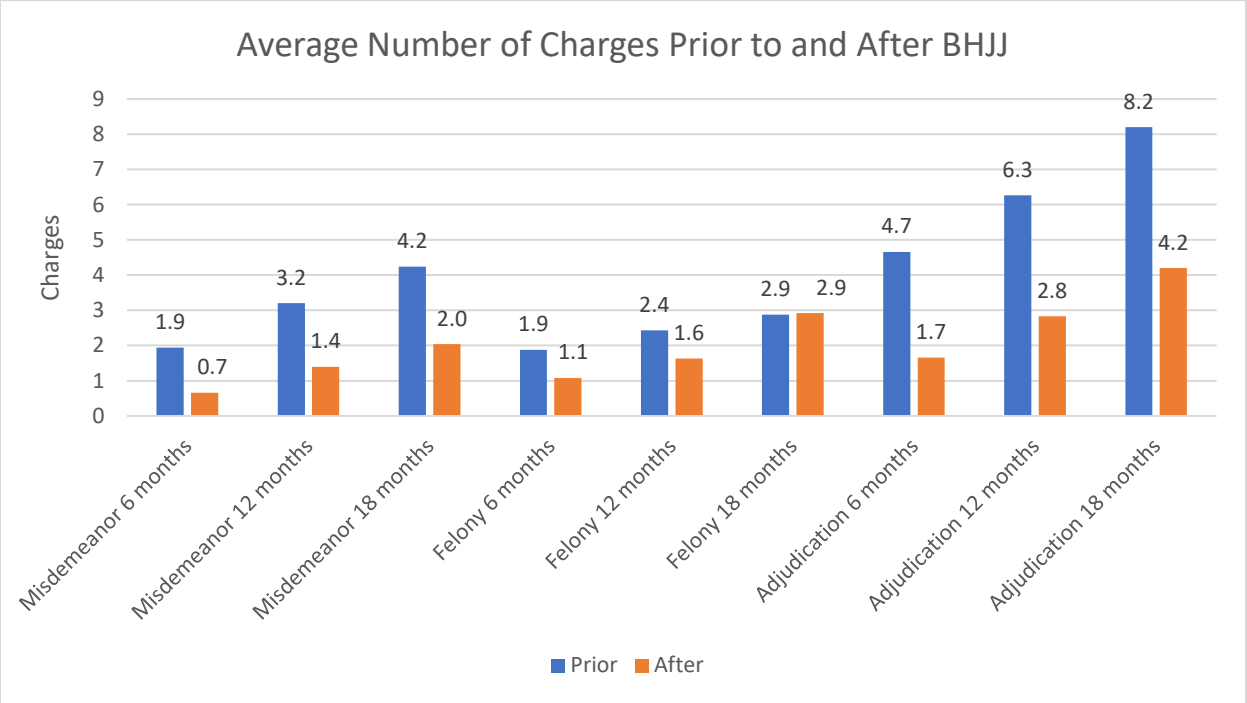


Figure 149 and Figure 150 shows mean differences in charges and adjudications for youth who successfully completed the program and those who did not successfully terminate. To be included in the analysis youth must have data at both time periods. This restricted the sample to 24 youth at 6 months, 19 youth at 12 months, and 15 youth at 18 months for youth who were successfully terminated and 10 youth at 6 months, 10 youth at 12 months, and 9 youth at 18 months for those who terminated unsuccessfully. **For youth who successfully completed, paired samples *t*-tests revealed that there was a significant reduction in the average number of misdemeanor charges and delinquent adjudications in each of the time periods we examined.** For example, the average number of misdemeanor charges declined from 3.8 in the 18 months prior to intake to 2.3 in the 18 months after termination. **Similarly, for youth who terminated unsuccessfully, paired samples *t*-tests revealed that there was a significant reduction in the average number of misdemeanor charges and delinquent adjudications for each of the time periods we examined.** For example, the average number of misdemeanors was 4.1 in the 18 months prior to intake and 1.5 in the 18 months after termination.

Figure 149.

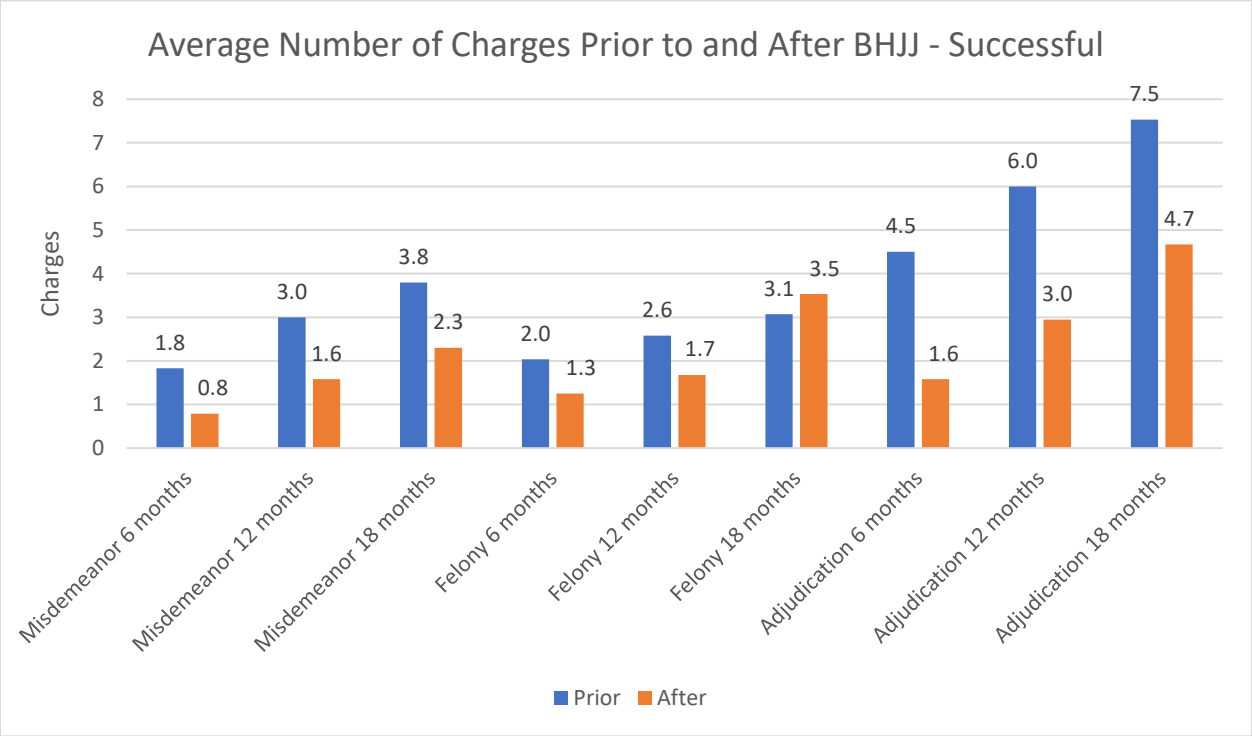
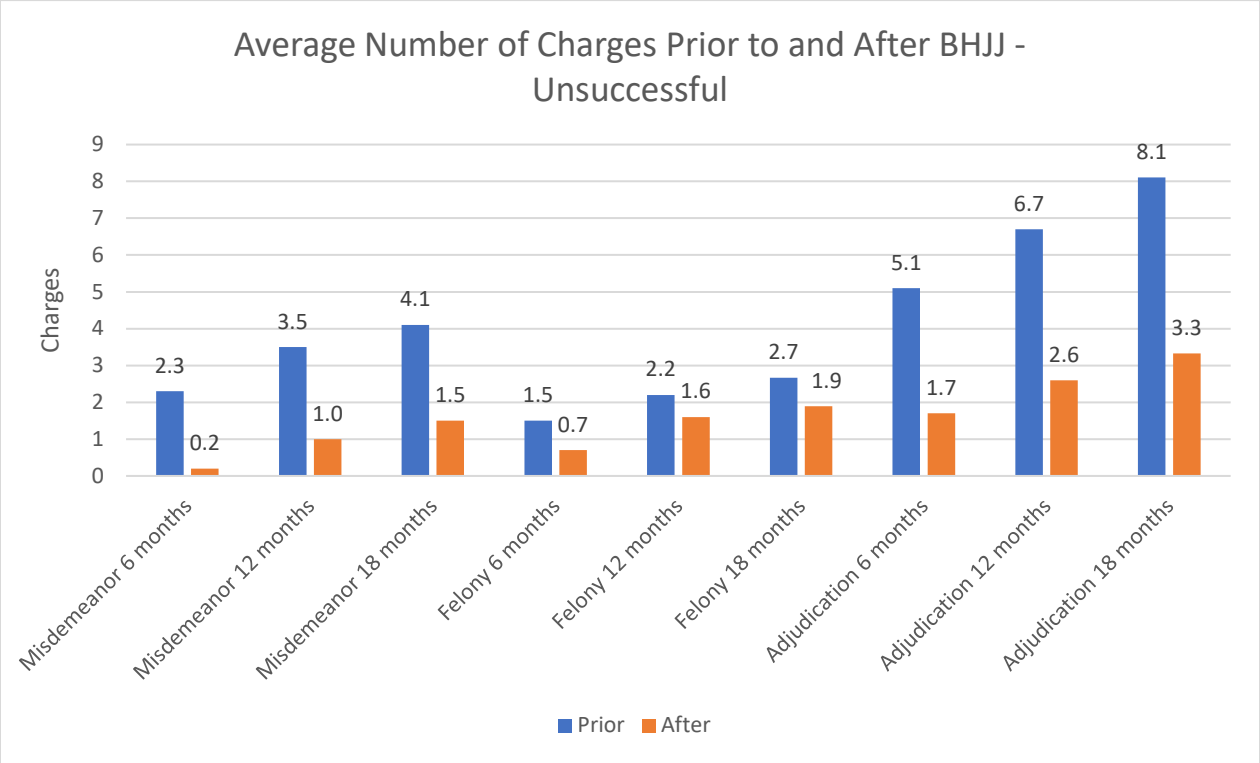


Figure 150.



Wayne

Demographics

As of June 30, 2019, 67 youth were enrolled into the BHJJ program in Wayne County. The average age at enrollment was 15.2 years (SD=1.68). More males (63.6%, n = 42) than females (36.4%, n = 24) have been enrolled. White youth (77.3%, n = 51), Multiracial youth (12.1%, n = 8), and Black youth (10.6%, n = 7) comprised the majority of the total sample.

There were 25 new enrollments in Wayne County during the current reporting period (July 1, 2017 through June 30, 2019). The average age at enrollment was 15.2 (SD = 1.79). Males (60.0%, n = 15) outnumbered females (40.0%, n = 10), and more White youth (76.0%, n = 19) than Multiracial (20.0%, n = 5) or Black youth (4.0%, n = 1) were enrolled. No youth self-identified as Hispanic/Latinx.

Unless otherwise noted, the following sections describe data from the past four years of BHJJ programming from July 1, 2015 through June 30, 2019.

Custody Arrangement and Household Information

At intake, 44.7% of youth (n = 17) lived with their biological mother only, while 26.3% (n = 10) lived with two biological parents or one biological and one step/adoptive parent (see Table 190). Over three-quarters of youth (76.3%, n = 29) of BHJJ youth lived with at least one biological at enrollment.

Over eighty-six percent (86.1%; n = 31) of the BHJJ caregivers had at least a high school diploma or GED, and 5.6% (n = 2) had a bachelor's degree or higher. Nearly fourteen percent of caregivers (13.9%; n = 5) reported they did not graduate from high school (see Table 191).

Caregivers were asked to report their annual household income (see Table 192). The income range with the highest endorsement was $10,000 - $14,999 (21.6%, n = 8). Overall, 54.1% (n = 20) reported a family income of $24,999 or less. When examined by race, 38.5% (n = 10) of White families, 60.0% (n = 3) of Black families, and 16.7% (n = 1) of Multiracial families reported a household income of $14,999 or less. Table 192 displays the reported household income overall and by race.

Table 190. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	26.3% (n = 10)
Biological Mother Only	44.7% (n = 17)
Biological Father Only	5.3% (n = 2)
Adoptive Parent(s)	10.5% (n = 4)
Aunt/Uncle	NA
Grandparents	13.2% (n = 5)
Other	NA

Table 191. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	13.9% (n = 5)
High School Graduate or G.E.D.	50.0% (n = 18)
Some College or Associate Degree	30.6% (n = 11)
Bachelor's Degree	5.6% (n = 2)
More than a Bachelor's Degree	NA

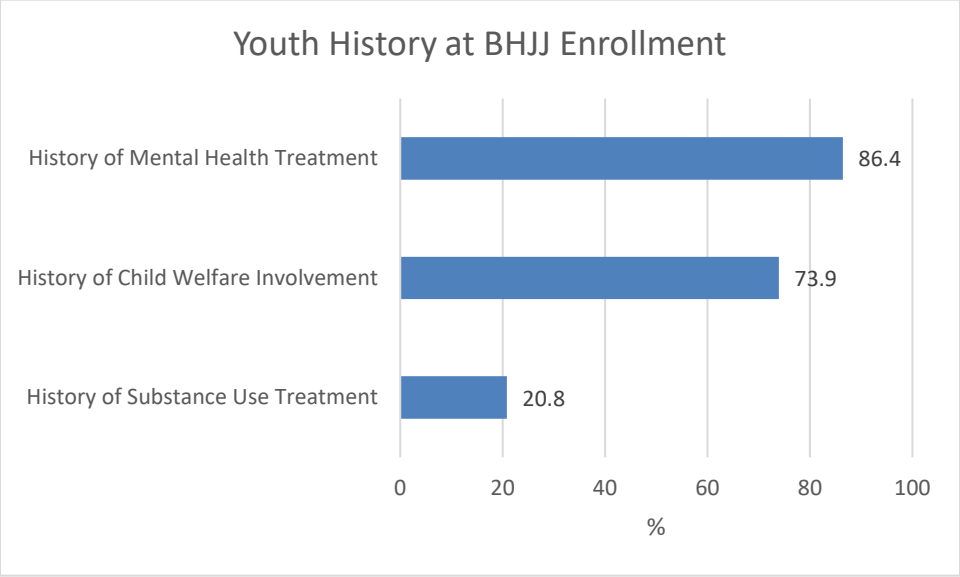
Table 192. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Black	Multiracial
Less than $5,000	8.1% (n = 3)	3.8% (n = 1)	40.0% (n = 2)	0
$5,000 - $9,999	5.4% (n = 2)	3.8% (n = 1)	20.0% (n = 1)	0
$10,000 - $14,999	21.6% (n = 8)	30.8% (n = 8)	0	0
$15,000 - $19,999	5.4% (n = 2)	3.8% (n = 1)	0	16.7% (n = 1)
$20,000 - $24,999	13.5% (n = 5)	11.5% (n = 3)	0	33.3% (n = 2)
$25,000 - $34,999	16.2% (n = 6)	15.4% (n = 4)	20.0% (n = 1)	16.7% (n = 1)
$35,000 - $49,999	10.8% (n = 4)	7.7% (n = 2)	20.0% (n = 1)	16.7% (n = 1)
$50,000 - $74,999	8.1% (n = 3)	7.7% (n = 2)	0	16.7% (n = 1)
$75,000 or greater	10.8% (n = 4)	15.4% (n = 4)	0	0

Youth and Family History

Workers were asked to identify a youth's prior behavioral health and child welfare system involvement (see Figure 151). These three items were new to the past biennium, therefore, data are only available for youth enrolled between July 1, 2017 and June 30, 2019. Nearly three-quarters of the youth (73.9%, n = 17) had a history of child welfare involvement prior to BHJJ enrollment. Twenty-one percent (20.8%, n = 5) of youth had received substance use treatment in their lifetime prior to BHJJ enrollment and 86.4% (n = 19) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 151.



Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history. Chi-square analyses were conducted on each item to test for gender differences and significant differences are identified in Table 193. A significantly larger proportion of the caregivers of females reported lifetime histories of running away and a history of living in a household with someone convicted of a crime.

Caregivers reported that 15.4% (n = 2) of females and 16.7% (n = 4) of males had a history of being physically abused while 23.1% (n = 3) of females and 4.2% (n = 1) of males had a history of being sexual abused. Caregivers of 61.5% (n = 8) of females and 50.0% (n = 12) of males reported hearing the child talking about committing suicide and 30.8% (n = 4) of females and 25.0% (n = 6) of males had attempted suicide at least once. A majority of the caregivers of females (84.6%, n = 11) and males (69.6%, n = 16) reported a family history of depression. Caregiver of 91.7% of females (n = 11) and 41.7% of males (n = 10) reported a family history of problems with substance use.

Table 193. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	15.4% (n = 2)	16.7% (n = 4)
Has the child ever been sexually abused?	23.1% (n = 3)	4.2% (n = 1)
Has the child ever run away?	84.6% (n = 11)**	37.5% (n = 9)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	50.0% (n = 6)	56.5% (n = 13)
Has the child ever talked about committing suicide?	61.5% (n = 8)	50.0% (n = 12)
Has the child ever attempted suicide?	30.8% (n = 4)	25.0% (n = 6)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	61.5% (n = 8)	41.7% (n = 10)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	84.6% (n = 11)	69.6% (n = 16)
Has anyone in the child's biological family had a mental illness, other than depression?	30.8% (n = 4)	57.1% (n = 12)
Has the child ever lived in a household in which someone was convicted of a crime?	91.7% (n = 11)**	41.7% (n = 10)
Has anyone in the child's biological family had a drinking or drug problem?	76.9% (n = 10)	65.2% (n = 15)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	53.8% (n = 7)	52.4% (n = 11)

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

Problems Leading to Service

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-related problems (100.0% and 100.0% respectively) (see Table 194).

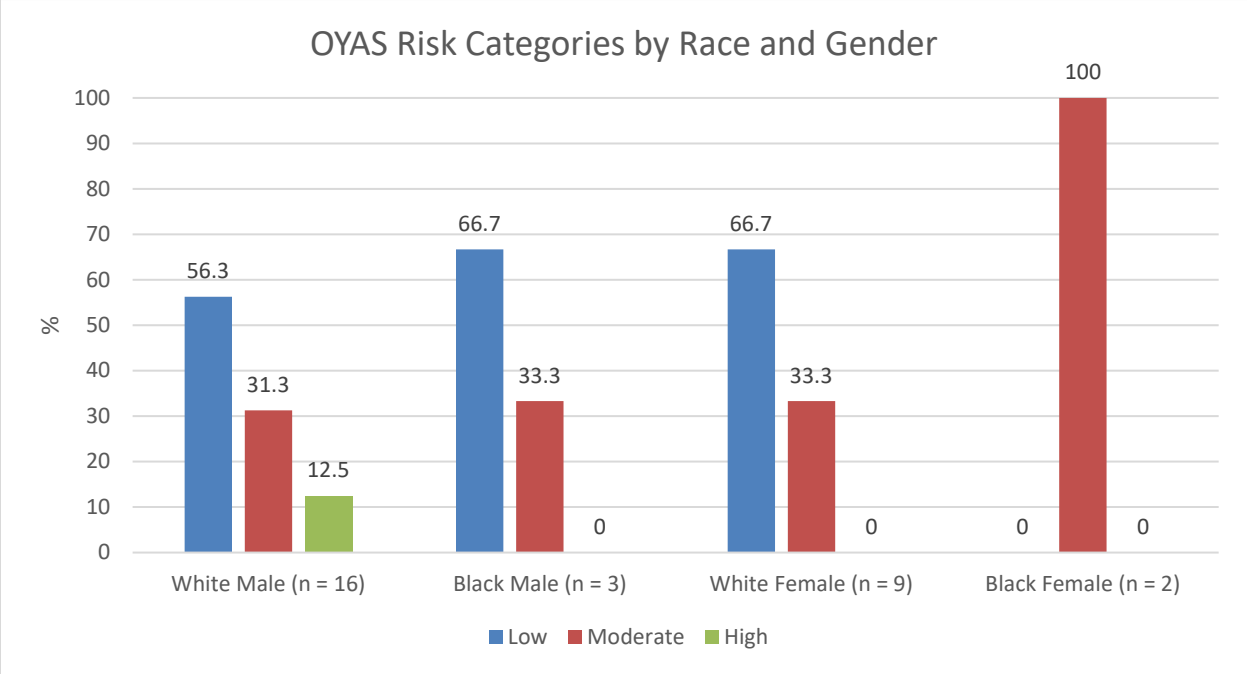
Table 194. Problems Leading to Services

Problems Leading to Services	Females	Males
Adjustment-related problems	28.6% (n = 4)	11.5% (n = 3)
Anxiety-related problems	28.6% (n = 4)	19.2% (n = 5)
Conduct/delinquency-related problems	100.0% (n = 14)	100.0% (n = 26)
Depression-related problems	50.0% (n = 7)	23.1% (n = 6)
Eating disorders	0	0
Hyperactive and attention-related problems	42.9% (n = 6)	42.3% (n = 11)
Learning disabilities	0	7.7% (n = 2)
Pervasive development disabilities	0	3.8% (n = 1)
Psychotic behaviors	7.1% (n = 1)	3.8% (n = 1)
School performance problems not related to learning disabilities	42.9% (n = 6)	42.3% (n = 11)
Specific developmental disabilities	0	3.8% (n = 1)
Substance use, abuse, dependence-related problems	75.0% (n = 3)	38.5% (n = 5)
Suicide-related problems	28.6% (n = 4)	11.5% (n = 3)

Ohio Youth Assessment System

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 152 shows the distribution of OYAS risk categories for BHJJ youth by race and gender. The majority of youth in the Wayne County BHJJ program were identified as Low risk on the OYAS. Due to small sample sizes in the Black male and female groups, comparisons of OYAS levels based on race are discouraged.

Figure 152.



DSM Diagnoses

Workers were asked to report any DSM 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 diagnosis for females and males was Oppositional Defiant Disorder (see Table 195). Chi-square analysis indicated females were significantly more likely than males to be diagnosed with Depressive Disorders.

Table 195. Most Common DSM Diagnoses

DSM Diagnosis	Females (n = 14)	Males (n = 26)
Adjustment Disorder	0	0
Alcohol-related Disorders	0	0
Attention Deficit Hyperactivity Disorder	35.7% (n = 5)	38.5% (n = 10)
Bipolar Disorder	0	0
Cannabis-related Disorders	21.4% (n = 3)	26.9% (n = 7)
Conduct Disorder	7.1% (n = 1)	3.8% (n = 1)
Depressive Disorders	42.9% (n = 6)*	11.5% (n = 3)
Disruptive Behavior Disorder	0	0
Unspecified Mood Disorder	0	3.8% (n = 1)
Oppositional Defiant Disorder	**92.9% (n = 13)**	**84.6% (n = 22)**
Post-traumatic Stress Disorder	14.3% (n = 2)	3.8% (n = 1)
Unspecified Trauma and Stressor Related Disorder	0	0
Disruptive Mood Dysregulation Disorder	0	11.5% (n = 3)
Co-Occurring Disorder	21.4% (n = 3)	26.9% (n = 7)

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

Educational Information

Several items focused on educational 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. The wording on some items (e.g. IEP at intake, attendance at intake) was changed from previous versions of the forms. For those items, we present data from only the past biennium (when the new forms were in use). Those items will have smaller sample sizes compared to items that have been consistent for the past four years.

Over sixty-three percent (63.8%, n = 23) of youth were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in BHJJ treatment BHJJ, 9.4% (n = 3) of the youth were expelled or suspended from school (an 85.3% decrease from intake to termination).

Educational data were analyzed for youth who were eligible for inclusion (youth on summer break or who had graduated at the time of the survey were not included in the analyses). At intake, 100% (n = 22) of youth were currently attending school while at termination, 96.9% (n = 31) 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 196 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 197 displays this information based on completion status. At intake, 38.5% of youth were earning mostly A's and B's, and C's while at termination, 66.7% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 197). For example, at intake, 25.0% of youth who would go on to be unsuccessful completers and 38.7% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 33.3% of unsuccessful completers and 71.0% of successful completers received mostly A's, B's, or C's.

Table 196. Academic Performance

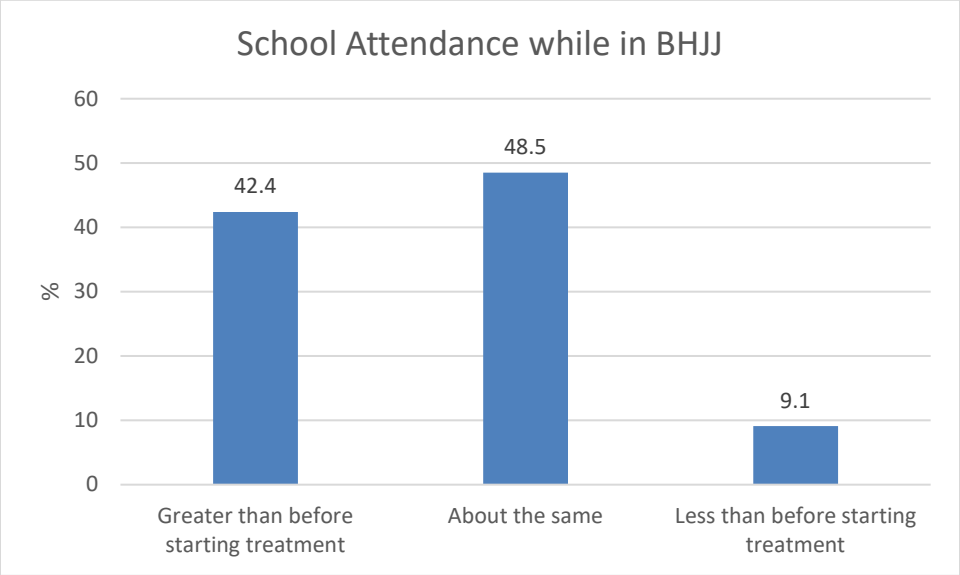
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	10.3% (n = 4)	18.2% (n = 6)
Mostly B's and C's	28.2% (n = 11)	48.5% (n = 16)
Mostly C's and D's	30.8% (n = 12)	24.2% (n = 8)
Mostly D's and F's	30.8% (n = 12)	9.1% (n = 3)

Table 197. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	0	0	9.7% (n = 3)	19.4% (n = 6)
Mostly B's and C's	25.0% (n = 1)	33.3% (n = 1)	29.0% (n = 9)	51.6% (n = 16)
Mostly C's and D's	25.0% (n = 1)	33.3% (n = 1)	29.0% (n = 9)	22.6% (n = 7)
Mostly D's and F's	50.0% (n = 2)	33.3% (n = 1)	32.2% (n = 10)	6.5% (n = 2)

At termination, workers reported that 42.4% (n = 14) of youth were attending school more than before starting treatment and 48.5% (n = 16) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 153). At intake, 44.4% (n = 8) of the youth attending school had Individualized Education Plans (IEPs) while at termination, 43.8% (n = 14) of the youth attending school had Individualized Education Plans (IEPs).

Figure 153.



Ohio Scales

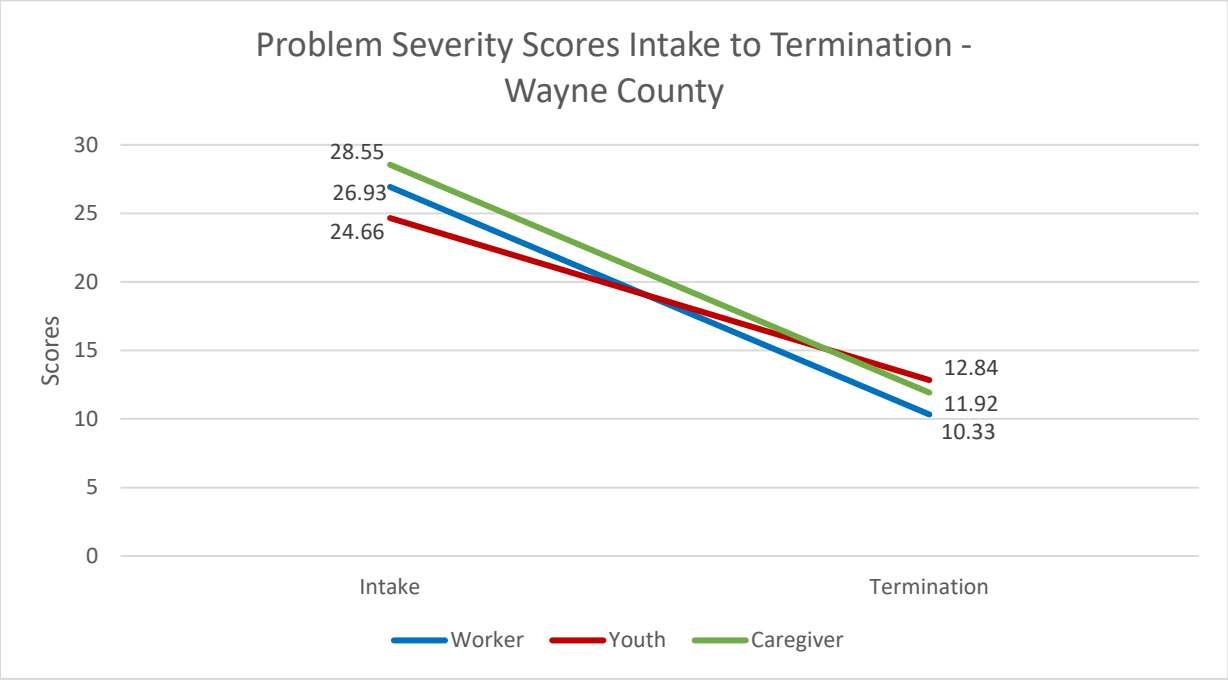
One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum of service, separate charts are included that display the means from intake to termination. Decreases in Problem Severity and increases in Functioning correspond to positive change.

All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Paired samples t-tests were used to compare Problem Severity scores at intake to Problem Severity scores at the other assessment periods. A paired samples t-test compares the means of two variables by computing the difference between the two variables for each case and testing to see if the average difference is significantly different from zero. In order for a case to be included in the analyses, the rater must have scores for both assessment periods. For example, a caregiver must supply scores for both the intake and three-month assessment period to be included in the paired samples t-test for that time point. If the caregiver only has an intake score, his or her data is not included in the analysis.

Problem Severity

Overall means for the Problem Severity scale by rater between intake and termination for Wayne County youth are presented in Figure 154.

Figure 154.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Problem Severity at both measurement intervals compared to intake (see Table 198). Significant improvements were noted at three months: $t(23) = 5.06$, $p < .001$; and at termination $t(32) = 8.96$, $p < .001$ with large effect sizes.

Table 198. Paired Samples T-Tests for Problem Severity – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	29.24 (SD=10.42; n=24)	17.30 (SD=8.70; n=24)	5.06***	1.03
Intake to Termination	26.47 (SD=10.18; n=33)	10.33 (SD=7.55; n=33)	8.96***	1.56

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvements in Problem Severity at both measurement intervals compared to intake (see Table 199). Significant improvements were noted at three months: $t(22) = 2.99$, $p < .01$; and at termination $t(31) = 3.46$, $p < .01$ with moderate effect sizes.

Table 199. Paired Samples T-Tests for Problem Severity – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	26.10 (SD=17.15; n=23)	15.48 (SD=8.47; n=23)	2.99**	.62
Intake to Termination	24.70 (SD=15.50; n=32)	12.84 (SD=12.27; n=32)	3.46**	.61

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Problem Severity at both measurement intervals compared to intake (see Table 200). Significant improvements were noted at three months: $t(23) = 3.99$, $p < .01$ and at termination $t(30) = 6.01$, $p < .001$ with large effect sizes.

Table 200. Paired Samples T-Tests for Problem Severity – Caregiver

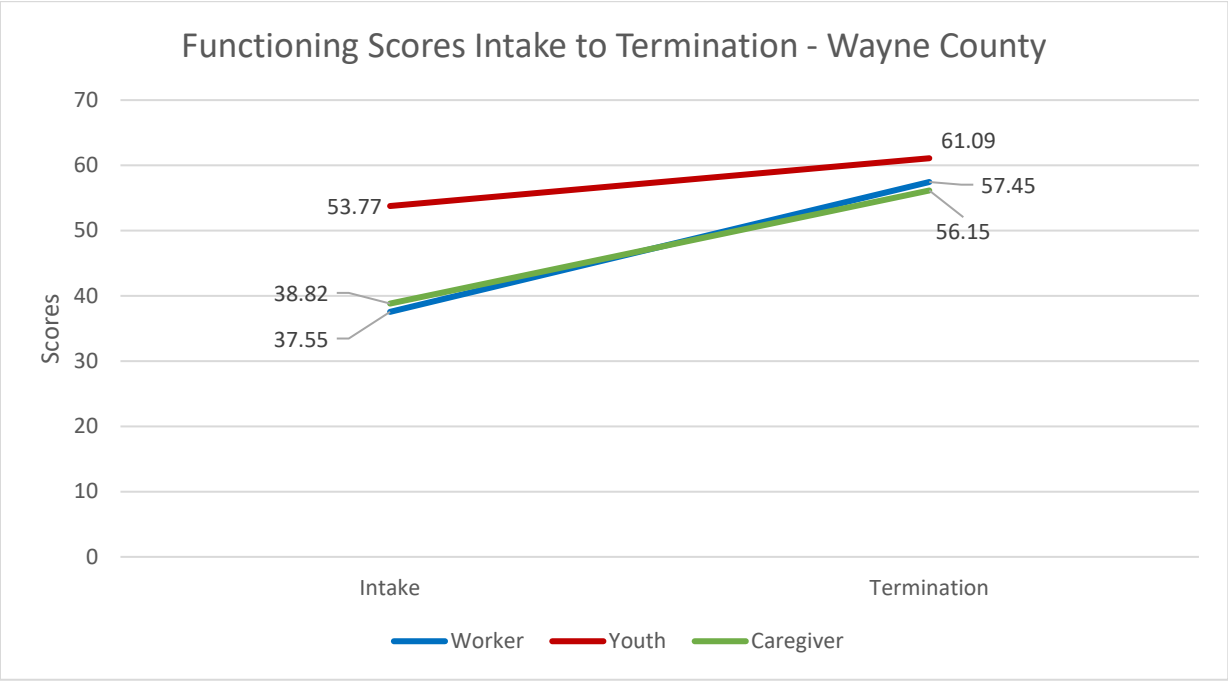
	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	28.30 (SD=16.07; n=24)	16.63 (SD=11.78; n=24)	3.99**	.81
Intake to Termination	28.95 (SD=16.24; n=31)	12.16 (SD=10.87; n=31)	6.01***	1.08

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

Functioning Scores

Overall means for the Functioning scale by rater between intake and termination for Wayne County youth are presented in Figure 155.

Figure 155.



Worker Ratings

For workers, paired samples t-tests indicated significant improvement in Functioning scores at both measurement intervals compared to intake (see Table 201). Significant improvements were noted at three months: $t(22) = -5.24$, $p < .001$ and at termination $t(32) = -9.30$, $p < .001$ with large effect sizes.

Table 201. Paired Samples T-Tests for Functioning Scores – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	35.70 (SD=8.00; n=23)	46.04 (SD=9.97; n=23)	-5.24***	1.09
Intake to Termination	37.48 (SD=9.60; n=33)	57.45 (SD=11.79; n=33)	-9.30***	1.62

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

Youth Ratings

Youth reported significant improvement in Functioning scores from intake to termination $t(32) = -2.67$, $p < .05$ with a small effect size (see Table 202).

Table 202. Paired Samples T-Tests for Functioning Scores – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	52.48 (SD=13.00; n=23)	56.96 (SD=11.14; n=23)	-1.35	.28
Intake to Termination	52.70 (SD=11.72; n=33)	61.09 (SD=15.06; n=33)	-2.67*	.46

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Functioning scores at both measurement intervals compared to intake (see Table 203). Significant improvements were noted at three months: $t(23) = -3.23$, $p < .01$ with a moderate effect size; and at termination $t(31) = -5.74$, $p < .001$ with a large effect size.

Table 203. Paired Samples T-Tests for Functioning Scores – Caregiver

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	39.04 (SD=14.88; n=24)	49.75 (SD=14.01; n=24)	-3.23**	.66
Intake to Termination	38.09 (SD=13.31; n=32)	56.12 (SD=15.63; n=32)	-5.74***	1.01

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

Violence and Delinquency Questionnaire

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey composed of three general domains: exposure to violence, violence perpetration, and peer delinquency. The VDQ is offered at intake and termination into the BHJJ program. At intake, each item prompts the youth to answer within the context of the past year. At termination, youth are directed to answer "since the last time you answered these questions".

This section will be divided into three distinct parts that examine the prevalence of violence exposure as either a victim or witness, self-reported delinquent behavior from intake to termination, and delinquent behavior by peers from intake to termination. Table 204 provides the percentage of those who had experienced violence as either a victim or witness in the past year.

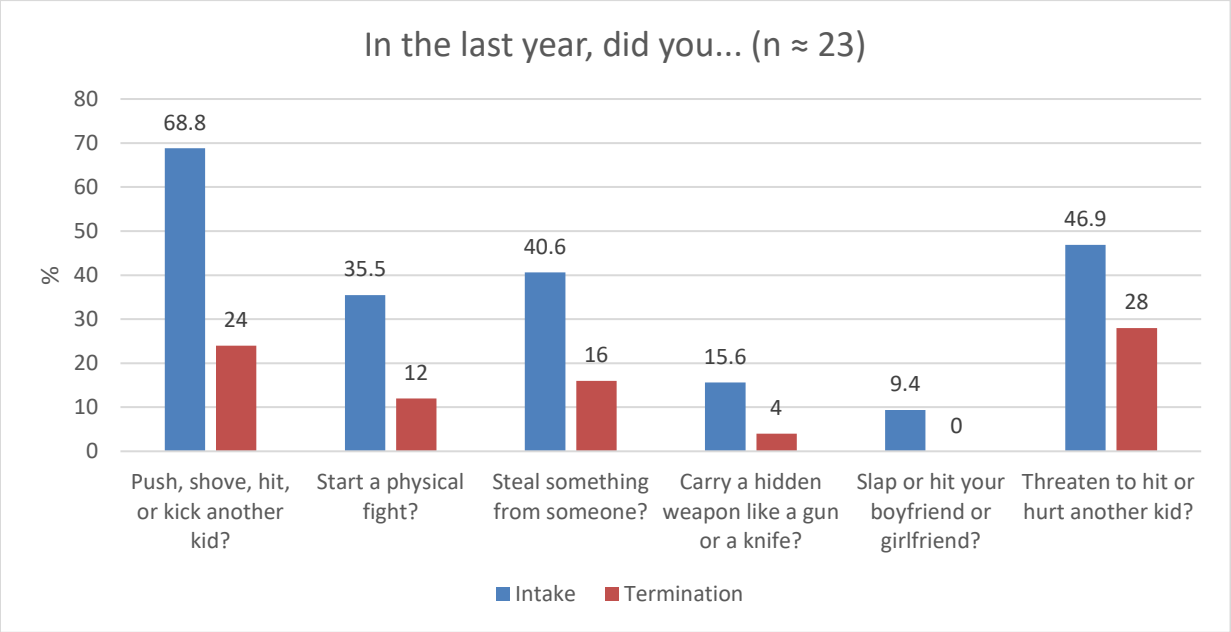
Table 204. Violence Exposure

	% Yes BHJJ Sample (n = 32)
In the last year, did someone threaten to hurt you when you thought they might really do it?	43.8%
In the last year, have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?	15.6%
In the last year, did a boyfriend or girlfriend or anyone you went on a date with slap or hit you?	6.3%
In the last year, did anyone steal anything from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?	46.9%
Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	25.0%
In the last year, did anyone hit or attack you WITHOUT using an object or weapon?	31.3%
In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?	31.3%
In the last year, did a grown-up touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?	3.1%
Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. In the last year, did another child or teen make you do sexual things?	0
In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	9.4%
In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	15.6%

In the last year, in real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt them?	43.8%
In the last year, was anyone close to you murdered, like a friend, neighbor, or someone in your family?	6.3%
In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	28.1%
Not including spanking on your bottom, did a grown-up in your life hit, beat, kick or physically hurt you in any way?	15.6%
When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. In the last year, were you neglected?	3.1%

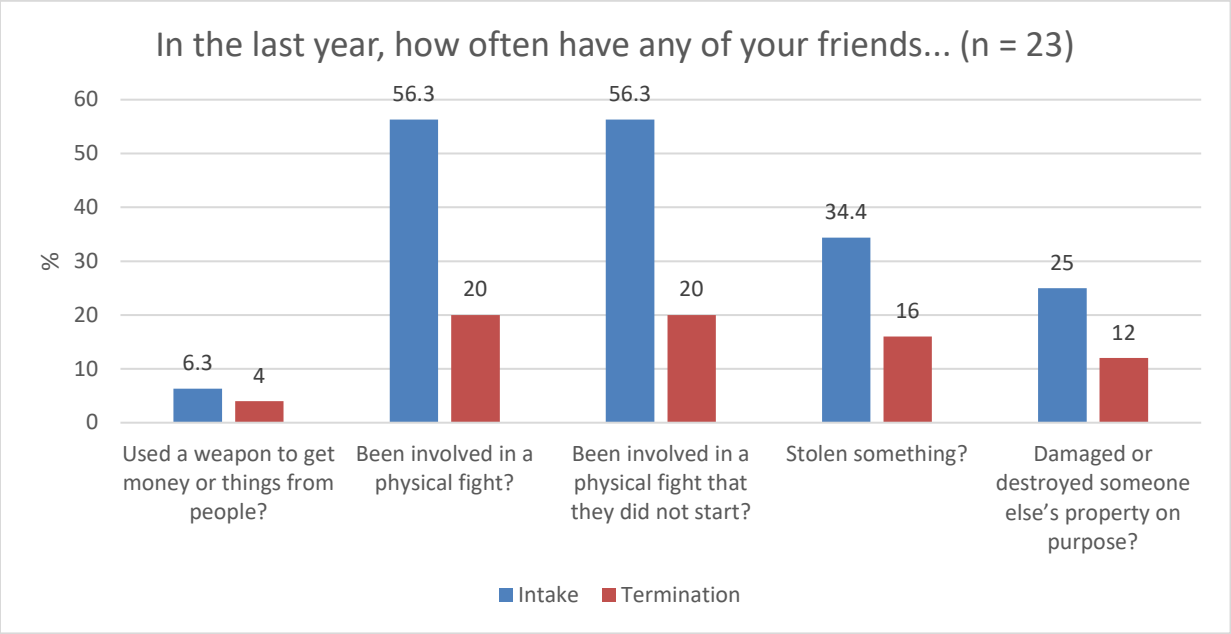
Delinquent behaviors were measured as self-report items of violent and weapon carrying behaviors as well as stealing. At intake, youth were asked how often they engaged in each behavior in the last year while at termination, youth were asked how often they engaged in the behavior since the last time they were asked. Figure 156 presents the percentage of youth who identified that they had engaged in each type of behavior at least once. Depending on the item, data were available for a range between 22 and 23 matched pairs (Mode = 23). McNemar's tests revealed statistically significant improvements from intake to termination for two items: push, shove, hit, or kick another kid, and start a physical fight.

Figure 156.



Self-reported peer delinquency was also measured at intake (how often in the last year) and at termination (how often since the last time they were asked). Figure 157 presents the percentage of youth who identified how often their friends had engaged in delinquent behavior at intake and termination. Depending on the item, data were available for 23 pairs. McNemar's tests revealed statistically significant improvements from intake to termination for two items: been involved in a physical fight, and been involved in a physical fight that they did not start.

Figure 157.



Resilience

As part of the 2017 - 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family.

Figure 158 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were “pretty much true” and “very much true”, we combined these responses. Generally, the majority of youth indicated high levels of endorsement for each one of these items.

Figure 158.

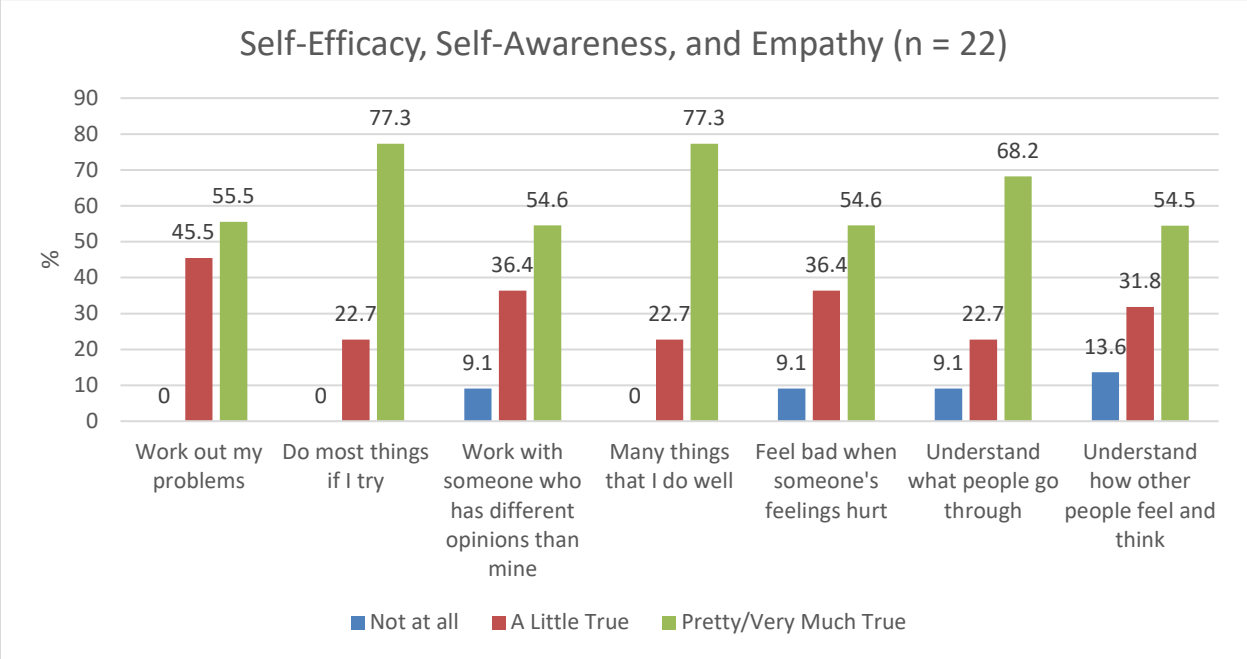


Figure 159 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. Youth in the sample indicated fairly high levels of endorsement of the three items.

Figure 159.

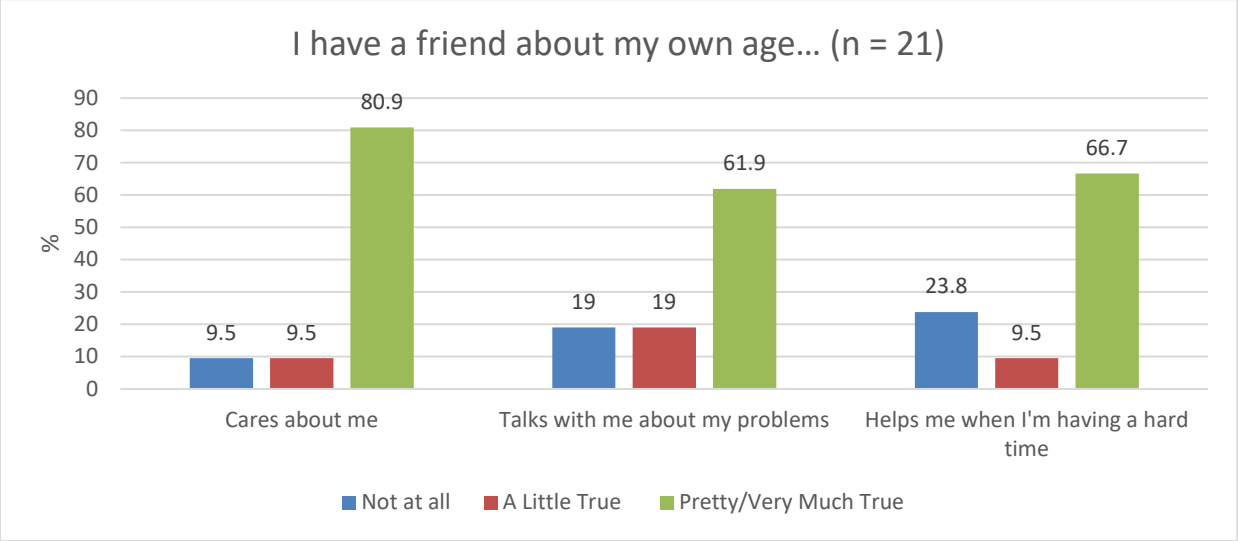
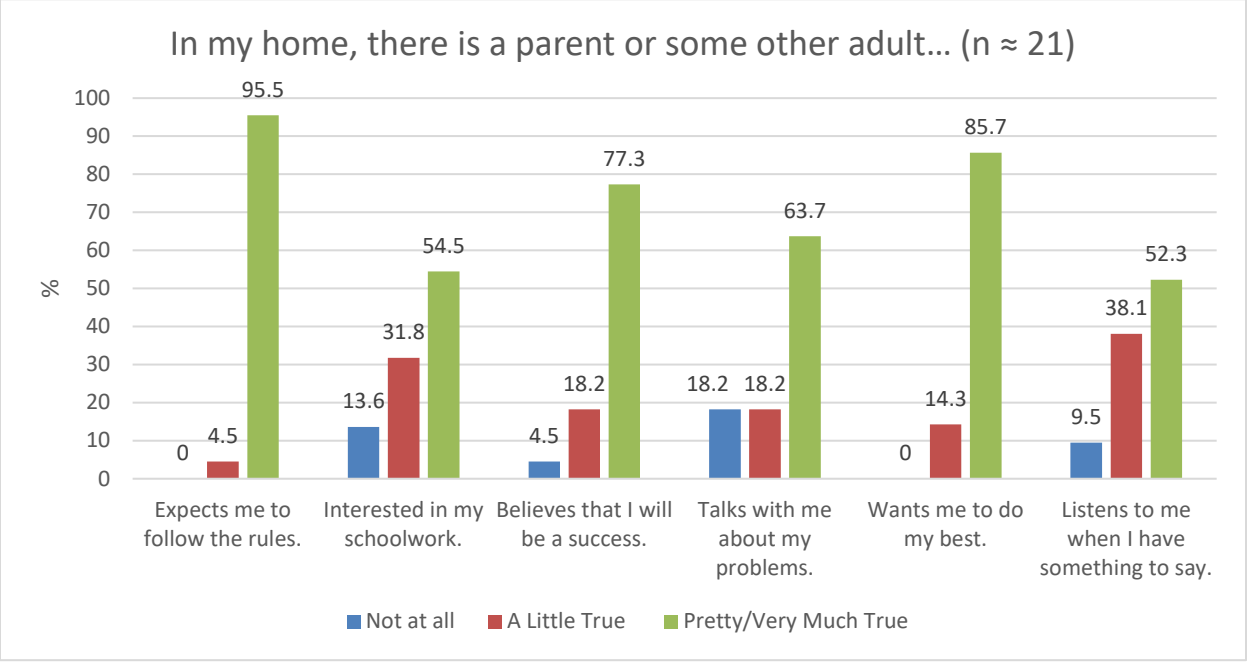


Figure 160 shows intake data on parental or support from other adults in their house. While the majority of youth identified that each of the items were either pretty much or very much true, the two items with the lowest endorsement was “interested in my schoolwork” and “listens to me when I have something to say”.

Figure 160.



In addition to intake data, Figure 161 through Figure 163 show the proportion of youth who identified that each of the statements were either pretty much or very much true from intake to termination. Due to sample size restrictions, McNemar's tests were not conducted. Figure 161 shows differences from intake to termination for the items measuring self-efficacy, self-awareness, and empathy. The number of valid responses was between 15 and 16 for each of the items. For each of the items, a larger proportion of youth indicated that the statements were either pretty much or very much true.

Figure 161.

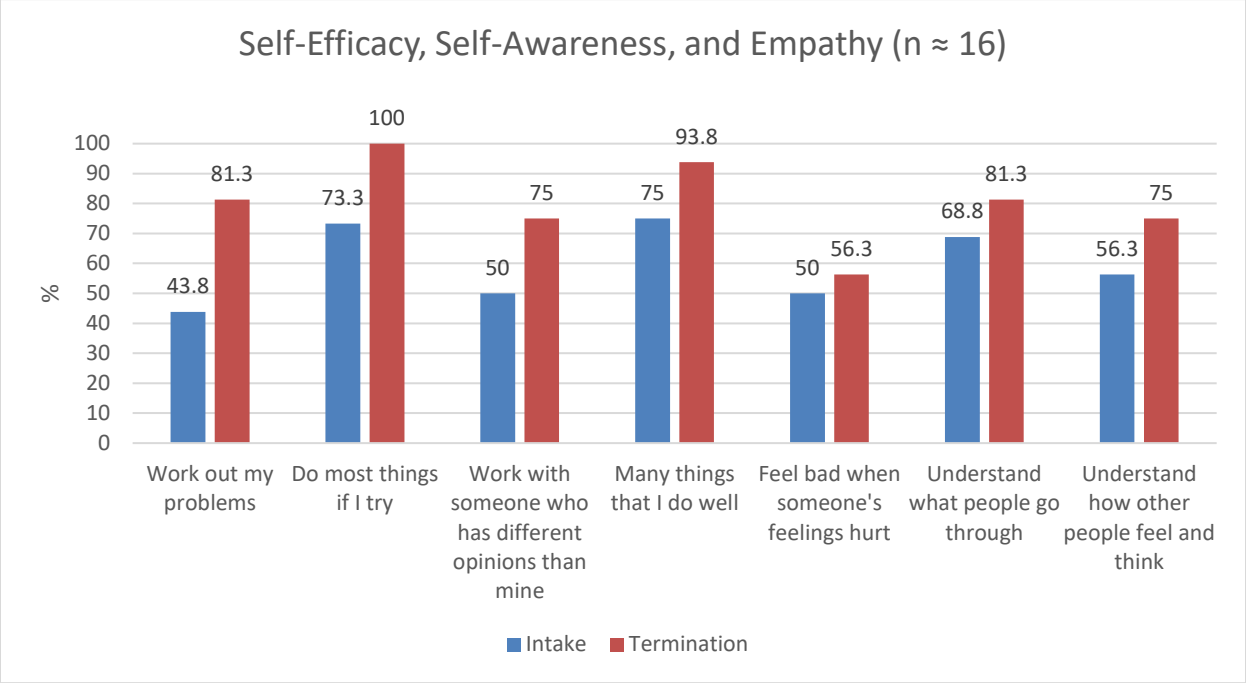


Figure 162 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring peer support. While the proportion of youth who indicated that each item was either pretty much or very much true were high, there was an improvement in each of the items at termination.

Figure 162.

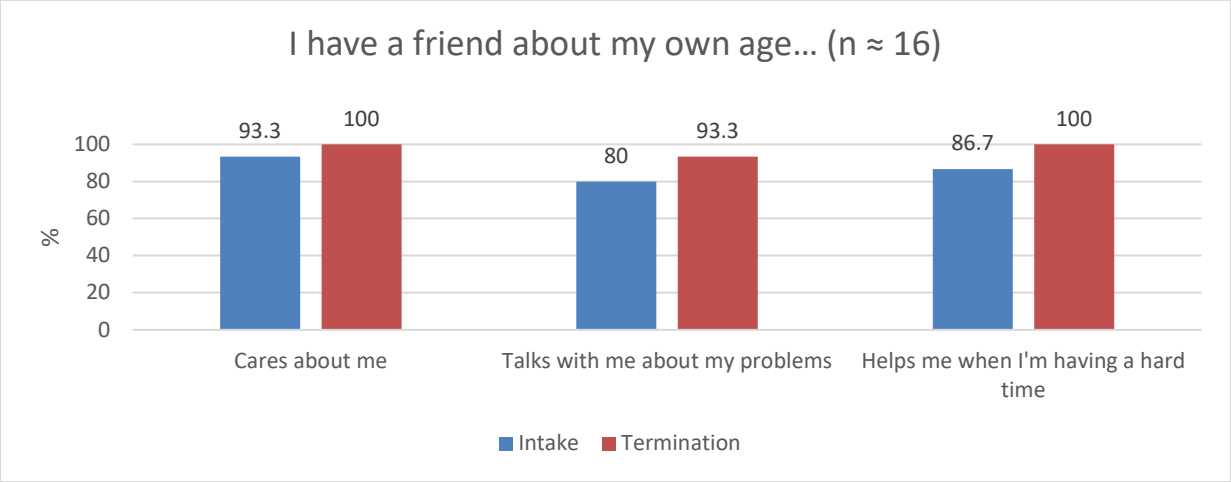
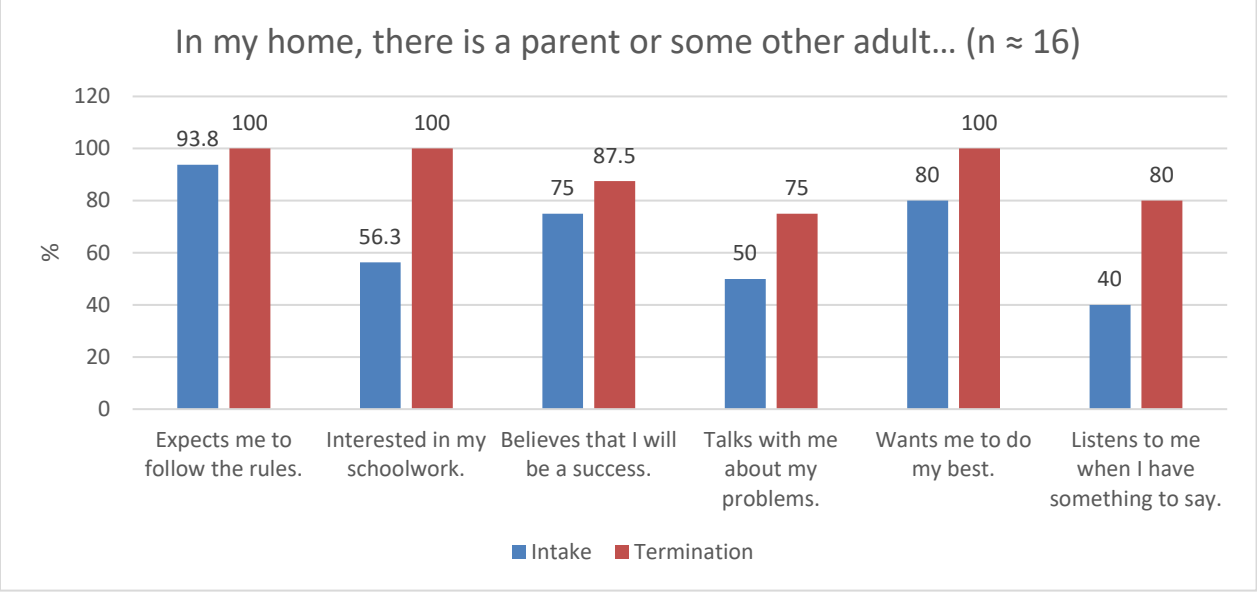


Figure 163 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring parental support or support from other adults in the home. The proportion of positive responses increased for each of the items from intake to termination. Three items in particular, "interested in my schoolwork", "talks with me about my problems", and "listens to me when I have something to say" had marked increases from intake to termination.

Figure 163.



TSCC

The TSCC was administered at intake and termination from BHJJ. Paired-samples t-tests were conducted to show whether means at intake and termination on each TSCC subscale differed significantly. Data were analyzed separately for females (see Figure 164) and males (see Figure 165) who had completed the TSCC at both intake and termination in Wayne County.

Research has found that females consistently report more trauma symptoms than males (Singer et al., 1995). We examined trauma symptoms for females and males in the BHJJ sample. Consistent with previous research, BHJJ females reported higher scores on each trauma symptom subscale than males. For example, at intake, the average score on the Depression domain was 6.67 for females and 2.80 for males. Paired samples t-tests revealed significant improvements in trauma symptoms for the Anxiety and Sexual Concerns domains for females and the Anger domain for males (see Table 205 and Table 206).

Table 205. TSCC Subscales from Intake to Termination among Females

Females	Intake	Termination	t	d
Anxiety	4.89 (SD = 4.20; n = 9)	2.89 (SD = 2.85; n = 9)	2.40*	.80
Depression	6.67 (SD = 3.67; n = 9)	6.22 (SD = 4.60; n = 9)	.215	.07
Anger	9.00 (SD = 4.00; n = 9)	7.33 (SD = 4.33; n = 9)	.778	.26
Posttraumatic Stress	6.00 (SD = 4.92; n = 9)	6.33 (SD = 5.34; n = 9)	-.216	.07
Dissociation	6.89 (SD = 4.34; n = 9)	4.89 (SD = 4.26; n = 9)	1.38	.46
Sexual Concerns	3.78 (SD = 1.79; n = 9)	1.89 (SD = 1.76; n = 9)	2.80*	.93

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

Figure 164.

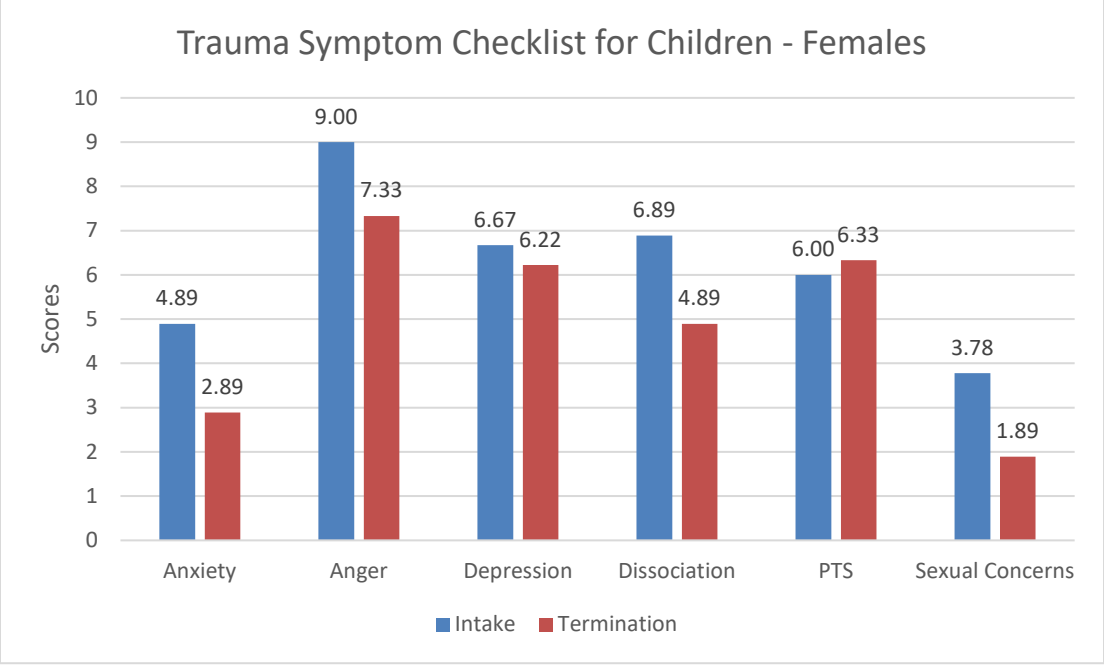
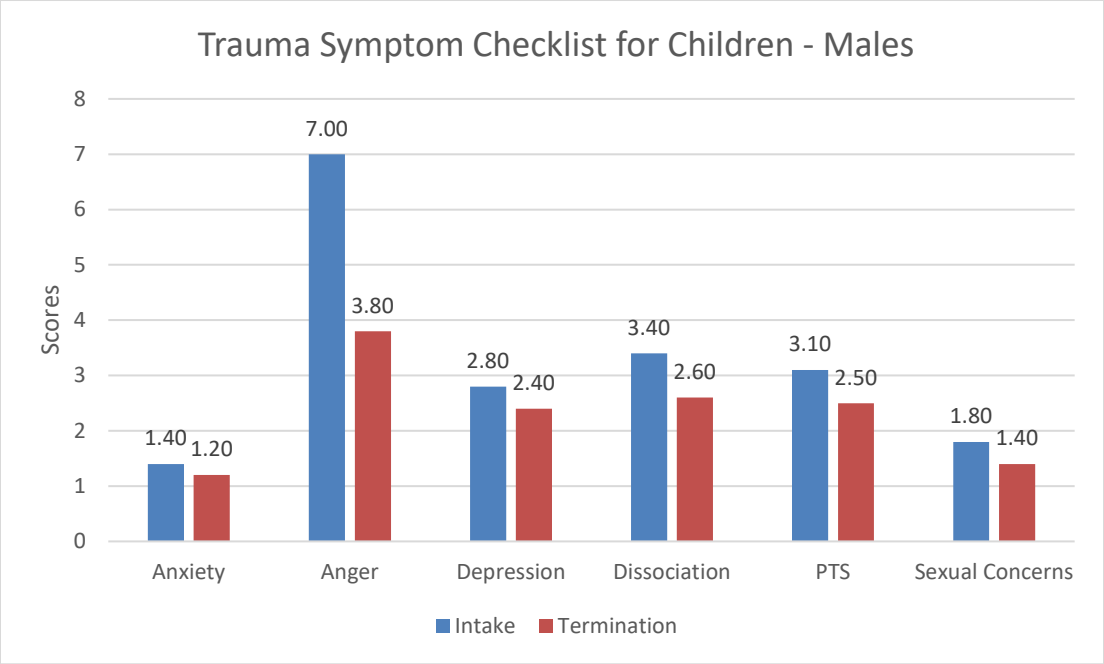


Table 206. TSCC Subscales from Intake to Termination for Males

Males	Intake	Termination	t	d
Anxiety	1.40 (SD = 1.43; n = 10)	1.20 (SD = 1.40; n = 10)	.35	.11
Depression	2.80 (SD = 2.30; n = 10)	2.40 (SD = 2.95; n = 10)	.43	.14
Anger	7.00 (SD = 3.71; n = 10)	3.80 (SD = 2.74; n = 10)	2.40*	.76
Posttraumatic Stress	3.10 (SD = 2.02; n = 10)	2.50 (SD = 2.55; n = 10)	.94	.30
Dissociation	3.40 (SD = 3.60; n = 10)	2.60 (SD = 2.17; n = 10)	.80	.25
Sexual Concerns	1.80 (SD = 1.93; n = 10)	1.40 (SD = 1.43; n = 10)	.71	.23

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

Figure 165.



Substance Use Survey

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 207 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use by gender in Wayne County. For both females and males, alcohol, tobacco, and cannabis were the most commonly used substances. Chi-squared tests revealed no significant differences based on gender.

Table 207. Self-Reported Substance Use at Intake by Gender – Wayne County

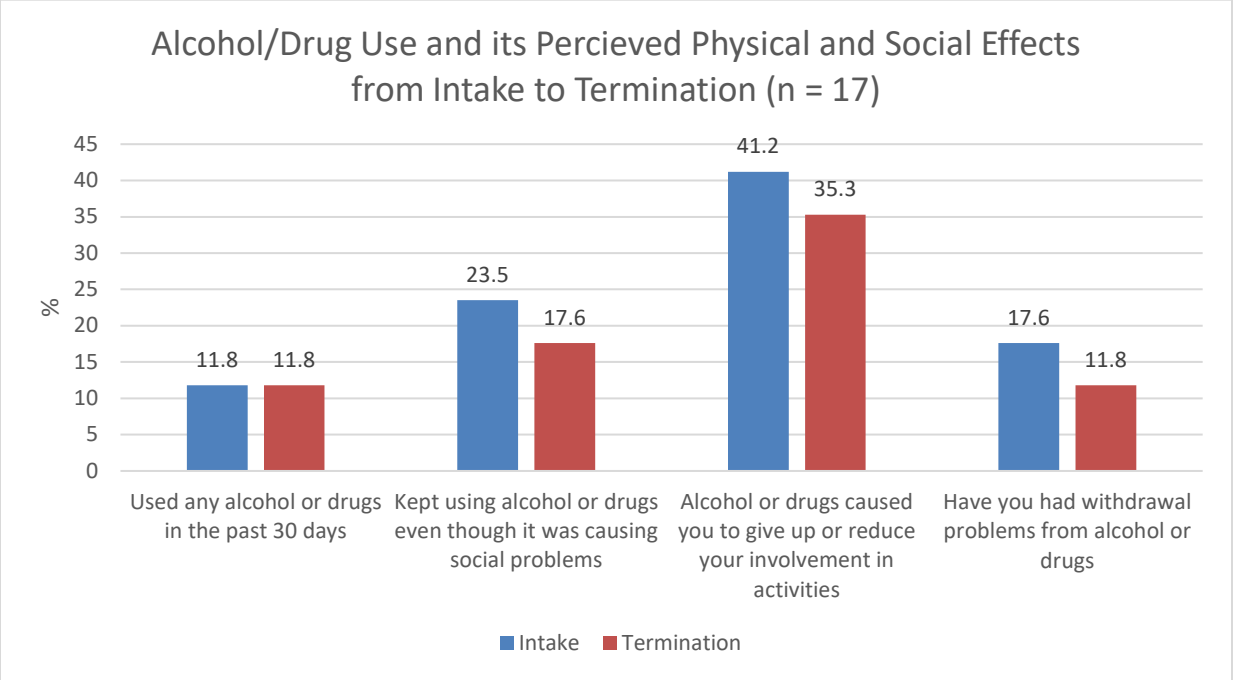
	Male		Female	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	69.2% (n = 9)	13.11 (SD = 1.62)	44.4% (n = 4)	12.50 (SD = 3.69)
Tobacco	61.5% (n = 8)	13.00 (SD = 1.83)	33.3% (n = 3)	10.33 (SD = 4.62)
Cannabis	76.9% (n = 10)	13.33 (SD = 1.73)	44.4% (n = 4)	12.75 (SD = 3.30)
Hallucinogens	23.1% (n = 3)	14.67 (SD = 1.53)	11.1% (n = 1)	12.00[a]
Inhalants	7.7% (n = 1)	16.00[a]	0.0% (n = 0)	
Opioids	23.1% (n = 3)	14.33 (SD = 1.53)	22.2% (n = 2)	13.00 (SD = 4.24)
Sedatives	15.4% (n = 2)	14.50 (SD = 2.12)	22.2% (n = 2)	13.50 (SD = 3.54)
Caffeine	46.2% (n = 6)	12.17 (SD = 1.60)	44.4% (n = 4)	9.00 (SD = 4.00)
Stimulants	15.4% (n = 2)	15.00 (SD = 1.41)	22.2% (n = 2)	12.50 (SD = 4.95)
Over the counter medications	30.8% (n = 4)	15.00 (SD = 1.41)	22.2% (n = 2)	15.50 (SD = 0.71)
Other prescription drugs	15.4% (n = 2)	12.00 (SD = 5.66)	11.1% (n = 1)	13.00[a]
Herbs/Flowers	0.0% (n = 0)		0.0% (n = 0)	

[a] No Standard Deviations are calculated.

In addition to questions pertaining to the use of specific substances, youth were asked questions around general alcohol/drug use and its perceived effects on physical health and social functioning. The proportion of youth who indicated that they had used any alcohol or drugs in the past 30 days stayed steady at 11.8% at intake and termination (see Figure 166).

From intake to termination, the proportion of youth who indicated that they had continued to use alcohol/drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people at least sometimes and the proportion of those who indicated that alcohol or drugs had caused them to give up or reduce their involvement in activities declined from intake to termination. The proportion of youth who indicated that they had withdrawal problems from alcohol or drugs also declined from intake to termination. While none of these differences were statistically significant, it is likely a function of low cell sizes.

Figure 166.



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.

Between July 1, 2015 and June 30, 2019, there have been 36 youth terminated from the BHJJ program in Wayne County. Eighty-six percent (86.1%, n = 31) of the youth terminated from the BHJJ program were identified as successful treatment completers. Nearly three percent (2.8%, n = 1) were terminated from the program due to some type of incarceration. Table 208 presents all of the reasons for termination from BHJJ and displays reasons for termination for White and Black participants.

Table 208. Reasons for Termination from BHJJ

Termination Reason	All Youth Enrolled between July 2015 and June 2019	White Youth Enrolled between July 2015 and June 2019	Black Youth Enrolled between July 2015 and June 2019
Successfully Completed Services	86.1% (n = 31)	92.0% (n = 23)	75.0% (n = 3)
Client Did Not Return/Rejected Services	0	0	0
Out of Home Placement	0	0	0
Client/Family Moved	0	0	0
Client Withdrawn	0	0	0
Client AWOL	2.8% (n = 1)	0	25.0% (n = 1)
Client Incarcerated	2.8% (n = 1)	4.0% (n = 1)	0
Other	8.3% (n = 3)	4.0% (n = 1)	0

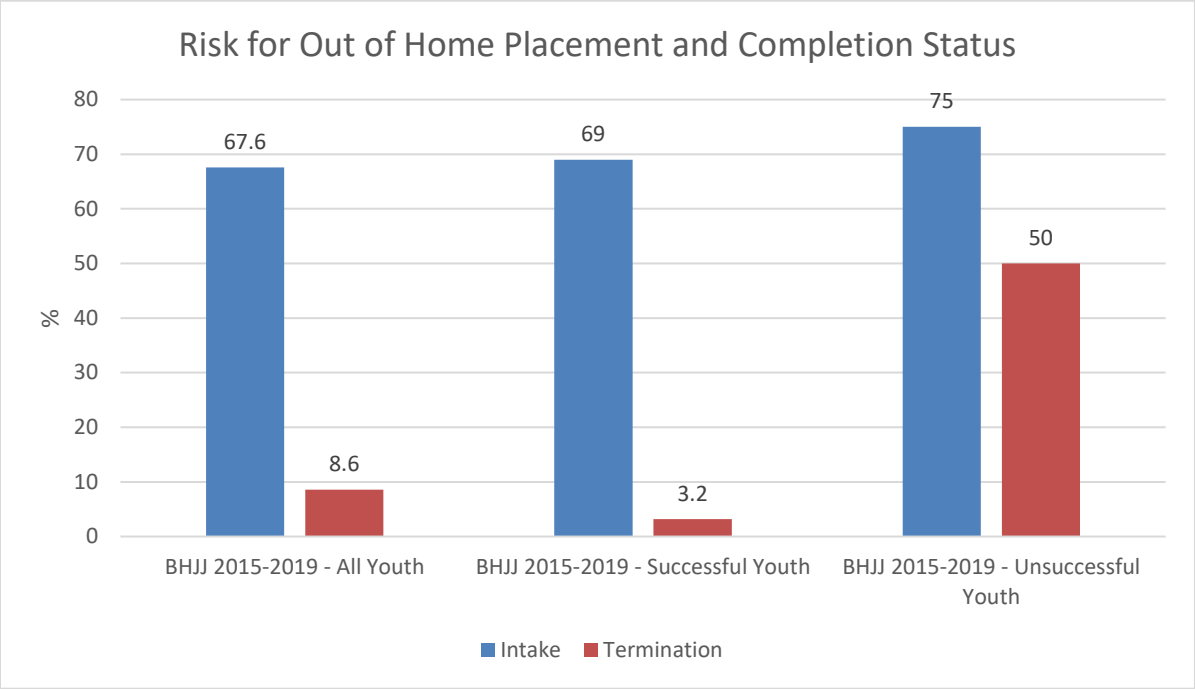
Average Length of Stay

Since the start of BHJJ, the average length of stay (ALOS) in the program was 127.3 days. For youth identified as successful treatment completers, the ALOS was 130.2 days while for unsuccessful treatment completers, the ALOS was 109.4 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, 67.6% of the youth (n = 25) were at risk for out of home placement. At termination, 8.6% (n = 3) of youth were at risk for out of home placement (see Figure 167). Of those youth who successfully completed BHJJ treatment, 3.2% (n = 1) were at risk for out of home placement at termination while 50.0% (n = 2) of youth who completed unsuccessfully were at risk for out of home placement (see Figure 167).

Figure 167.



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 services through BHJJ. Workers reported that police contacts had been reduced for 83.3% (n = 30) of the youth and had stayed the same for 11.1% (n= 4) of the youth, and the worker was unable to estimate for 5.6% of youth (n = 2).

YSSF

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the services they received through the BHJJ program in Wayne County as well as how services impacted their children and family. At termination from the BHJJ program, 93.8% (n =30) of caregivers either strongly agreed or agreed that BHJJ staff were sensitive to their cultural/ethnic background and 100% (n =33) either strongly agreed or agreed that the location of the services was convenient (see Figure 168). Over eighty-seven percent (87.9%, n = 29) of caregivers reported that as a result of the services their child/family received, their child gets along better with family members and 75.7% (n = 25) reported their child is better able to do the things they want to do (see Figure 169).

Figure 168.

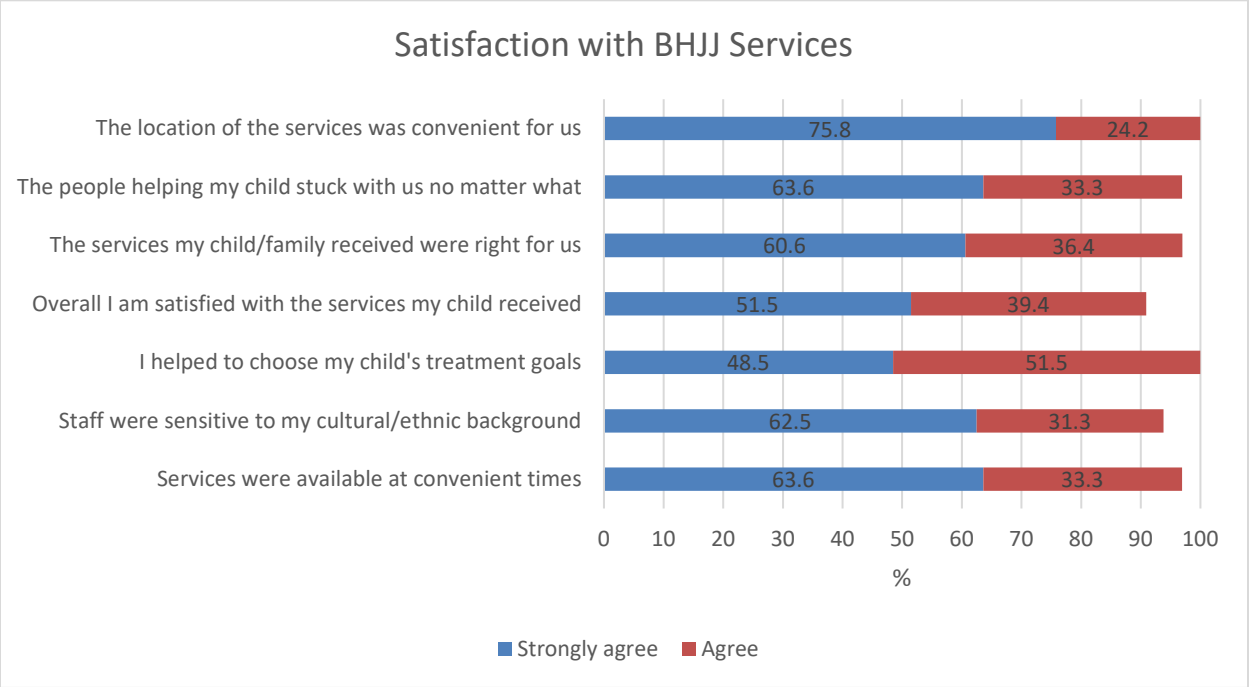
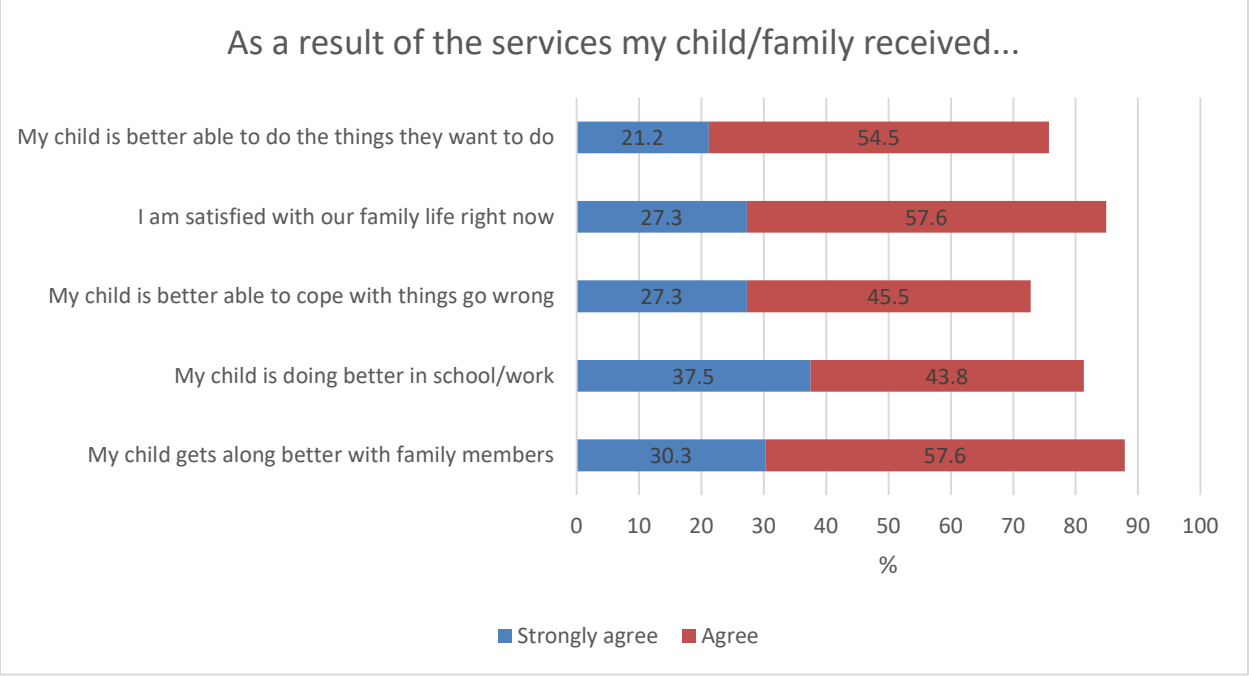


Figure 169.



Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve months prior to the end of the data collection period for inclusion in the analysis. Due to a small number of youth who terminated unsuccessfully, we were not able to separate out these data by completion status. These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 72.5% (n = 29) of BHJJ youth in Wayne county enrolled between July 1, 2015 and June 30, 2019 had a misdemeanor charge, 15.0% (n = 6) had a felony charge, and 90.0% (n = 36) had been adjudicated delinquent in the 12 months prior to enrollment (see Table 209).

Table 209. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 40)	57.5% (n = 23)	10.0% (n = 4)	82.5% (n = 33)
12 months (n = 40)	72.5% (n = 29)	15.0% (n = 6)	90.0% (n = 36)
18 months (n = 40)	72.5% (n = 29)	15.0% (n = 6)	92.5% (n = 37)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 210). In the 12 months after enrollment in BHJJ, 30.6% (n = 11) of participants were charged with at least one new misdemeanor, 8.3% (n = 3) were charged with at least one new felony, and 38.9% (n = 14) were adjudicated delinquent.

Table 210. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 40)	22.5% (n = 9)	5.0% (n = 2)	37.5% (n = 15)
12 months (n = 36)	30.6% (n = 11)	8.3% (n = 3)	38.9% (n = 14)
18 months (n = 31)	41.9% (n = 13)	12.9% (n = 4)	45.2% (n = 14)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 211). In the 12 months after termination from BHJJ, 25.8% (n = 8) of youth were charged with at least one new misdemeanor and 6.5% (n = 2) were charged with at least one new felony, and 25.8% (n = 8) were adjudicated delinquent in the 12 months following their termination from BHJJ.

Table 211. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 35)	17.1% (n = 6)	2.9% (n = 1)	20.0% (n = 7)
12 months (n = 31)	25.8% (n = 8)	6.5% (n = 2)	25.8% (n = 8)
18 months (n = 22)	36.4% (n = 8)	9.1% (n = 2)	45.5% (n = 10)

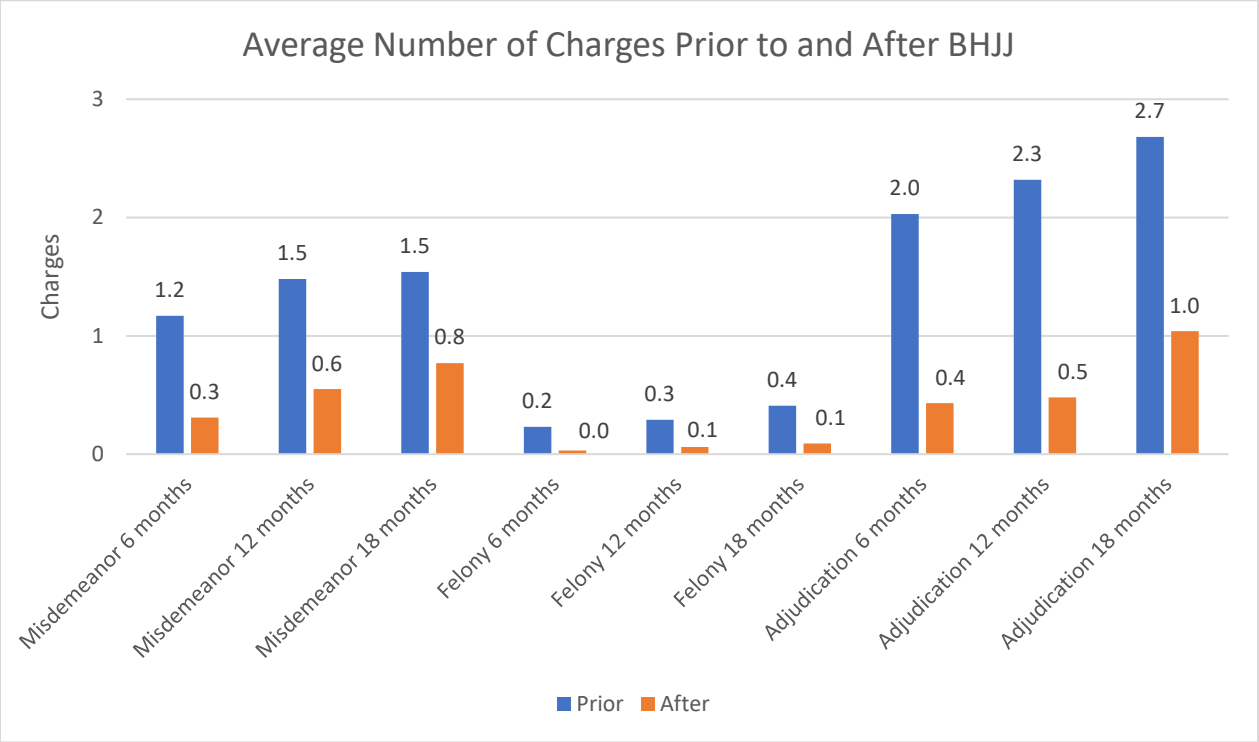
ODYS Commitments

None of the 40 youth who enrolled since July 1, 2015 were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ.

Average Numbers of Charges and Adjudications

In addition to whether a youth was charged or adjudicated delinquent, we examined whether there were differences in the average number of charges and adjudications in equivalent periods of time prior to enrollment and after termination. We conducted paired samples *t*-tests to examine whether there were statistically significant differences in the mean number of charges and adjudications at each time period prior to and after BHJJ participation. Figure 170 shows the average number of charges for youth who had data at both time periods. This restriction resulted in a sample of 35 youth at 6 months, 31 youth at 12 months, and 22 youth at 18 months. **Paired samples *t*-tests revealed statistically significant declines in the average number of misdemeanor charges and delinquent adjudications in each of the time periods we examined.** For example, the average number of misdemeanor charges 12 months prior to BHJJ enrollment was 1.48 while the average number of misdemeanor charges 12 months after BHJJ termination was 0.55.

Figure 170.


Average Number of Charges Prior to and After BHJJ
Charges
3
2
1
0
1.2
0.3
1.5
0.6
1.5
0.8
0.2
0.0
0.3
0.1
0.4
0.1
2.0
0.4
2.3
0.5
2.7
1.0
Misdemeanor 6 months
Misdemeanor 12 months
Misdemeanor 18 months
Felony 6 months
Felony 12 months
Felony 18 months
Adjudication 6 months
Adjudication 12 months
Adjudication 18 months
Prior
After

Holmes

Demographics

As of June 30, 2019, 45 youth were enrolled into the BHJJ program in Holmes County. The average age at enrollment was 14.7 years (SD=1.92). More males (63.6%, n = 28) than females (36.4%, n = 16) have been enrolled. White youth (88.6%, n = 39) and Multiracial youth (4.5%, n = 2) comprised the majority of the total sample.

There were 17 new enrollments in Holmes County during the current reporting period (July 1, 2017 through June 30, 2019). The average age at enrollment was 15.2 (SD = 1.79). Males (58.8%, n = 10) outnumbered females (41.2%, n = 7) and the majority of youth identified as White (88.2%, n = 19). No youth self-identified as Hispanic/Latinx.

Unless otherwise noted, the following sections describe data from the past four years of BHJJ programming from July 1, 2015 through June 30, 2019.

Custody Arrangement and Household Information

At intake, 36.7% of youth (n = 11) lived with their biological mother only, while 30.0% (n = 9) lived with two biological parents or one biological and one step/adoptive parent (see Table 212). Eighty percent (80.0%, n = 24) of BHJJ youth lived with at least one biological at enrollment.

Over eighty-three percent (83.3%; n = 25) of the BHJJ caregivers had at least a high school diploma or GED, and 6.7% (n = 2) had a bachelor's degree or higher. Over sixteen percent of caregivers (16.7%; n = 5) reported they did not graduate from high school (see Table 213).

Caregivers were asked to report their annual household income (see Table 214). The income range with the highest endorsement was $20,000 - $24,999 (20.0%, n = 6). Overall, 63.3% (n = 19) reported a family income of $24,999 or less. Table 214 displays the reported household income overall and by race.

Table 212. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	30.0% (n = 9)
Biological Mother Only	36.7% (n = 11)
Biological Father Only	13.3% (n = 4)
Adoptive Parent(s)	3.3% (n = 1)
Aunt/Uncle	6.7% (n = 2)
Grandparents	10.0% (n = 3)
Other	0

Table 213. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	16.7% (n = 5)
High School Graduate or G.E.D.	66.7% (n = 20)
Some College or Associate Degree	10.0% (n = 3)
Bachelor's Degree	6.7% (n = 2)
More than a Bachelor's Degree	NA

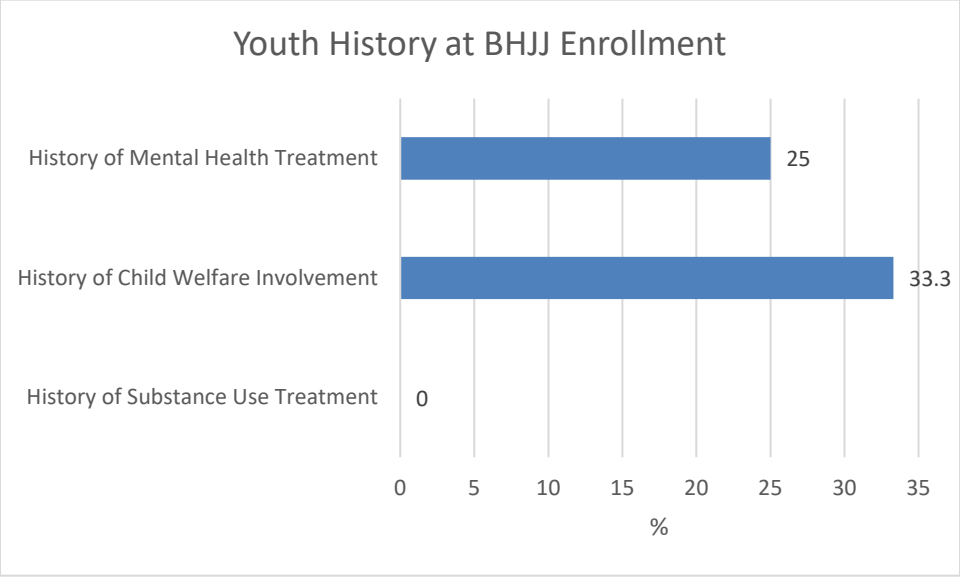
Table 214. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Multiracial
Less than $5,000	16.7% (n = 5)	18.5% (n = 5)	0
$5,000 - $9,999	6.7% (n = 2)	7.4% (n = 2)	0
$10,000 - $14,999	6.7% (n = 2)	7.4% (n = 2)	0
$15,000 - $19,999	13.3% (n = 4)	11.1% (n = 3)	50.0% (n = 1)
$20,000 - $24,999	20.0% (n = 6)	22.2% (n = 6)	0
$25,000 - $34,999	10.0% (n = 3)	11.1% (n = 3)	0
$35,000 - $49,999	10.0% (n = 3)	11.1% (n = 3)	0
$50,000 - $74,999	13.3% (n = 4)	7.4% (n = 2)	50.0% (n = 1)
$75,000 or greater	3.3% (n = 1)	3.7% (n = 1)	0

Youth and Family History

Workers were asked to identify a youth's prior behavioral health and child welfare system involvement (see Figure 171). These three items were new to the past biennium, therefore, data are only available for youth enrolled between July 1, 2017 and June 30, 2019. One-third of the youth (33.3%, n = 2) had a history of child welfare involvement prior to BHJJ enrollment. No youth received substance use treatment in their lifetime prior to BHJJ enrollment and 25.0% (n = 2) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 171.



Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history (see Table 215). While Chi-square analyses were conducted on each item, there were no significant differences partly due to a small sample. Caregivers reported that 28.6% (n = 4) of females and 13.3% (n = 2) of males had a history of being physically abused while 53.8% (n = 7) of females and 25.0% (n = 4) of males had a history of being sexual abused. Caregivers of 42.9% (n = 6) of females and 37.5% (n = 6) of males reported hearing the child talking about committing suicide and 14.3% (n = 2) of females and 6.3% (n = 1) of males had attempted suicide at least once. A majority of the caregivers of females (85.7%, n = 12) and males (62.5%, n = 10) reported a family history of depression. A majority of the caregivers of females (64.3%, n = 9) and males (56.3%, n = 9) reported a family history of problems with substance use.

Table 215. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	28.6% (n = 4)	13.3% (n = 2)
Has the child ever been sexually abused?	53.8% (n = 7)	25.0% (n = 4)
Has the child ever run away?	28.6% (n = 4)	31.3% (n = 5)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	14.3% (n = 2)	31.3% (n = 5)
Has the child ever talked about committing suicide?	42.9% (n = 6)	37.5% (n = 6)
Has the child ever attempted suicide?	14.3% (n = 2)	6.3% (n = 1)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	35.7% (n = 5)	43.8% (n = 7)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	85.7% (n = 12)	62.5% (n = 10)
Has anyone in the child's biological family had a mental illness, other than depression?	57.1% (n = 8)	60.0% (n = 9)
Has the child ever lived in a household in which someone was convicted of a crime?	38.5% (n = 5)	37.5% (n = 6)
Has anyone in the child's biological family had a drinking or drug problem?	64.3% (n = 9)	56.3% (n = 9)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	50.0% (n = 7)	25.0% (n = 4)

Problems Leading to Service

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 school performance problems not related to learning disabilities (57.1% and 43.8% respectively) (see Table 216).

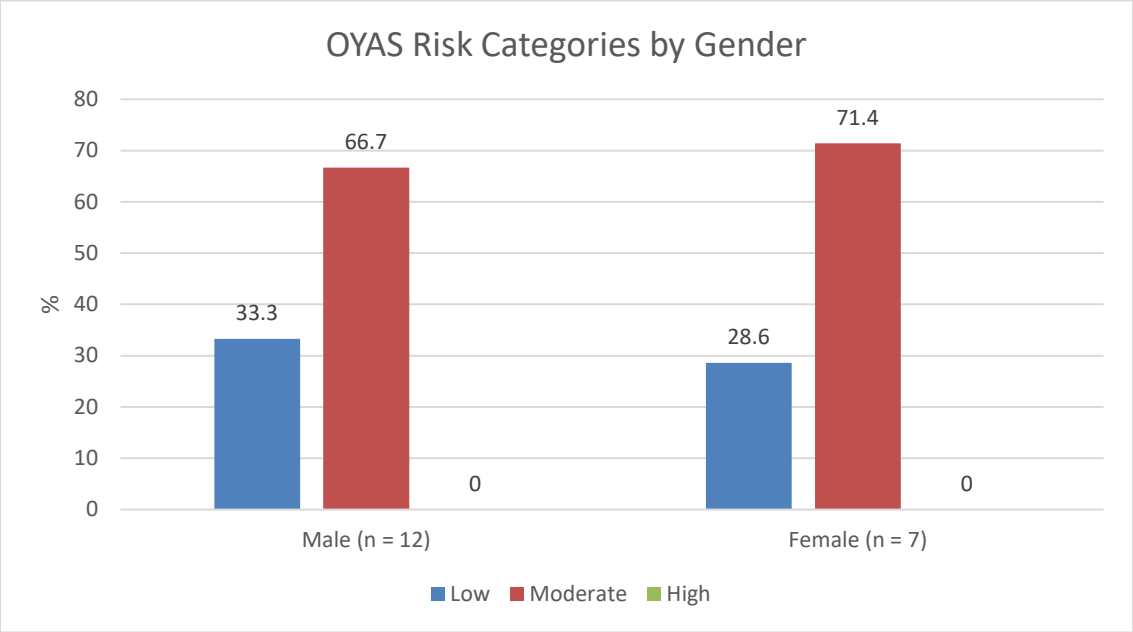
Table 216. Problems Leading to Services

Problems Leading to Services	Females	Males
Adjustment-related problems	7.1% (n = 1)	0
Anxiety-related problems	28.6% (n = 4)	25.0% (n = 4)
Conduct/delinquency-related problems	50.0% (n = 7)	31.3% (n = 5)
Depression-related problems	14.3% (n = 2)	12.5% (n = 2)
Eating disorders	0	0
Hyperactive and attention-related problems	35.7% (n = 5)	18.8% (n = 3)
Learning disabilities	0	12.5% (n = 2)
Pervasive development disabilities	0	0
Psychotic behaviors	0	0
School performance problems not related to learning disabilities	57.1% (n = 8)	43.8% (n = 7)
Specific developmental disabilities	0	0
Substance use, abuse, dependence-related problems	18.2% (n = 2)	27.3% (n = 3)
Suicide-related problems	21.4% (n = 3)	0

Ohio Youth Assessment System

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 172 shows the distribution of OYAS risk categories for BHJJ youth by gender (racial comparisons were not possible). The majority of males (66.7%, n = 4) and females (71.4%, n = 5) youth in the Holmes County BHJJ program were identified as Moderate risk on the OYAS.

Figure 172.



DSM Diagnoses

Workers were asked to report any DSM 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 diagnosis for females and males was Oppositional Defiant Disorder (see Table 217).

Table 217. Most Common DSM Diagnoses

DSM Diagnosis	Females (n = 13)	Males (n = 16)
Adjustment Disorder	0	0
Alcohol-related Disorders	0	0
Attention Deficit Hyperactivity Disorder	15.4% (n = 2)	0
Bipolar Disorder	0	0
Cannabis-related Disorders	7.7% (n = 1)	6.3% (n = 1)
Conduct Disorder	0	0
Depressive Disorders	15.4% (n = 2)	0
Disruptive Behavior Disorder	0	0
Unspecified Mood Disorder	0	0
Oppositional Defiant Disorder	**100% (n = 13)**	**100% (n = 16)**
Post-traumatic Stress Disorder	0	0
Unspecified Trauma and Stressor Related Disorder	0	0
Disruptive Mood Dysregulation Disorder	0	0
Co-Occurring Disorder	7.7% (n = 1)	6.3% (n = 1)

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

Educational Information

Several items focused on educational 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. The wording on some items (e.g. IEP at intake, attendance at intake) was changed from previous versions of the forms. For those items, we present data from only the past biennium (when the new forms were in use). Those items will have smaller sample sizes compared to items that have been consistent for the past four years.

Over thirty-seven percent (37.0%, n = 10) of youth were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in BHJJ treatment BHJJ, 14.8% (n = 4) of the youth were expelled or suspended from school (a 60.0% decrease from intake to termination).

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, 83.3% (n = 5) of youth were currently attending school while at termination, 96.0% (n = 24) 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 218 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 219 displays this information based on completion status. At intake, 68.0% of youth were earning mostly A's and B's, and C's while at termination, 71.4% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 219). For example, at intake, 100% of youth who would go on to be unsuccessful completers and 65.0% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 0% of unsuccessful completers and 80.0% of successful completers received mostly A's, B's, or C's.

Table 218. Academic Performance

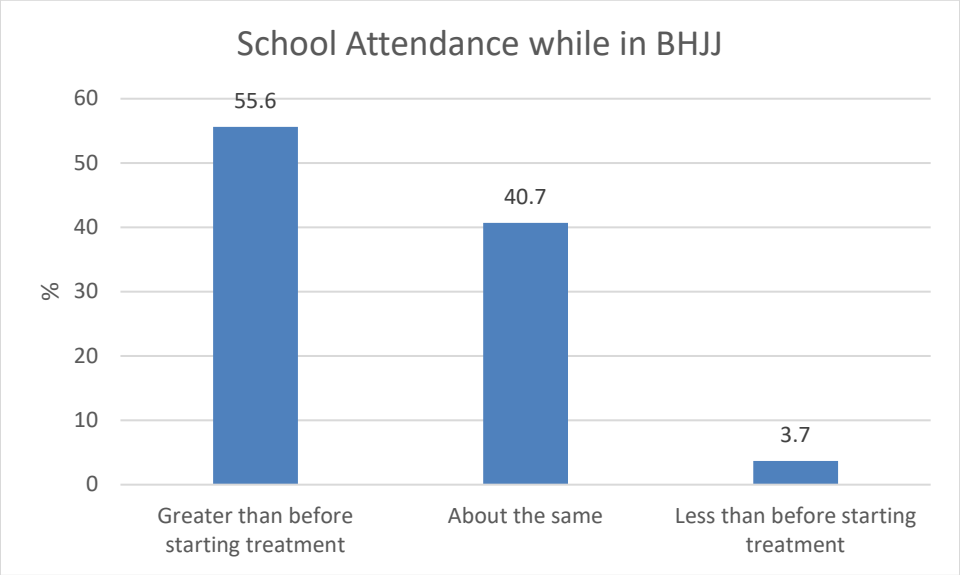
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	36.0% (n = 9)	32.1% (n = 9)
Mostly B's and C's	32.0% (n = 8)	39.3% (n = 11)
Mostly C's and D's	20.0% (n = 5)	17.9% (n = 5)
Mostly D's and F's	12.0% (n = 3)	10.7% (n = 3)

Table 219. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	0	0	35.0% (n = 7)	36.0% (n = 9)
Mostly B's and C's	100% (n = 2)	0	30.0% (n = 6)	44.0% (n = 11)
Mostly C's and D's	0	100% (n = 2)	20.0% (n = 4)	8.0% (n = 2)
Mostly D's and F's	0	0	15.0% (n = 3)	12.0% (n = 3)

At termination, workers reported that 55.6% (n = 15) of youth were attending school more than before starting treatment and 40.7% (n = 11) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 173). At intake, no youth attending school had Individualized Education Plans (IEPs) while at termination, 15.4% (n = 4) of the youth attending school had Individualized Education Plans (IEPs).

Figure 173.



Ohio Scales

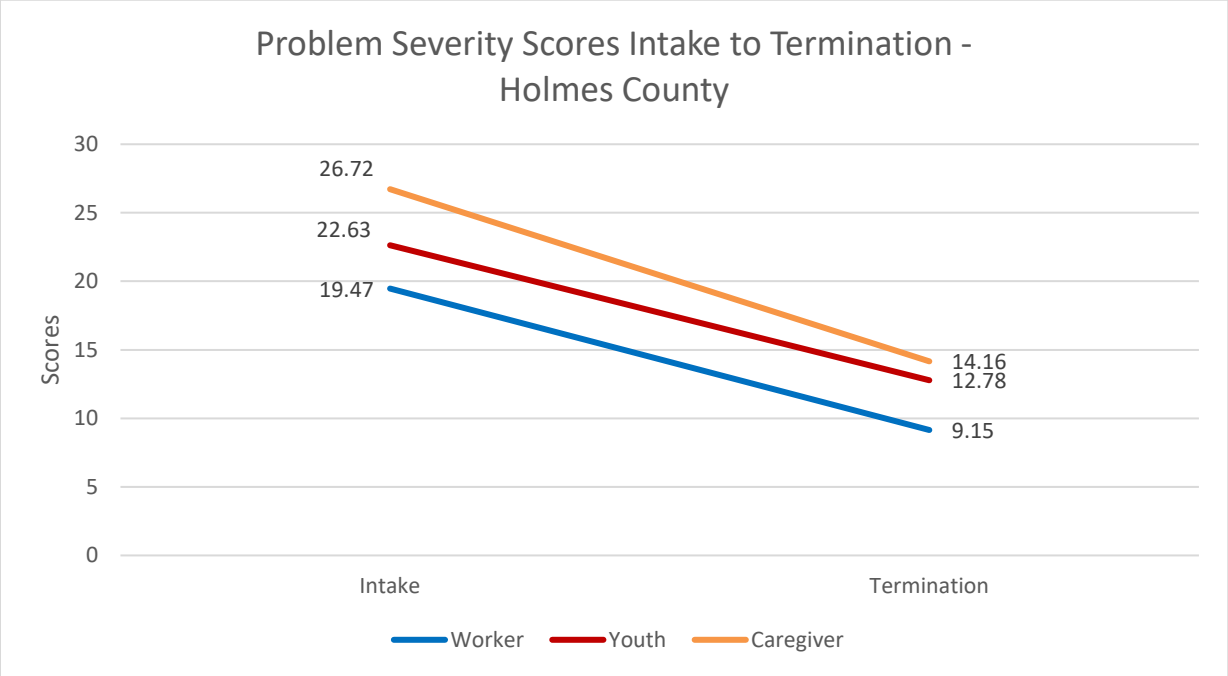
One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum of service, separate charts are included that display the means from intake to termination. Decreases in Problem Severity and increases in Functioning correspond to positive change.

All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Paired samples t-tests were used to compare Problem Severity scores at intake to Problem Severity scores at the other assessment periods. A paired samples t-test compares the means of two variables by computing the difference between the two variables for each case and testing to see if the average difference is significantly different from zero. In order for a case to be included in the analyses, the rater must have scores for both assessment periods. For example, a caregiver must supply scores for both the intake and three-month assessment period to be included in the paired samples t-test for that time point. If the caregiver only has an intake score, his or her data is not included in the analysis.

Problem Severity

Overall means for the Problem Severity scale by rater between intake and termination for Holmes County youth are presented in Figure 174.

Figure 174.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Problem Severity at both measurement intervals compared to intake (see Table 220). Significant improvements were noted at three months: $t(19) = 5.82$, $p < .001$; and at termination $t(27) = 7.17$, $p < .001$. Large effect sizes were found for the period between intake to three months and the period between intake to termination.

Table 220. Paired Samples T-Tests for Problem Severity – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	20.73 (SD=6.93; n=20)	11.99 (SD=8.22; n=20)	5.82***	1.30
Intake to Termination	19.63 (SD=7.59; n=28)	9.15 (SD=8.24; n=28)	7.17***	1.36

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvements in Problem Severity at both measurement intervals compared to intake (see Table 221). Significant improvements were noted at three months: $t(18) = 3.92$, $p < .01$; and at termination $t(26) = 4.55$, $p < .001$. Large effect sizes were found for the period between intake to three months and the period between intake to termination.

Table 221. Paired Samples T-Tests for Problem Severity – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	22.89 (SD=11.03; n=19)	14.47 (SD=9.17; n=19)	3.92**	.90
Intake to Termination	22.74 (SD=11.60; n=27)	12.78 (SD=13.02; n=27)	4.55***	.88

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

Caregiver Ratings

Paired samples t-tests revealed significant improvements in Problem Severity at both measurement intervals compared to intake (see Table 222). Significant improvements were noted at three months: $t(19) = 2.45$, $p < .05$; and at termination $t(27) = 4.96$, $p < .001$. A moderate effect sizes was found for the period between intake to three months. A large effect size was found for the time period between intake to termination.

Table 222. Paired Samples T-Tests for Problem Severity – Caregiver

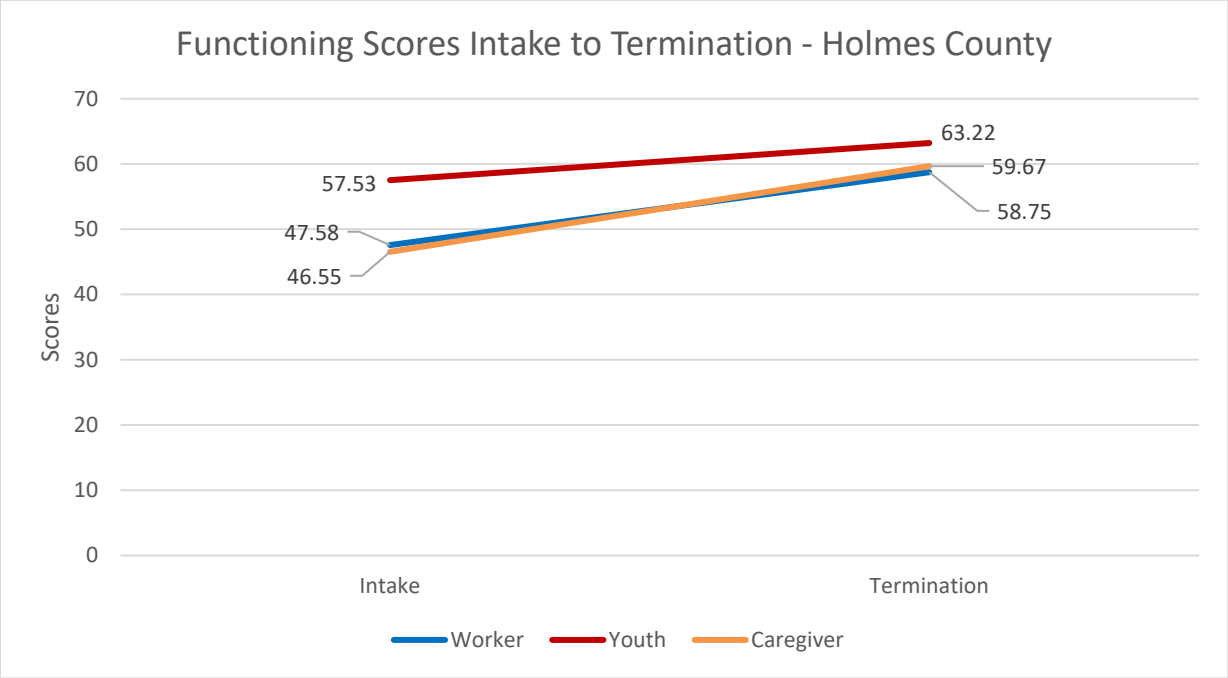
	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	28.61 (SD=15.16; n=20)	21.38 (SD=18.20; n=20)	2.45*	.55
Intake to Termination	26.97 (SD=14.98; n=28)	14.16 (SD=13.12; n=28)	4.96***	.94

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

Functioning Scores

Overall means for the Functioning scale by rater between intake and termination for Holmes County youth are presented in Figure 175..

Figure 175.



Worker Ratings

For workers, paired samples t-tests indicated significant improvement in Functioning scores from intake to three months and to termination (see Table 223). Workers reported statistically significant improvements in Functioning scores from intake to three months $t(19) = -3.69$, $p < .01$, and from intake to termination $t(27) = -5.08$, $p < .001$ with large effect sizes.

Table 223. Paired Samples T-Tests for Functioning Scores – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	45.60 (SD=9.42; n=20)	51.55 (SD=11.16; n=20)	-3.69**	.82
Intake to Termination	47.36 (SD=8.57; n=28)	58.75 (SD=13.92; n=28)	-5.08***	.96

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvement in Functioning scores from intake to termination $t(26) = -2.18$, $p < .05$ with a small effect size (see Table 224).

Table 224. Paired Samples T-Tests for Functioning Scores – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	57.05 (SD=14.89; n=19)	59.21 (SD=13.11; n=19)	-.79	.18
Intake to Termination	57.81 (SD=13.11; n=27)	63.22 (SD=11.61; n=27)	-2.18*	.42

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Functioning scores at both measurement intervals compared to intake (see Table 225). Significant improvements were noted at three months: $t(18) = -3.08$, $p < .01$ with a moderate effect size; and at termination $t(26) = -4.39$, $p < .001$ with a large effect size.

Table 225. Paired Samples T-Tests for Functioning Scores – Caregiver

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	44.42 (SD=11.05; n=19)	51.00 (SD=14.95; n=19)	-3.08**	.71
Intake to Termination	46.00 (SD=13.14; n=27)	59.67 (SD=15.86; n=27)	-4.39***	.84

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

Violence and Delinquency Questionnaire

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey composed of three general domains: exposure to violence, violence perpetration, and peer delinquency. The VDQ is offered at intake and termination into the BHJJ program. At intake, each item prompts the youth to answer within the context of the past year. At termination, youth are directed to answer "since the last time you answered these questions".

This section will be divided into three distinct parts that examine the prevalence of violence exposure as either a victim or witness, self-reported delinquent behavior from intake to termination, and delinquent behavior by peers from intake to termination. Table 226 provides the percentage of those who had experienced violence as either a victim or witness in the past year.

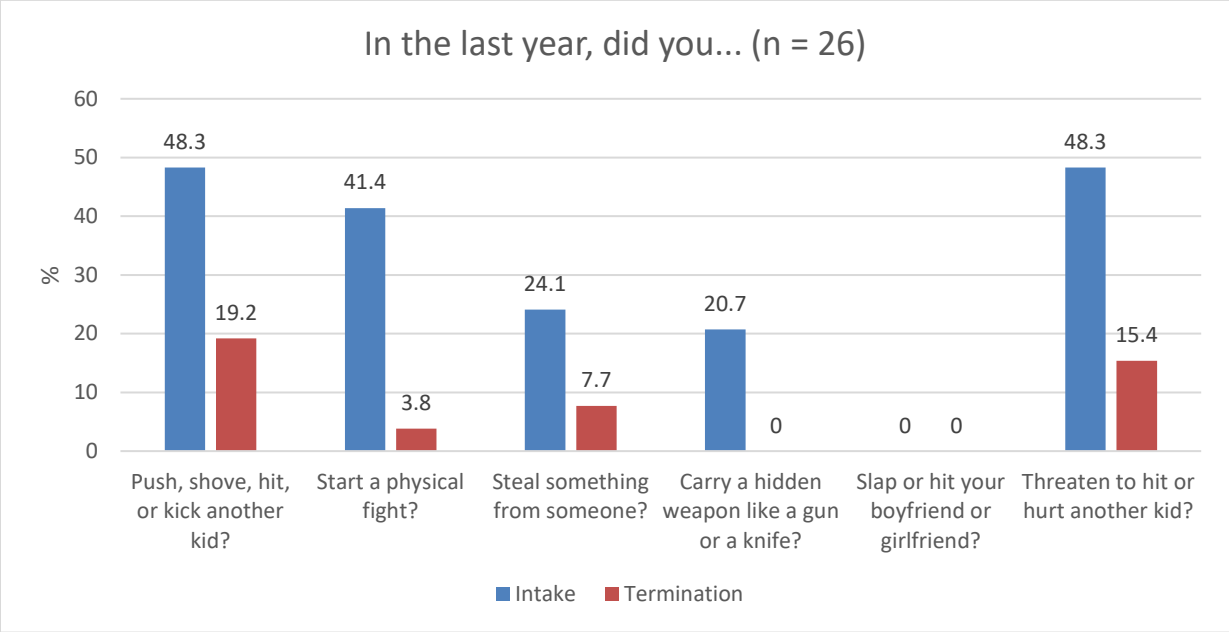
Table 226. Violence Exposure

	% Yes BHJJ Sample (n = 29)
In the last year, did someone threaten to hurt you when you thought they might really do it?	34.5%
In the last year, have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?	20.7%
In the last year, did a boyfriend or girlfriend or anyone you went on a date with slap or hit you?	3.4%
In the last year, did anyone steal anything from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?	24.1%
Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	6.9%
In the last year, did anyone hit or attack you WITHOUT using an object or weapon?	31.0%
In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?	48.3%
In the last year, did a grown-up touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?	6.9%
Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. In the last year, did another child or teen make you do sexual things?	10.3%
In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	6.9%
In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	13.8%

In the last year, in real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt them?	20.7%
In the last year, was anyone close to you murdered, like a friend, neighbor, or someone in your family?	10.3%
In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	31.0%
Not including spanking on your bottom, did a grown-up in your life hit, beat, kick or physically hurt you in any way?	13.8%
When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. In the last year, were you neglected?	0

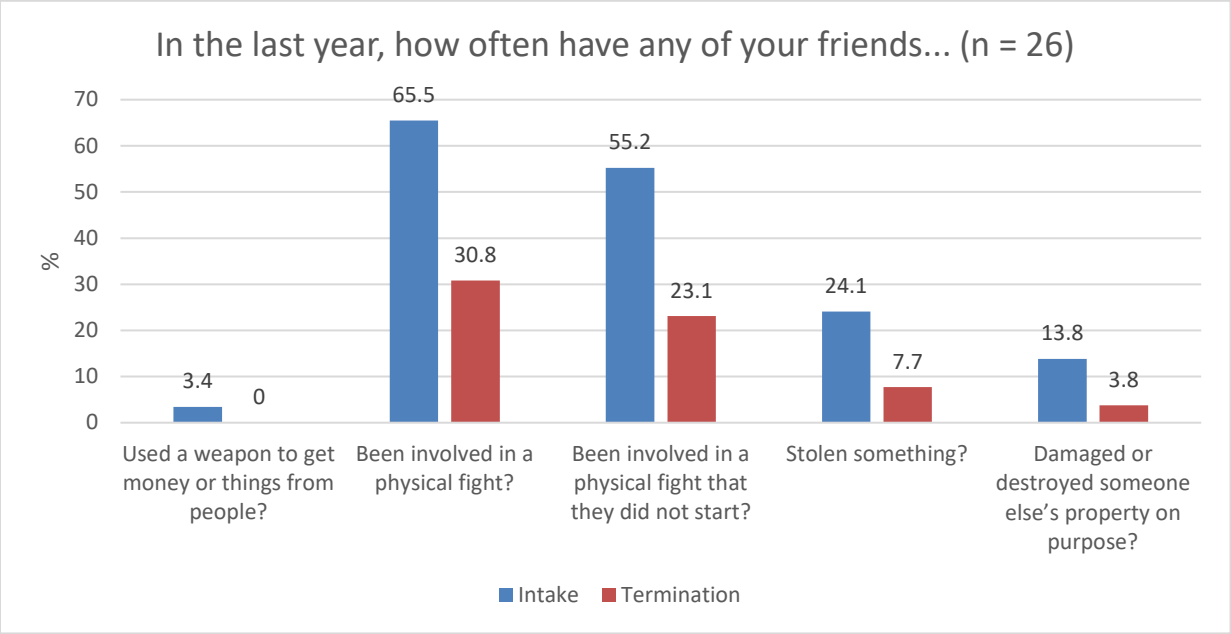
Delinquent behaviors were measured as self-report items of violent and weapon carrying behaviors as well as stealing. At intake, youth were asked how often they engaged in each behavior in the last year while at termination, youth were asked how often they engaged in the behavior since the last time they were asked. Figure 176 presents the percentage of youth who identified that they had engaged in each type of behavior at least once. Depending on the item, data were available for 26 pairs. McNemar's tests revealed statistically significant improvements from intake to termination for one item: start a physical fight.

Figure 176.



Self-reported peer delinquency was also measured at intake (how often in the last year) and at termination (how often since the last time they were asked). Figure 177 presents the percentage of youth who identified how often their friends had engaged in delinquent behavior at intake and termination. Depending on the item, data were available for 26 pairs. McNemar's tests revealed statistically significant improvements from intake to termination for one item: been involved in a physical fight that they did not start.

Figure 177.



Resilience

As part of the 2017 - 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family.

Figure 178 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were “pretty much true” and “very much true”, we combined these responses. Generally, the majority of youth indicated high levels of endorsement for each one of these items except for “I can work with someone who has different opinions than mine” and “I try to understand what other people go through”.

Figure 178.

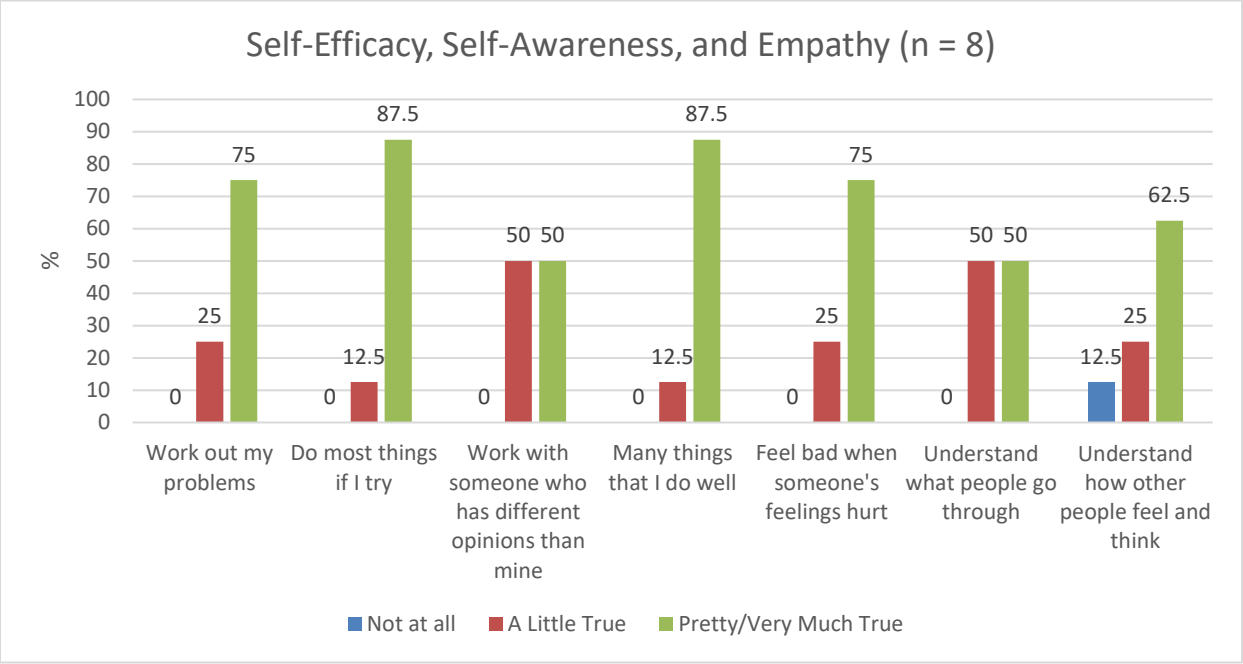


Figure 179 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. The majority of youth identified that each of the statements were either pretty much or very much true.

Figure 179.

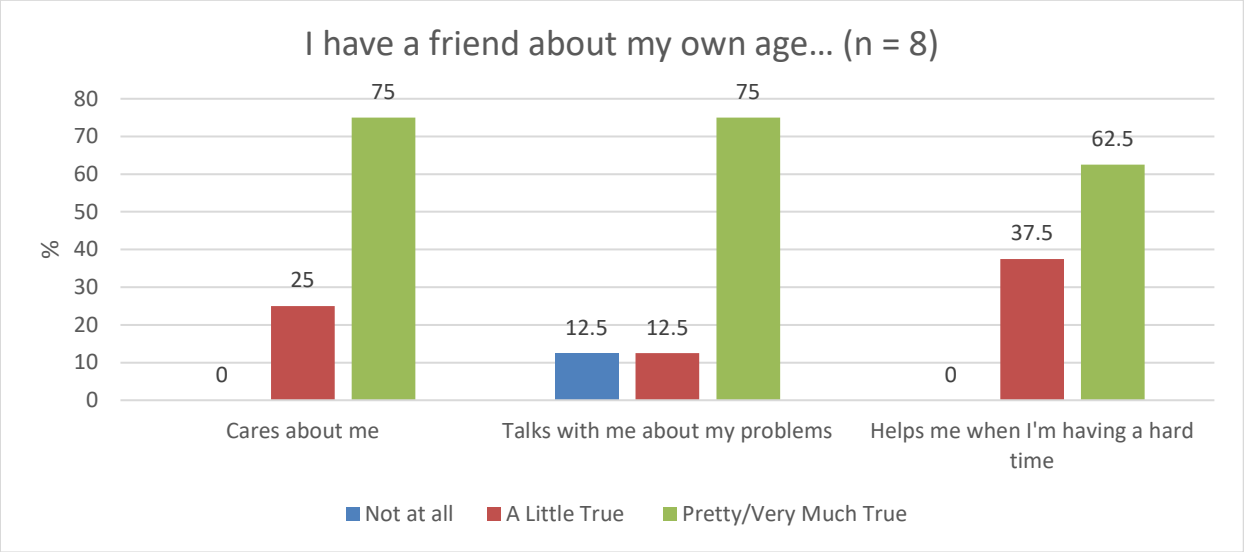
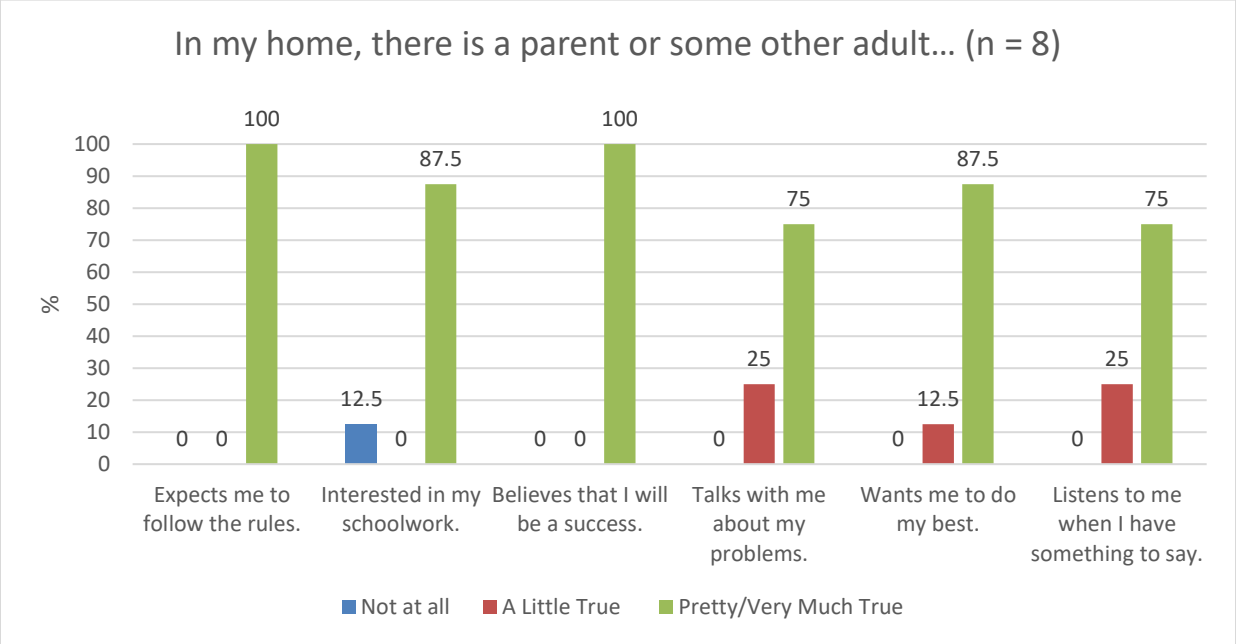


Figure 180 shows intake data on parental or support from other adults in their house. A majority of youth identified that each of the statements were either pretty much or very much true.

Figure 180.



TSCC

The TSCC was administered at intake and termination from BHJJ. Paired-samples t-tests were conducted to show whether means at intake and termination on each TSCC subscale differed significantly. Data were analyzed separately for females (see Figure 181) and males (see Figure 182) who had completed the TSCC at both intake and termination in Holmes County.

Research has found that females consistently report more trauma symptoms than males (Singer et al., 1995). We examined trauma symptoms for females and males in the BHJJ sample. Consistent with previous research, BHJJ females in Holmes County reported higher scores on each trauma symptom subscale than males except for the Anger domain. For example, at intake, the average score on the Posttraumatic Stress domain was 10.46 for females and 6.23 for males. Paired samples t-tests revealed no statistically significant improvements in trauma symptoms for females and significant improvements on all domains except for the Depression domain for males (see Table 227 and Table 228).

Table 227. TSCC Subscales from Intake to Termination among Females

Females	Intake	Termination	t	d
Anxiety	7.92 (SD = 5.60; n = 13)	6.23 (SD = 6.35; n = 13)	1.29	.36
Depression	9.62 (SD = 5.08; n = 13)	8.08 (SD = 5.45; n = 13)	1.39	.39
Anger	8.77 (SD = 6.18; n = 13)	6.92 (SD = 7.27; n = 13)	1.20	.33
Posttraumatic Stress	10.46 (SD = 6.32; n = 13)	8.69 (SD = 7.78; n = 13)	.94	.26
Dissociation	8.31 (SD = 5.72; n = 13)	7.23 (SD = 6.72; n = 13)	.87	.24
Sexual Concerns	2.85 (SD = 2.30; n = 13)	2.85 (SD = 3.11; n = 13)	.00	.00

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

Figure 181.

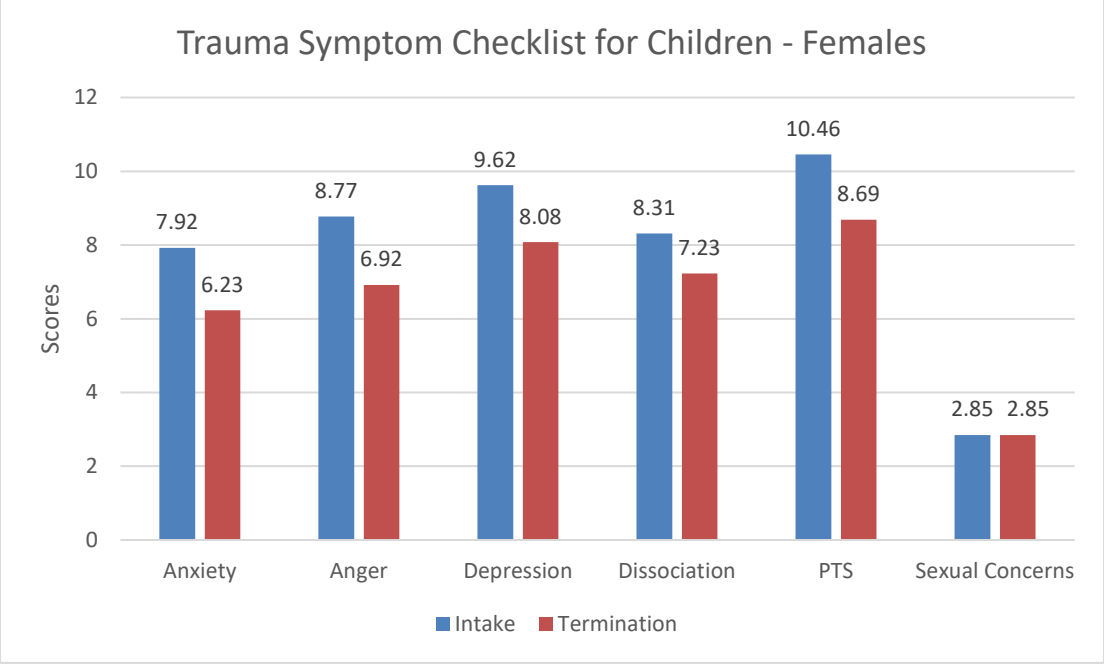
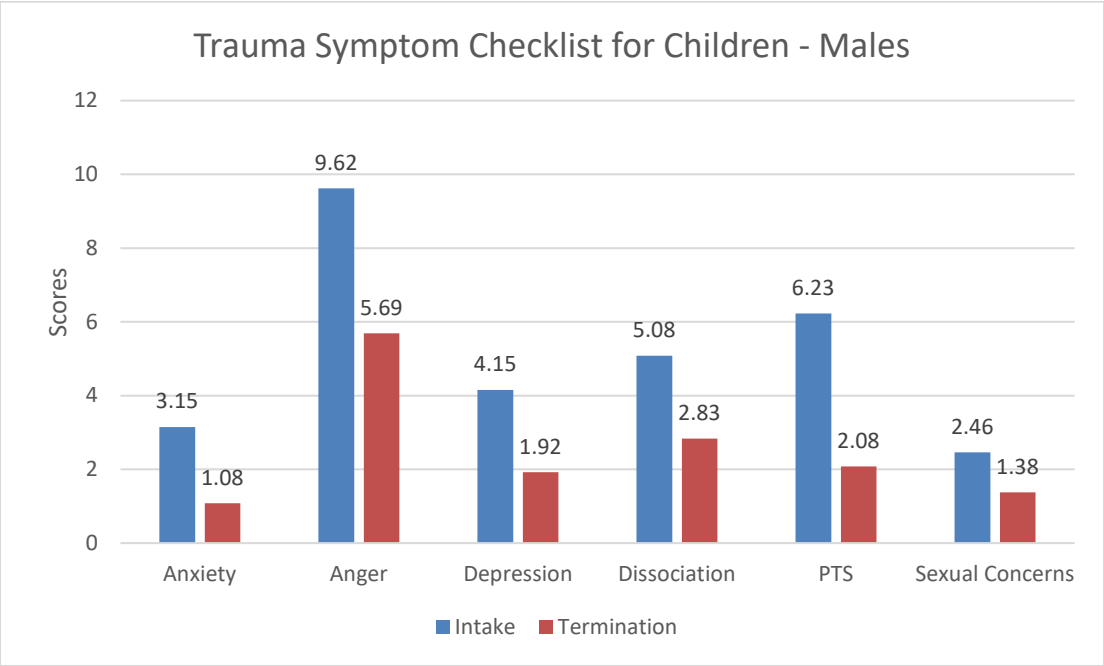


Table 228. TSCC Subscales from Intake to Termination for Males

Males	Intake	Termination	t	d
Anxiety	3.15 (SD = 3.74; n = 13)	1.08 (SD = 2.22; n = 13)	2.49*	.69
Depression	4.15 (SD = 5.30; n = 13)	1.92 (SD = 2.72; n = 13)	1.75	.49
Anger	9.62 (SD = 6.01; n = 13)	5.69 (SD = 6.05; n = 13)	3.11**	.86
Posttraumatic Stress	6.23 (SD = 5.59; n = 13)	2.08 (SD = 2.87; n = 13)	3.89**	1.01
Dissociation	5.08 (SD = 3.92; n = 13)	2.83 (SD = 2.29; n = 13)	3.23**	.93
Sexual Concerns	2.46 (SD = 2.26; n = 13)	1.38 (SD = 1.39; n = 13)	2.69*	.75

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

Figure 182.



Substance Use Survey

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 229 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use in Holmes County. Caffeine and alcohol were the two most commonly reported substances.

Table 229. Self-Reported Substance Use at Intake– Holmes County

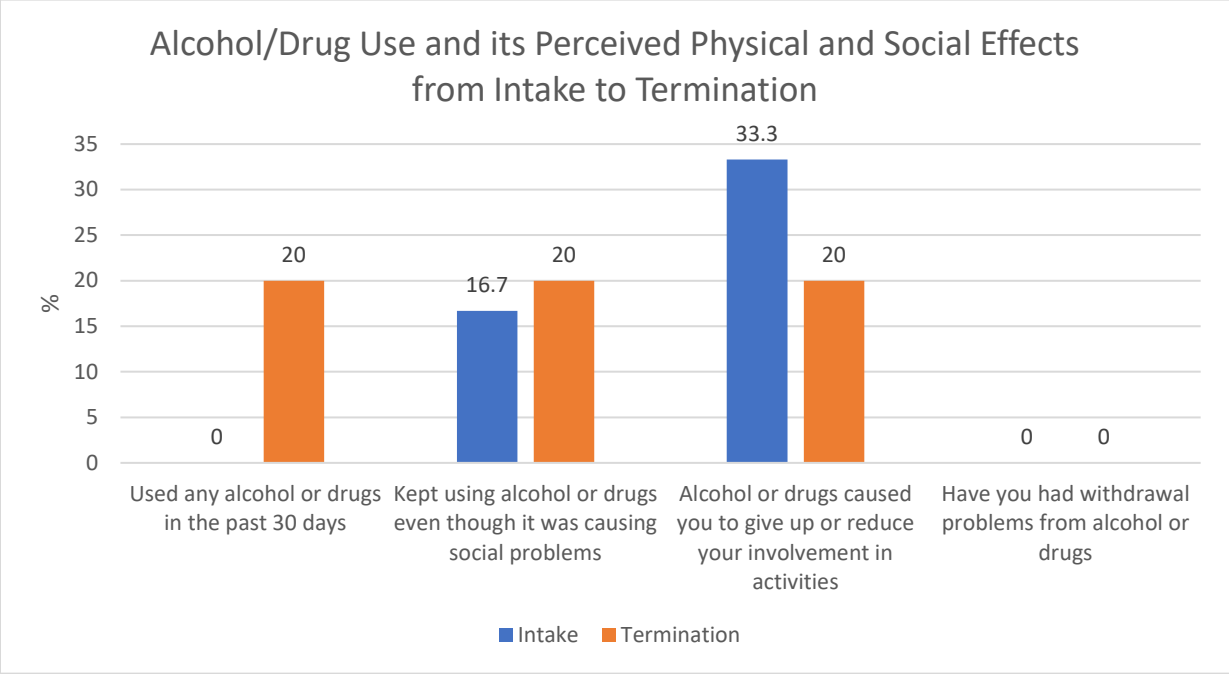
	% Ever Used	Age of First Use
Alcohol	44.4% (n = 4)	15.00 (SD = 1.00)
Tobacco	33.3% (n = 3)	13.33 (SD = 0.58)
Cannabis	33.3% (n = 3)	13.33 (SD = 0.58)
Hallucinogens	0.0% (n = 0)	
Inhalants	0.0% (n = 0)	
Opioids	0.0% (n = 0)	
Sedatives	0.0% (n = 0)	
Caffeine	50.0% (n = 4)	12.00 (SD = 3.16)
Stimulants	0.0% (n = 0)	
Over the counter medications	0.0% (n = 0)	
Other prescription drugs	25.0% (n = 2)	15.00 (SD = 1.41)
Herbs/Flowers	0.0% (n = 0)	

[a] No Standard Deviations are calculated.

In addition to questions pertaining to the use of specific substances, youth were asked questions around general alcohol/drug use and its perceived effects on physical health and social functioning. Due to a low number of valid responses, we examined raw proportions at intake and termination for each question. Rather than using only those who had responses at intake and at termination, we examined all valid responses which ranged between 6 and 8 at intake and 5 and 6 at termination.

The proportion of youth who indicated that they had used any alcohol or drugs in the past 30 days increased from 0% at intake to 20% at termination (see Figure 183). From intake to termination, the proportion of youth who indicated that they had continued to use alcohol/drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people at least sometimes increased slightly while the proportion of youth who indicated having withdrawal problems from alcohol or drugs and those who indicated that alcohol/drugs caused them to give up or reduce involvement in activities at work, school, home, and social events decreased from intake to termination. No youth indicated any problems with withdrawal from alcohol or drugs at intake or at termination. Data should be interpreted with caution as a very small sample is represented here.

Figure 183.



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.

Between July 1, 2015 and June 30, 2019, there have been 27 youth terminated from the BHJJ program in Holmes County. Ninety-three percent (92.6%, n = 25) of the youth terminated from the BHJJ program were identified as successful treatment completers. Nearly four percent (3.7%, n = 1) were terminated from the program due to some type of out of home placement. Table 230 presents all of the reasons for termination from BHJJ.

Table 230. Reasons for Termination from BHJJ

Termination Reason	All Youth Enrolled between July 2015 and June 2019
Successfully Completed Services	92.6% (n = 25)
Client Did Not Return/Rejected Services	0
Out of Home Placement	3.7% (n = 1)
Client/Family Moved	0
Client Withdrawn	0
Client AWOL	0
Client Incarcerated	0
Other	3.7% (n = 1)

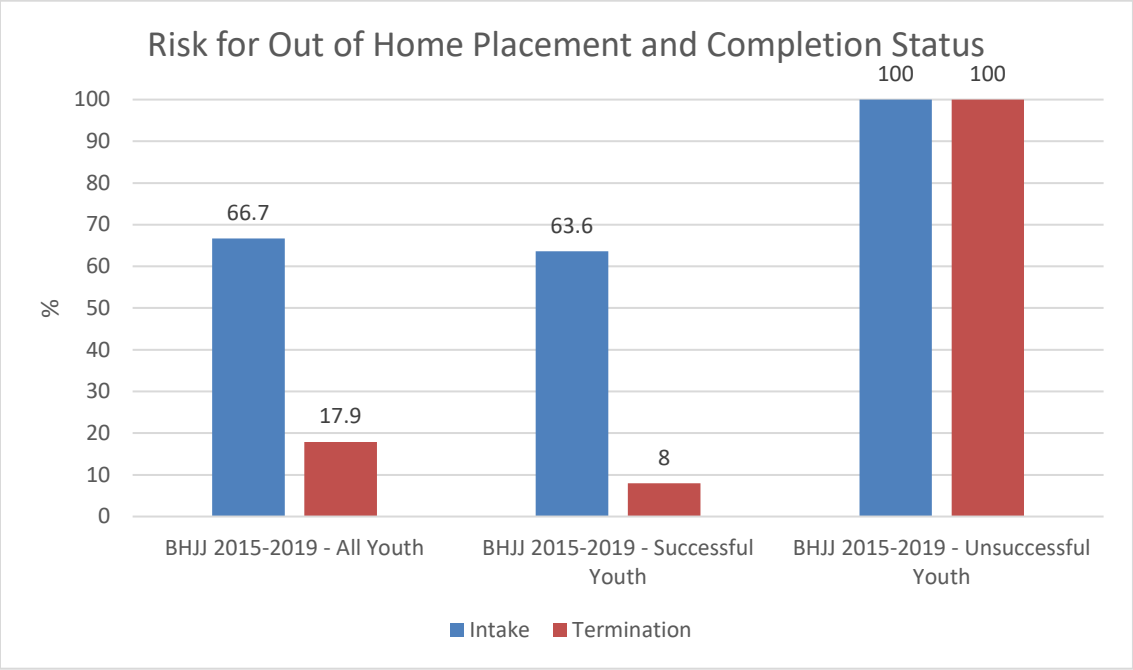
Average Length of Stay

Since the start of BHJJ, the average length of stay (ALOS) in the program was 143.3 days. For youth identified as successful treatment completers, the ALOS was 142.3 days while for unsuccessful treatment completers, the ALOS was 155.5 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, 66.7% of the youth (n = 18) were at risk for out of home placement. At termination, 17.9% (n = 5) of youth were at risk for out of home placement (see Figure 184). Of those youth who successfully completed BHJJ treatment, 8.0% (n = 2) were at risk for out of home placement at termination while 100.0% (n = 2) of youth who completed unsuccessfully were at risk for out of home placement (see Figure 184).

Figure 184.



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 services through BHJJ. Workers reported that police contacts had been reduced for 92.9% (n = 26) of the youth, had stayed the same for 3.6% (n= 1) of the youth, and increased for 3.6% (n = 1) of the youth.

YSSF

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the services they received through the BHJJ program in Holmes County as well as how services impacted their children and family. At termination from the BHJJ program, 100% (n =27) of caregivers either strongly agreed or agreed that the BHJJ services they received were right for them and 100% (n =27) either strongly agreed or agreed that the location of the services was convenient (see Figure 185). Over eighty-five percent (85.1%, n = 23) of caregivers reported that as a result of the services their

child/family received, their child gets along better with family members and 85.1% (n = 23) reported their child is better able to do the things they want to do (see Figure 186).

Figure 185.

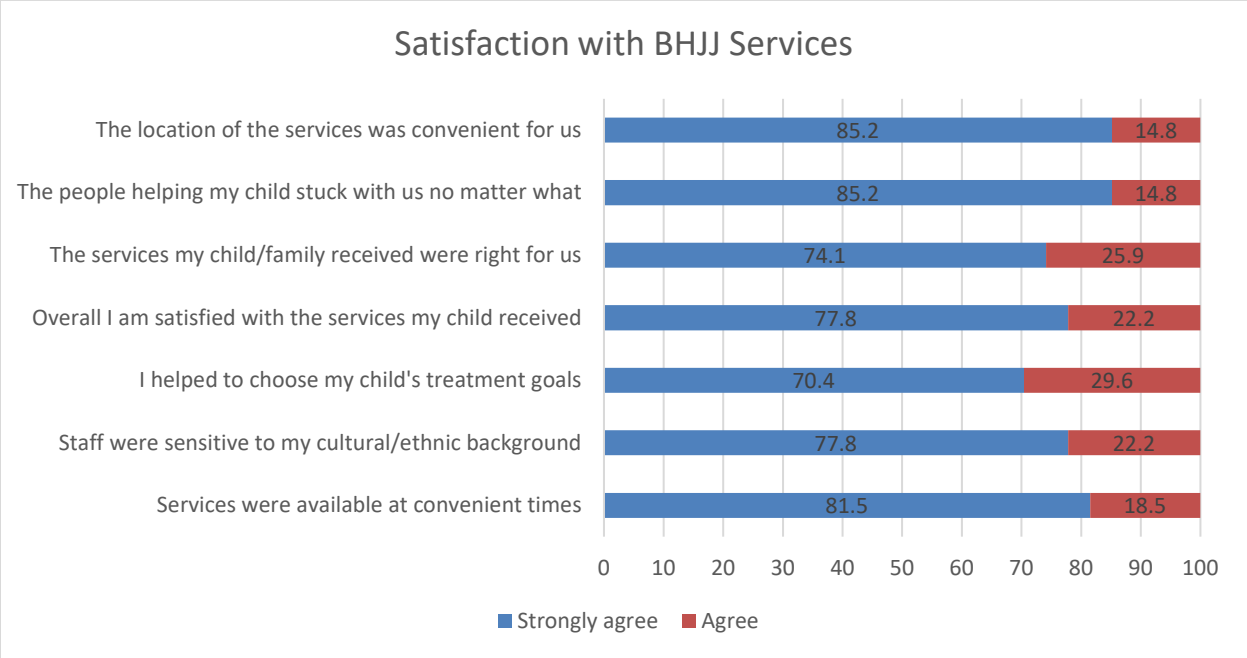
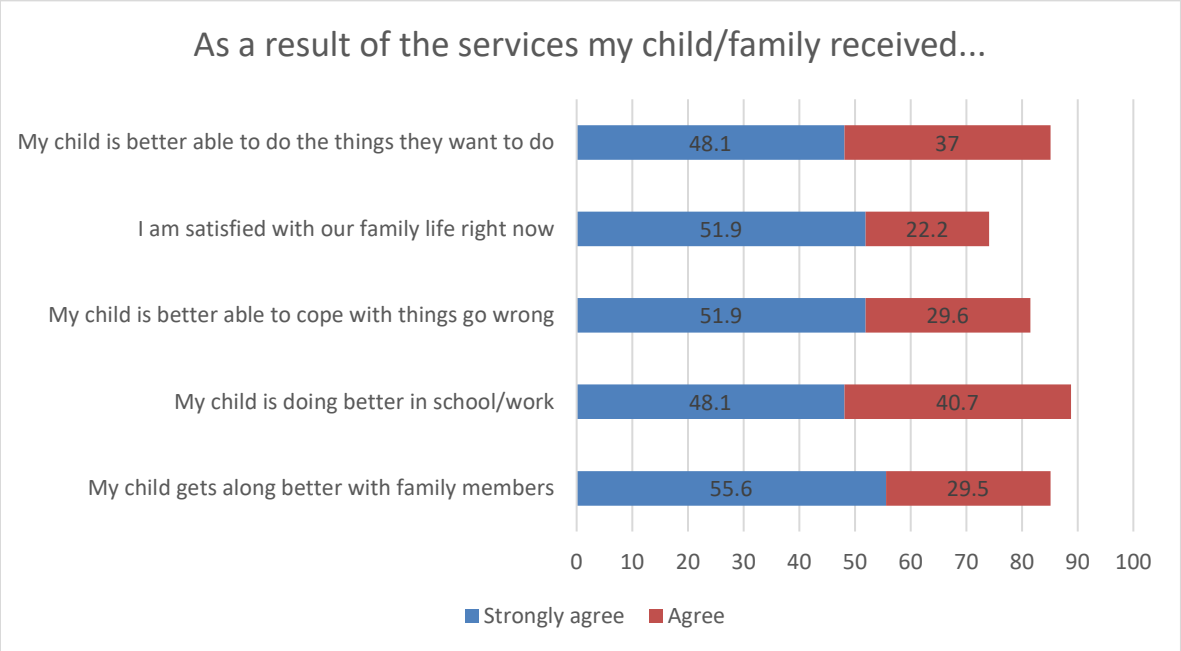


Figure 186.



Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve months prior to the end of the data collection period for inclusion in the analysis. Due to a small number of youth who terminated unsuccessfully, we were not able to separate out these data by completion status. These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 51.6% (n = 16) of BHJJ youth in Holmes county enrolled between July 1, 2015 and June 30, 2019 had a misdemeanor charge and 77.4% (n = 24) had been adjudicated delinquent in the 12 months prior to enrollment (see Table 231). None of the youth were charged with a felony.

Table 231. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 31)	45.2% (n = 14)	0.0% (n = 0)	71.0% (n = 22)
12 months (n = 31)	51.6% (n = 16)	0.0% (n = 0)	77.4% (n = 24)
18 months (n = 31)	58.1% (n = 18)	0.0% (n = 0)	83.9% (n = 26)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 232). In the 12 months after enrollment in BHJJ, 13.8% (n = 4) of participants were charged with at least one new misdemeanor, 3.4% (n = 1) were charged with at least one new felony, and 37.9% (n = 11) were adjudicated delinquent.

Table 232. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 30)	6.7% (n = 2)	3.3% (n = 1)	33.3% (n = 10)
12 months (n = 29)	13.8% (n = 4)	3.4% (n = 1)	37.9% (n = 11)
18 months (n = 22)	18.2% (n = 4)	0.0% (n = 0)	36.4% (n = 8)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 233). In the 12 months after termination from BHJJ, 19.0% (n = 4) of youth were charged with at least one new misdemeanor and 9.5% (n = 2) were adjudicated delinquent. None of the youth were charged with a felony.

Table 233. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 26)	15.4% (n = 4)	3.8% (n = 1)	15.4% (n = 4)
12 months (n = 21)	19.0% (n = 4)	0.0% (n = 0)	9.5% (n = 2)
18 months (n = 18)	27.8% (n = 5)	0.0% (n = 0)	22.2% (n = 4)

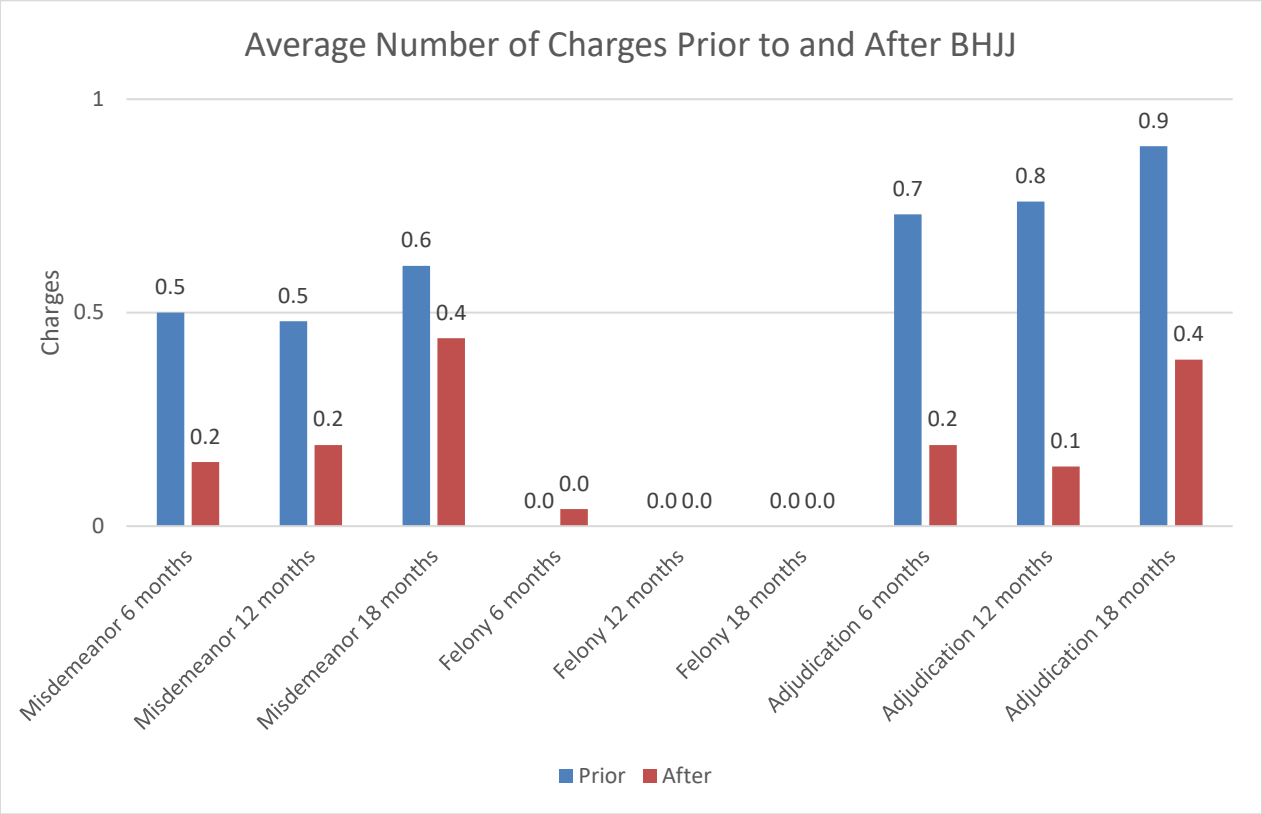
ODYS Commitments

None of the 31 youth who enrolled since July 1, 2015 were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ.

Average Numbers of Charges and Adjudications

In addition to whether a youth was charged or adjudicated delinquent, we examined whether there were differences in the average number of charges and adjudications in equivalent periods of time prior to enrollment and after termination. We conducted paired samples *t*-tests to examine whether there were statistically significant differences in the mean number of charges and adjudications at each time period prior to and after BHJJ participation. Figure 187 shows the average number of charges for youth who had data at both time periods. This restriction resulted in a sample of 26 youth at 6 months, 21 youth at 12 months, and 18 youth at 18 months. **Paired samples *t*-tests revealed statistically significant declines in the average number of misdemeanor charges at 6 months and delinquent adjudications at 6 and 12 months.** For example, the average number of misdemeanor charges 12 months prior to BHJJ enrollment was 0.48 while the average number of misdemeanor charges 12 months after BHJJ termination was 0.19.

Figure 187.



Note. The average number of Felony charges at 6 months after termination was 0.04.

Trumbull

Demographics

As of June 30, 2019, 84 youth were enrolled into the BHJJ program in Trumbull County. The average age at enrollment was 15.0 years (SD=1.49). More males (55.4%, n = 46) than females (44.6%, n = 37) have been enrolled. White youth (65.4%, n = 53), Black youth (23.5%, n = 19) and Multiracial youth (7.4%, n = 6) comprised the majority of the total sample.

There were 20 new enrollments in Trumbull County during the current reporting period (July 1, 2017 through June 30, 2019). The average age at enrollment was 15.2 (SD = 1.53). There were an equal number of males (50.0%, n = 10) and females (50.0%, n = 10), and more White youth (60.0%, n = 12) than Black youth (30.0%, n = 6). Twenty percent (20.0%, n = 4) of youth self-identified as Hispanic/Latinx.

Unless otherwise noted, the following sections describe data from the past four years of BHJJ programming from July 1, 2015 through June 30, 2019.

Custody Arrangement and Household Information

At intake, 40.0% of youth (n = 18) lived with their biological mother only, while 22.2% (n = 10) lived with two biological parents or one biological and one step/adoptive parent (see Table 234). Over seventy-one percent (71.1%, n = 32) of BHJJ youth lived with at least one biological at enrollment.

Over eighty-nine percent (89.9%; n = 40) of the BHJJ caregivers had at least a high school diploma or GED, and 22.2% (n = 10) had a bachelor's degree or higher. Over eleven percent of caregivers (11.1%; n = 5) reported they did not graduate from high school (see Table 235).

Caregivers were asked to report their annual household income (see Table 236). The income range with the highest endorsement was $10,000 - $14,999 (22.7%, n = 10). Overall, 59.1% (n = 26) reported a family income of $24,999 or less. When examined by race, 33.3% (n = 9) of White families, 63.6% (n = 7) of Black families, and 33.3% (n = 1) of Multiracial families reported a household income of $14,999 or less. Table 236 displays the reported household income overall and by race.

Table 234. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	22.2% (n = 10)
Biological Mother Only	40.0% (n = 18)
Biological Father Only	8.9% (n = 4)
Adoptive Parent(s)	4.4% (n = 2)
Aunt/Uncle	6.7% (n = 3)
Grandparents	13.3% (n = 6)
Other	4.4 (n = 2)

Table 235. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	11.1% (n = 5)
High School Graduate or G.E.D.	35.6% (n = 16)
Some College or Associate Degree	33.3% (n = 15)
Bachelor's Degree	11.1% (n = 5)
More than a Bachelor's Degree	11.1% (n = 5)

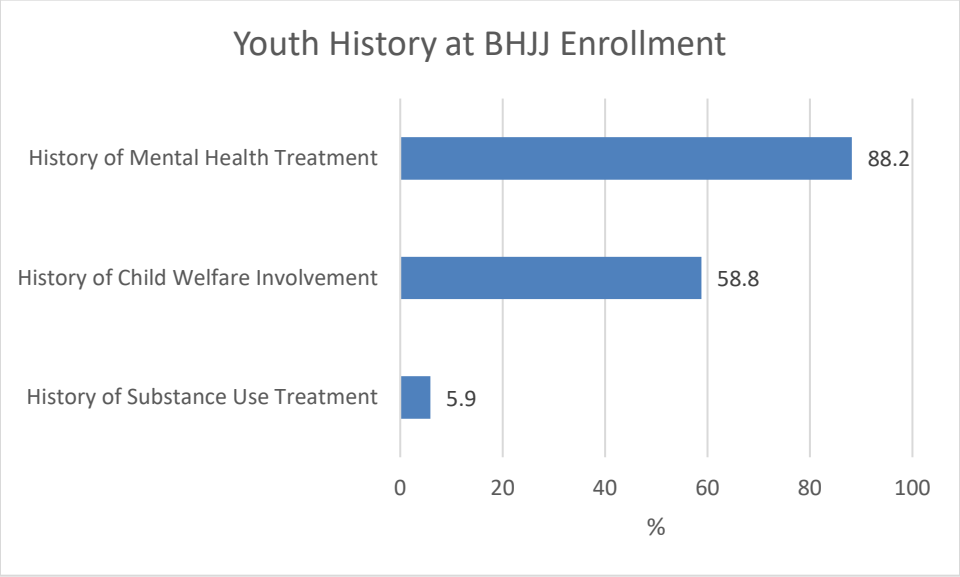
Table 236. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Black	Multiracial
Less than $5,000	11.4% (n = 5)	11.1% (n = 3)	9.1% (n = 1)	0
$5,000 - $9,999	9.1% (n = 4)	3.7% (n = 1)	27.3% (n = 3)	0
$10,000 - $14,999	22.7% (n = 10)	18.5% (n = 5)	27.3% (n = 3)	33.3% (n = 1)
$15,000 - $19,999	6.8% (n = 3)	11.1% (n = 3)	0	0
$20,000 - $24,999	9.1% (n = 4)	7.4% (n = 2)	9.1% (n = 1)	0
$25,000 - $34,999	6.8% (n = 3)	11.1% (n = 3)	0	0
$35,000 - $49,999	18.2% (n = 8)	18.5% (n = 5)	9.1% (n = 1)	66.7% (n = 2)
$50,000 - $74,999	11.4% (n = 5)	11.1% (n = 3)	18.2% (n = 2)	0
$75,000 or greater	4.6% (n = 2)	7.4% (n = 2)	0	0

Youth and Family History

Workers were asked to identify a youth's prior behavioral health and child welfare system involvement (see Figure 188). These three items were new to the past biennium, therefore, data are only available for youth enrolled between July 1, 2017 and June 30, 2019. Over fifty-eight percent of the youth (58.8%, n = 10) had a history of child welfare involvement prior to BHJJ enrollment. Six percent (5.9%, n = 1) of youth had received substance use treatment in their lifetime prior to BHJJ enrollment and 88.2% (n = 15) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 188.



Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history. Chi-square analyses were conducted on each item to test for gender differences and significant differences are identified in Table 237. A significantly larger proportion of the caregivers of females reported lifetime histories of sexual abuse and talking about suicide.

Caregivers reported that 25.0% (n = 5) of females and 25.0% (n = 6) of males had a history of being physically abused while 35.0% (n = 7) of females and 8.0% (n = 2) of males had a history of being sexual abused. Caregivers of 71.4% (n = 15) of females and 37.5% (n = 9) of males reported hearing the child talking about committing suicide and 25.0% (n = 5) of females and 12.0% (n = 3) of males had attempted suicide at least once. A majority of the caregivers of females (90.0%, n = 18) and males (65.2%, n = 15) reported a family history of depression. Caregiver of 65.0% of females (n = 13) and 59.1% of males (n = 13) reported a family history of problems with substance use.

Table 237. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	25.0% (n = 5)	25.0% (n = 6)
Has the child ever been sexually abused?	35.0% (n = 7)*	8.0% (n = 2)
Has the child ever run away?	42.9% (n = 9)	44.0% (n = 11)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	14.3% (n = 3)	39.1% (n = 9)
Has the child ever talked about committing suicide?	71.4% (n = 15)*	37.5% (n = 9)
Has the child ever attempted suicide?	25.0% (n = 5)	12.0% (n = 3)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	42.1% (n = 8)	48.0% (n = 12)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	90.0% (n = 18)	65.2% (n = 15)
Has anyone in the child's biological family had a mental illness, other than depression?	68.4% (n = 13)	50.0% (n = 11)
Has the child ever lived in a household in which someone was convicted of a crime?	28.6% (n = 6)	47.8% (n = 11)
Has anyone in the child's biological family had a drinking or drug problem?	65.0% (n = 13)	59.1% (n = 13)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	47.6% (n = 10)	33.3% (n = 8)

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

Problems Leading to Service

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-related problems (100.0% and 100.0% respectively) (see Table 238). Chi-square analysis indicated females had significantly higher rates of problems related to anxiety, depression, and suicide.

Table 238. Problems Leading to Services

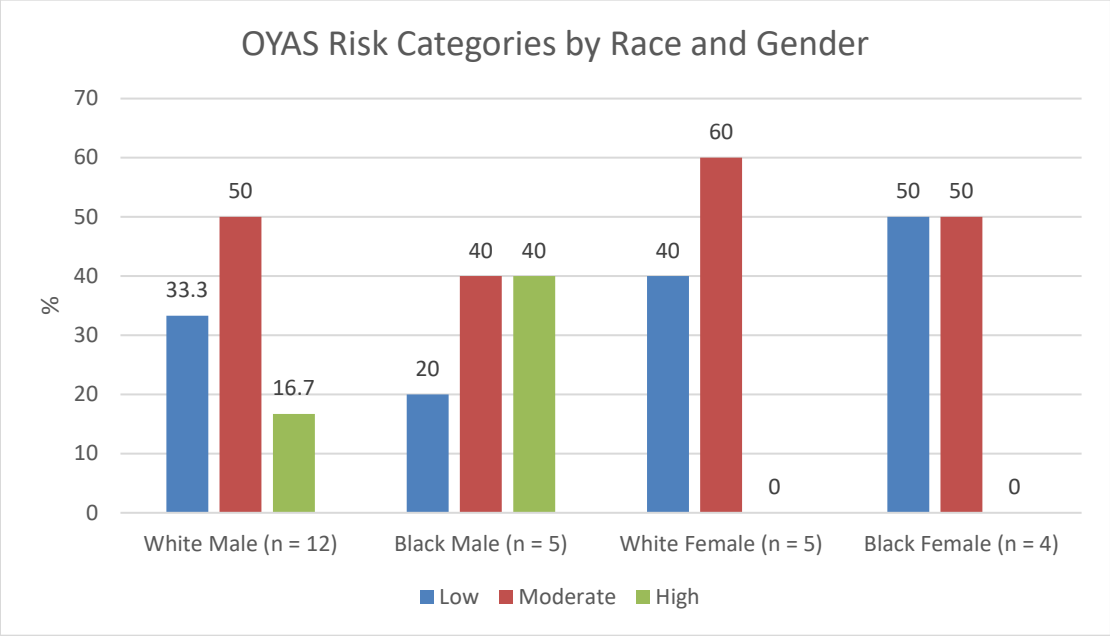
Problems Leading to Services	Females	Males
Adjustment-related problems	18.2% (n = 4)	4.3% (n = 1)
Anxiety-related problems	40.9% (n = 9)*	13.0% (n = 3)
Conduct/delinquency-related problems	100.0% (n = 22)	100.0% (n = 23)
Depression-related problems	40.9% (n = 9)*	13.0% (n = 3)
Eating disorders	4.5% (n = 1)	0
Hyperactive and attention-related problems	27.3% (n = 6)	30.4% (n = 7)
Learning disabilities	9.1% (n = 2)	4.3% (n = 1)
Pervasive development disabilities	0	0
Psychotic behaviors	4.5% (n = 1)	0
School performance problems not related to learning disabilities	45.5% (n = 10)	43.5% (n = 10)
Specific developmental disabilities	0	0
Substance use, abuse, dependence-related problems	14.3% (n = 2)	22.2% (n = 4)
Suicide-related problems	31.8% (n = 7)*	4.3% (n = 1)

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

Ohio Youth Assessment System

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 189 shows the distribution of OYAS risk categories for BHJJ youth by race and gender. In Trumbull County, 16.7% (n = 2) of White males and 40.0% (n = 2) of Black males enrolled in the BHJJ program were identified as High risk on the OYAS, while no White or Black females were identified as High risk. Due to small sample sizes, caution should be applied when making any comparisons.

Figure 189.



DSM Diagnoses

Workers were asked to report any DSM 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 diagnosis for females and males was Oppositional Defiant Disorder (see Table 239). Chi-square analysis indicated females were significantly more likely than males to be diagnosed with Unspecified Mood Disorders.

Table 239. Most Common DSM Diagnoses

DSM Diagnosis	Females (n = 21)	Males (n = 22)
Adjustment Disorder	0	0
Alcohol-related Disorders	0	0
Attention Deficit Hyperactivity Disorder	19.0% (n = 4)	22.7% (n = 5)
Bipolar Disorder	4.8% (n = 1)	0
Cannabis-related Disorders	4.8% (n = 1)	4.5% (n = 1)
Conduct Disorder	4.8% (n = 1)	0
Depressive Disorders	4.8% (n = 1)	4.5% (n = 1)
Disruptive Behavior Disorder	0	0
Unspecified Mood Disorder	33.3% (n = 7)*	9.1% (n = 2)
Oppositional Defiant Disorder	**52.4% (n = 11)**	**77.3% (n = 17)**
Post-traumatic Stress Disorder	19.0% (n = 4)	9.1% (n = 2)
Unspecified Trauma and Stressor Related Disorder	0	0
Disruptive Mood Dysregulation Disorder	9.5% (n = 2)	9.1% (n = 2)
Co-Occurring Disorder	4.8% (n = 1)	4.5% (n = 1)

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

Educational Information

Several items focused on educational 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. The wording on some items (e.g. IEP at intake, attendance at intake) was changed from previous versions of the forms. For those items, we present data from only the past biennium (when the new forms were in use). Those items will have smaller sample sizes compared to items that have been consistent for the past four years.

Thirty-nine percent (39.0%, n = 16) of youth were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in BHJJ treatment BHJJ, 31.8% (n = 7) of the youth were expelled or suspended from school (a 18.5% decrease from intake to termination).

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, 90.0% (n = 9) of youth were currently attending school while at termination, 80.0% (n = 16) 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 240 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 241 displays this information based on completion status. At intake, 47.7% of youth were earning mostly A's and B's, and C's while at termination, 33.3% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 241). For example, at intake, 0% of youth who would go on to be unsuccessful completers and 50.0% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 0% of unsuccessful completers and 36.9% of successful completers received mostly A's, B's, or C's.

Table 240. Academic Performance

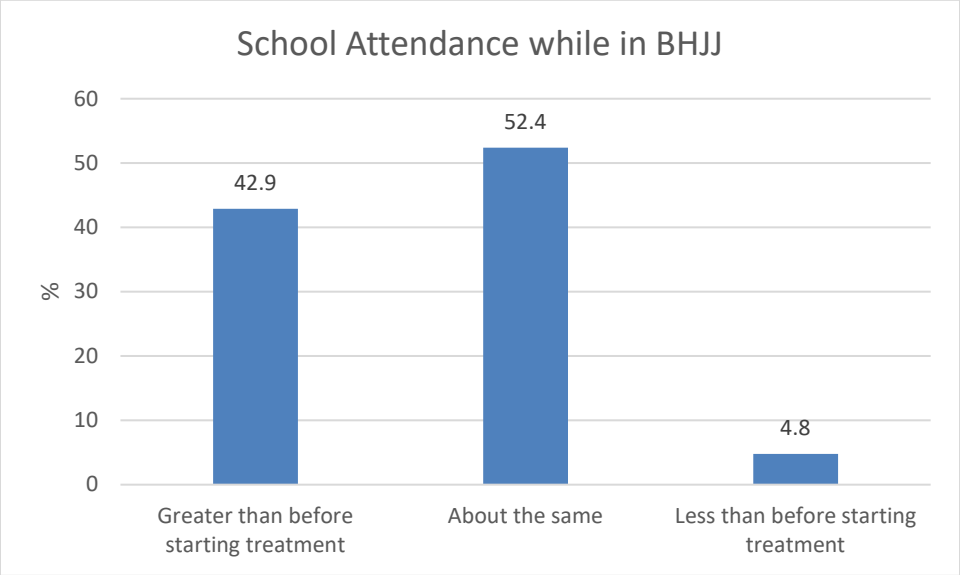
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	16.7% (n = 7)	14.3% (n = 3)
Mostly B's and C's	31.0% (n = 12)	19.0% (n = 4)
Mostly C's and D's	31.0% (n = 13)	38.1% (n = 8)
Mostly D's and F's	21.4% (n = 9)	28.6% (n = 6)

Table 241. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	0	0	22.2% (n = 4)	15.8% (n = 3)
Mostly B's and C's	0	0	27.8% (n = 5)	21.1% (n = 4)
Mostly C's and D's	50.0% (n = 1)	0	27.8% (n = 5)	42.1% (n = 8)
Mostly D's and F's	50.0% (n = 1)	100% (n = 2)	22.2% (n = 4)	21.1% (n = 4)

At termination, workers reported that 42.9% (n = 9) of youth were attending school more than before starting treatment and 52.4% (n = 11) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 190). At intake, 41.7% (n = 5) of youth attending school had Individualized Education Plans (IEPs) while at termination, 27.3% (n = 6) of the youth attending school had Individualized Education Plans (IEPs).

Figure 190.



Ohio Scales

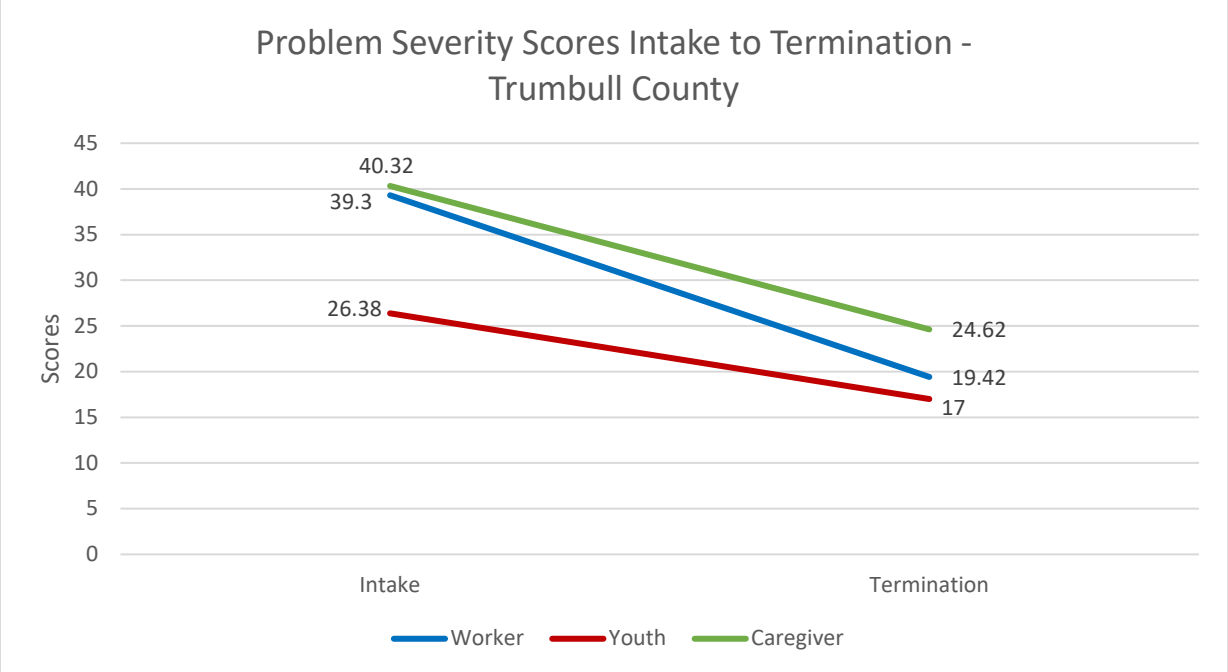
One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum of service, separate charts are included that display the means from intake to termination. Decreases in Problem Severity and increases in Functioning correspond to positive change.
All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Results for Trumbull County will be limited to intake and termination data.

Paired samples t-tests were used to compare Problem Severity scores at intake to Problem Severity scores at termination. 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 termination to be included in the analysis. If the caregiver only has an intake score, his or her data is not included.

Problem Severity

Overall means for the Problem Severity scale by rater between intake and termination for Trumbull County youth are presented in Figure 191.

Figure 191.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Problem Severity from intake to termination $t(15) = 5.64$, $p < .001$ with a large effect size (see Table 242).

Table 242. Paired Samples T-Tests for Problem Severity – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	37.62 (SD=11.72; n=16)	20.19 (SD=7.68; n=16)	5.64***	1.41

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated no statistically significant improvements in Problem Severity from intake to termination $t(15) = 2.07$ (see Table 243).

Table 243. Paired Samples T-Tests for Problem Severity – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	25.29 (SD=15.44; n=16)	17.94 (SD=10.67; n=16)	2.07	.52

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Problem Severity from intake to termination $t(14) = 2.38$, $p < .05$ with a moderate effect size (see Table 244).

Table 244. Paired Samples T-Tests for Problem Severity – Caregiver

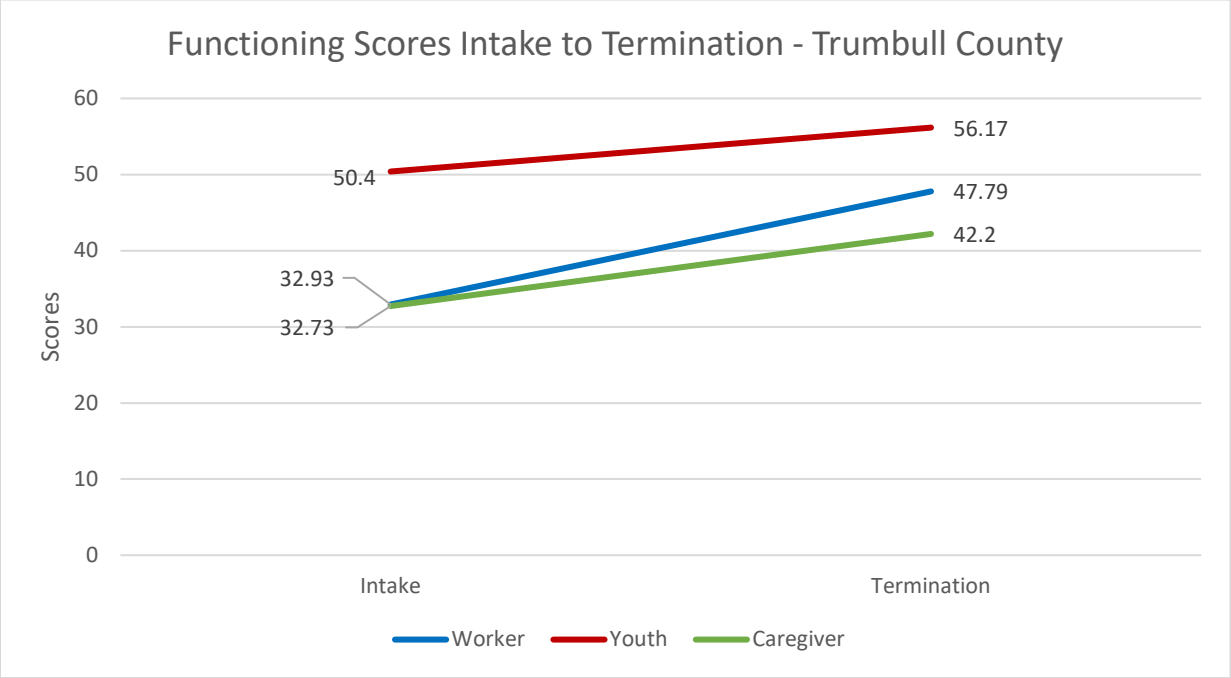
	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	34.44 (SD=13.19; n=15)	24.86 (SD=14.98; n=15)	2.38*	.61

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

Functioning Scores

Overall means for the Functioning scale by rater between intake and termination for Trumbull County youth are presented in Figure 192.

Figure 192.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Functioning scores from intake to termination $t(15) = -3.22$, $p < .01$ with a large effect size (see Table 245).

Table 245. Paired Samples T-Tests for Functioning Scores – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	34.25 (SD=11.58; n=16)	46.38 (SD=12.54; n=16)	-3.22**	.80

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated no statistically significant improvements in Functioning scores from intake to termination $t(15) = -.07$ (see Table 246).

Table 246. Paired Samples T-Tests for Functioning Scores – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	54.69 (SD=13.68; n=16)	55.06 (SD=18.00; n=16)	-.07	.02

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed no significant improvements in Functioning scores from intake to termination $t(15) = -.73$ (see Table 247).

Table 247. Paired Samples T-Tests for Functioning Scores – Caregiver

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	38.81 (SD=15.56; n=16)	42.25 (SD=15.22; n=16)	-.73	.18

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

Violence and Delinquency Questionnaire

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey composed of three general domains: exposure to violence, violence perpetration, and peer delinquency. The VDQ is offered at intake and termination into the BHJJ program. At intake, each item prompts the youth to answer within the context of the past year. At termination, youth are directed to answer "since the last time you answered these questions".

This section will be divided into three distinct parts that examine the prevalence of violence exposure as either a victim or witness, self-reported delinquent behavior from intake to termination, and delinquent behavior by peers from intake to termination. Table 248 provides the percentage of those who had experienced violence as either a victim or witness in the past year.

Table 248. Violence Exposure

	% Yes BHJJ Sample (n = 44)
In the last year, did someone threaten to hurt you when you thought they might really do it?	40.9%
In the last year, have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?	13.6%
In the last year, did a boyfriend or girlfriend or anyone you went on a date with slap or hit you?	9.1%
In the last year, did anyone steal anything from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?	54.5%
Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	31.8%
In the last year, did anyone hit or attack you WITHOUT using an object or weapon?	43.2%
In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?	40.9%
In the last year, did a grown-up touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?	0
Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. In the last year, did another child or teen make you do sexual things?	4.5%
In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	31.8%
In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	37.2%
In the last year, in real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt them?	46.5%
In the last year, was anyone close to you murdered, like a friend, neighbor, or someone in your family?	11.4%
In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	52.3%
Not including spanking on your bottom, did a grown-up in your life hit, beat, kick or physically hurt you in any way?	44.2%
When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. In the last year, were you neglected?	11.4%

Due to low sample sizes, we are unable to present the comparisons between intake and termination for both self-reported and peer delinquency.

Resilience

As part of the 2017 - 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family.

Figure 193 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were “pretty much true” and “very much true”, we combined these responses. Generally, the majority of youth indicated high levels of endorsement for each one of these items except for “I can work out my problems” and “I can work with someone who has different opinions than mine”.

Figure 193.

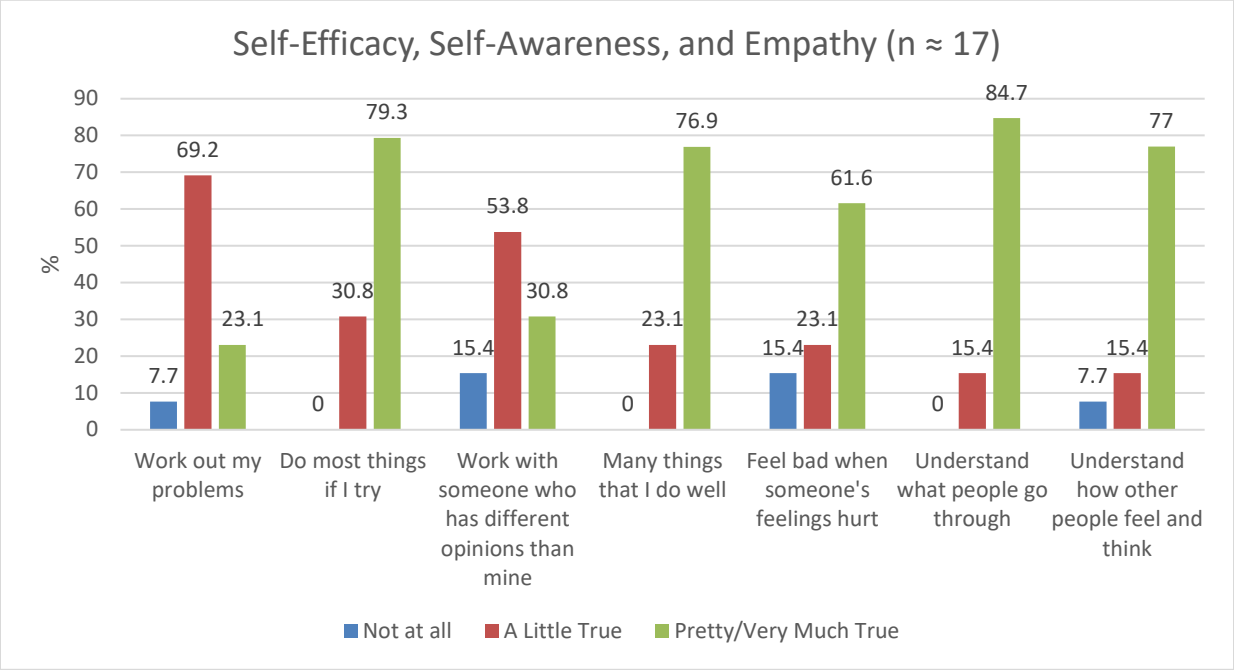


Figure 194 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. The majority of youth identified that each of the statements were either pretty much or very much true.

Figure 194.

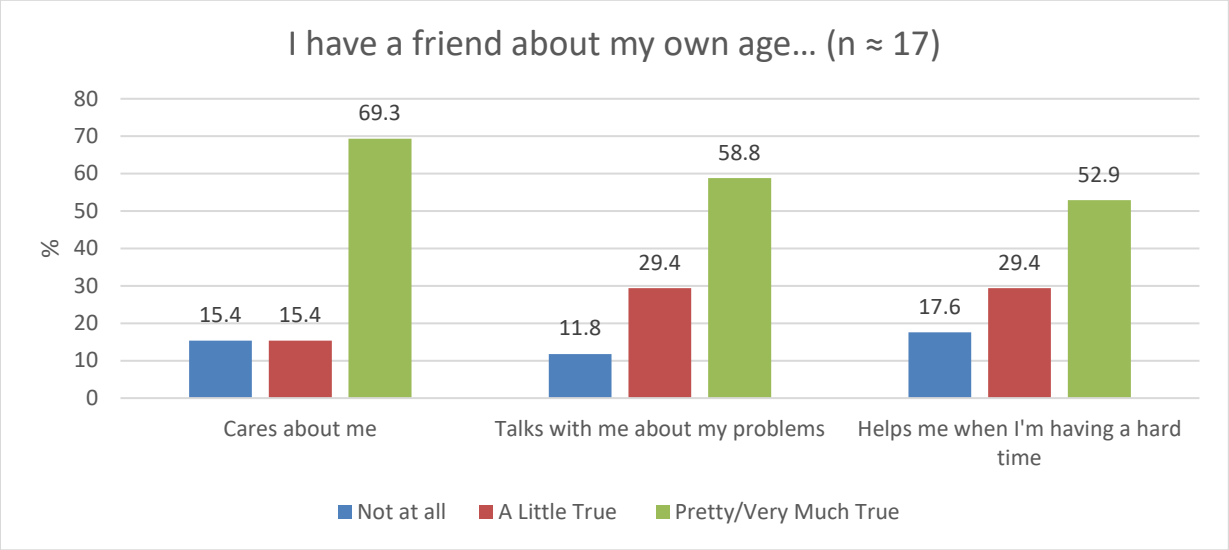
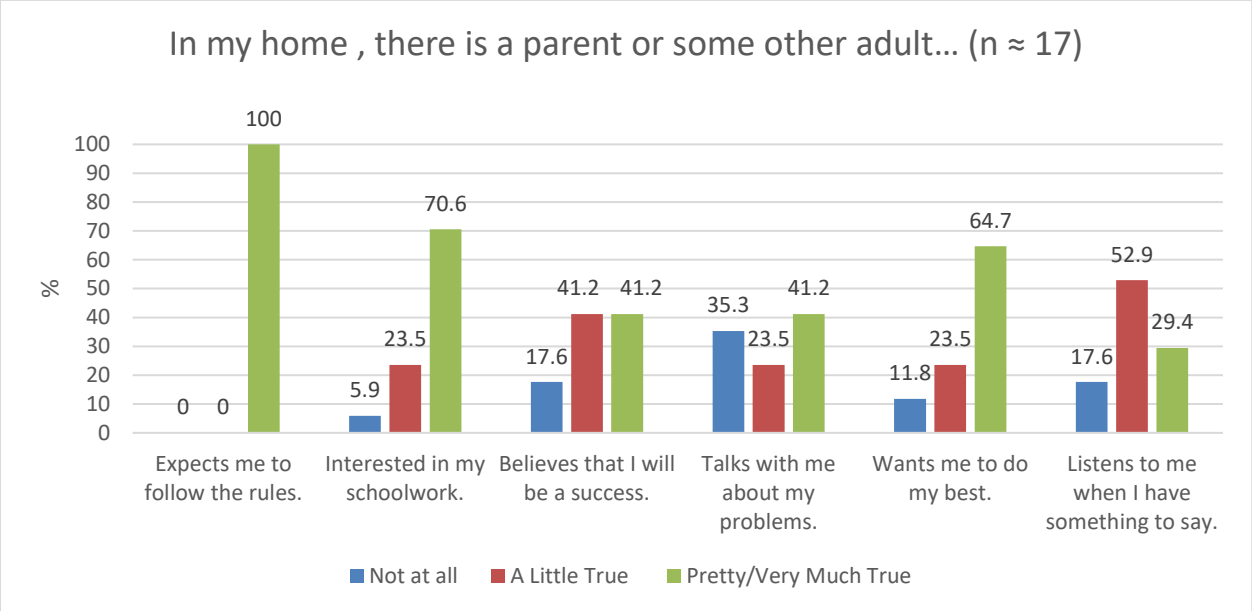


Figure 195 shows intake data on parental or support from other adults in their house. Less than half of the youth indicated that the items "believes that I will be a success", "talks with me about my problems", and "listens to me when I have something to say" were either pretty much or very much true.

Figure 195.



TSCC

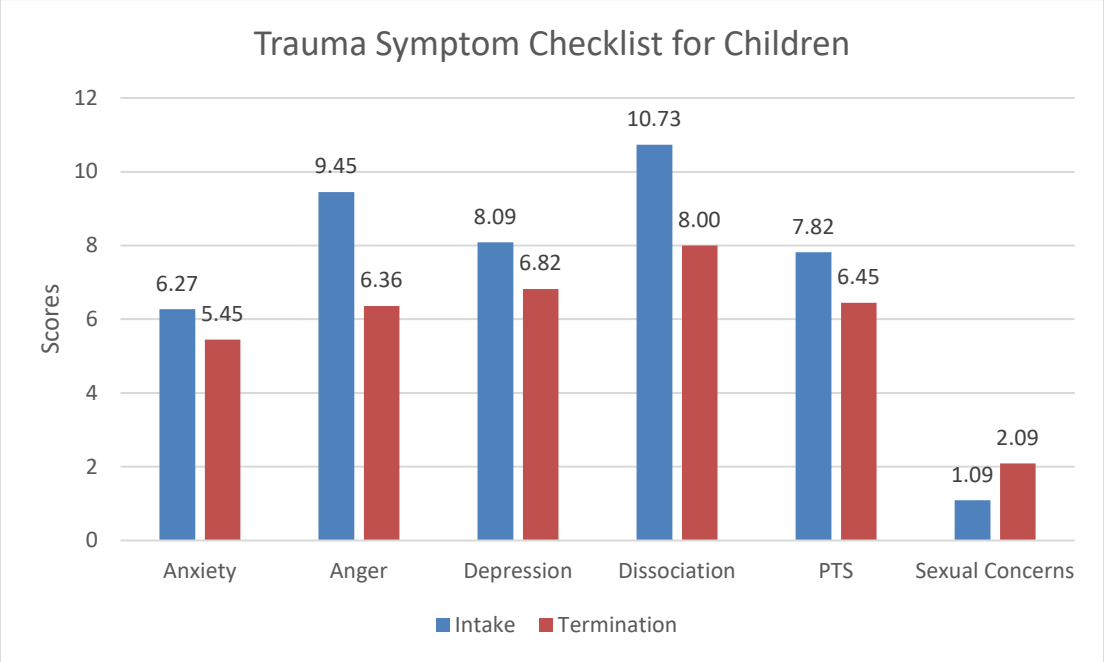
The TSCC was administered at intake and termination from BHJJ. Paired-samples t-tests were conducted to show whether means at intake and termination on each TSCC subscale differed significantly. We were unable to examine gender effects due to the low sample size of both males (n = 6) and females (n = 5). Paired samples t-tests revealed significant improvements in trauma symptoms for the Anger, Posttraumatic Stress, and Dissociation domain from intake to termination (see Table 249).

Table 249. TSCC Subscales from Intake to Termination among all Participants

	Intake	Termination	t	d
Anxiety	6.27 (SD = 4.22; n = 11)	5.45 (SD = 4.48; n = 11)	1.48	.45
Depression	8.09 (SD = 6.07; n = 11)	6.82 (SD = 4.90; n = 11)	1.13	.34
Anger	9.45 (SD = 5.45; n = 11)	6.36 (SD = 4.52; n = 11)	2.44*	.83
Posttraumatic Stress	7.82 (SD = 6.55; n = 11)	6.45 (SD = 5.72; n = 11)	1.90*	.58
Dissociation	10.73 (SD = 6.77; n = 11)	8.00 (SD = 5.59; n = 11)	2.12*	.64
Sexual Concerns	1.09 (SD = 1.81; n = 11)	2.09 (SD = 2.26; n = 11)	-.35	.10

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

Figure 196.



Substance Use Survey

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 250 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use in Trumbull County. Caffeine and alcohol were the two most commonly reported substances.

Table 250. Self-Reported Substance Use at Intake– Trumbull County

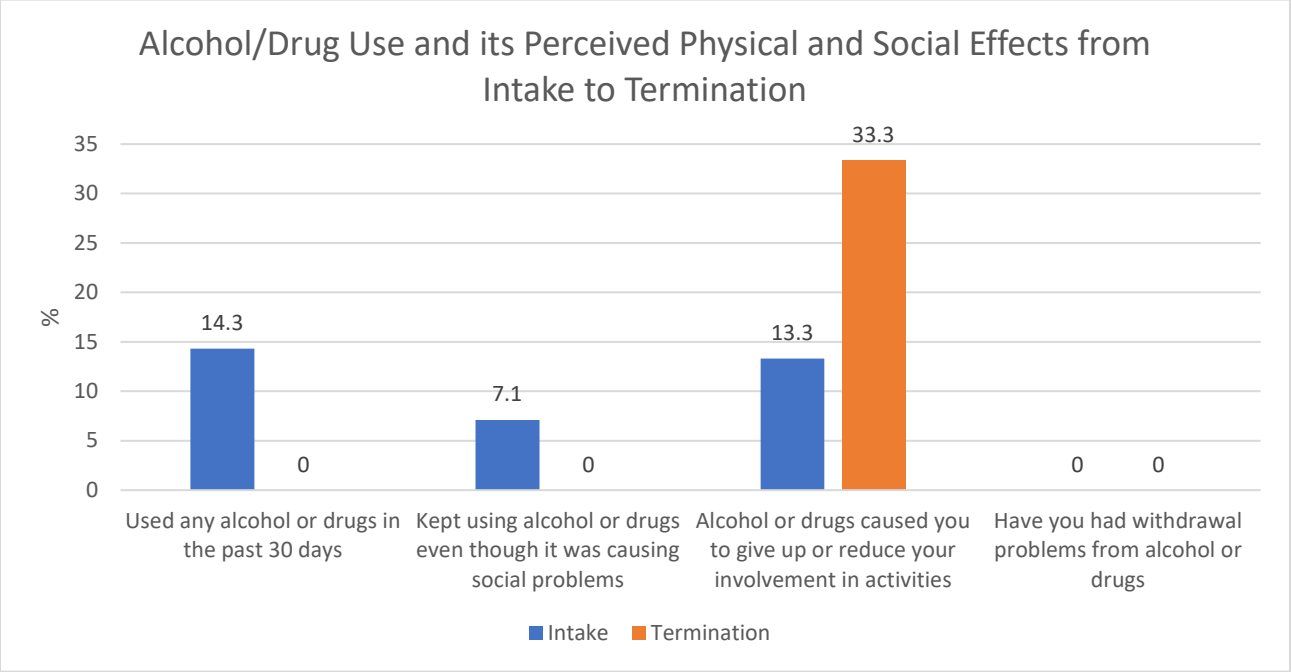
	% Ever Used	Age of First Use
Alcohol	41.2% (n = 7)	12.67 (SD = 2.42)
Tobacco	41.2% (n = 7)	10.50 (SD = 2.59)
Cannabis	35.3% (n = 6)	13.40 (SD = 1.52)
Hallucinogens	0.0% (n = 0)	
Inhalants	5.9% (n = 1)	
Opioids	5.9% (n = 1)	14.00[a]
Sedatives	0.0% (n = 0)	
Caffeine	52.9% (n = 9)	8.63 (SD = 4.03)
Stimulants	5.9% (n = 1)	
Over the counter medications	0.0% (n = 0)	
Other prescription drugs	5.9% (n = 1)	
Herbs/Flowers	5.9% (n = 1)	

[a] No Standard Deviations are calculated.

In addition to questions pertaining to the use of specific substances, youth were asked questions around general alcohol/drug use and its perceived effects on physical health and social functioning. Due to a low number of valid responses, we examined raw proportions at intake and termination for each question. Rather than using only those who had responses at intake and at termination, we examined all valid responses which ranged between 14 and 15 at intake and there were 6 at termination.

The proportion of youth who indicated that they had used any alcohol or drugs in the past 30 days decreased from 14.3% at intake to 0.0% at termination (see Figure 197). From intake to termination, the proportion of youth who indicated that they had continued to use alcohol/drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people at least sometimes decreased slightly while the proportion of youth who indicated that alcohol/drugs caused them to give up or reduce involvement in activities at work, school, home, and social events increased from intake to termination. No youth indicated any problems with withdrawal from alcohol or drugs at intake or at termination. Data should be interpreted with caution as a very small sample is represented here.

Figure 197.



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.

Between July 1, 2015 and June 30, 2019, there have been 23 youth terminated from the BHJJ program in Trumbull County. Ninety-one percent (91.3%, n = 21) of the youth terminated from the BHJJ program were identified as successful treatment completers. Four percent (4.3%, n = 1) were terminated from the program due to being AWOL. Table 251 presents all of the reasons for termination from BHJJ and displays reasons for termination for White and Black participants.

Table 251. Reasons for Termination from BHJJ

Termination Reason	All Youth Enrolled between July 2015 and June 2019	White Youth Enrolled between July 2015 and June 2019	Black Youth Enrolled between July 2015 and June 2019
Successfully Completed Services	91.3% (n = 21)	100% (n = 14)	66.7% (n = 4)
Client Did Not Return/Rejected Services	4.3% (n = 1)	0	16.7% (n = 1)
Out of Home Placement	0	0	0
Client/Family Moved	0	0	0
Client Withdrawn	0	0	0
Client AWOL	4.3% (n = 1)	0	16.7% (n = 1)
Client Incarcerated	0	0	0
Other	0	0	0

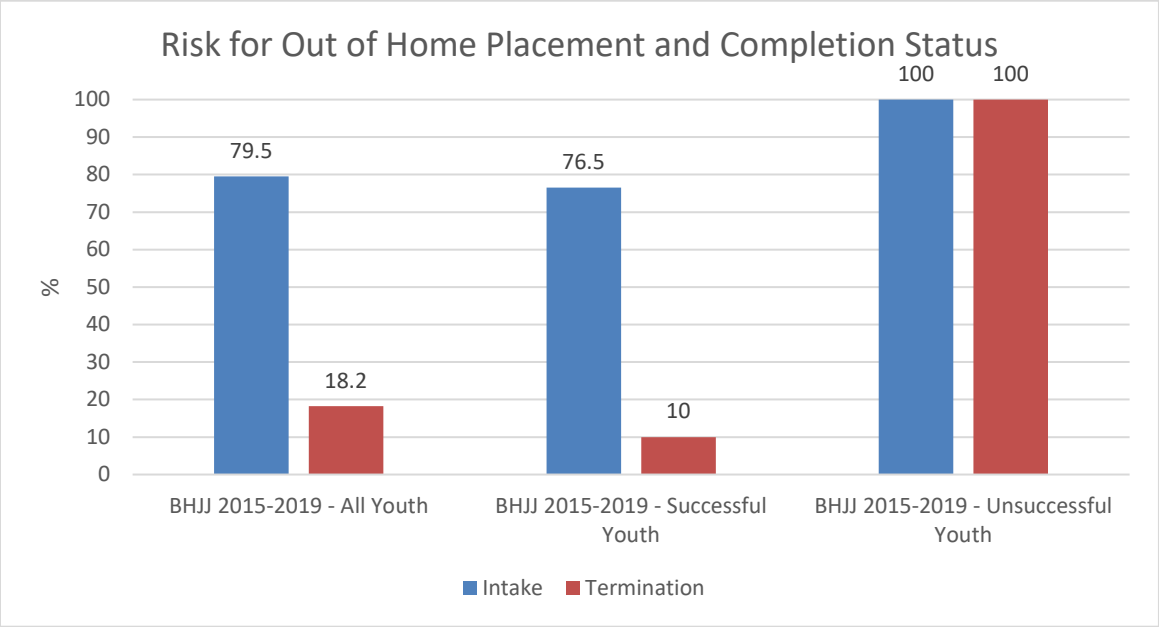
Average Length of Stay

Since the start of BHJJ, the average length of stay (ALOS) in the program was 146.8 days. For youth identified as successful treatment completers, the ALOS was 146.5 days while for unsuccessful treatment completers, the ALOS was 153.0 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, 79.5% of the youth (n = 31) were at risk for out of home placement. At termination, 18.2% (n = 4) of youth were at risk for out of home placement (see Figure 198). Of those youth who successfully completed BHJJ treatment, 10.0% (n = 2) were at risk for out of home placement at termination while 100% (n = 2) of youth who completed unsuccessfully were at risk for out of home placement (see Figure 198).

Figure 198.



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 services through BHJJ. Workers reported that police contacts had been reduced for 73.9% (n = 17) of the youth and had stayed the same for 26.1% (n= 6) of the youth.

YSSF

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the services they received through the BHJJ program in Trumbull County as well as how services impacted their children and family. At termination from the BHJJ program, 76.9% (n =20) of caregivers either strongly agreed or agreed that the BHJJ staff were sensitive to their cultural/ethnic background and 88.4% (n =23) either strongly agreed or agreed that the location of the services was convenient (see Figure 199). Thirty-two percent (32.0%, n = 8) of caregivers reported that as a result of the services their child/family received, their child gets along better with family members and 40.0% (n = 10) reported their child is better able to do the things they want to do (see Figure 200).

Figure 199.

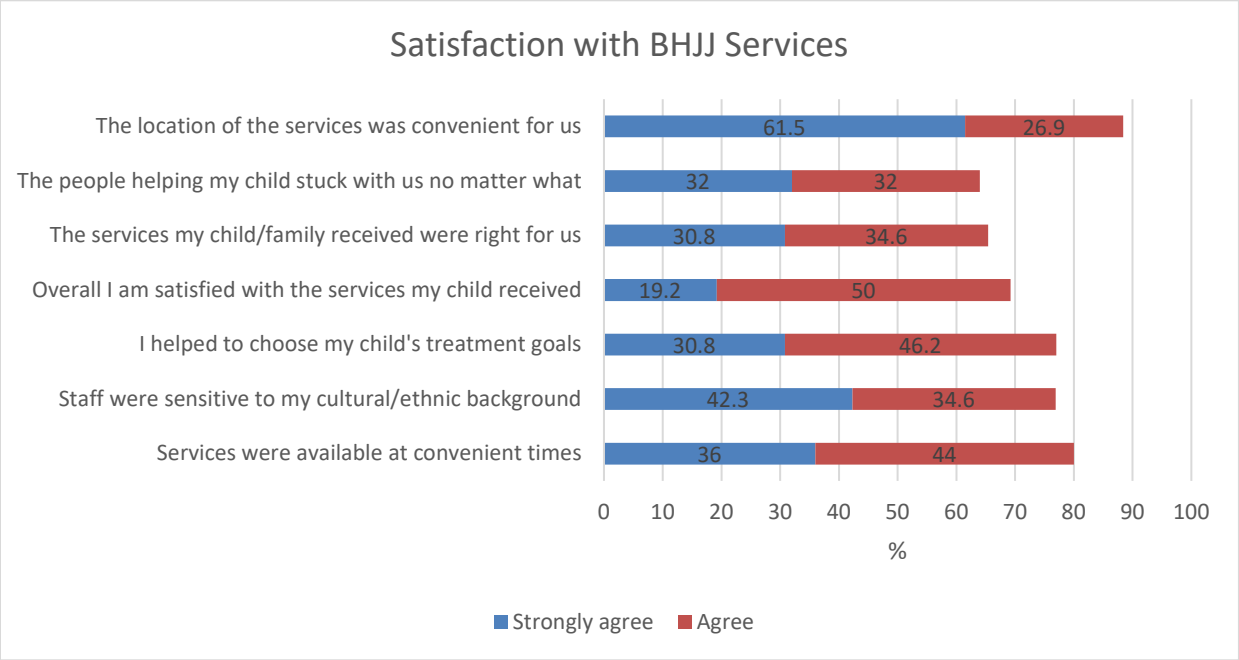
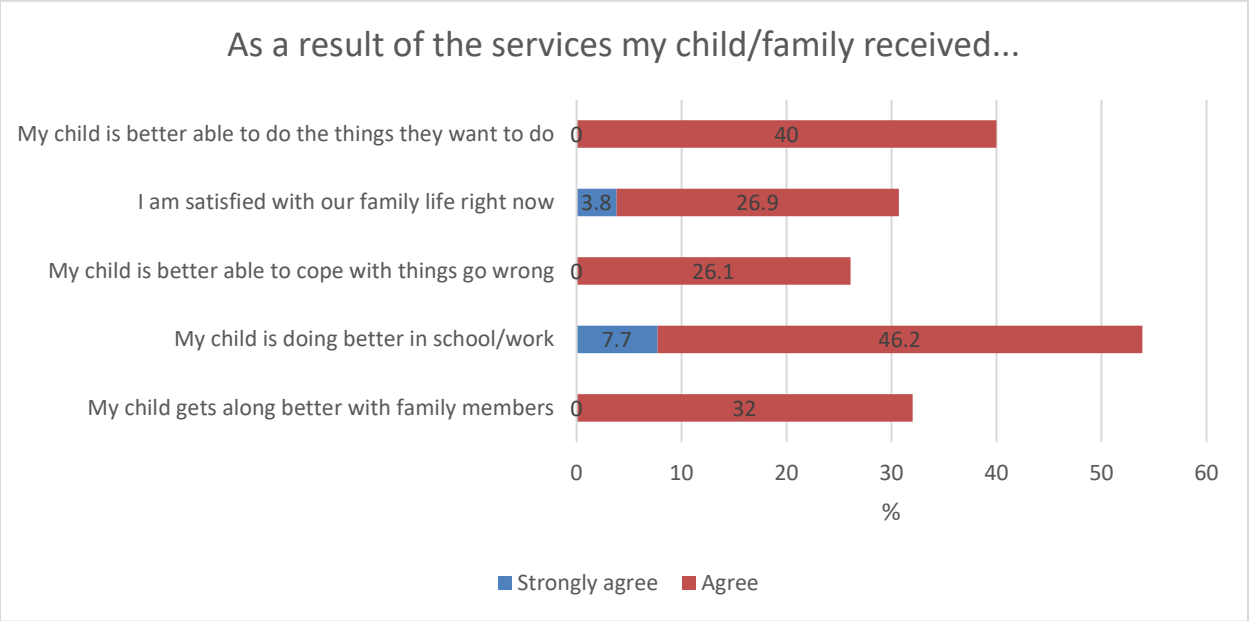


Figure 200.



Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve months prior to the end of the data collection period for inclusion in the analysis. Due to a small number of youth who terminated unsuccessfully, we were not able to separate out these data by completion status. These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 58.3% (n = 28) of BHJJ youth in Trumbull county enrolled between July 1, 2015 and June 30, 2019 had a misdemeanor charge, 6.3% (n = 3) had a felony charge, and 79.2% (n = 38) had been adjudicated delinquent in the 12 months prior to enrollment (see Table 252).

Table 252. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 48)	50.0% (n = 24)	4.2% (n = 2)	72.9% (n = 35)
12 months (n = 48)	58.3% (n = 28)	6.3% (n = 3)	79.2% (n = 38)
18 months (n = 48)	58.3% (n = 28)	6.3% (n = 3)	81.3% (n = 39)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 253). In the 12 months after enrollment in BHJJ, 44.4% (n = 20) of participants were charged with at least one new misdemeanor, 4.4% (n = 2) were charged with at least one new felony, and 62.2% (n = 28) were adjudicated delinquent.

Table 253. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 47)	29.8% (n = 14)	4.3% (n = 2)	51.1% (n = 24)
12 months (n = 45)	44.4% (n = 20)	4.4% (n = 2)	62.2% (n = 28)
18 months (n = 40)	47.5% (n = 19)	5.0% (n = 2)	65.0% (n = 26)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 254). In the 12 months after termination from BHJJ, 38.1% (n = 8) of youth were charged with at least one new misdemeanor and 9.5% (n = 2) were charged with at least one new felony, and 52.4% (n = 11) were adjudicated delinquent.

Table 254. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 21)	28.6% (n = 6)	4.8% (n = 1)	42.9% (n = 9)
12 months (n = 21)	38.1% (n = 8)	9.5% (n = 2)	52.4% (n = 11)
18 months (n = 19)	52.6% (n = 10)	10.5% (n = 2)	57.9% (n = 11)

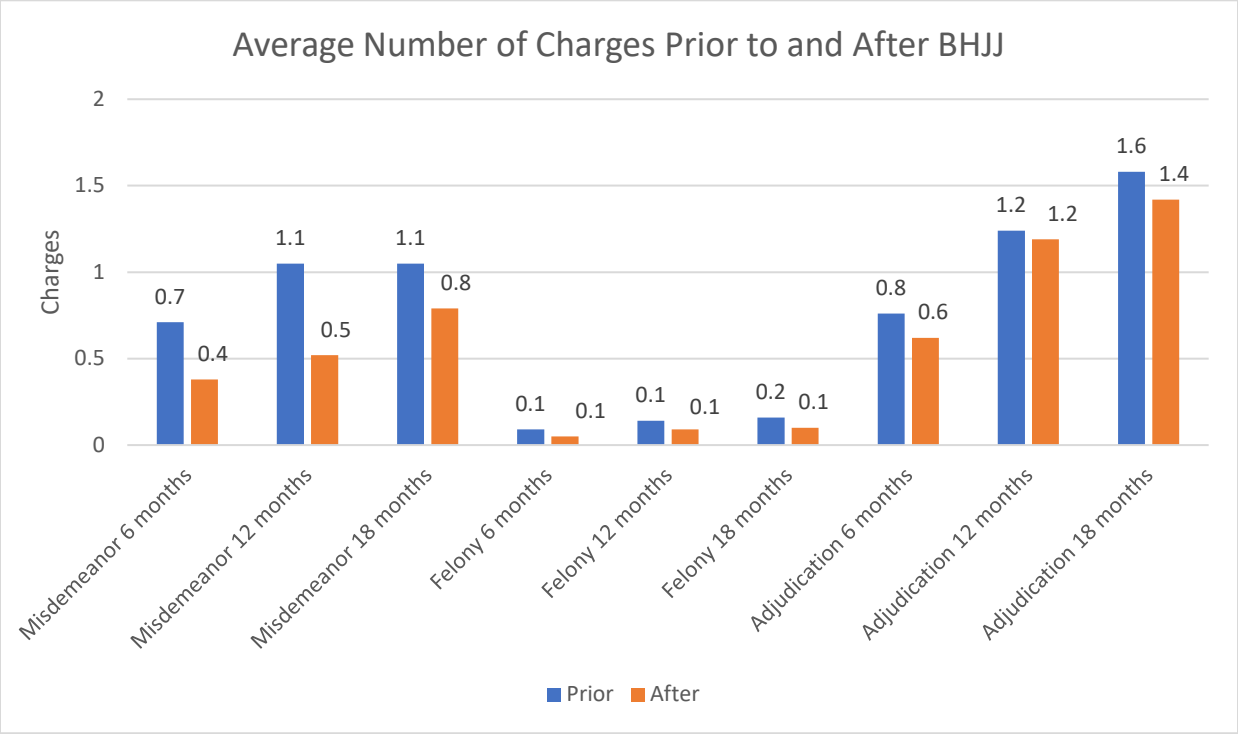
ODYS Commitments

Among a total of 48 youth who enrolled since July 1, 2015, 2.1% (n = 1) were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ. **Conversely, 97.9% of youth participating in BHJJ were not admitted to an ODYS facility at any point after enrollment.**

Average Numbers of Charges and Adjudications

In addition to whether a youth was charged or adjudicated delinquent, we examined whether there were differences in the average number of charges and adjudications in equivalent periods of time prior to enrollment and after termination. We conducted paired samples *t*-tests to examine whether there were statistically significant differences in the mean number of charges and adjudications at each time period prior to and after BHJJ participation. Figure 201 shows the average number of charges for youth who had data at both time periods. This restriction resulted in a sample of 21 youth at 6 months, 21 youth at 12 months, and 19 youth at 18 months. **Paired samples *t*-tests revealed statistically significant declines in the average number of misdemeanor charges at 12 months.** The average number of misdemeanor charges 12 months prior to BHJJ enrollment was 1.05 while the average number of misdemeanor charges 12 months after BHJJ termination was 0.52.

Figure 201.


Average Number of Charges Prior to and After BHJJ
Charges
2
1.5
1
0.5
0
0.7
0.4
1.1
0.5
1.1
0.8
0.1
0.1
0.1
0.1
0.2
0.1
0.8
0.6
1.2
1.2
1.6
1.4
Misdemeanor 6 months
Misdemeanor 12 months
Misdemeanor 18 months
Felony 6 months
Felony 12 months
Felony 18 months
Adjudication 6 months
Adjudication 12 months
Adjudication 18 months
Prior
After

Mahoning

Demographics

As of June 30, 2019, 48 youth were enrolled into the BHJJ program in Mahoning County. The average age at enrollment was 15.2 years (SD=1.65). More males (68.8%, n = 33) than females (31.3%, n = 15) have been enrolled. White youth (54.3%, n = 25), Black youth (37.0%, n = 17) and Multiracial youth (8.7%, n = 4) comprised the majority of the total sample.

There were 9 new enrollments in Mahoning County during the current reporting period (July 1, 2017 through June 30, 2019). The average age at enrollment was 13.7 (SD = 1.23). There were more males (62.5%, n = 5) than females (37.5%, n = 3), and more White youth (75.0%, n = 6) than Black youth (25.0%, n = 2). Over twelve percent (12.5%, n = 1) of youth self-identified as Hispanic/Latinx.

Unless otherwise noted, the following sections describe data from the past four years of BHJJ programming from July 1, 2015 through June 30, 2019.

Custody Arrangement and Household Information

At intake, 44.4% of youth (n = 8) lived with their biological mother only, while 11.1% (n = 2) lived with two biological parents or one biological and one step/adoptive parent (see Table 255). Over sixty-one percent (61.1%, n = 11) of BHJJ youth lived with at least one biological at enrollment.

Over eighty-eight percent (88.2%; n = 15) of the BHJJ caregivers had at least a high school diploma or GED, and 11.8% (n = 2) had a bachelor's degree or higher. Over eleven percent of caregivers (11.8%; n = 2) reported they did not graduate from high school (see Table 256).

Caregivers were asked to report their annual household income (see Table 257). The income ranges with the highest endorsement was less than $5,000 and $50,000 - $74,999 (n = 4). Overall, 66.7% (n = 12) reported a family income of $24,999 or less. When examined by race, no White families, 71.4% (n = 5) of Black families, and 100% (n = 3) of Multiracial families reported a household income of $14,999 or less. Table 257 displays the reported household income overall and by race.

Table 255. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	11.1% (n = 2)
Biological Mother Only	44.4% (n = 8)
Biological Father Only	5.6% (n = 1)
Adoptive Parent(s)	16.7% (n = 3)
Aunt/Uncle	0
Grandparents	22.2% (n = 4)
Other	0

Table 256. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	11.8% (n = 2)
High School Graduate or G.E.D.	35.3% (n = 6)
Some College or Associate Degree	41.1% (n = 7)
Bachelor's Degree	5.9% (n = 1)
More than a Bachelor's Degree	5.9% (n = 1)

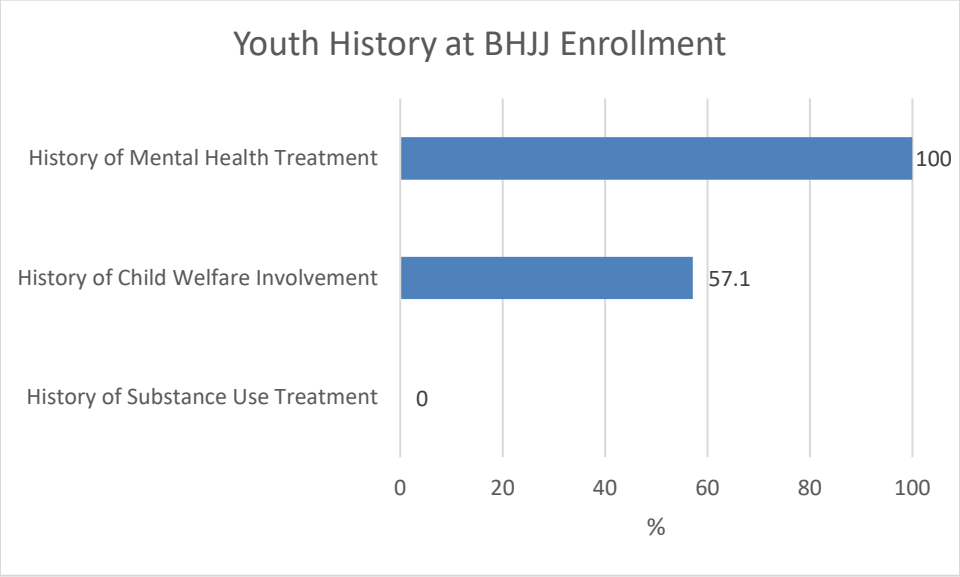
Table 257. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Black	Multiracial
Less than $5,000	22.2% (n = 4)	0	28.6% (n = 2)	66.7% (n = 2)
$5,000 - $9,999	5.6% (n = 1)	0	14.3% (n = 1)	0
$10,000 - $14,999	16.7% (n = 3)	0	28.6% (n = 2)	33.3% (n = 1)
$15,000 - $19,999	11.1% (n = 2)	12.5% (n = 1)	14.3% (n = 1)	0
$20,000 - $24,999	11.1% (n = 2)	12.5% (n = 1)	14.3% (n = 1)	0
$25,000 - $34,999	0	0	0	0
$35,000 - $49,999	0	0	0	0
$50,000 - $74,999	22.2% (n = 4)	50.0% (n = 4)	0	0
$75,000 or greater	11.1% (n = 2)	25.0% (n = 2)	0	0

Youth and Family History

Workers were asked to identify a youth's prior behavioral health and child welfare system involvement (see Figure 202). These three items were new to the past biennium, therefore, data are only available for youth enrolled between July 1, 2017 and June 30, 2019. Over fifty-seven percent of the youth (57.1%, n = 4) had a history of child welfare involvement prior to BHJJ enrollment. No youth had received substance use treatment in their lifetime prior to BHJJ enrollment and 100% (n = 8) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 202.



Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history (see Table 258). Statistical testing for gender differences were not conducted due to small sample sizes.

Caregivers reported that none of females and 15.4% (n = 2) of males had a history of being physically abused while 25.0% (n = 1) of females and 21.4% (n = 3) of males had a history of being sexual abused. Caregivers of 50.0% (n = 2) of females and 38.5% (n = 5) of males reported hearing the child talking about committing suicide and none of females and 14.3% (n = 2) of males had attempted suicide at least once. A majority of the caregivers of females (75.0%, n = 3) and males (69.2%, n = 9) reported a family history of depression. Half of the caregivers of females (50.0%, n = 2) and a majority of the caregivers of males (64.3%, n = 9) reported a family history of problems with substance use.

Table 258. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	0	15.4% (n = 2)
Has the child ever been sexually abused?	25.0% (n = 1)	21.4% (n = 3)
Has the child ever run away?	25.0% (n = 1)	38.5% (n = 5)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	25.0% (n = 1)	33.3% (n = 4)
Has the child ever talked about committing suicide?	50.0% (n = 2)	38.5% (n = 5)
Has the child ever attempted suicide?	0	14.3% (n = 2)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	25.0% (n = 1)	42.9% (n = 6)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	75.0% (n = 3)	69.2% (n = 9)
Has anyone in the child's biological family had a mental illness, other than depression?	66.7% (n = 2)	53.8% (n = 7)
Has the child ever lived in a household in which someone was convicted of a crime?	50.0% (n = 2)	53.8% (n = 7)
Has anyone in the child's biological family had a drinking or drug problem?	50.0% (n = 2)	64.3% (n = 9)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	75.0% (n = 3)	50.0% (n = 7)

Problems Leading to Service

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-related problems (100.0% and 100.0% respectively) (see Table 259).

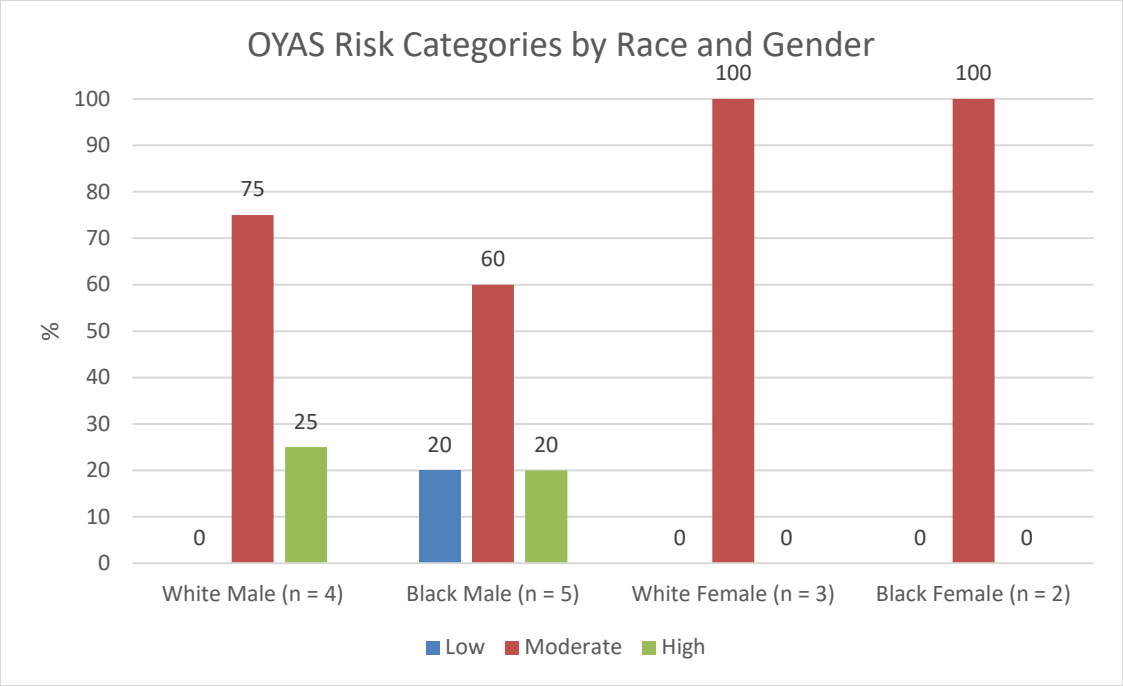
Table 259. Problems Leading to Services

Problems Leading to Services	Females	Males
Adjustment-related problems	0	15.4% (n = 2)
Anxiety-related problems	0	7.7% (n = 1)
Conduct/delinquency-related problems	100.0% (n = 4)	100.0% (n = 13)
Depression-related problems	0	15.4% (n = 2)
Eating disorders	0	0
Hyperactive and attention-related problems	0	38.5% (n = 5)
Learning disabilities	0	7.7% (n = 1)
Pervasive development disabilities	0	0
Psychotic behaviors	0	15.4% (n = 2)
School performance problems not related to learning disabilities	25.0% (n = 1)	46.2% (n = 6)
Specific developmental disabilities	0	0
Substance use, abuse, dependence-related problems	0	25.0% (n = 2)
Suicide-related problems	0	23.1% (n = 3)

Ohio Youth Assessment System

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 203 shows the distribution of OYAS risk categories for BHJJ youth by race and gender. In Mahoning County, the majority of youth enrolled in BHJJ were identified as Moderate risk on the OYAS. Due to small sample sizes, caution should be applied when making any comparisons.

Figure 203.



DSM Diagnoses

Workers were asked to report any DSM 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 diagnosis for females and males was Oppositional Defiant Disorder (see Table 260). Chi-square analyses were not performed due to the small sample size of females.

Table 260. Most Common DSM Diagnoses

DSM Diagnosis	Females (n = 4)	Males (n = 13)
Adjustment Disorder	0	0
Alcohol-related Disorders	0	0
Attention Deficit Hyperactivity Disorder	0	30.8% (n = 4)
Bipolar Disorder	0	0
Cannabis-related Disorders	0	7.7% (n = 1)
Conduct Disorder	0	23.1% (n = 3)
Depressive Disorders	0	0
Disruptive Behavior Disorder	0	0
Unspecified Mood Disorder	0	0
Oppositional Defiant Disorder	**100% (n = 4)**	**61.5% (n = 8)**
Post-traumatic Stress Disorder	0	0
Unspecified Trauma and Stressor Related Disorder	0	0
Disruptive Mood Dysregulation Disorder	0	0
Co-Occurring Disorder	0	7.7% (n = 1)

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

Educational Information

Several items focused on educational 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. The wording on some items (e.g. IEP at intake, attendance at intake) was changed from previous versions of the forms. For those items, we present data from only the past biennium (when the new forms were in use). Those items will have smaller sample sizes compared to items that have been consistent for the past four years.

Fifty-six percent (56.3%, n = 9) of youth were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in BHJJ treatment BHJJ, 58.3% (n = 7) 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, 87.5% (n = 7) of youth were currently attending school while at termination, 100.0% (n = 12) 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 261 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 262 displays this information based on completion status. At intake, 50.0% of youth were earning mostly A's and B's, and C's while at termination, 45.5% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 262). For example, at intake, 100% of youth who would go on to be unsuccessful completers and 50.0% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 0% of unsuccessful completers and 50.0% of successful completers received mostly A's, B's, or C's.

Table 261. Academic Performance

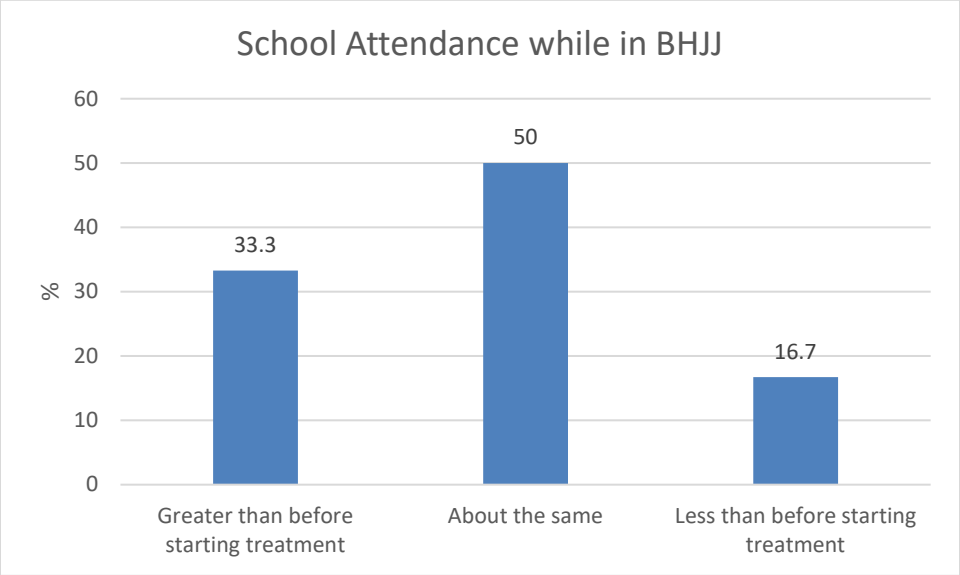
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	14.3% (n = 2)	18.2% (n = 2)
Mostly B's and C's	35.7% (n = 5)	27.3% (n = 3)
Mostly C's and D's	28.6% (n = 4)	36.4% (n = 4)
Mostly D's and F's	21.4% (n = 3)	18.2% (n = 2)

Table 262. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	0	0	25.0% (n = 1)	33.3% (n = 2)
Mostly B's and C's	100% (n = 1)	0	25.0% (n = 1)	16.7% (n = 1)
Mostly C's and D's	0	100% (n = 1)	25.0% (n = 1)	33.3% (n = 2)
Mostly D's and F's	0	0	25.0% (n = 1)	16.7% (n = 1)

At termination, workers reported that 33.3% (n = 4) of youth were attending school more than before starting treatment and 50.0% (n = 6) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 204). At intake, 66.7% (n = 4) of youth attending school had Individualized Education Plans (IEPs) while at termination, 50.0% (n = 6) of the youth attending school had Individualized Education Plans (IEPs).

Figure 204.



Ohio Scales

One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Data at termination were available for six youth for the caregiver and worker reports, and four youth for the youth reports. Therefore, we did not conduct any statistical analyses and instead present separate means at intake and termination in Table 263 and
Table 264.

Table 263. Problem Severity Scores at Intake and Termination for Youth

	Problem Severity	
	Intake	Termination
Worker	31.41 (SD = 13.01; n = 17)	15.50 (SD = 10.21; n = 6)
Youth	27.89 (SD = 16.95; n = 15)	22.00 (SD = 9.63; n = 4)
Caregiver	36.35 (SD = 17.87; n = 17)	21.50 (SD = 14.40; n = 6)

Table 264. Functioning Scores at Intake and Termination for Youth

	Functioning	
	Intake	Termination
Worker	34.47 (SD = 15.06; n = 17)	52.83 (SD = 14.13; n = 6)
Youth	55.27 (SD = 14.41; n = 15)	59.00 (SD = 10.86; n = 4)
Caregiver	37.29 (SD = 17.08; n = 17)	58.17 (SD = 11.96; n = 6)

Violence and Delinquency Questionnaire

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey composed of three general domains: exposure to violence, violence perpetration, and peer delinquency. The VDQ is offered at intake and termination into the BHJJ program. At intake, each item prompts the youth to answer within the context of the past year. At termination, youth are directed to answer “since the last time you answered these questions”.

This section will be divided into three distinct parts that examine the prevalence of violence exposure as either a victim or witness, self-reported delinquent behavior from intake to termination, and delinquent behavior by peers from intake to termination. Table 265 provides the percentage of those who had experienced violence as either a victim or witness in the past year.

Table 265. Violence Exposure

	% Yes BHJJ Sample (n = 14)
In the last year, did someone threaten to hurt you when you thought they might really do it?	35.7%
In the last year, have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?	35.7%
In the last year, did a boyfriend or girlfriend or anyone you went on a date with slap or hit you?	7.1%
In the last year, did anyone steal anything from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?	50.0%
Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	21.4%
In the last year, did anyone hit or attack you WITHOUT using an object or weapon?	35.7%
In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?	50.0%
In the last year, did a grown-up touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?	14.3%
Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. In the last year, did another child or teen make you do sexual things?	14.3%
In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	28.6%
In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	21.4%
In the last year, in real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt them?	28.6%
In the last year, was anyone close to you murdered, like a friend, neighbor, or someone in your family?	30.8%
In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	35.7%
Not including spanking on your bottom, did a grown-up in your life hit, beat, kick or physically hurt you in any way?	50.0%
When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. In the last year, were you neglected?	7.1%

Due to low sample sizes, we are unable to present the comparisons between intake and termination for both self-reported and peer delinquency.

Resilience

As part of the 2017 - 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family.

Figure 205 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were “pretty much true” and “very much true”, we combined these responses. Generally, the majority of youth indicated high levels of endorsement for each one of these items except for “I can work out my problems”.

Figure 205.

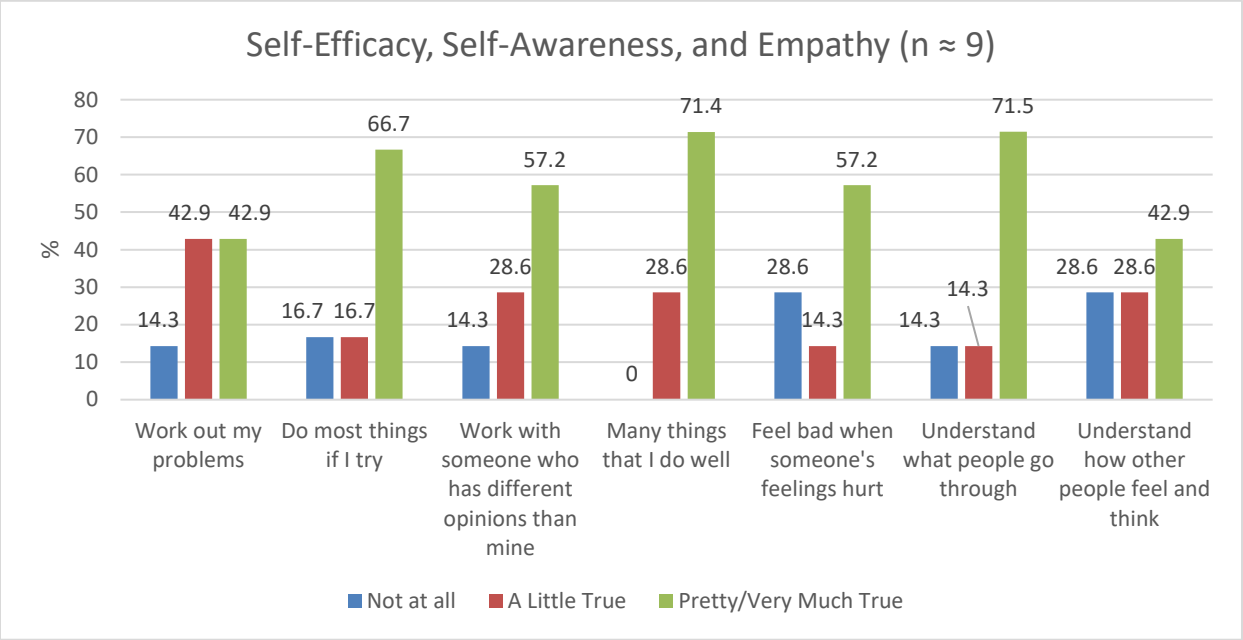


Figure 206 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. The majority of youth identified that each of the statements were either pretty much or very much true.

Figure 206.

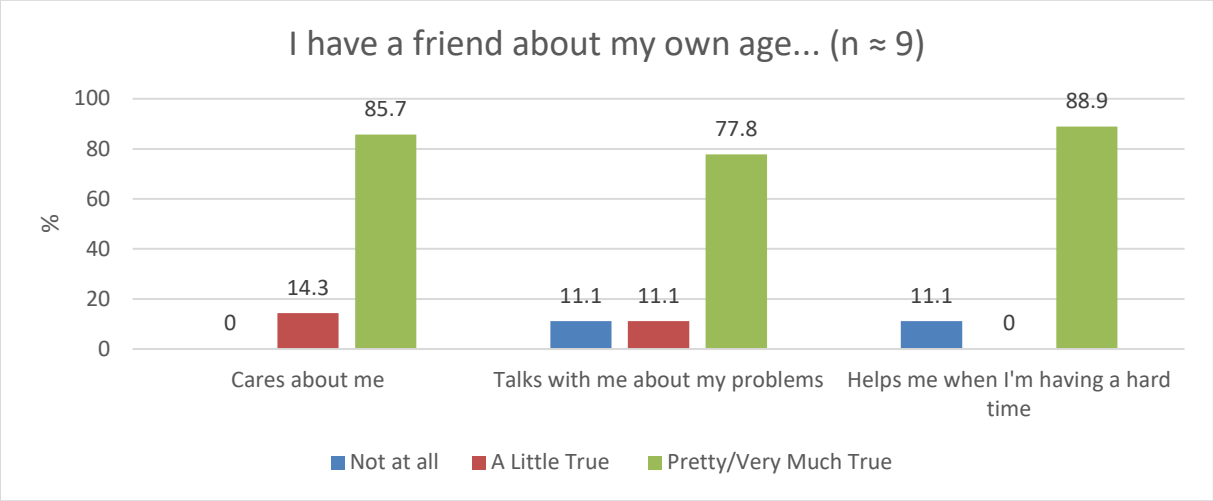
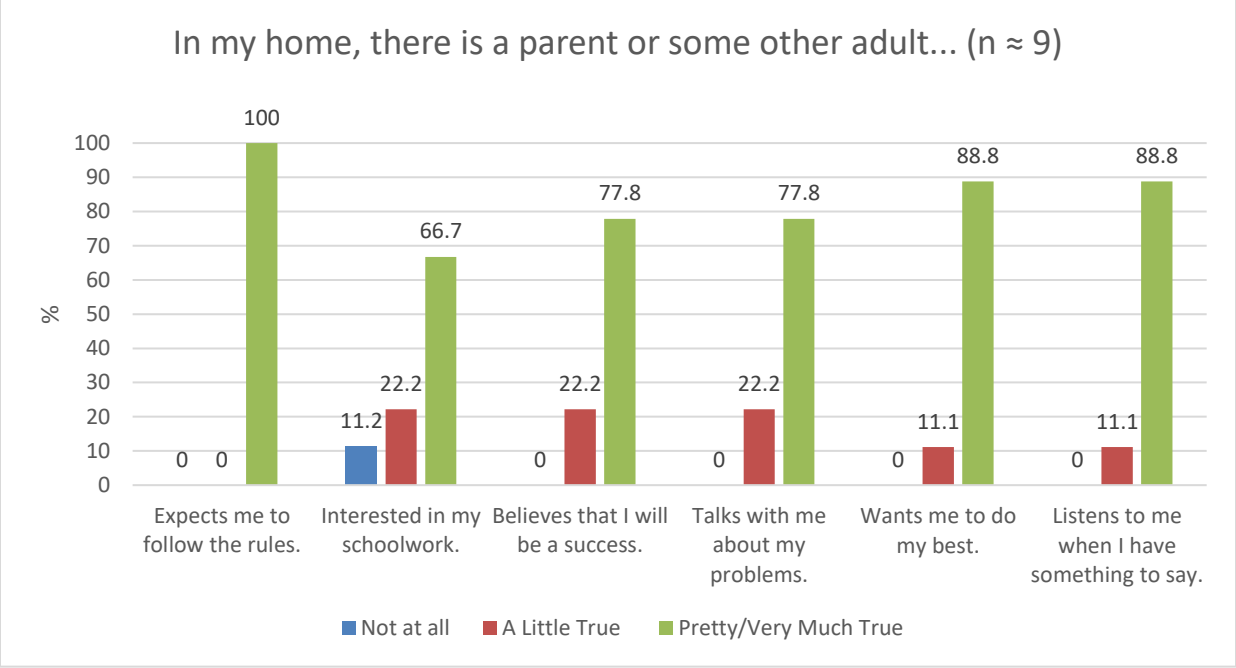


Figure 207 shows intake data on parental or support from other adults in their house. For each of the items, a majority of youth responded either pretty much or very much true.

Figure 207.



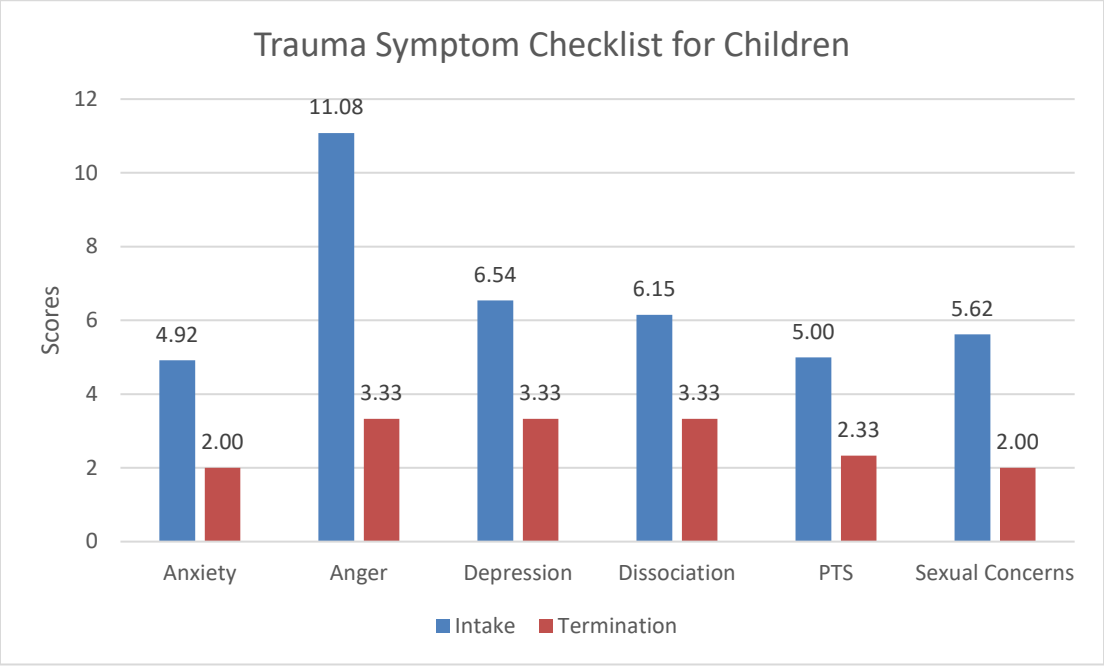
TSCC

The TSCC was administered at intake and termination from BHJJ. Paired-samples t-tests were not conducted due to the small sample at termination. Table 266 displays the mean scores for participants at intake and termination from BHJJ.

Table 266. TSCC Subscales from Intake to Termination for all Particpants

	Intake	Termination
Anxiety	4.92 (SD = 5.07; n = 13)	2.00 (SD = 1.73; n = 3)
Depression	6.54 (SD = 6.39; n = 13)	3.33 (SD = 2.08; n = 3)
Anger	11.08 (SD = 5.54; n = 13)	3.33 (SD = 1.53; n = 3)
Posttraumatic Stress	5.00(SD = 5.58; n = 13)	2.33 (SD = 3.21; n = 3)
Dissociation	6.15 (SD = 5.34; n = 13)	3.33(SD = 2.89; n = 3)
Sexual Concerns	5.62 (SD = 7.04; n = 13)	2.00 (SD = 1.73; n = 3)

Figure 208.



Substance Use Survey

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 267 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use in Mahoning County. Alcohol, tobacco, and cannabis were the three most commonly reported substances.

Table 267. Self-Reported Substance Use at Intake– Mahoning County

	% Ever Used	Age of First Use
Alcohol	37.5% (n = 3)	13.00 (SD = 2.65)
Tobacco	37.5% (n = 3)	12.33 (SD = 1.52)
Cannabis	37.5% (n = 3)	13.00 (SD = 2.65)
Hallucinogens	0.0% (n = 0)	
Inhalants	12.5% (n = 1)	13.00[a]
Opioids	0.0% (n = 0)	
Sedatives	12.5% (n = 1)	14.00[a]
Caffeine	25.0% (n = 2)	13.00[a]
Stimulants	12.5% (n = 1)	14.00[a]
Over the counter medications	25.0% (n = 2)	15.00[a]
Other prescription drugs	12.5% (n = 1)	10.00[a]
Herbs/Flowers	0.0% (n = 0)	

[a] No Standard Deviations are calculated.

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.

Between July 1, 2015 and June 30, 2019, there have been seven youth terminated from the BHJJ program in Mahoning County. Eighty-five percent (85.7%, n = 6) of the youth terminated from the BHJJ program were identified as successful treatment completers. Table 268 presents all of the reasons for termination from BHJJ.

Table 268. Reasons for Termination from BHJJ

Termination Reason	All Youth Enrolled between July 2015 and June 2019
Successfully Completed Services	85.7% (n = 6)
Client Did Not Return/Rejected Services	14.3% (n = 1)
Out of Home Placement	0
Client/Family Moved	0
Client Withdrawn	0
Client AWOL	0
Client Incarcerated	0
Other	0

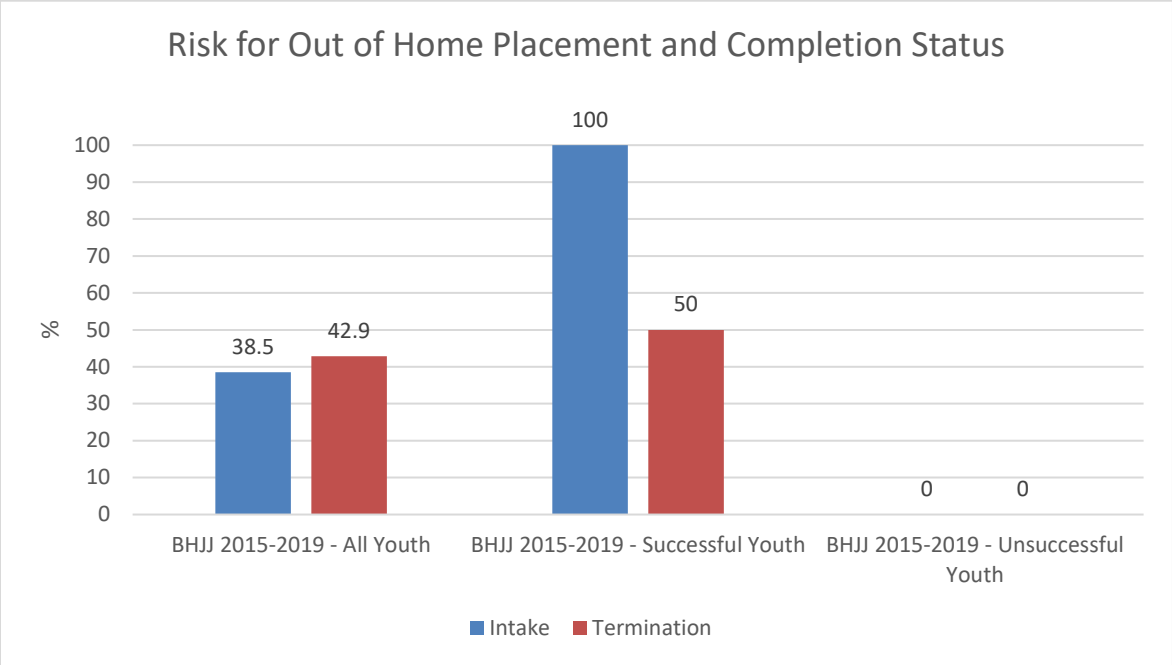
Average Length of Stay

Since the start of BHJJ, the average length of stay (ALOS) in the program was 135.0 days. For youth identified as successful treatment completers, the ALOS was 144.5 days while for unsuccessful treatment completers, the ALOS was 78.0 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, 38.5% of the youth (n = 5) were at risk for out of home placement. At termination, 42.9% (n = 3) of youth were at risk for out of home placement (see Figure 209). Of those youth who successfully completed BHJJ treatment, 50.0% (n = 3) were at risk for out of home placement at termination while 0% (n = 1) of youth who completed unsuccessfully were at risk for out of home placement (see Figure 209).

Figure 209.



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 services through BHJJ. Workers reported that police contacts had been reduced for 85.7% (n = 6) of the youth and had stayed the same for 14.3% (n= 1) of the youth.

YSSF

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the services they received through the BHJJ program in Mahoning County as well as how services impacted their children and family. At termination from the BHJJ program, 100% (n =8) of caregivers either strongly agreed or agreed that the BHJJ staff were sensitive to their cultural/ethnic background and 100% (n =8) either strongly agreed or agreed that the location of the services was convenient (see Figure 210). Fifty percent (50.0%, n = 4) of caregivers reported that as a result of the services their child/family received, their child gets along better with family members and 42.9% (n = 3) reported their child is better able to do the things they want to do (see Figure 211).

Figure 210.

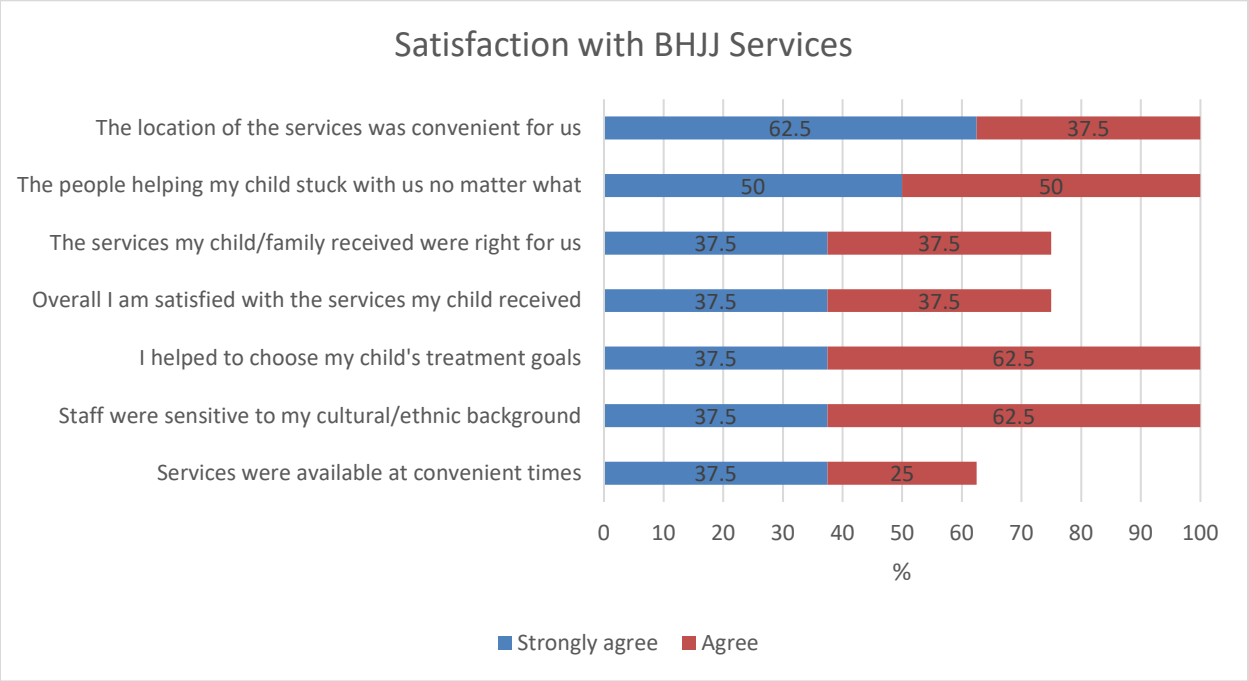
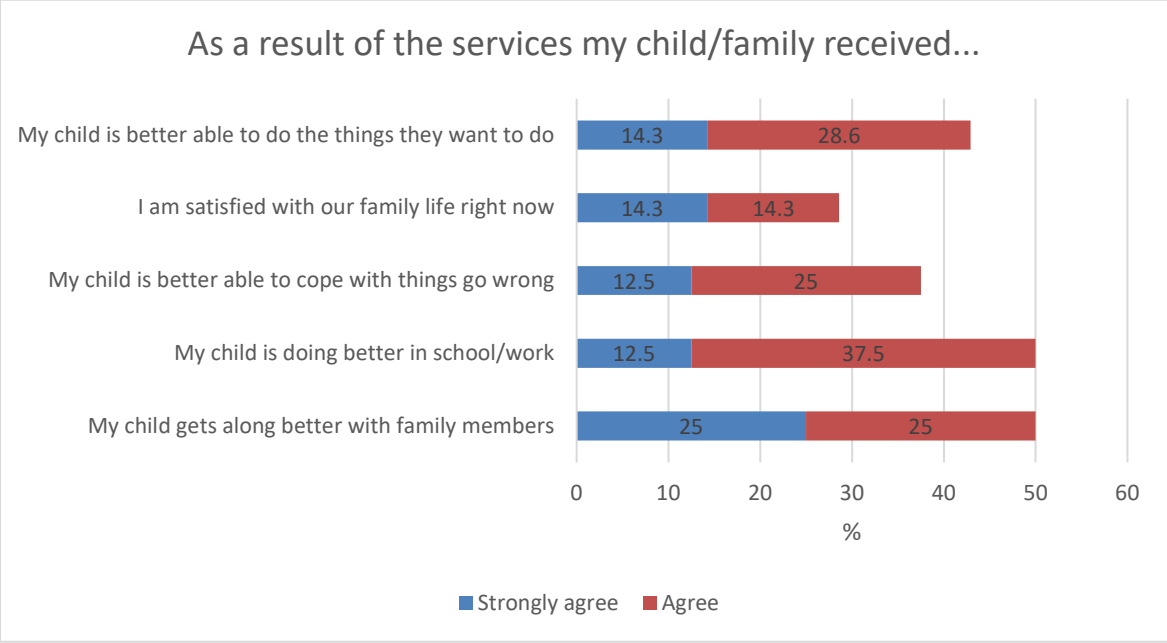


Figure 211.



Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve months prior to the end of the data collection period for inclusion in the analysis. Due to a small number of youth who terminated unsuccessfully, we were not able to separate out these data by completion status. These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 37.5% (n = 6) of BHJJ youth in Mahoning county enrolled between July 1, 2015 and June 30, 2019 had a misdemeanor charge, 6.3% (n = 1) had a felony charge, and 6.3% (n = 1) had been adjudicated delinquent in the 12 months prior to enrollment (see Table 269).

Table 269. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n =16)	31.3% (n = 5)	6.3% (n = 1)	6.3% (n = 1)
12 months (n = 16)	37.5% (n = 6)	6.3% (n = 1)	6.3% (n = 1)
18 months (n = 16)	37.5% (n = 6)	6.3% (n = 1)	6.3% (n = 1)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 270). In the 12 months after enrollment in BHJJ, 12.5% (n = 2) of participants were charged with at least one new misdemeanor and 25.0% (n = 4) were adjudicated delinquent. None of the youth were charged with a felony.

Table 270. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 16)	0.0% (n = 0)	0.0% (n = 0)	12.5% (n = 2)
12 months (n = 16)	12.5% (n = 2)	0.0% (n = 0)	25.0% (n = 4)
18 months (n = 15)	6.7% (n = 1)	0.0% (n = 0)	26.7% (n = 4)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 271). In the 12 months after termination from BHJJ, 14.3% (n = 1) of youth were charged with at least one new misdemeanor and 42.9% (n = 3) were adjudicated delinquent. None of the youth were charged with a felony.

Table 271. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 7)	14.3% (n = 1)	0.0% (n = 0)	42.9% (n = 9)
12 months (n = 7)	14.3% (n = 1)	0.0% (n = 0)	42.9% (n = 3)
18 months (n = 7)	14.3% (n = 1)	0.0% (n = 0)	57.1% (n = 4)

ODYS Commitments

None of the 16 youth who enrolled since July 1, 2015 were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ.

Lorain

Demographics

As of June 30, 2019, 154 youth were enrolled into the BHJJ program in Lorain County. The average age at enrollment was 16.3 years (SD=1.06). More males (70.1%, n = 108) than females (29.9%, n = 46) have been enrolled. White youth (52.9%, n = 81), Black youth (22.2%, n = 34) and Multiracial youth (14.4%, n = 22) comprised the majority of the total sample.

There were 45 new enrollments in Lorain County during the current reporting period (July 1, 2017 through June 30, 2019). The average age at enrollment was 16.2 (SD = 1.25). More males (82.2%, n = 37) than females (17.8%, n = 8), and more White youth (46.7%, n = 21) than Black youth (33.3%, n = 15). Twenty-four percent (24.4%, n = 11) of youth self-identified as Hispanic/Latinx.

Unless otherwise noted, the following sections describe data from the past four years of BHJJ programming from July 1, 2015 through June 30, 2019.

Custody Arrangement and Household Information

At intake, 63.0% of youth (n = 63) lived with their biological mother only, while 19.0% (n = 19) lived with two biological parents or one biological and one step/adoptive parent (see Table 272). Eighty-five percent (85.0%, n = 85) of BHJJ youth lived with at least one biological at enrollment.

Over eighty-eight percent (88.5%; n = 85) of the BHJJ caregivers had at least a high school diploma or GED, and 8.4% (n = 8) had a bachelor's degree or higher. Over eleven percent of caregivers (11.5%; n = 11) reported they did not graduate from high school (see Table 273).

Caregivers were asked to report their annual household income (see Table 274). The income range with the highest endorsement was less than $5,000 (20.2%, n = 20). Overall, 68.7% (n = 15) reported a family income of $24,999 or less. When examined by race, 47.1% (n = 8) of White families, 57.1% (n = 8) of Black families, and 50.0% (n = 1) of Multiracial families reported a household income of $14,999 or less. Table 274 displays the reported household income overall and by race.

Table 272. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	19.0% (n = 19)
Biological Mother Only	63.0% (n = 63)
Biological Father Only	3.0% (n = 3)
Adoptive Parent(s)	2.0% (n = 2)
Aunt/Uncle	4.0% (n = 4)
Grandparents	6.0% (n = 6)
Other	3.0% (n = 3)

Table 273. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	11.5% (n = 11)
High School Graduate or G.E.D.	41.7% (n = 40)
Some College or Associate Degree	38.6% (n = 37)
Bachelor's Degree	4.2% (n = 4)
More than a Bachelor's Degree	4.2% (n = 4)

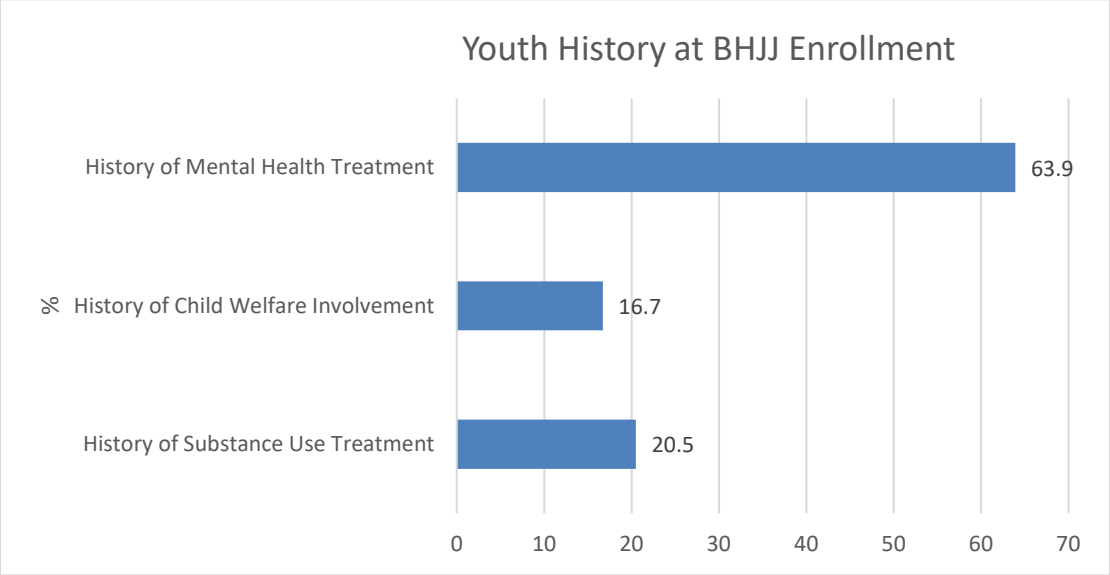
Table 274. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Black	Multiracial
Less than $5,000	20.2% (n = 20)	29.4% (n = 5)	7.1% (n = 1)	0
$5,000 - $9,999	6.1% (n = 6)	0	7.1% (n = 1)	50.0% (n = 2)
$10,000 - $14,999	17.2% (n = 17)	17.6% (n = 3)	42.9% (n = 6)	0
$15,000 - $19,999	10.1% (n = 10)	5.9% (n = 1)	0	0
$20,000 - $24,999	15.2% (n = 15)	17.6% (n = 3)	28.6% (n = 4)	0
$25,000 - $34,999	10.1% (n = 10)	5.9% (n = 1)	0	50.0% (n = 2)
$35,000 - $49,999	9.1% (n = 9)	17.6% (n = 3)	7.1% (n = 1)	0
$50,000 - $74,999	7.1% (n = 7)	0	7.1% (n = 1)	0
$75,000 or greater	5.0% (n = 5)	5.9% (n = 1)	0	0

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 Figure 212). These three items were new to the past biennium, therefore, data are only available for youth enrolled between July 1, 2017 and June 30, 2019. Over sixteen percent of the youth (16.7%, n = 6) had a history of child welfare involvement prior to BHJJ enrollment. Twenty percent (20.5%, n = 8) of youth had received substance use treatment in their lifetime prior to BHJJ enrollment and 63.9% (n = 23) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 212.



Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history. Chi-square analyses were conducted to test on each item to test for gender differences and significant differences are identified in Table 275. A significantly larger proportion of the caregivers of females reported lifetime histories of physical abuse, sexual abuse, talking about suicide, attempting suicide, exposure to domestic violence, and a family history of problems with substance abuse.

Caregivers reported that 25.7% (n = 9) of females and 7.6% (n = 5) of males had a history of being physically abused while 28.6% (n = 10) of females and 4.6% (n = 3) of males had a history of being sexual abused. Caregivers of 60.0% (n = 21) of females and 31.8% (n = 21) of males reported hearing the child talking about committing suicide and 36.4% (n = 12) of females and 16.9% (n = 11) of males had attempted suicide at least once. A majority of the caregivers of females (68.6%, n = 24) and half of the caregivers of males (50.0%, n = 33) reported a family history of depression. A majority of the caregivers of females (72.7%, n = 24) and nearly half of the caregivers of males (43.8%, n = 28) reported a family history of problems with substance use.

Table 275. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	25.7% (n = 9)*	7.6% (n = 5)
Has the child ever been sexually abused?	28.6% (n = 10)**	4.6% (n = 3)
Has the child ever run away?	50.0% (n = 17)	39.4% (n = 26)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	84.8% (n = 28)	84.4% (n = 54)
Has the child ever talked about committing suicide?	60.0% (n = 21)**	31.8% (n = 21)
Has the child ever attempted suicide?	36.4% (n = 12)*	16.9% (n = 11)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	54.3% (n = 19)*	30.3% (n = 20)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	68.6% (n = 24)	50.0% (n = 33)
Has anyone in the child's biological family had a mental illness, other than depression?	63.6% (n = 21)	51.6% (n = 33)
Has the child ever lived in a household in which someone was convicted of a crime?	56.3% (n = 18)	42.9% (n = 27)
Has anyone in the child's biological family had a drinking or drug problem?	72.7% (n = 24)**	43.8% (n = 28)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	28.6% (n = 10)	30.3% (n = 20)

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

Problems Leading to Service

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 substance use, abuse, dependence-related problems (100.0% and 97.1% respectively) (see Table 276). Chi-square analyses indicated females had significantly higher rates of problems related to depression and suicide. Males had significantly higher rates of hyperactive and attention-related problems.

Table 276. Problems Leading to Services

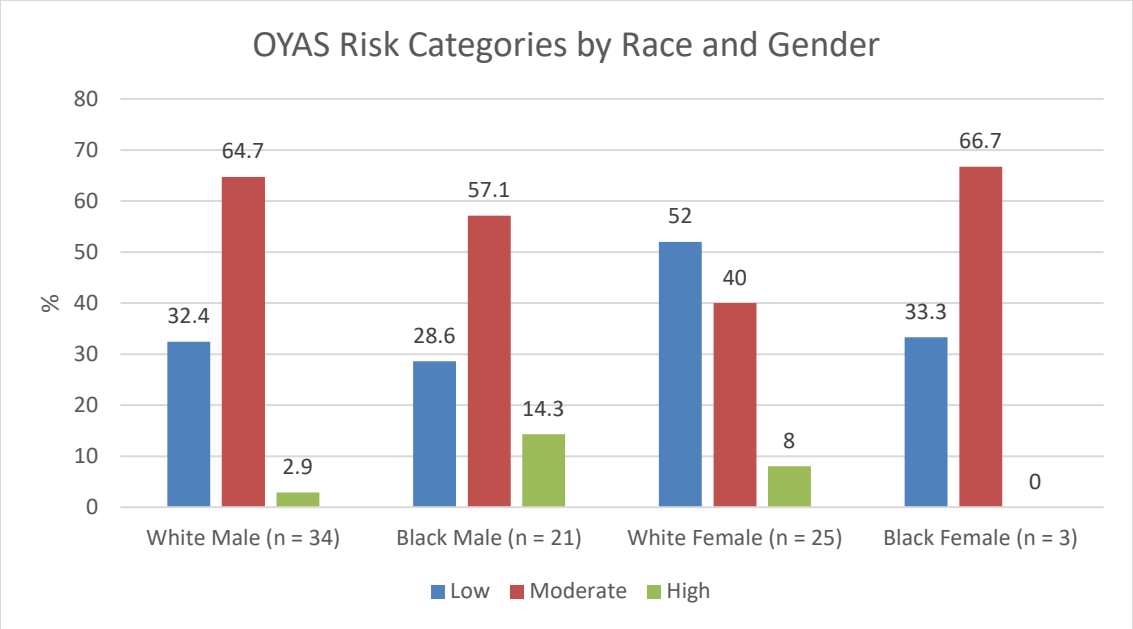
Problems Leading to Services	Females	Males
Adjustment-related problems	28.6% (n = 10)	13.4% (n = 9)
Anxiety-related problems	48.6% (n = 17)	43.3% (n = 29)
Conduct/delinquency-related problems	88.6% (n = 31)	91.0% (n = 61)
Depression-related problems	68.6% (n = 24)***	29.9% (n = 20)
Eating disorders	0	0
Hyperactive and attention-related problems	14.3% (n = 5)	35.8% (n = 24)*
Learning disabilities	5.7% (n = 2)	9.0% (n = 6)
Pervasive development disabilities	0	0
Psychotic behaviors	0	1.5% (n = 1)
School performance problems not related to learning disabilities	57.1% (n = 20)	65.7% (n = 44)
Specific developmental disabilities	0	1.5% (n = 1)
Substance use, abuse, dependence-related problems	100.0% (n = 28)	97.1% (n = 34)
Suicide-related problems	45.7% (n = 16)***	13.4% (n = 9)

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

Ohio Youth Assessment System

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 213 shows the distribution of OYAS risk categories for BHJJ youth by race and gender. In Lorain County, 2.9% (n = 1) of White males and 14.3% (n = 3) of Black males enrolled in the BHJJ program were identified as High risk on the OYAS, while 8.0% (n = 2) of White females and no Black females were identified as High risk.

Figure 213.



DSM Diagnoses

Workers were asked to report any DSM 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 diagnosis for females and males were Cannabis-related Disorders (see Table 277). Chi-square analysis indicated females were significantly more likely than males to be diagnosed with Alcohol-related Disorders and Depressive Disorders while males were significantly more likely than females to be diagnoses with Conduct Disorder.

Table 277. Most Common DSM Diagnoses

DSM Diagnosis	Females (n = 35)	Males (n = 67)
Adjustment Disorder	8.6% (n = 3)	7.5% (n = 5)
Alcohol-related Disorders	37.1% (n = 13)*	14.9% (n = 10)
Attention Deficit Hyperactivity Disorder	20.0% (n = 7)	35.8% (n = 24)
Bipolar Disorder	2.9% (n = 1)	1.5% (n = 1)
Cannabis-related Disorders	**97.1% (n = 34)**	**98.5% (n = 66)**
Conduct Disorder	0	14.9% (n = 10)*
Depressive Disorders	42.9% (n = 15)**	17.9% (n = 12)
Disruptive Behavior Disorder	0	3.0% (n = 2)
Unspecified Mood Disorder	11.4% (n = 4)	3.0% (n = 2)
Oppositional Defiant Disorder	25.7% (n = 9)	29.9% (n = 20)
Post-traumatic Stress Disorder	17.1% (n = 6)	6.0% (n = 4)
Unspecified Trauma and Stressor Related Disorder	5.7% (n = 2)	1.5% (n = 1)
Disruptive Mood Dysregulation Disorder	8.6% (n = 3)	7.5% (n = 5)
Co-Occurring Disorder	100% (n = 35)	100% (n = 67)

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

Educational Information

Several items focused on educational 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. The wording on some items (e.g. IEP at intake, attendance at intake) was changed from previous versions of the forms. For those items, we present data from only the past biennium (when the new forms were in use). Those items will have smaller sample sizes compared to items that have been consistent for the past four years.

Fifty-seven percent (56.6%, n = 56) of youth were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in BHJJ treatment BHJJ, 32.1% (n = 25) of the youth were expelled or suspended from school (a 43.3% decrease from intake to termination).

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, 90.9% (n = 30) of youth were currently attending school while at termination, 81.4% (n = 57) 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 278 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 279 displays this information based on completion status. At intake, 47.3% of youth were earning mostly A's and B's, and C's while at termination, 55.9% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 279). For example, at intake, 50.0% of youth who would go on to be unsuccessful completers and 48.2% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 28.6% of unsuccessful completers and 59.7% of successful completers received mostly A's, B's, or C's.

Table 278. Academic Performance

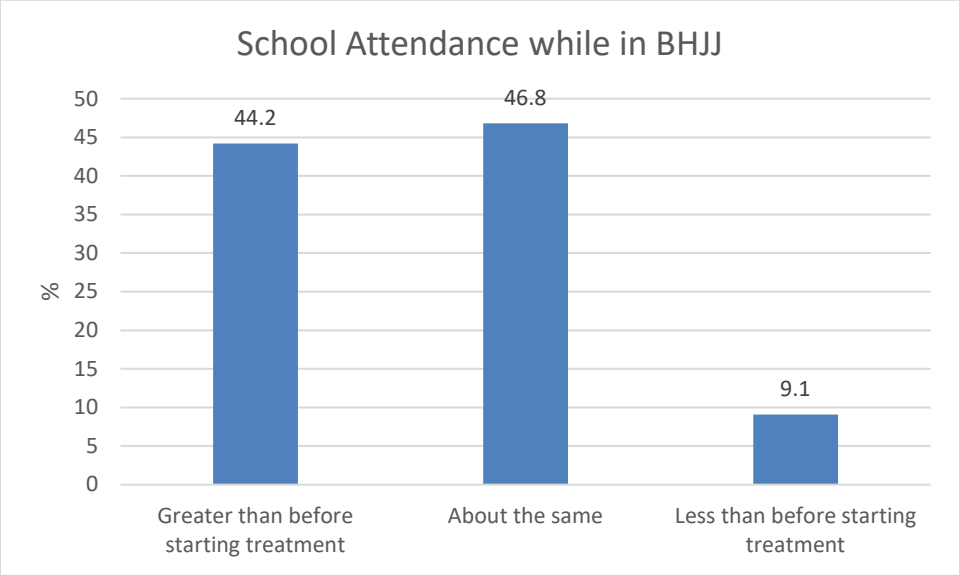
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	16.1% (n = 15)	20.8% (n = 16)
Mostly B's and C's	31.2% (n = 29)	35.1% (n = 27)
Mostly C's and D's	26.9% (n = 25)	11.7% (n = 9)
Mostly D's and F's	25.8% (n = 24)	32.5% (n = 25)

Table 279. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	6.3% (n = 1)	0	20.4% (n = 11)	24.6% (n = 14)
Mostly B's and C's	43.8% (n = 7)	28.6% (n = 4)	27.8% (n = 15)	35.1% (n = 20)
Mostly C's and D's	25.0% (n = 4)	14.3% (n = 2)	24.1% (n = 13)	10.5% (n = 6)
Mostly D's and F's	25.0% (n = 4)	57.1% (n = 8)	27.8% (n = 15)	29.8% (n = 17)

At termination, workers reported that 44.2% (n = 34) of youth were attending school more than before starting treatment and 46.8% (n = 36) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 214). At intake, 44.7% (n = 17) of youth attending school had Individualized Education Plans (IEPs) while at termination, 38.5% (n = 30) of the youth attending school had Individualized Education Plans (IEPs).

Figure 214.



Ohio Scales

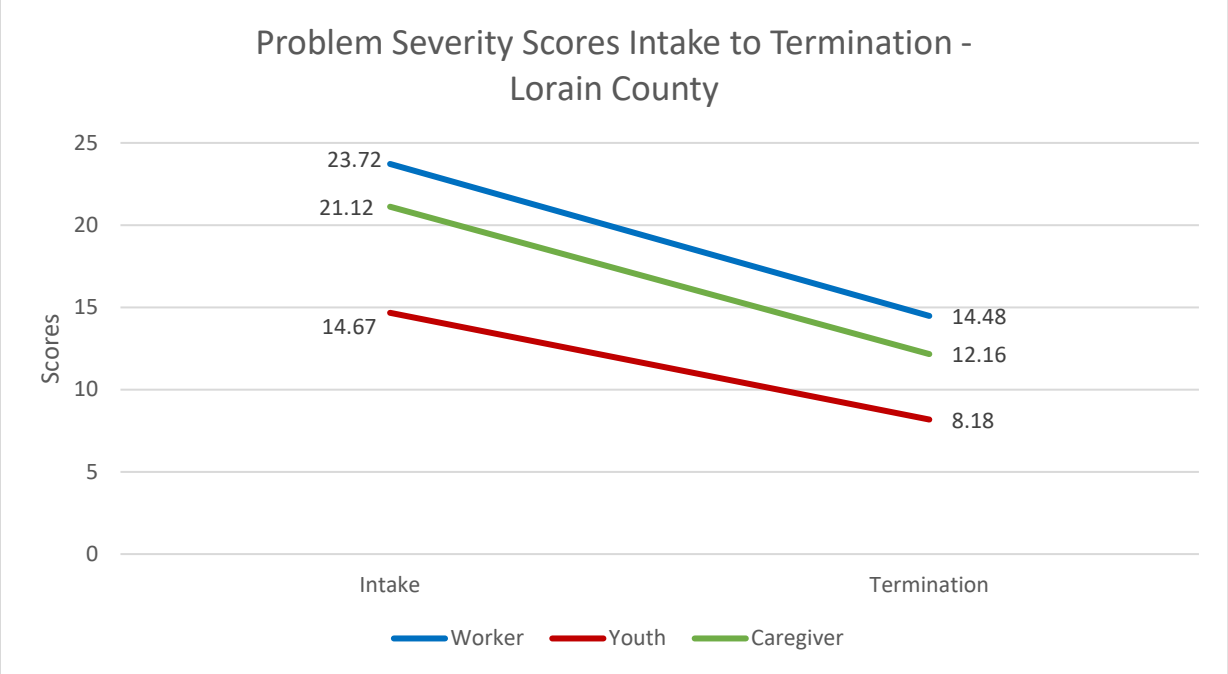
One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum of service, separate charts are included that display the means from intake to termination. Decreases in Problem Severity and increases in Functioning correspond to positive change.

All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Paired samples t-tests were used to compare Problem Severity scores at intake to Problem Severity scores at the other assessment periods. A paired samples t-test compares the means of two variables by computing the difference between the two variables for each case and testing to see if the average difference is significantly different from zero. In order for a case to be included in the analyses, the rater must have scores for both assessment periods. For example, a caregiver must supply scores for both the intake and three-month assessment period to be included in the paired samples t-test for that time point. If the caregiver only has an intake score, his or her data is not included in the analysis.

Problem Severity

Overall means for the Problem Severity scale by rater between intake and termination for Lorain County youth are presented in Figure 215.

Figure 215.



Worker Ratings

For workers, paired samples t-tests revealed significant improvements in Problem Severity at both measurement intervals compared to intake (see Table 280). Significant improvements were noted at three months: $t(57) = 2.37$, $p < .05$ with a small effect size; and at termination $t(72) = 6.23$, $p < .001$ with a moderate effect size.

Table 280. Paired Samples T-Tests for Problem Severity – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	23.00 (SD=11.29; n=58)	19.67 (SD=10.19; n=58)	2.37*	.31
Intake to Termination	23.08 (SD=12.39; n=73)	14.23 (SD=7.73; n=73)	6.23***	.73

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvement in Problem Severity from intake to termination $t(70) = 5.23$, $p < .001$ with a moderate effect size (see Table 281).

Table 281. Paired Samples T-Tests for Problem Severity – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	14.20 (SD=11.30; n=60)	12.32 (SD=11.37; n=60)	1.50	.19
Intake to Termination	14.90 (SD=11.58; n=71)	8.18 (SD=7.24; n=71)	5.23***	.62

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Problem Severity at both measurement intervals compared to intake (see Table 282). Significant improvements were noted at three months: $t(58) = 2.51$, $p < .05$ with a small effect size; and at termination $t(74) = 4.83$, $p < .001$ with a moderate effect size.

Table 282. Paired Samples T-Tests for Problem Severity – Caregiver

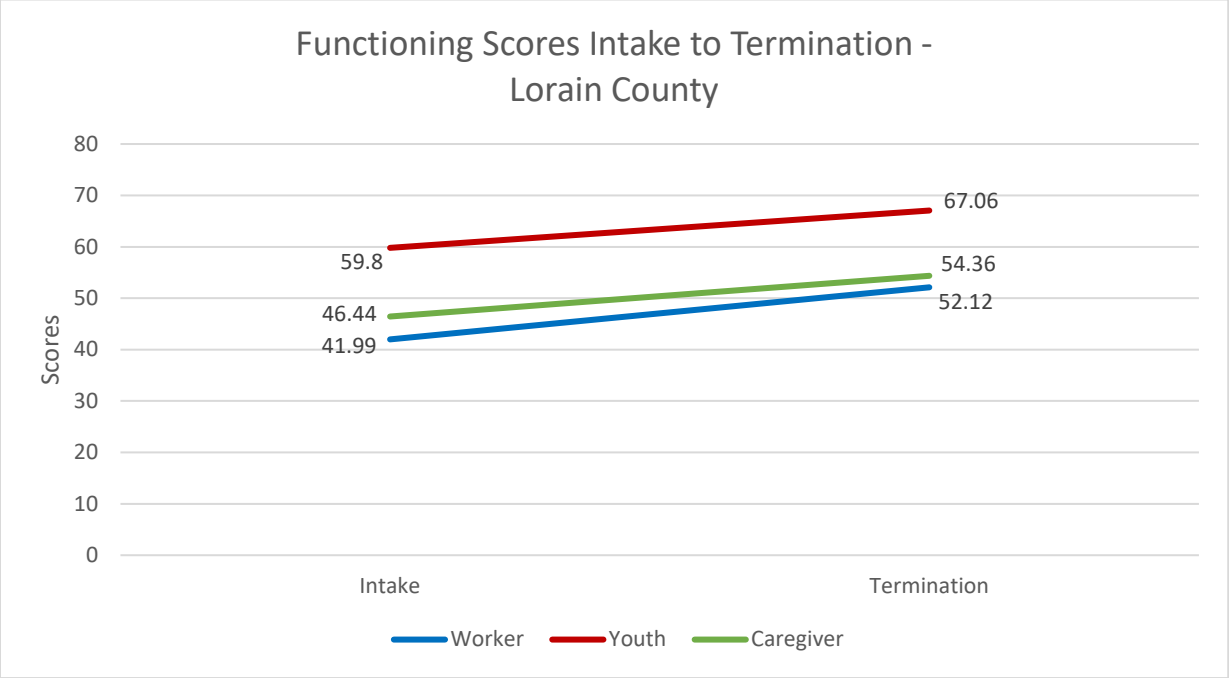
	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	20.27 (SD=15.60; n=59)	15.77 (SD=11.83; n=59)	2.51*	.33
Intake to Termination	20.67 (SD=16.53; n=75)	12.16 (SD=9.96; n=75)	4.83***	.56

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

Functioning Scores

Overall means for the Functioning scale by rater between intake and termination for Lorain County youth are presented in Figure 216.

Figure 216.



Worker Ratings

For workers, paired samples t-tests indicated significant improvement in Functioning scores from intake to three months and to termination (see Table 283). Workers reported statistically significant improvements in Functioning scores from intake to three months $t(58) = -2.14$, $p < .05$ with a small effect size; and from intake to termination $t(73) = -6.01$, $p < .001$ with a moderate effect size.

Table 283. Paired Samples T-Tests for Functioning Scores – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	42.74 (SD=11.69; n=59)	45.98 (SD=11.99; n=59)	-2.14*	.28
Intake to Termination	43.04 (SD=11.84; n=74)	52.26 (SD=11.15; n=74)	-6.01***	.70

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvement in functioning scores from intake to termination $t(70) = -4.86$, $p < .001$ with a moderate effect size (see Table 284).

Table 284. Paired Samples T-Tests for Functioning Scores – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	60.60 (SD=14.47; n=60)	61.97 (SD=11.35; n=60)	-.74	.10
Intake to Termination	59.90 (SD=14.04; n=71)	67.06 (SD=9.85; n=71)	-4.86***	.58

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvements in Functioning scores from intake to termination $t(74) = -3.96$, $p < .001$ with a small effect size (see Table 285).

Table 285. Paired Samples T-Tests for Functioning Scores – Caregiver

	Mean Time 1	Mean Time 2	*t*	d
Intake to Three Months	48.00 (SD=16.55; n=59)	50.24 (SD=16.82; n=59)	-.96	.12
Intake to Termination	47.65 (SD=17.44; n=75)	54.36 (SD=15.58; n=75)	-3.96***	.46

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

Violence and Delinquency Questionnaire

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey composed of three general domains: exposure to violence, violence perpetration, and peer delinquency. The VDQ is offered at intake and termination into the BHJJ program. At intake, each item prompts the youth to answer within the context of the past year. At termination, youth are directed to answer "since the last time you answered these questions".

This section will be divided into three distinct parts that examine the prevalence of violence exposure as either a victim or witness, self-reported delinquent behavior from intake to termination, and delinquent behavior by peers from intake to termination.
Table 286 provides the percentage of those who had experienced violence as either a victim or witness in the past year.

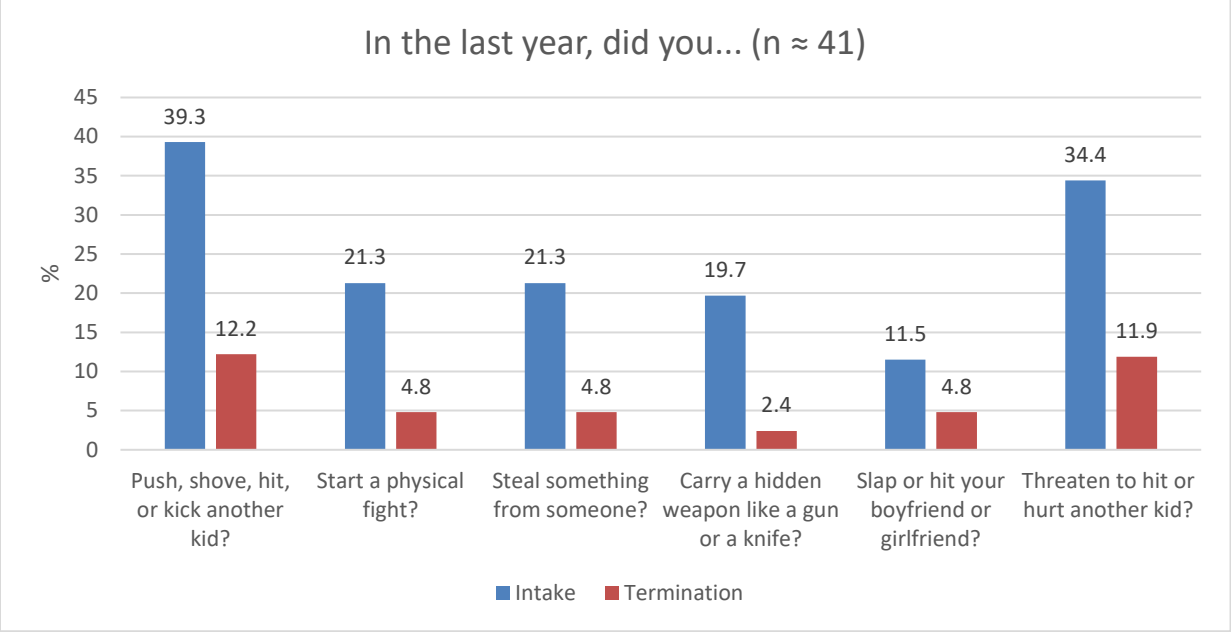
Table 286. Violence Exposure

	% Yes BHJJ Sample (n = 61)
In the last year, did someone threaten to hurt you when you thought they might really do it?	18.0%
In the last year, have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?	6.6%
In the last year, did a boyfriend or girlfriend or anyone you went on a date with slap or hit you?	14.8%
In the last year, did anyone steal anything from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?	44.3%
Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	11.5%
In the last year, did anyone hit or attack you WITHOUT using an object or weapon?	32.8%
In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?	23.0%
In the last year, did a grown-up touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?	3.3%
Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. In the last year, did another child or teen make you do sexual things?	0
In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	14.8%

In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	18.0%
In the last year, in real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt them?	32.8%
In the last year, was anyone close to you murdered, like a friend, neighbor, or someone in your family?	5.0%
In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	21.3%
Not including spanking on your bottom, did a grown-up in your life hit, beat, kick or physically hurt you in any way?	13.1%
When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. In the last year, were you neglected?	8.2%

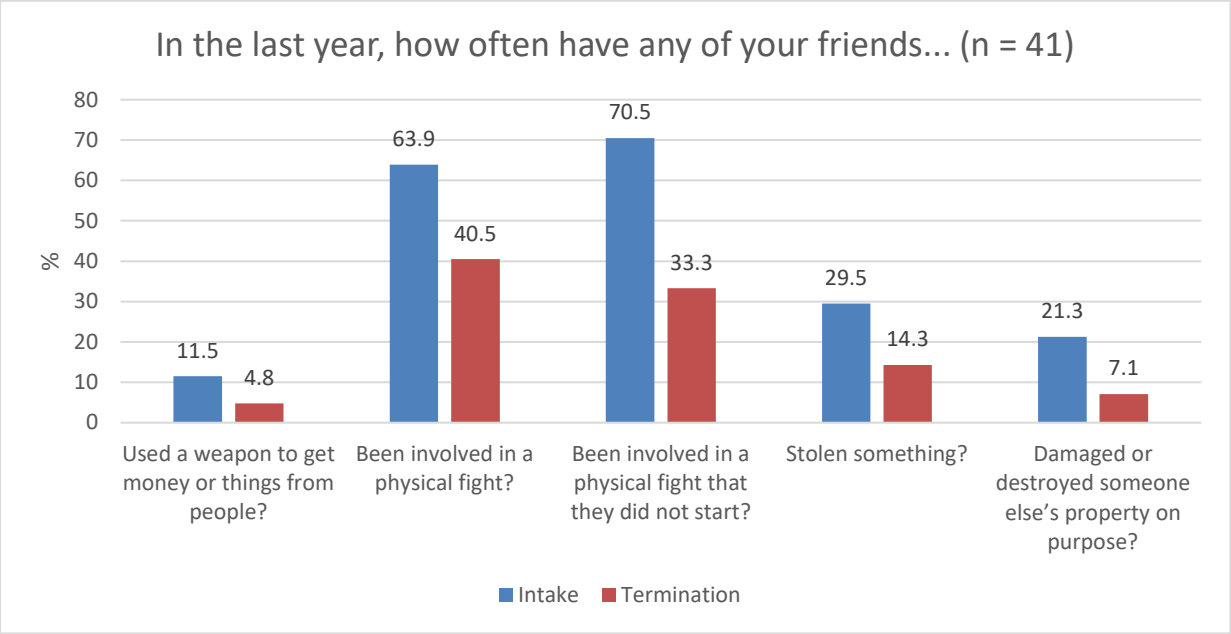
Delinquent behaviors were measured as self-report items of violent and weapon carrying behaviors as well as stealing. At intake, youth were asked how often they engaged in each behavior in the last year while at termination, youth were asked how often they engaged in the behavior since the last time they were asked. Figure 217 presents the percentage of youth who identified that they had engaged in each type of behavior at least once. Depending on the item, data were available for a range between 40 and 41 matched pairs (Mode = 41). McNemar's tests revealed statistically significant improvements from intake to termination for four items: push, shove, hit, or kick another kid, steal something from someone, carry a hidden weapon like a gun or a knife, and threaten to hit or hurt another kid.

Figure 217.



Self-reported peer delinquency was also measured at intake (how often in the last year) and at termination (how often since the last time they were asked). Figure 218 presents the percentage of youth who identified how often their friends had engaged in delinquent behavior at intake and termination. Depending on the item, data were available for 41 pairs. McNemar's tests revealed statistically significant improvements from intake to termination for two items: been involved in a physical fight, and been involved in a physical fight that they did not start.

Figure 218.



Resilience

As part of the 2017 - 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family.

Figure 219 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were “pretty much true” and “very much true”, we combined these responses. Generally, the majority of youth indicated high levels of endorsement for each one of these items. It is important to note, that the largest proportion of youth responding “not at all” or “a little true” were for two of the three items that measure empathy including “I feel bad when someone gets their feelings hurt” and “I try to understand how other people feel and think”.

Figure 219.

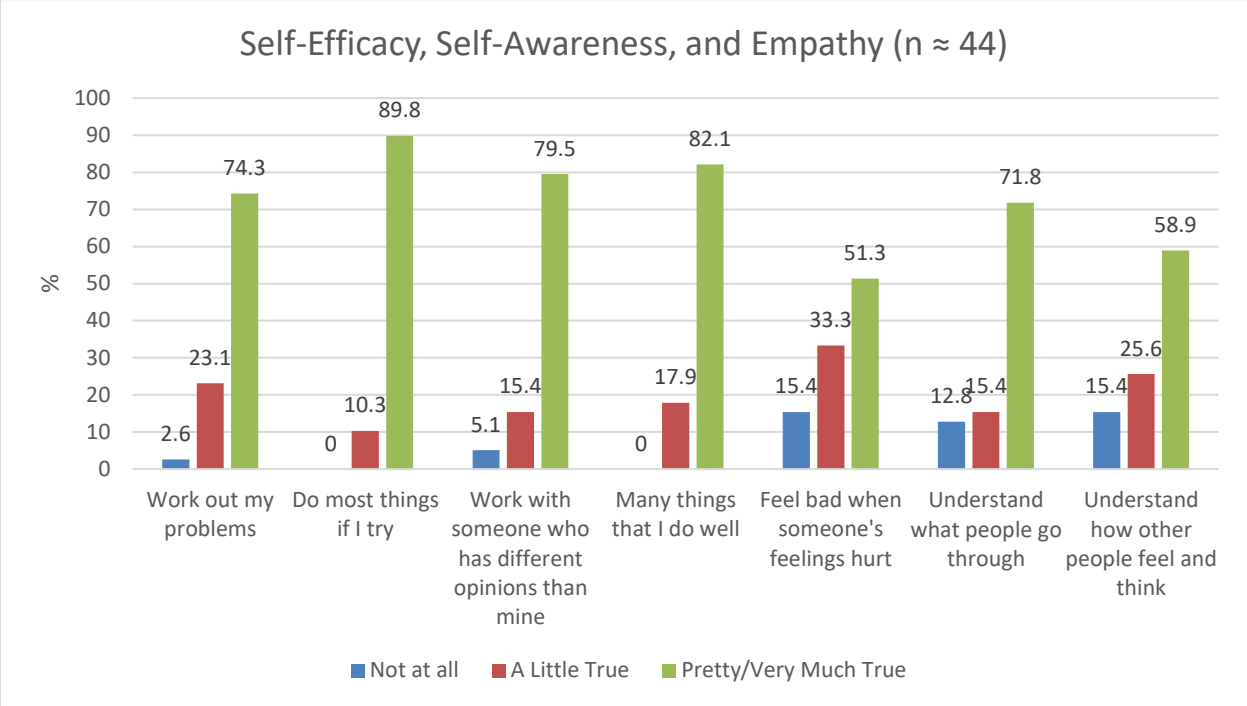


Figure 220 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. The majority of youth identified that each of the statements were either pretty much or very much true.

Figure 220.

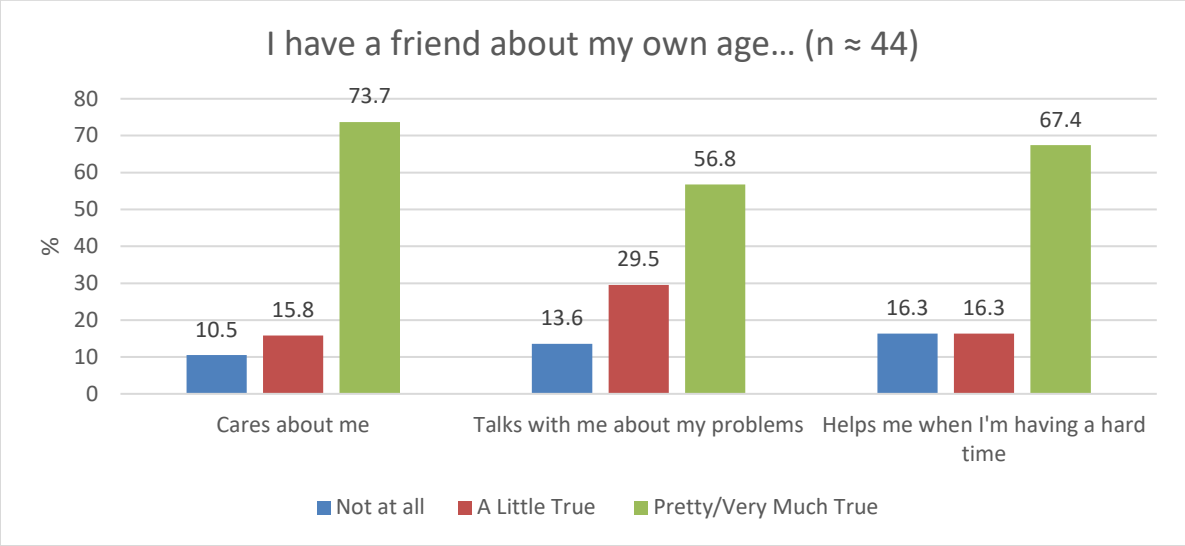
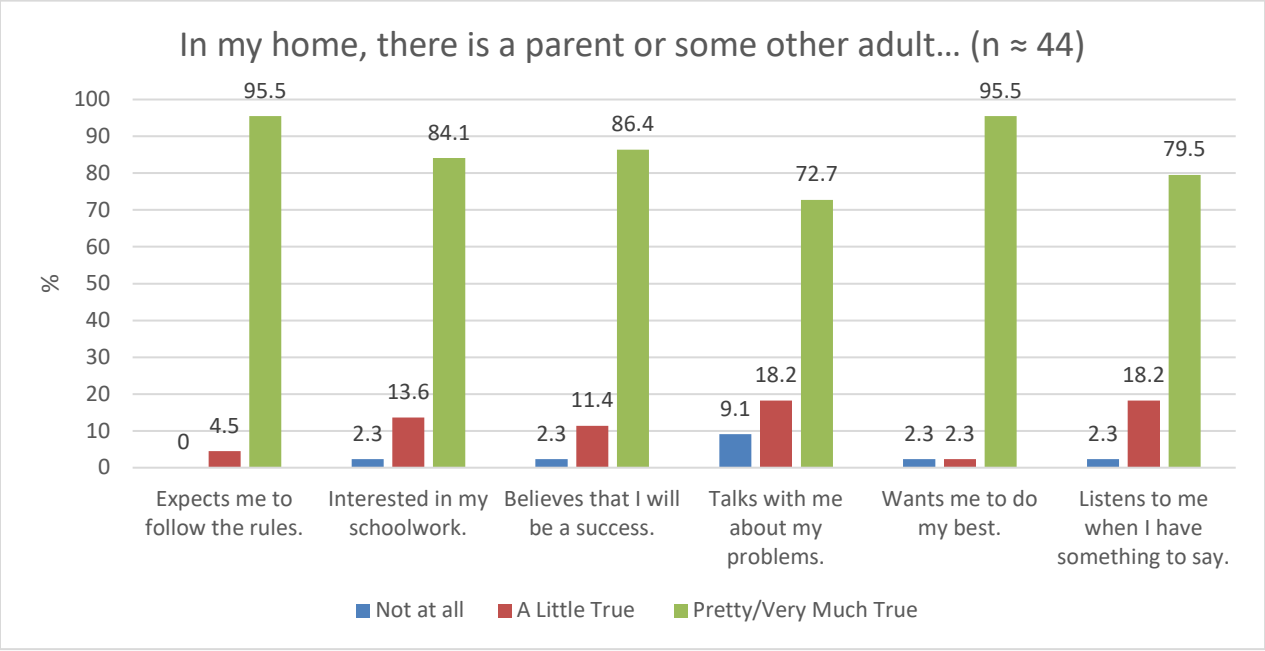


Figure 221 shows intake data on parental or support from other adults in their house. The majority of youth indicated that each of the statements were either pretty much or very much true.

Figure 221.



In addition to intake data, Figure 222 through Figure 224 show the proportion of youth who identified that each of the statements were either pretty much or very much true from intake to termination. Due to sample size restrictions, McNemar's tests were not conducted. Figure 222 shows differences from intake to termination for the items measuring self-efficacy, self-awareness, and empathy. Youth exhibited an improvement from intake to termination in each of the items.

Figure 222.

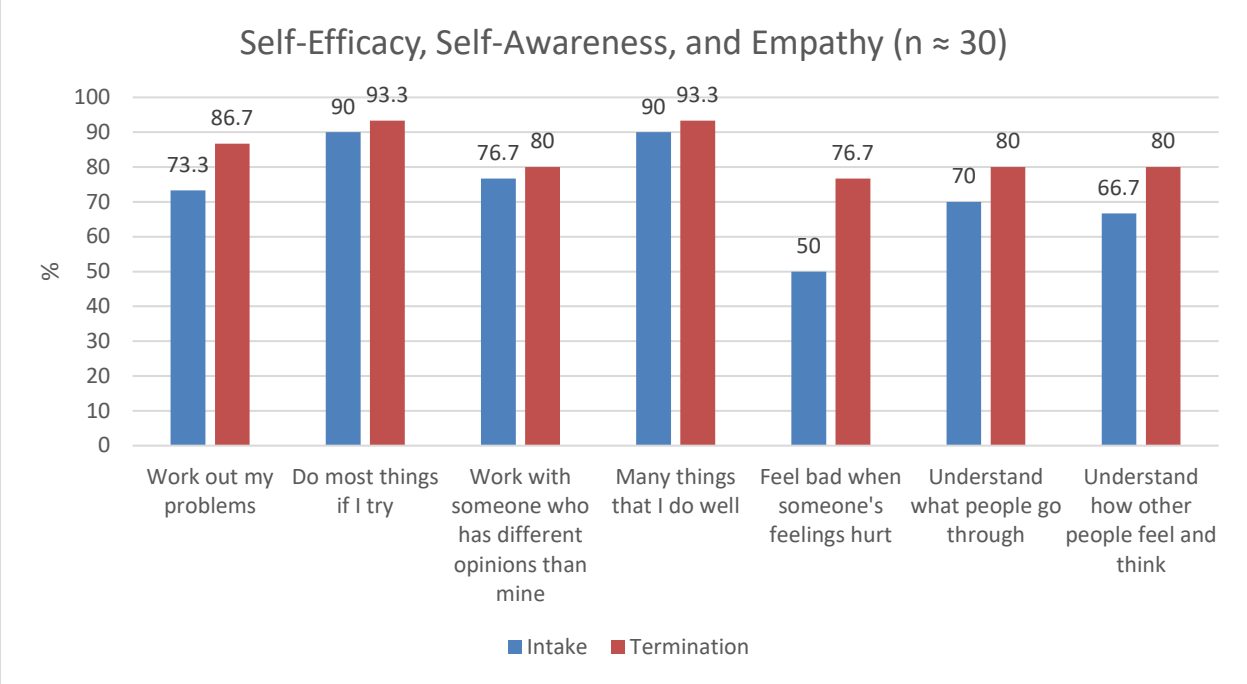


Figure 223 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring peer support. For each of the items, the proportion of positive responses either stayed the same or improved from intake to termination.

Figure 223.

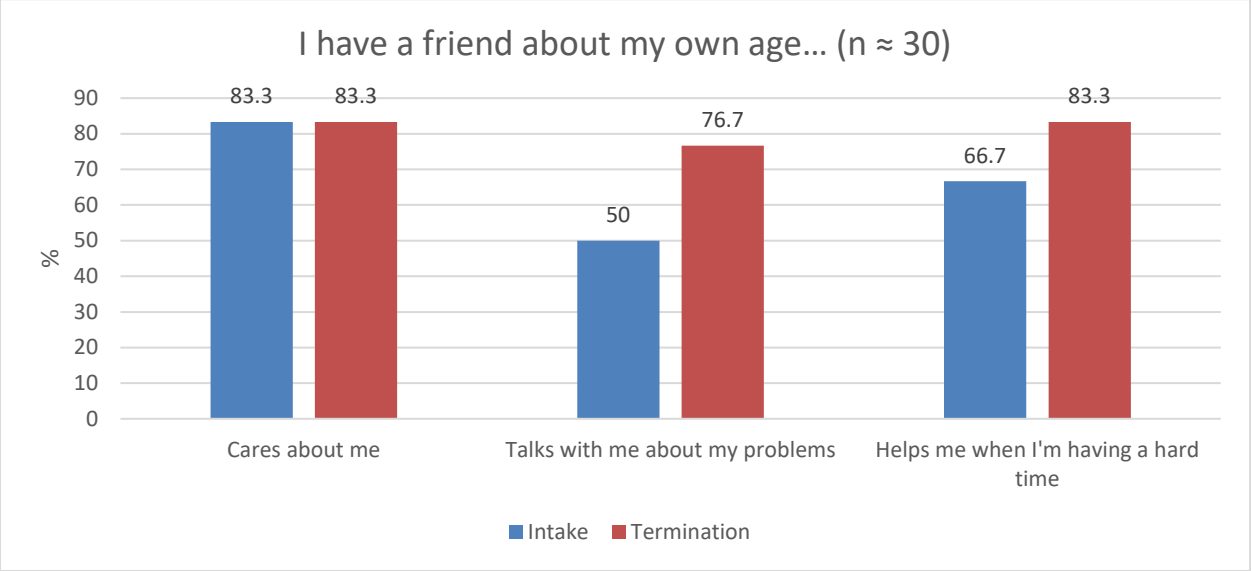
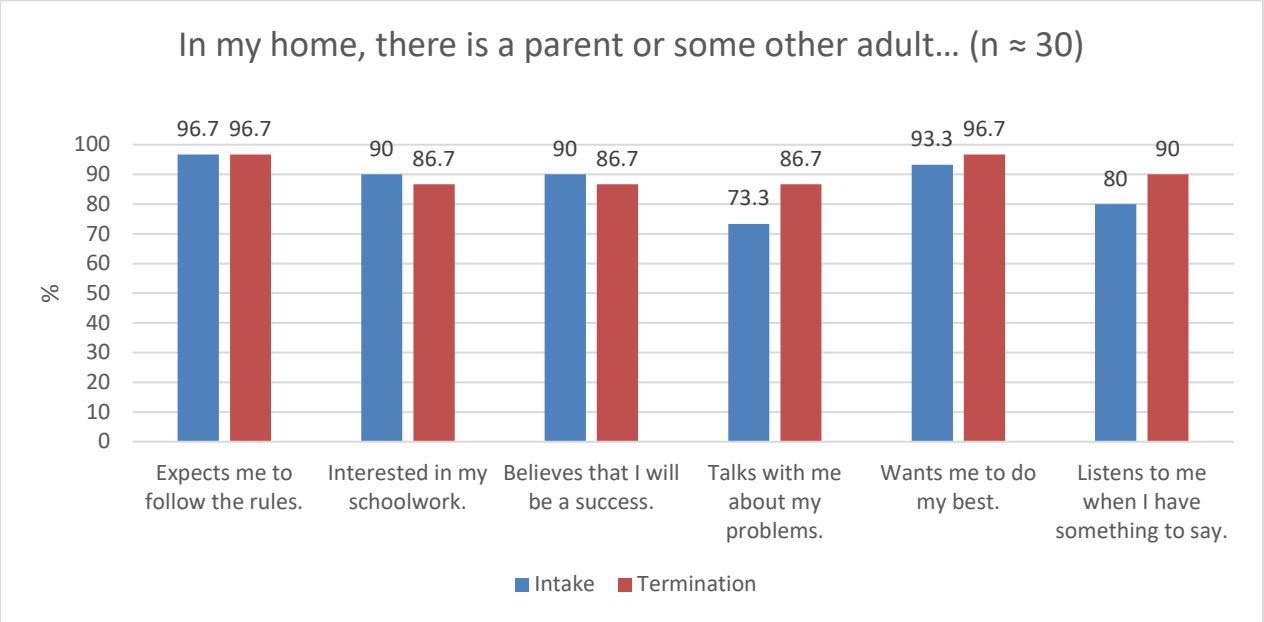


Figure 224 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring parental support or support from other adults in the home. The proportion of positive responses for two items, “interested in my schoolwork” and “believes that I will be a success” declined slightly from intake to termination.

Figure 224.



TSCC

The TSCC was administered at intake and termination from BHJJ. Paired-samples t-tests were conducted to show whether means at intake and termination on each TSCC subscale differed significantly. Data were analyzed separately for females (see Figure 225) and males (see Figure 226) who had completed the TSCC at both intake and termination in Lorain County.

Research has found that females consistently report more trauma symptoms than males (Singer et al., 1995). We examined trauma symptoms for females and males in the BHJJ sample. Consistent with previous research, BHJJ females in Lorain County reported higher scores on several trauma symptom subscales than males. For example, at intake, the average score on the Posttraumatic Stress domain was 7.39 for females and 4.95 for males. Paired samples t-tests revealed significant improvements on the Depression domain for females and every domain for males (see Table 287 and Table 288).

Table 287. TSCC Subscales from Intake to Termination among Females

Females	Intake	Termination	t	d
Anxiety	4.72 (SD = 4.40; n = 18)	2.94 (SD = 2.60; n = 18)	2.00	.47
Depression	7.33 (SD = 6.62; n = 18)	3.78 (SD = 3.46; n = 18)	2.49*	.59
Anger	5.61 (SD = 6.30; n = 18)	4.67 (SD = 4.34; n = 18)	.77	.18
Posttraumatic Stress	7.39 (SD = 7.47; n = 18)	4.39 (SD = 3.90; n = 18)	1.83	.43
Dissociation	6.00 (SD = 6.01; n = 18)	4.06 (SD = 3.40; n = 18)	1.26	.30
Sexual Concerns	2.33 (SD = 3.34; n = 18)	.94 (SD = 1.63; n = 18)	1.58	.37

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

Figure 225.

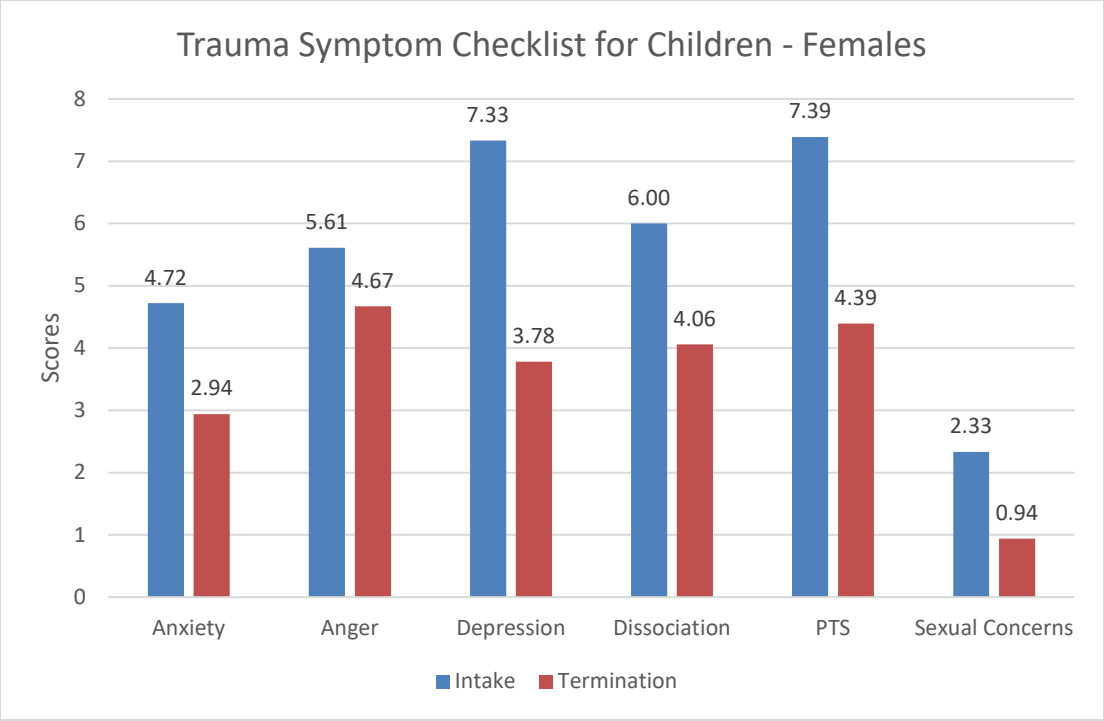
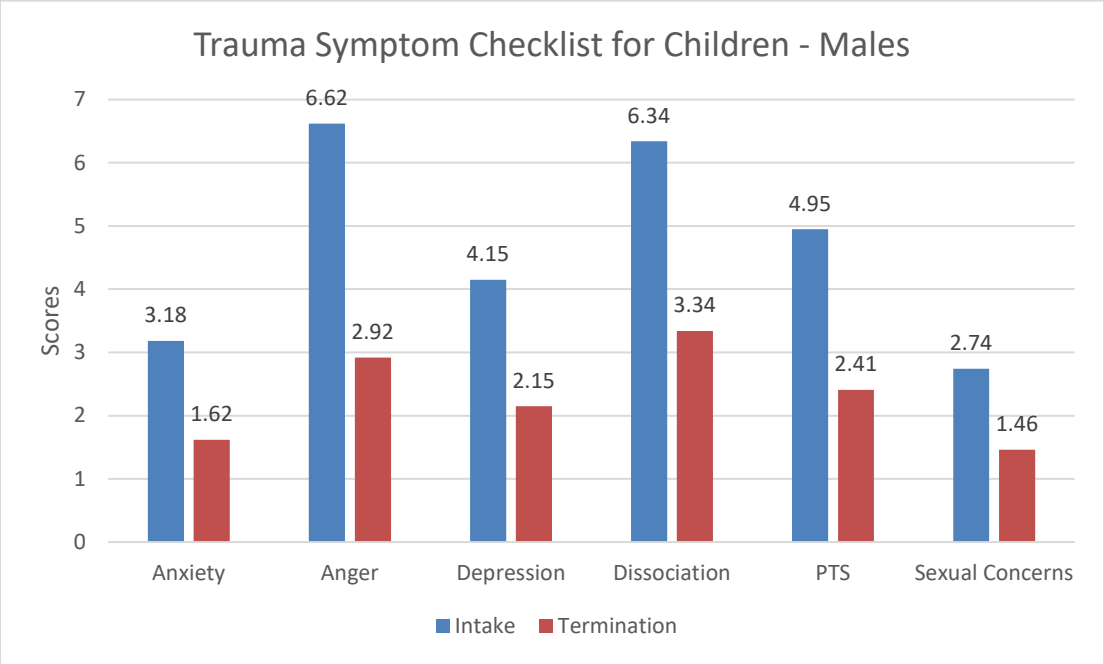


Table 288. TSCC Subscales from Intake to Termination for Males

Males	Intake	Termination	t	d
Anxiety	3.18 (SD = 2.98; n = 39)	1.62 (SD = 2.26; n = 39)	3.63**	.58
Depression	4.15 (SD = 4.71; n = 39)	2.15 (SD = 2.80; n = 39)	2.75**	.44
Anger	6.62 (SD = 5.48; n = 39)	2.92 (SD = 3.14; n = 39)	4.12***	.66
Posttraumatic Stress	4.95 (SD = 5.01; n = 39)	2.41 (SD = 2.96; n = 39)	3.23**	.52
Dissociation	6.34 (SD = 5.57; n = 39)	3.34 (SD = 3.91; n = 39)	3.92***	.64
Sexual Concerns	2.74 (SD = 3.25; n = 39)	1.46 (SD = 2.19; n = 39)	2.83**	.45

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

Figure 226.



Substance Use Survey

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 289 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use in Lorain County. Alcohol, tobacco, cannabis, and caffeine were the most commonly used substances.

Table 289. Self-Reported Substance Use at Intake – Lorain County

	% Ever Used	Age of First Use
Alcohol	70.5% (n = 31)	13.45 (SD = 3.19)
Tobacco	62.8% (n = 27)	13.00 (SD = 2.00)
Cannabis	95.5% (n = 42)	13.13 (SD = 2.33)
Hallucinogens	9.1% (n = 4)	15.50 (SD = 1.29)
Inhalants	2.3% (n = 1)	16.00[a]
Opioids	9.1% (n = 4)	14.75 (SD = 1.26)
Sedatives	11.4% (n = 5)	15.80 (SD = 0.84)
Caffeine	52.3% (n = 23)	11.53 (SD = 3.24)
Stimulants	7.0% (n = 3)	16.00 (SD = 1.00)
Over the counter medications	14.0% (n = 6)	14.67 (SD = 1.21)
Other prescription drugs	9.3% (n = 4)	11.00 (SD = 3.83)
Herbs/Flowers	2.3% (n = 1)	

[a] No Standard Deviations are calculated.

Thirty-Day Substance Use

If youth reported any lifetime use, they were also asked the number of days out of the past 30 in which had used each substance. Figure 227 shows the past 30-day use from intake to termination expressed as the average number of days for each of the 4 most commonly reported substances (alcohol, tobacco, marijuana, and caffeine). The data here are restricted to the youth who had reported having ever used each of the four substances. This restriction resulted in 7 youth who reported alcohol use, 13 youth who reported tobacco use, 18 youth who reported marijuana use, and 6 youth who reported caffeine use. For three of the four substances, the average number of days in which the youth used each of the four substances declined from intake to termination. The average number of days in which reported caffeine use increased slightly. None of these differences were statistically significant, in part due to a low number of responses.

Figure 227.

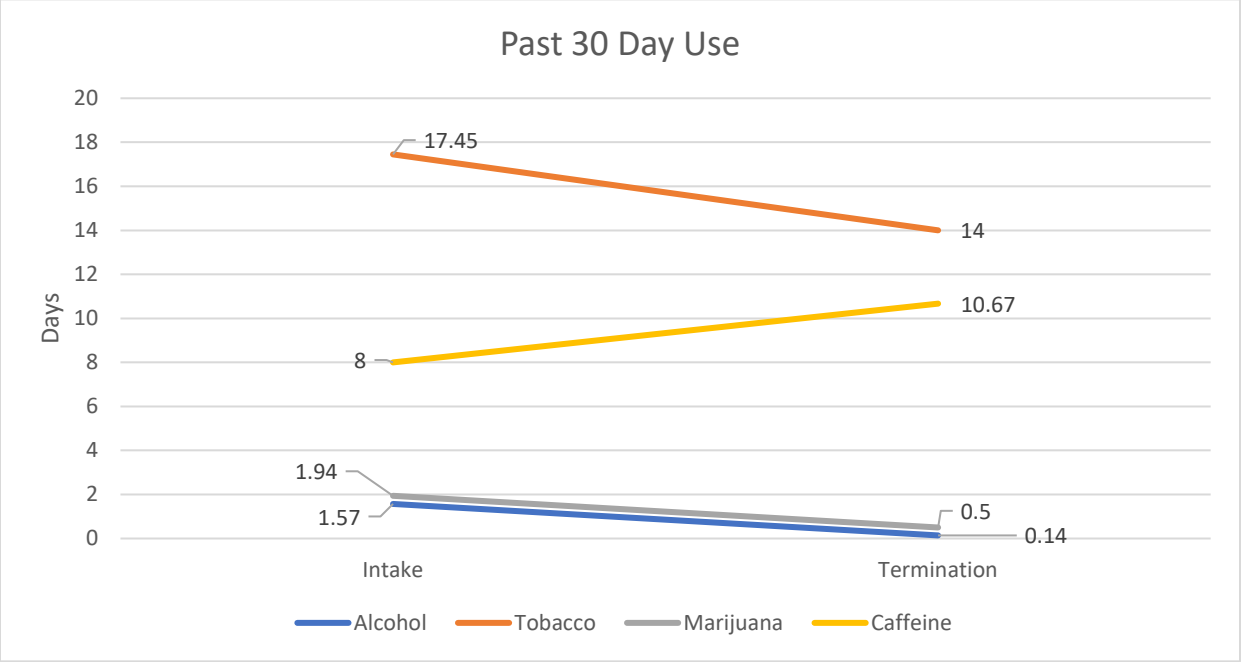
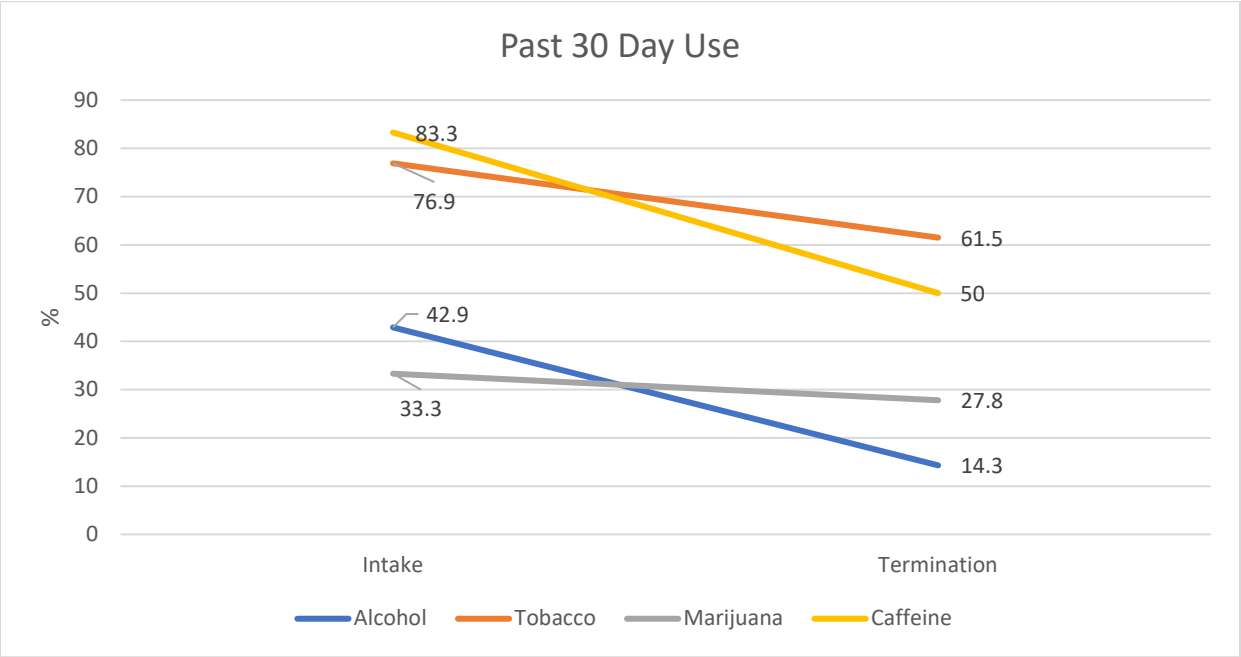


Figure 228 reports the proportion of youth who reported having used any of the four substances at all in the past 30 days. For each of the four most commonly reported substances, the proportion of youth who had reported past 30-day use declined. None of these differences were statistically significant.

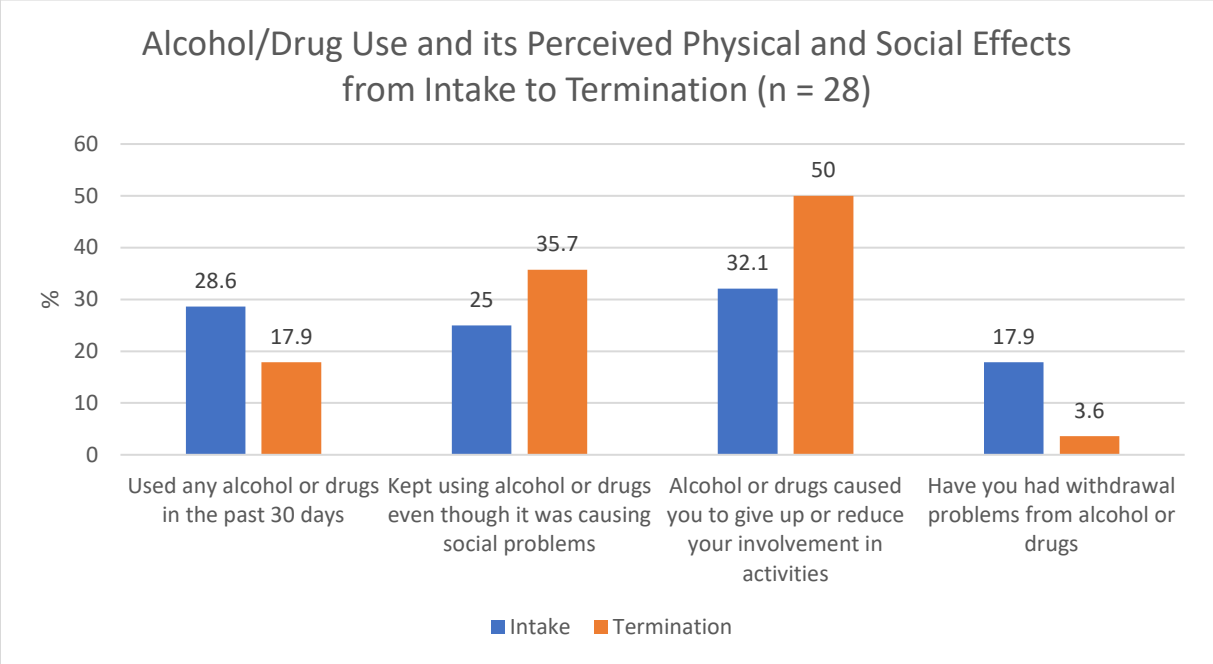
Figure 228.



In addition to questions pertaining to the use of specific substances, youth were asked questions around general alcohol/drug use and its perceived effects on physical health and social functioning. The proportion of youth who indicated that they had used any alcohol or drugs in the past 30 days decreased from 28.6% at intake to 17.9% at termination. It is important to note here that the percentage of youth who indicated that they had used in the past 30 days in this more general question seems lower than the percentage who indicated past 30-day use in the questions that asked about specific substances. Percentages in Figure 229 included only those who had indicated they had ever used the specific substance. Further, we suspect that when asked a general question about alcohol or drugs, many of the youth may not consider a substance to be a drug and therefore may answer no to a general question about alcohol/drugs.

From intake to termination, the proportion of youth who indicated that they had continued to use alcohol/drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people at least sometimes and the proportion of youth who indicated that alcohol/drugs caused them to give up or reduce involvement in activities at work, school, home, and social events increased from intake to termination. The proportion of those who indicated experiencing withdrawal problems from alcohol or drugs decreased from intake to termination. While none of these differences were statistically significant, it is likely a function of low cell sizes.

Figure 229.



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.

Between July 1, 2015 and June 30, 2019, there have been 82 youth terminated from the BHJJ program in Lorain County. Seventy-eight percent (78.0%, n = 64) of the youth terminated from the BHJJ program were identified as successful treatment completers. Nearly four percent (3.7%, n = 1) were terminated from the program due to some type of incarceration. Table 290 presents all of the reasons for termination from BHJJ and displays reasons for termination for White and Black participants.

Table 290. Reasons for Termination from BHJJ

Termination Reason	All Youth Enrolled between July 2015 and June 2019	White Youth Enrolled between July 2015 and June 2019	Black Youth Enrolled between July 2015 and June 2019
Successfully Completed Services	78.0% (n = 64)	85.7% (n = 36)	55.6% (n = 10)
Client Did Not Return/Rejected Services	2.4% (n = 2)	0	11.1% (n = 2)
Out of Home Placement	6.1% (n = 5)	7.1% (n = 3)	11.1% (n = 2)
Client/Family Moved	2.4% (n = 2)	0	5.6% (n = 1)
Client Withdrawn	0	0	0
Client AWOL	3.7% (n = 3)	2.4% (n = 1)	5.6% (n = 1)
Client Incarcerated	3.7% (n = 3)	0	5.6% (n = 1)
Other	3.7% (n = 3)	4.8% (n = 2)	5.6% (n = 1)

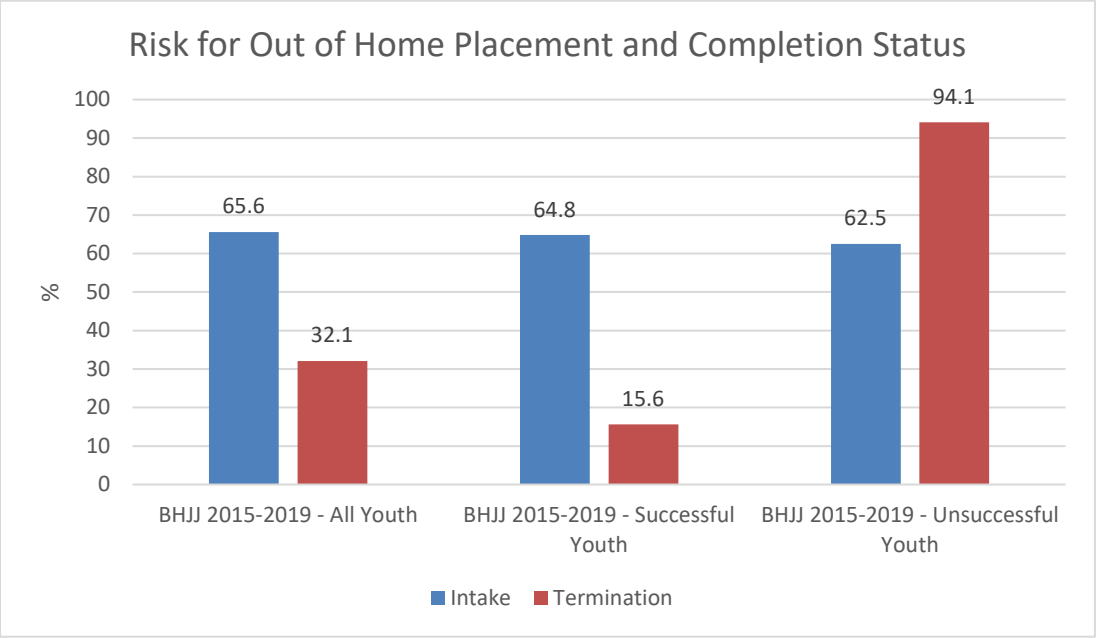
Average Length of Stay

Since the start of BHJJ, the average length of stay (ALOS) in the program was 146.7 days. For youth identified as successful treatment completers, the ALOS was 153.9 days while for unsuccessful treatment completers, the ALOS was 123.8 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, 65.6% of the youth (n = 63) were at risk for out of home placement. At termination, 32.1% (n = 26) of youth were at risk for out of home placement (see Figure 230). Of those youth who successfully completed BHJJ treatment, 15.6% (n = 10) were at risk for out of home placement at termination while 94.1% (n = 16) of youth who completed unsuccessfully were at risk for out of home placement (see Figure 230).

Figure 230.



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 services through BHJJ. Workers reported that police contacts had been reduced for 80.5% (n = 66) of the youth and had stayed the same for 17.1% (n= 14) of the youth, and increased for 2.4% of youth (n = 2).

YSSF

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the services they received through the BHJJ program in Lorain County as well as how services impacted their children and family. At termination from the BHJJ program, 94.7% (n =72) of caregivers either strongly agreed or agreed that the BHJJ staff were sensitive to their cultural/ethnic background and 98.7% (n =75) either strongly agreed or agreed that the location of the services was convenient (see Figure 231). Seventy-nine percent (79.3%, n = 61) of caregivers reported that as a result of the services their child/family received, their child gets along better with family members and 71.5% (n = 55) reported their child is better able to do the things they want to do (see Figure 232).

Figure 231.

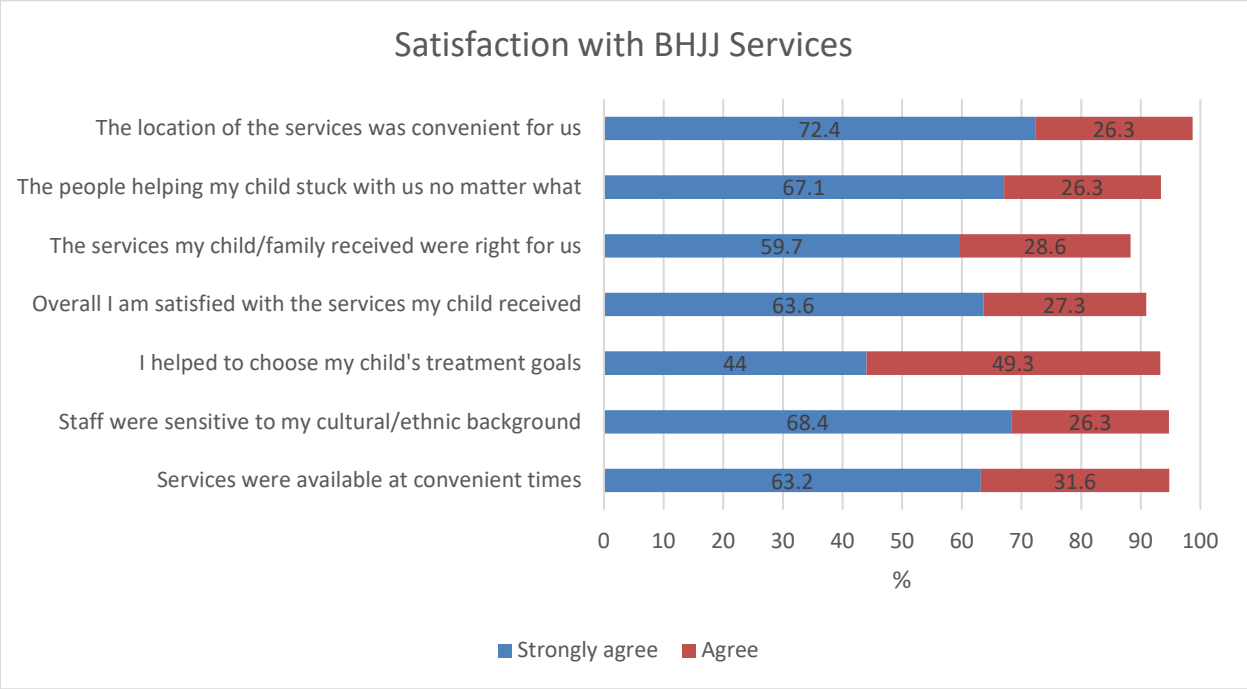
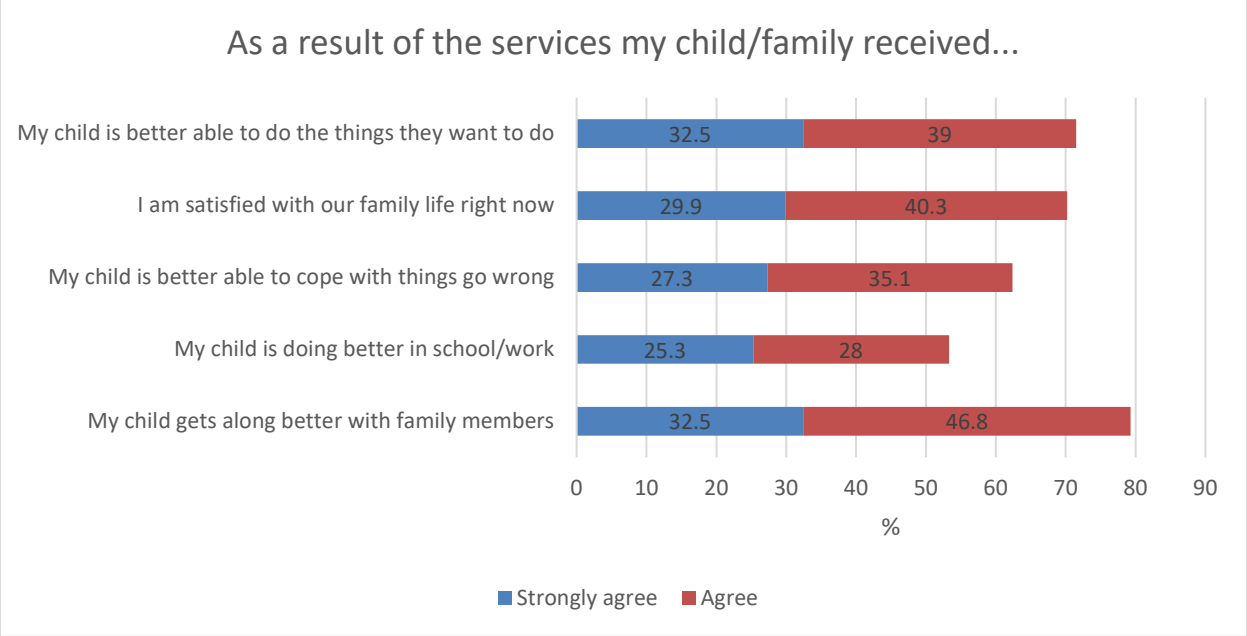


Figure 232.



Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve months prior to the end of the data collection period for inclusion in the analysis. These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 70.6% (n = 72) of BHJJ youth in Lorain county enrolled between July 1, 2015 and June 30, 2019 had either a misdemeanor charge, 24.5% (n = 25) had a felony charge, and 91.2% (n = 93) had been adjudicated delinquent in the 12 months prior to enrollment (see Table 291). With some notable exceptions, previous juvenile court information was similar for youth regardless of their completion status (successful vs. unsuccessful). In the 12 months prior to enrollment in BHJJ, 91.2% (n = 520) of successful completers and 94.4% (n = 17) of unsuccessful completers were adjudicated delinquent (see

Table 292 and Table 293). Chi-square analyses revealed no statistically significant differences based on completion status.

Table 291. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 102)	43.1% (n = 44)	11.8% (n = 12)	80.4% (n = 82)
12 months (n = 102)	70.6% (n = 72)	24.5% (n = 25)	91.2% (n = 93)
18 months (n = 102)	76.5% (n = 78)	30.4% (n = 31)	95.1% (n = 97)

Table 292. Charges Prior to BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 57)	49.1% (n = 28)	14.0% (n = 8)	80.7% (n = 46)
12 months (n = 57)	71.9% (n = 41)	26.3% (n = 15)	91.2% (n = 52)
18 months (n = 57)	75.4% (n = 43)	33.3% (n = 19)	94.7% (n = 54)

Table 293. Charges Prior to BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 18)	33.3% (n = 6)	16.7% (n = 3)	83.3% (n = 15)
12 months (n = 18)	72.2% (n = 13)	38.9% (n = 7)	94.4% (n = 17)
18 months (n = 18)	77.8% (n = 14)	38.9% (n = 7)	94.4% (n = 17)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 294). In the 12 months after enrollment in BHJJ, 19.1% (n = 13) of participants were charged with at least one new misdemeanor and 10.3% (n = 7) were charged with at least one new felony. Slightly less than forty percent (39.7%; n = 27) of the youth were adjudicated delinquent in the 12 months after their enrollment in BHJJ.

Table 294. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 89)	12.4% (n = 11)	5.6% (n = 5)	25.8% (n = 23)
12 months (n = 68)	19.1% (n = 13)	10.3% (n = 7)	39.7% (n = 27)
18 months (n = 56)	21.4% (n = 12)	14.3% (n = 8)	44.6% (n = 25)

In the 12 months after enrollment in BHJJ, 13.5% (n = 5) of successful completers were charged with at least one new misdemeanor, 5.4% (n = 2) were charged with at least one new felony, and 35.1% (n = 13) were adjudicated delinquent (see Table 295). Of the youth who completed unsuccessfully, 30.8% (n = 4) were charged with at least one new misdemeanor, 30.8% (n = 4) were charged with at least one new felony, and 46.2% (n = 6) were adjudicated delinquent in the 12 months after their enrollment in BHJJ (see Table 296). Chi-square analyses revealed that **a significantly higher percentage of unsuccessful completers were charged with at least one misdemeanor in the 6 months after intake and at least one felony in the 6 and 12 months after enrollment.**

Table 295. Recidivism after BHJJ Enrollment for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 51)	5.9% (n = 3)	2.0% (n = 1)	21.6% (n = 11)
12 months (n = 37)	13.5% (n = 5)	5.4% (n = 2)	35.1% (n = 13)
18 months (n = 33)	21.2% (n = 7)	15.2% (n = 5)	45.5% (n = 15)

Table 296. Recidivism after BHJJ Enrollment for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 16)	31.3% (n = 5)	25.0% (n = 4)	37.5% (n = 6)
12 months (n = 13)	30.8% (n = 4)	30.8% (n = 4)	46.2% (n = 6)
18 months (n = 9)	22.2% (n = 2)	22.2% (n = 2)	44.4% (n = 4)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 297). In the 12 months after termination from BHJJ, 18.2% (n = 8) of youth were charged with at least one new misdemeanor and 13.6% (n = 6) were charged with at least one new felony, and 25.0% (n = 11) were adjudicated delinquent.

Table 297. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 53)	13.2% (n = 7)	7.5% (n = 4)	13.2% (n = 7)
12 months (n = 44)	18.2% (n = 8)	13.6% (n = 6)	25.0% (n = 11)
18 months (n = 30)	16.7% (n = 5)	20.0% (n = 6)	36.7% (n = 11)

In the 12 months following their termination from BHJJ, 17.6% (n = 6) of successful completers were charged with at least one new misdemeanor, 11.8% (n = 4) were charged with at least one new felony, and 23.5% (n = 8) were adjudicated delinquent (see Table 298). Of the youth who completed unsuccessfully, 20.0% (n = 2) were charged with at least one new misdemeanor, 20.0% (n = 2) were charged with at least one new felony, and 30.0% (n = 3) were adjudicated delinquent in the 12 months after their termination from BHJJ (see Table 299). Chi-square analyses showed no statistically significant differences.

Table 298. Recidivism after BHJJ Termination for Youth Who Completed Successfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 38)	10.5% (n = 4)	5.3% (n = 2)	10.5% (n = 4)
12 months (n = 34)	17.6% (n = 6)	11.8% (n = 4)	23.5% (n = 8)
18 months (n = 25)	20.0% (n = 5)	20.0% (n = 5)	36.0% (n = 9)

Table 299. Recidivism after BHJJ Termination for Youth Who Completed Unsuccessfully

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 15)	20.0% (n = 3)	13.3% (n = 2)	20.0% (n = 3)
12 months (n = 10)	20.0% (n = 2)	20.0% (n = 2)	30.0% (n = 3)
18 months (n = 5)	0.0% (n = 0)	20.0% (n = 1)	40.0% (n = 2)

ODYS Commitments

Among a total of 102 youth who enrolled since July 1, 2015, 2.0% (n = 2) were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ. **Conversely, 98.0% of youth participating in BHJJ were not admitted to an ODYS facility at any point after enrollment.**

Average Numbers of Charges and Adjudications

In addition to whether a youth was charged or adjudicated delinquent, we examined whether there were differences in the average number of charges and adjudications in equivalent periods of time prior to enrollment and after termination. We conducted paired samples *t*-tests to examine whether there were statistically significant differences in the mean number of charges and adjudications at each time period prior to and after BHJJ participation.

Figure 233 shows the average number of charges for youth who had data at both time periods. This restriction resulted in a sample of 53 youth at 6 months, 44 youth at 12 months, and 30 youth at 18 months. **Paired samples *t*-tests revealed a statistically significant decline in the average number of misdemeanors for 6 and 12 months and adjudications at for each time period.** For example, the average number of misdemeanor charges 12 months prior to BHJJ enrollment was 1.32 while the average number of misdemeanor charges 12 months after BHJJ termination was 0.45.

Figure 233.

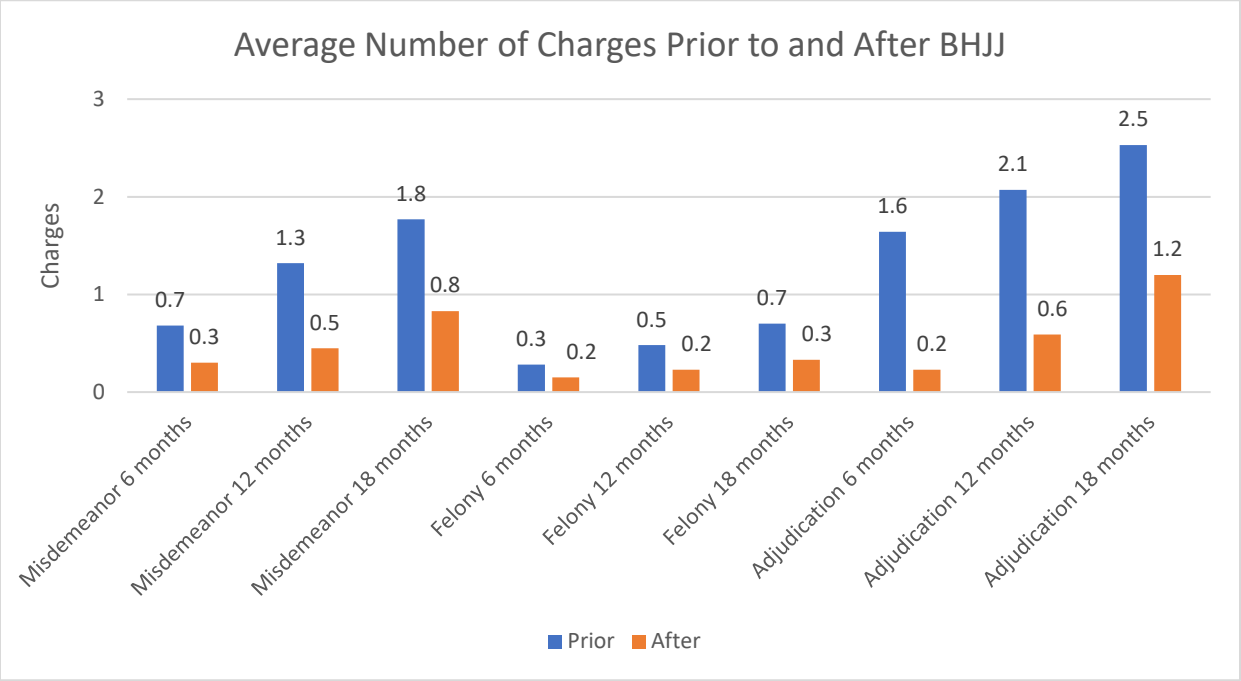


Figure 234 and Figure 235 shows mean differences in charges and adjudications for youth who successfully completed the program and those who did not successfully terminate. To be included in the analysis youth must have data at both time periods. This restricted the sample to 38 youth at 6 months, 34 youth at 12 months, and 25 youth at 18 months for youth who were successfully terminated and 15 youth at 6 months, 10 youth at 12 months, and 5 youth at 18 months for those who terminated unsuccessfully.

For youth who successfully completed, paired samples *t*-tests revealed that there was a significant reduction in the average number of misdemeanor charges in the 12 month period prior to and after BHJJ and adjudications in the 6 months prior to and after BHJJ. For example, the average number of misdemeanor charges declined from 1.23 in the 12 months prior to intake to 0.53 in the 12 months after termination. **For youth who terminated unsuccessfully, paired samples *t*-tests revealed that there was a significant reduction in the average number of delinquent adjudications at 6 and 12 months prior to and after BHJJ.** For example, the average number of delinquent adjudications was 2.8 in the 12 months prior to intake and 0.4 in the 12 months after termination.

Figure 234.

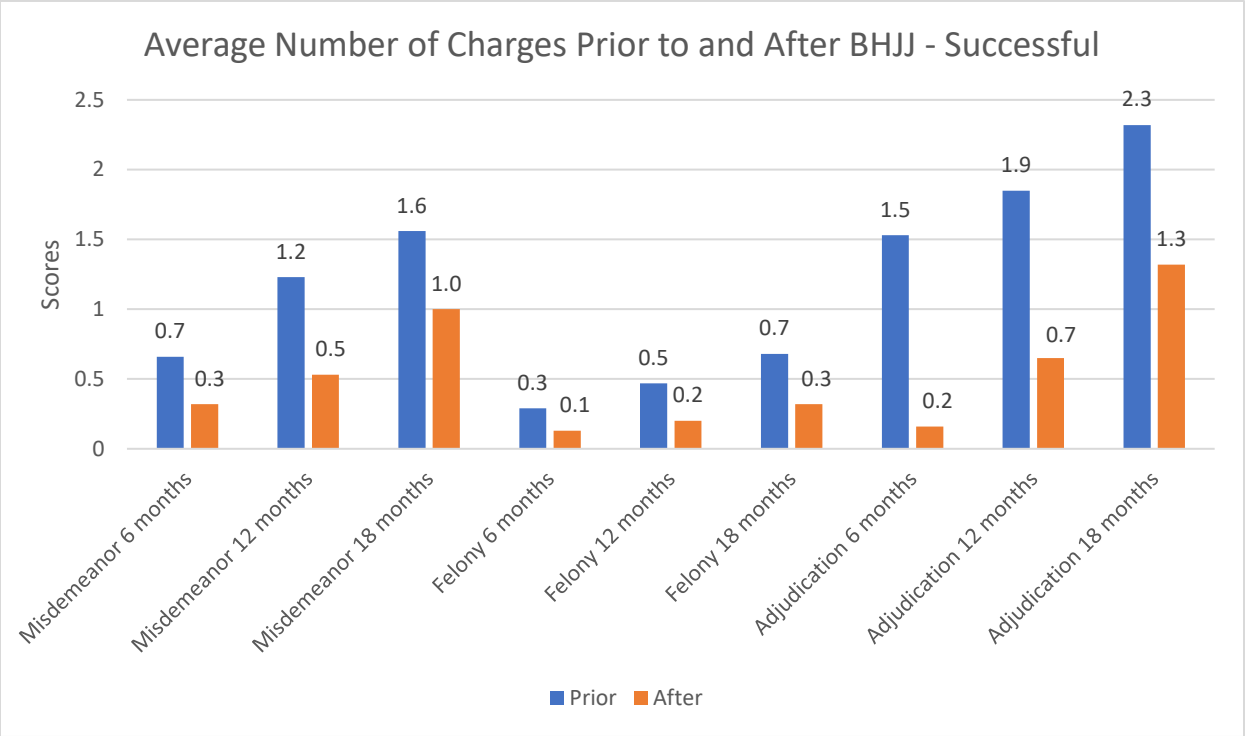
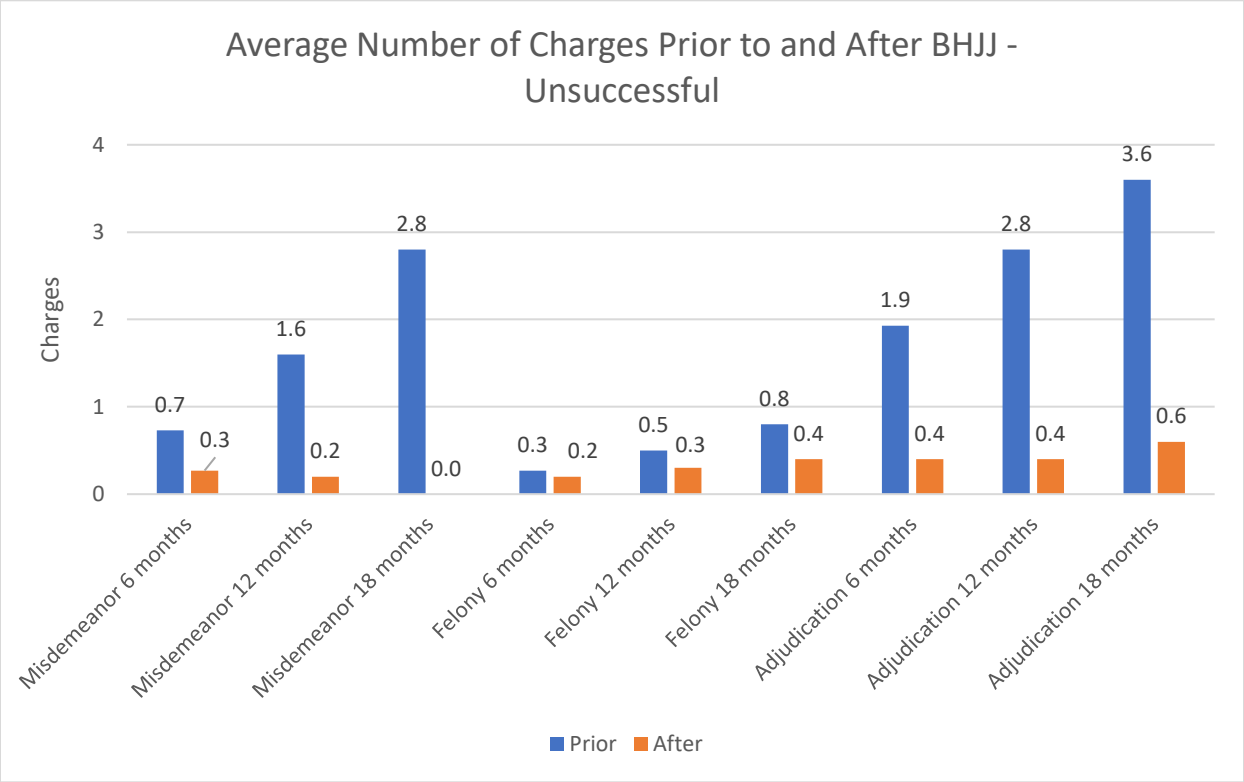


Figure 235.


Average Number of Charges Prior to and After BHJJ - Unsuccessful
Charges
4
3
2
1
0
0.7
0.3
1.6
0.2
2.8
0.0
0.3
0.2
0.5
0.3
0.8
0.4
1.9
0.4
2.8
0.4
3.6
0.6
Misdemeanor 6 months
Misdemeanor 12 months
Misdemeanor 18 months
Felony 6 months
Felony 12 months
Felony 18 months
Adjudication 6 months
Adjudication 12 months
Adjudication 18 months
Prior
After

Ashtabula

Demographics

As of June 30, 2019, 75 youth were enrolled into the BHJJ program in Ashtabula County. The average age at enrollment was 15.4 years (SD=1.53). More males (59.7%, n = 42) than females (24.3%, n = 29) have been enrolled. White youth (87.1%, n = 61), Black youth (4.3%, n = 3) and Multiracial youth (7.1%, n = 5) comprised the majority of the total sample.

There were 43 new enrollments in Ashtabula County during the current reporting period (July 1, 2017 through June 30, 2019). The average age at enrollment was 15.5 (SD = 1.64). More males (54.8%, n = 23) than females (45.2%, n = 19), and more White youth (85.7%, n = 36) than Black youth (7.1%, n = 3). Nearly ten percent (9.5%, n = 4) of youth self-identified as Hispanic/Latinx.

Unless otherwise noted, the following sections describe data from the past four years of BHJJ programming from July 1, 2015 through June 30, 2019.

Custody Arrangement and Household Information

At intake, 52.4% of youth (n = 33) lived with their biological mother only, while 11.1% (n = 7) lived with two biological parents or one biological and one step/adoptive parent (see Table 300). Seventy-six percent (76.2%, n = 48) of BHJJ youth lived with at least one biological parent at enrollment.

Over eighty-three percent (83.3%; n = 50) of the BHJJ caregivers had at least a high school diploma or GED, and 8.3% (n = 5) had a bachelor's degree or higher. Over sixteen percent of caregivers (16.7%; n = 10) reported they did not graduate from high school (see Table 301).

Caregivers were asked to report their annual household income (see Table 302). The income range with the highest endorsement was $20,000 - $24,999 (18.3%, n = 11). Overall, 61.7% (n = 37) reported a family income of $24,999 or less. When examined by race, 33.3% (n = 17) of White families, 100% (n = 3) of Black families, and 40.0% (n = 2) of Multiracial families reported a household income of $14,999 or less. Table 302 displays the reported household income overall and by race.

Table 300. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	11.1% (n = 7)
Biological Mother Only	52.4% (n = 33)
Biological Father Only	12.7% (n = 8)
Adoptive Parent(s)	4.8% (n = 3)
Aunt/Uncle	0
Grandparents	14.3% (n = 9)
Other	4.8 (n = 3)

Table 301. Educational Outcomes for Caregivers of BHJJ Youth

Number of School Years Completed	Number of Caregivers
Less than High School	16.7% (n = 10)
High School Graduate or G.E.D.	43.3% (n = 26)
Some College or Associate Degree	31.7% (n = 19)
Bachelor's Degree	3.3% (n = 2)
More than a Bachelor's Degree	5.0% (n = 3)

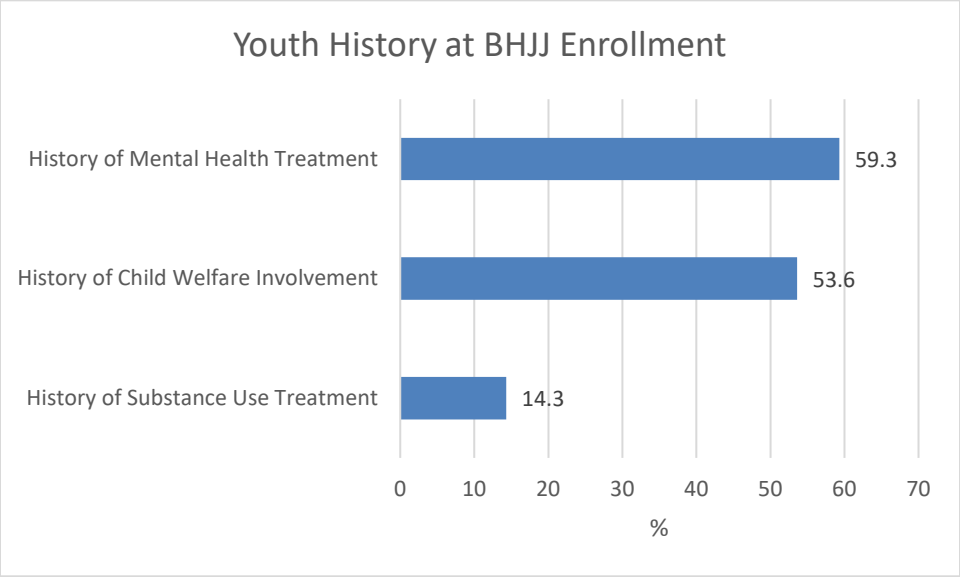
Table 302. Annual Household Incomes for BHJJ Families by Race

Household Income	Overall	White	Black	Multiracial
Less than $5,000	16.7% (n = 10)	11.8% (n = 6)	100% (n = 3)	20.0% (n = 1)
$5,000 - $9,999	3.3% (n = 2)	3.9% (n = 2)	0	0
$10,000 - $14,999	16.7% (n = 10)	17.6% (n = 9)	0	20.0% (n = 1)
$15,000 - $19,999	6.7% (n = 4)	5.9% (n = 3)	0	20.0% (n = 1)
$20,000 - $24,999	18.3% (n = 11)	19.6% (n = 10)	0	20.0% (n = 1)
$25,000 - $34,999	13.3% (n = 8)	15.7% (n = 8)	0	0
$35,000 - $49,999	11.7% (n = 7)	11.8% (n = 6)	0	20.0% (n = 1)
$50,000 - $74,999	8.3% (n = 5)	7.8% (n = 4)	0	0
$75,000 or greater	5.0% (n = 3)	5.9% (n = 3)	0	0

Youth and Family History

Workers were asked to identify a youth's prior behavioral health and child welfare system involvement (see Figure 236). These three items were new to the past biennium, therefore, data are only available for youth enrolled between July 1, 2017 and June 30, 2019. Over fifty-three percent of the youth (53.6%, n = 15) had a history of child welfare involvement prior to BHJJ enrollment. Fourteen percent (14.3%, n = 4) of youth had received substance use treatment in their lifetime prior to BHJJ enrollment and 59.3% (n = 16) of youth had received mental health treatment in their lifetime prior to BHJJ enrollment.

Figure 236.



Caregivers were asked to respond to a series of questions designed to obtain data related to the youth's family history (see Table 303). Chi-square analyses indicated a significantly larger proportion of the caregivers of females reported lifetime histories of sexual abuse. Caregivers reported that 12.5% (n = 3) of females and 27.0% (n = 10) of males had a history of being physically abused while 16.0% (n = 4) of females and none of males had a history of being sexual abused. Caregivers of 52.0% (n = 13) of females and 41.7% (n = 15) of males reported hearing the child talking about committing suicide and 20.0% (n = 5) of females and 7.9% (n = 3) of males had attempted suicide at least once. A majority of the caregivers of females (62.5%, n = 15) and males (68.6%, n = 24) reported a family history of depression. A majority of the caregivers of females (66.7%, n = 16) and almost half of the caregivers of males (47.2%, n = 17) reported a family history of problems with substance use.

Table 303. Youth and Family History

Question	Females	Males
Has the child ever been physically abused?	12.5% (n = 3)	27.0% (n = 10)
Has the child ever been sexually abused?	16.0% (n = 4)*	0
Has the child ever run away?	60.0% (n = 15)	51.4% (n = 19)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	32.0% (n = 8)	44.7% (n = 17)
Has the child ever talked about committing suicide?	52.0% (n = 13)	41.7% (n = 15)
Has the child ever attempted suicide?	20.0% (n = 5)	7.9% (n = 3)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	44.0% (n = 11)	48.6% (n = 18)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	62.5% (n = 15)	68.6% (n = 24)
Has anyone in the child's biological family had a mental illness, other than depression?	52.2% (n = 12)	66.7% (n = 24)
Has the child ever lived in a household in which someone was convicted of a crime?	40.0% (n = 10)	37.1% (n = 13)
Has anyone in the child's biological family had a drinking or drug problem?	66.7% (n = 16)	47.2% (n = 17)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	44.0% (n = 11)	37.8% (n = 14)

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

Problems Leading to Service

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-related problems (78.3% and 89.5% respectively) (see Table 304). Chi-square analyses indicated males had significantly higher rates of hyperactive and attention-related problems. Females had significantly higher rates of suicide-related problems.

Table 304. Problems Leading to Services

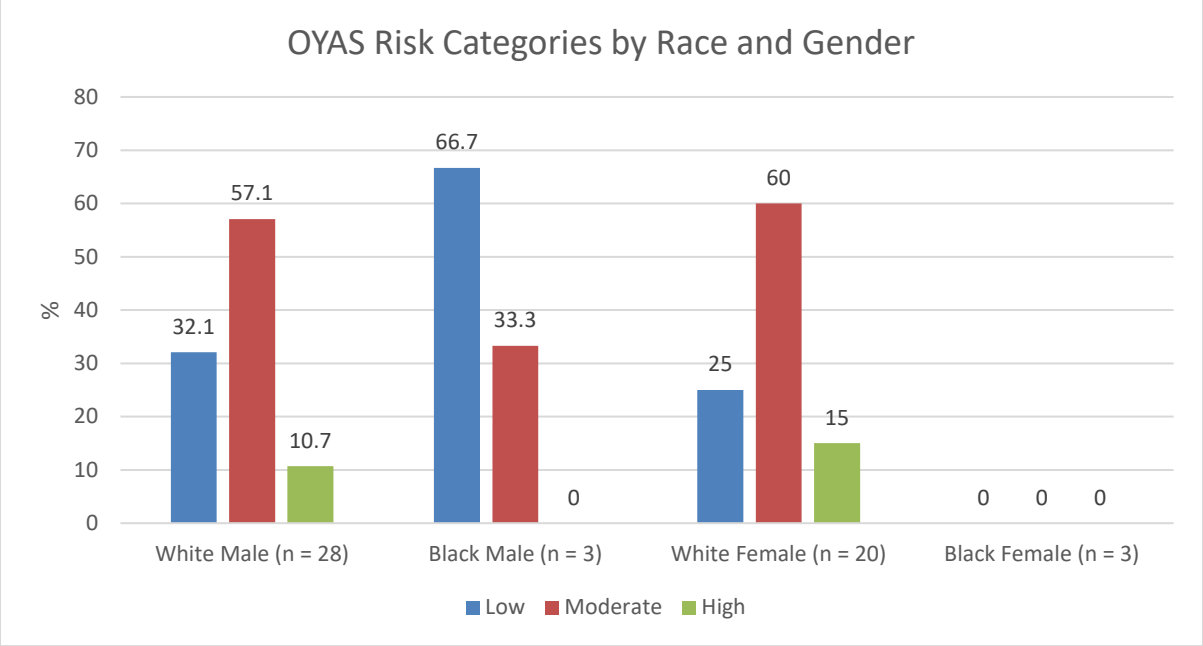
Problems Leading to Services	Females	Males
Adjustment-related problems	21.7% (n = 5)	15.8% (n = 6)
Anxiety-related problems	30.4% (n = 7)	34.2% (n = 13)
Conduct/delinquency-related problems	78.3% (n = 18)	89.5% (n = 34)
Depression-related problems	34.8% (n = 8)	26.3% (n = 10)
Eating disorders	4.3% (n = 1)	0
Hyperactive and attention-related problems	13.0% (n = 3)	39.5% (n = 15)*
Learning disabilities	4.3% (n = 1)	13.2% (n = 5)
Pervasive development disabilities	4.3% (n = 1)	7.9% (n = 3)
Psychotic behaviors	0	0
School performance problems not related to learning disabilities	39.1% (n = 9)	39.5% (n = 15)
Specific developmental disabilities	0	0
Substance use, abuse, dependence-related problems	20.0% (n = 2)	32.0% (n = 8)
Suicide-related problems	34.8% (n = 8)*	13.2% (n = 5)

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

Ohio Youth Assessment System

Ohio Youth Assessment System (OYAS) data were collected at the time point closest to a youth's respective enrollment dates. Figure 237 shows the distribution of OYAS risk categories for BHJJ youth by race and gender. In Ashtabula County, the majority of youth enrolled in BHJJ were identified as Moderate risk on the OYAS. Due to small sample sizes in the Black male and female groups, comparisons of OYAS levels based on race are discouraged.

Figure 237.



DSM Diagnoses

Workers were asked to report any DSM 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 diagnosis for females and males was Oppositional Defiant Disorder (see Table 305). Chi-square analysis indicated no significant differences for diagnoses based on gender.

Table 305. Most Common DSM Diagnoses

DSM Diagnosis	Females (n = 15)	Males (n = 29)
Adjustment Disorder	6.7% (n = 1)	0
Alcohol-related Disorders	0	0
Attention Deficit Hyperactivity Disorder	13.3% (n = 2)	20.7% (n = 6)
Bipolar Disorder	6.7% (n = 1)	6.9% (n = 2)
Cannabis-related Disorders	0	0
Conduct Disorder	6.7% (n = 1)	0
Depressive Disorders	6.7% (n = 1)	10.3% (n = 3)
Disruptive Behavior Disorder	0	0
Unspecified Mood Disorder	6.7% (n = 1)	31.0% (n = 9)
Oppositional Defiant Disorder	**53.3% (n = 8)**	**55.2% (n = 16)**
Post-traumatic Stress Disorder	0	6.9% (n = 2)
Unspecified Trauma and Stressor Related Disorder	0	0
Disruptive Mood Dysregulation Disorder	20.0% (n = 3)	10.3% (n = 3)
Co-Occurring Disorder	0	0

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

Educational Information

Several items focused on educational 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. The wording on some items (e.g. IEP at intake, attendance at intake) was changed from previous versions of the forms. For those items, we present data from only the past biennium (when the new forms were in use). Those items will have smaller sample sizes compared to items that have been consistent for the past four years.

Fifty-two percent (51.9%, n = 28) of youth were either suspended or expelled from school in the 12 months prior to their enrollment in the BHJJ project. While in BHJJ treatment BHJJ, 17.9% (n = 5) of the youth were expelled or suspended from school (a 65.5% decrease from intake to termination).

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, 90.5% (n = 19) of youth were currently attending school while at termination, 92.9% (n = 26) 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 306 displays the grades typically received by the BHJJ youth at intake and termination from the program while Table 307 displays this information based on completion status. At intake, 48.2% of youth were earning mostly A's and B's, and C's while at termination, 38.5% were earning mostly A's, B's, or C's. Academic improvement varied by BHJJ completion status (see Table 307). For example, at intake, 50.0% of youth who would go on to be unsuccessful completers and 28.6% of youth who would go on to be successful completers received mostly A's, B's, or C's. At termination, 50.0% of unsuccessful completers and 33.3% of successful completers received mostly A's, B's, or C's.

Table 306. Academic Performance

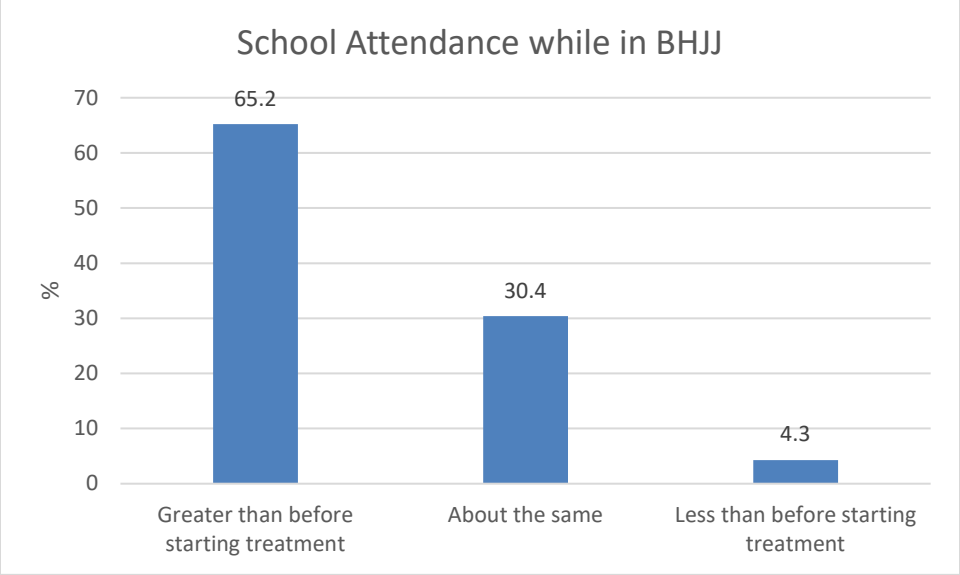
Typical Grades	Frequency at Intake	Frequency at Termination
Mostly A's and B's	16.1% (n = 9)	15.4% (n = 4)
Mostly B's and C's	32.1% (n = 18)	23.1% (n = 6)
Mostly C's and D's	25.0% (n = 14)	42.3% (n = 11)
Mostly D's and F's	26.8% (n = 15)	19.2% (n = 5)

Table 307. Academic Performance for Youth by Completion Status

	Unsuccessful Completers		Successful Completers	
Typical Grades	Frequency at Intake	Frequency at Termination	Frequency at Intake	Frequency at Termination
Mostly A's and B's	0	0	4.8% (n = 1)	11.1% (n = 2)
Mostly B's and C's	50.0% (n = 1)	50.0% (n = 1)	23.8% (n = 5)	22.2% (n = 4)
Mostly C's and D's	0	50.0% (n = 1)	42.9% (n = 9)	44.4% (n = 8)
Mostly D's and F's	50.0% (n = 1)	0	28.6% (n = 6)	22.2% (n = 4)

At termination, workers reported that 65.2% (n = 15) of youth were attending school more than before starting treatment and 30.4% (n = 7) of youth were attending school 'about the same' amount compared to before starting treatment (see Figure 238). At intake, 41.7% (n = 10) of youth attending school had Individualized Education Plans (IEPs) while at termination, 35.7% (n = 10) of the youth attending school had Individualized Education Plans (IEPs).

Figure 238.



Ohio Scales

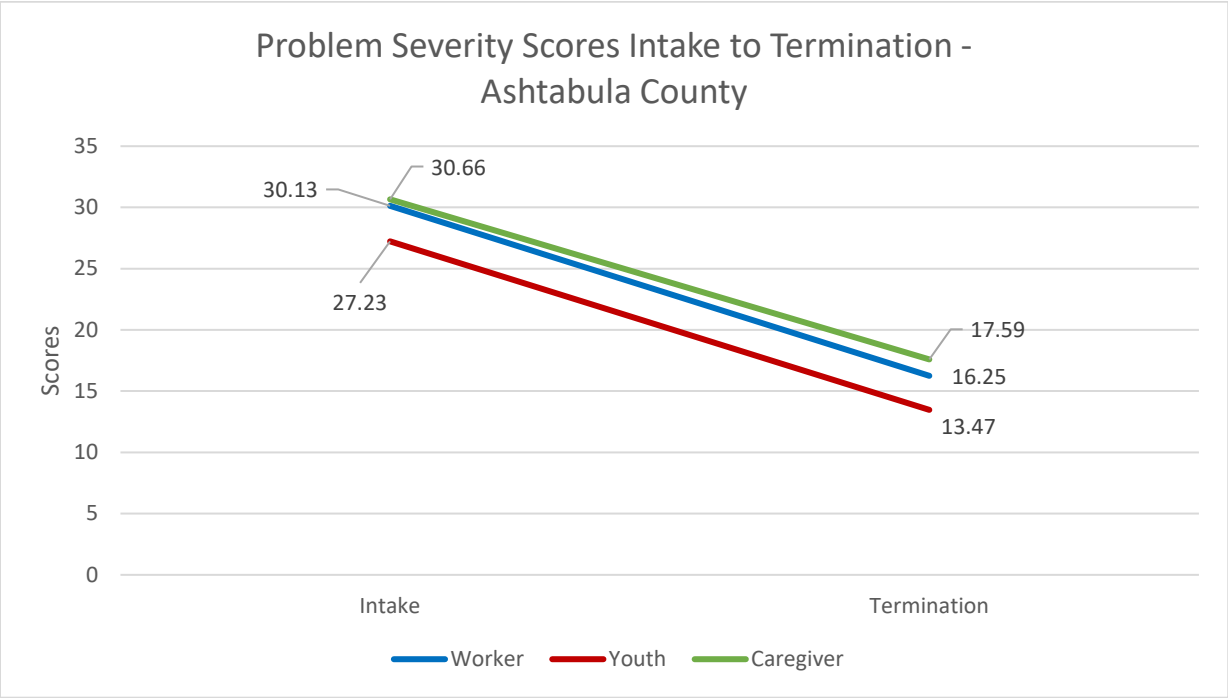
One of the main measures in the data collection packet was the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. Because termination can occur at any point in time along the continuum of service, separate charts are included that display the means from intake to termination. Decreases in Problem Severity and increases in Functioning correspond to positive change.
All Problem Severity and Functioning analyses were conducted on assessment periods with enough valid cases to produce meaningful results. Results for Ashtabula County will be limited to intake and termination data.

Paired samples t-tests were used to compare Problem Severity scores at intake to Problem Severity scores at termination. 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 termination to be included in the analysis. If the caregiver only has an intake score, his or her data is not included.

Problem Severity

Overall means for the Problem Severity scale by rater between intake and termination for Ashtabula County youth are presented in Figure 239.

Figure 239.



Worker Ratings

For workers, paired samples t-tests indicated significant improvement in Problem Severity from intake to termination (see Table 308). Improvements were noted at termination $t(27) = 5.96$, $p < .001$ with a large effect size.

Table 308. Paired Samples T-Tests for Problem Severity – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	30.66 (SD=9.42; n=28)	16.51 (SD=9.24; n=28)	5.96***	1.12

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

Youth Ratings

Paired samples t-tests conducted on the youth ratings indicated significant improvement in Problem Severity from intake to termination (see Table 309). Improvements were noted at termination $t(20) = 3.09$, $p < .01$ with a moderate effect size.

Table 309. Paired Samples T-Tests for Problem Severity – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	24.54 (SD=13.14; n=21)	14.66 (SD=11.37; n=21)	3.09**	.67

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvement in Problem Severity at termination $t(25) = 3.94$, $p < .01$ (see Table 310). Data indicated a moderate effect size for the time period between intake to termination.

Table 310. Paired Samples T-Tests for Problem Severity – Caregiver

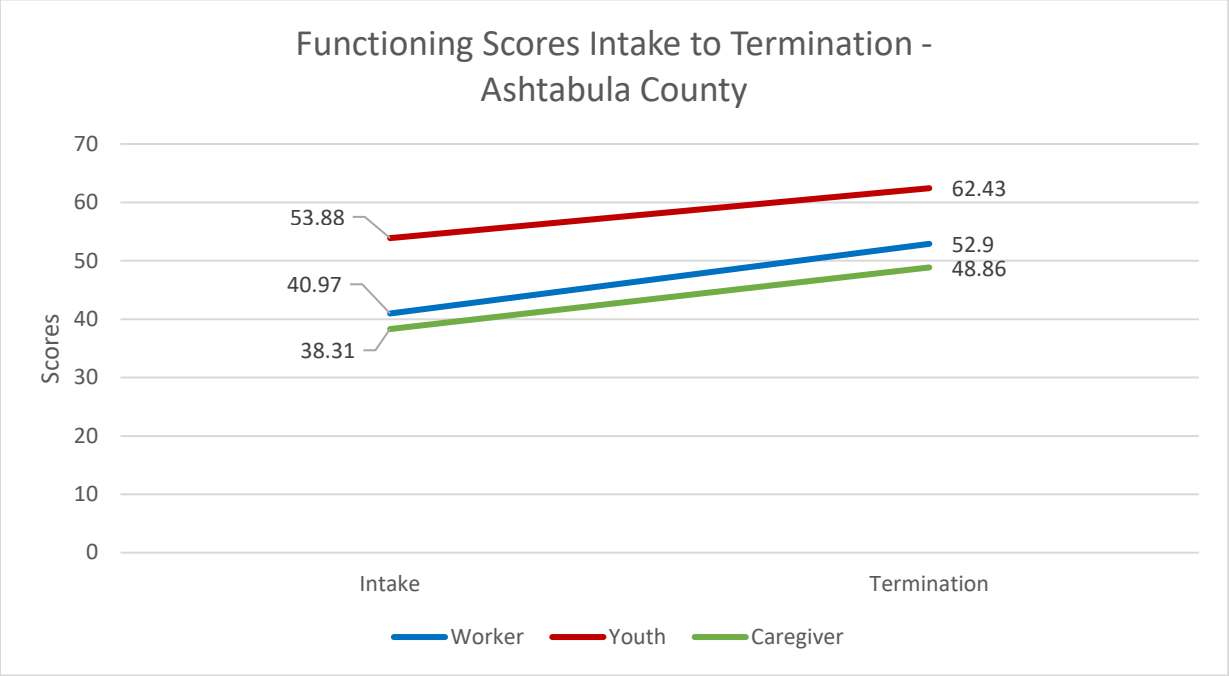
	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	28.59 (SD=11.17; n=26)	17.86 (SD=12.85; n=26)	3.94**	.77

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

Functioning Scores

Overall means for the Functioning scale by rater between intake and termination for Ashtabula County youth are presented in Figure 240.

Figure 240.



Worker Ratings

For workers, paired samples t-tests indicated significant improvement in Functioning scores from intake to termination $t(29) = -4.16$, $p < .001$ with a moderate effect size (see Table 311).

Table 311. Paired Samples T-Tests for Functioning Scores – Worker

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	41.70 (SD=9.96; n=30)	52.90 (SD=12.32; n=30)	-4.16***	.76

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

Youth Ratings

Paired samples t-tests conducted on the youth Functioning scores indicated significant improvement from intake to termination $t(20) = -2.90$, $p < .01$ with a moderate effect size (see Table 312).

Table 312. Paired Samples T-Tests for Functioning Scores – Youth

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	54.05 (SD=11.18; n=21)	61.90 (SD=14.37; n=21)	-2.90**	.63

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

Caregiver Ratings

For caregivers, paired samples t-tests revealed significant improvement in Functioning scores from intake to termination $t(28) = -4.50$, $p < .001$ with a large effect size (see Table 313).

Table 313. Paired Samples T-Tests for Functioning Scores – Caregiver

	Mean Time 1	Mean Time 2	*t*	d
Intake to Termination	37.31 (SD=11.38; n=29)	48.86 (SD=13.78; n=29)	-4.50***	.84

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

Violence and Delinquency Questionnaire

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey composed of three general domains: exposure to violence, violence perpetration, and peer delinquency. The VDQ is offered at intake and termination into the BHJJ program. At intake, each item prompts the youth to answer within the context of the past year. At termination, youth are directed to answer "since the last time you answered these questions".

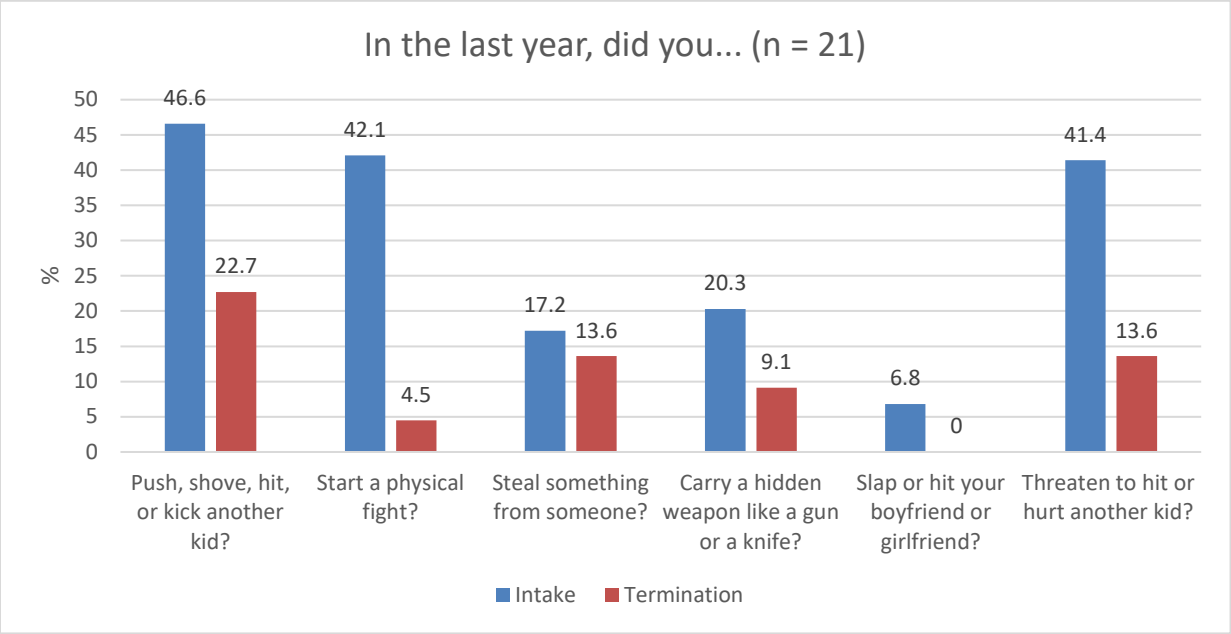
This section will be divided into three distinct parts that examine the prevalence of violence exposure as either a victim or witness, self-reported delinquent behavior from intake to termination, and delinquent behavior by peers from intake to termination. Table 314 provides the percentage of those who had experienced violence as either a victim or witness in the past year.

Table 314. Violence Exposure

	% Yes BHJJ Sample (n = 59)
In the last year, did someone threaten to hurt you when you thought they might really do it?	23.7%
In the last year, have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have? Or because someone said you were gay?	0
In the last year, did a boyfriend or girlfriend or anyone you went on a date with slap or hit you?	11.9%
In the last year, did anyone steal anything from you and never give it back? Things like a backpack, money, watch, clothing, bike, stereo, or anything else?	42.4%
Sometimes people are attacked WITH sticks, rocks, knives, or other things that would hurt. In the last year, did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	6.8%
In the last year, did anyone hit or attack you WITHOUT using an object or weapon?	23.7%
In the last year, did you get scared or feel really bad because kids were calling you names, saying mean things to you, or saying they didn't want you around?	30.5%
In the last year, did a grown-up touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up force you to have sex?	5.1%
Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. In the last year, did another child or teen make you do sexual things?	5.1%
In the last year, did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	15.3%
In the last year, in real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?	17.2%
In the last year, in real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt them?	34.5%
In the last year, was anyone close to you murdered, like a friend, neighbor, or someone in your family?	1.7%
In the last year, did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	25.4%
Not including spanking on your bottom, did a grown-up in your life hit, beat, kick or physically hurt you in any way?	28.8%
When someone is neglected, it means that the grown-ups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. In the last year, were you neglected?	10.2%

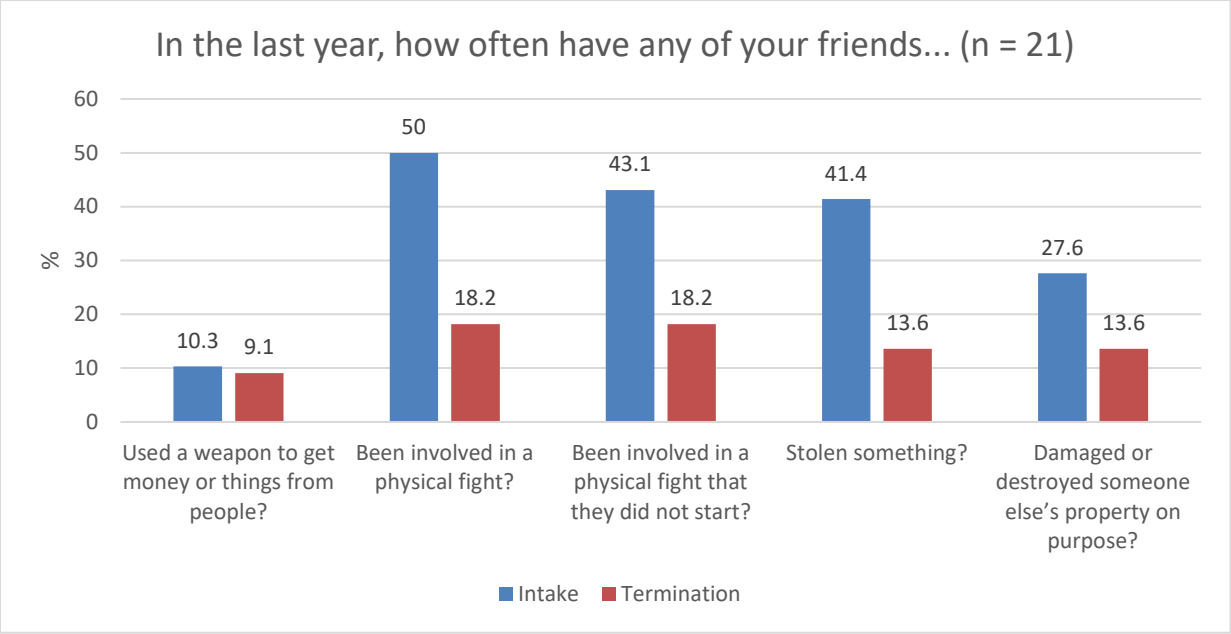
Delinquent behaviors were measured as self-report items of violent and weapon carrying behaviors as well as stealing. At intake, youth were asked how often they engaged in each behavior in the last year while at termination, youth were asked how often they engaged in the behavior since the last time they were asked. Figure 241 presents the percentage of youth who identified that they had engaged in each type of behavior at least once. Depending on the item, data were available for 21 matched pairs. McNemar's tests revealed statistically significant improvements from intake to termination for two items: start a physical fight, and threaten to hit or hurt another kid.

Figure 241.



Self-reported peer delinquency was also measured at intake (how often in the last year) and at termination (how often since the last time they were asked). Figure 242 presents the percentage of youth who identified how often their friends had engaged in delinquent behavior at intake and termination. Depending on the item, data were available for 21 pairs. McNemar's tests revealed no statistically significant improvements from intake to termination on any item.

Figure 242.



Resilience

As part of the 2017 - 2019 evaluation, we added a new scale to measure several aspects of resilience. We define resilience as a set of factors both within the individual and external factors such as relationships with family, peers, and other adults that help to insulate youth from adversity (Dray et al., 2017). As shown in the previous section that showed data on victimization, a large proportion of youth enrolled in BHJJ have directly or indirectly experienced violence. The Resilience survey is a 16-item Likert scale survey that measures internal factors of resilience such as self-efficacy, self-awareness, and empathy, and external factors such as support from peers and family.

Figure 243 shows intake data on self-efficacy, self-awareness, and empathy. As the most frequent responses were “pretty much true” and “very much true”, we combined these responses. Generally, the majority of youth indicated high levels of endorsement for each one of these items.

Figure 243.

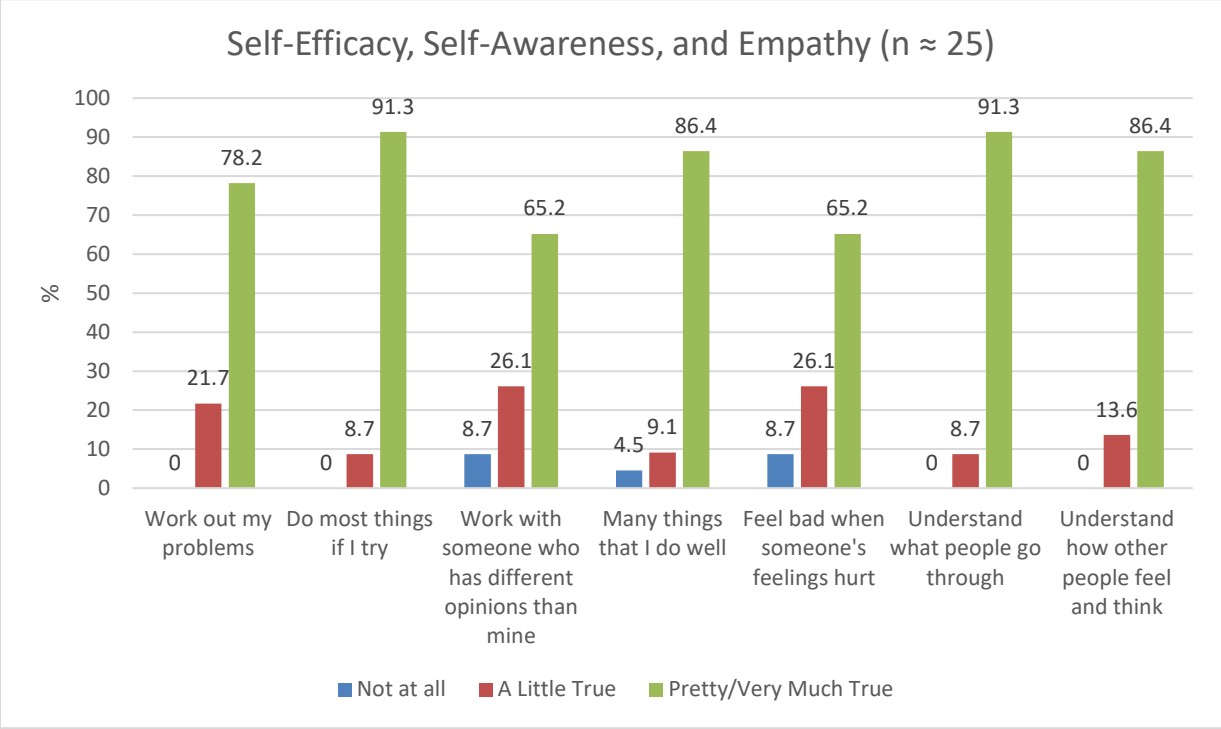


Figure 244 shows intake data on support from peers. Youth were asked whether they have a friend who really cares about them, talks with them about their problems, and helps them when they are having a hard time. The majority of youth identified that each of the statements were either pretty much or very much true.

Figure 244.

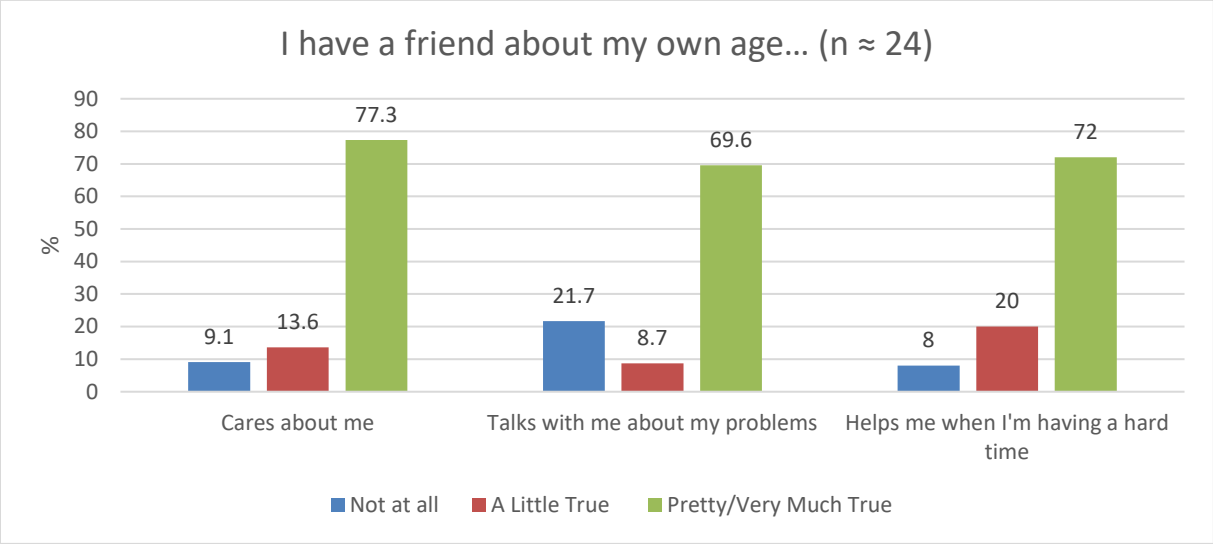
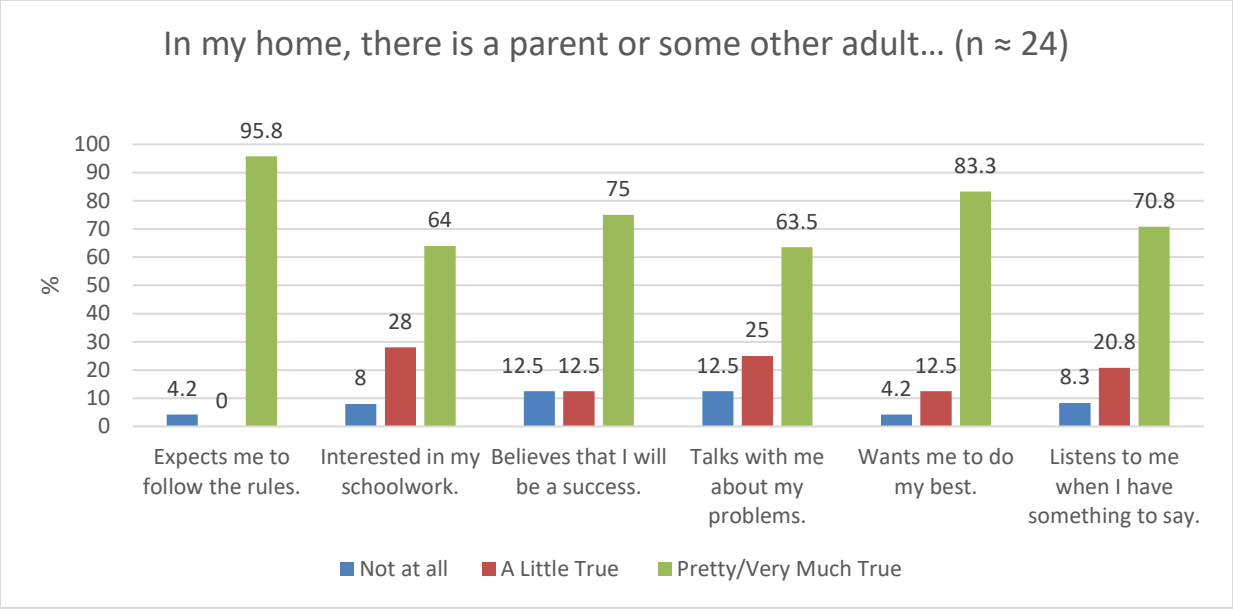


Figure 245 shows intake data on parental or support from other adults in their house. While the majority of youth identified that each of the items were either pretty much or very much true, the two items with the lowest endorsement was “interested in my schoolwork” and “talks with me about my problems”.

Figure 245.



In addition to intake data, Figure 246 through Figure 248 show the proportion of youth who identified that each of the statements were either pretty much or very much true from intake to termination. Due to sample size restrictions, McNemar's tests were not conducted. Figure 13 shows differences from intake to termination for the items measuring self-efficacy, self-awareness, and empathy. Youth exhibited either an improvement from intake to termination or no change in items measuring self-efficacy, self-awareness, and empathy except "there are many things that I do well", "I try to understand what other people go through", and "I try to understand how other people feel and think".

Figure 246.

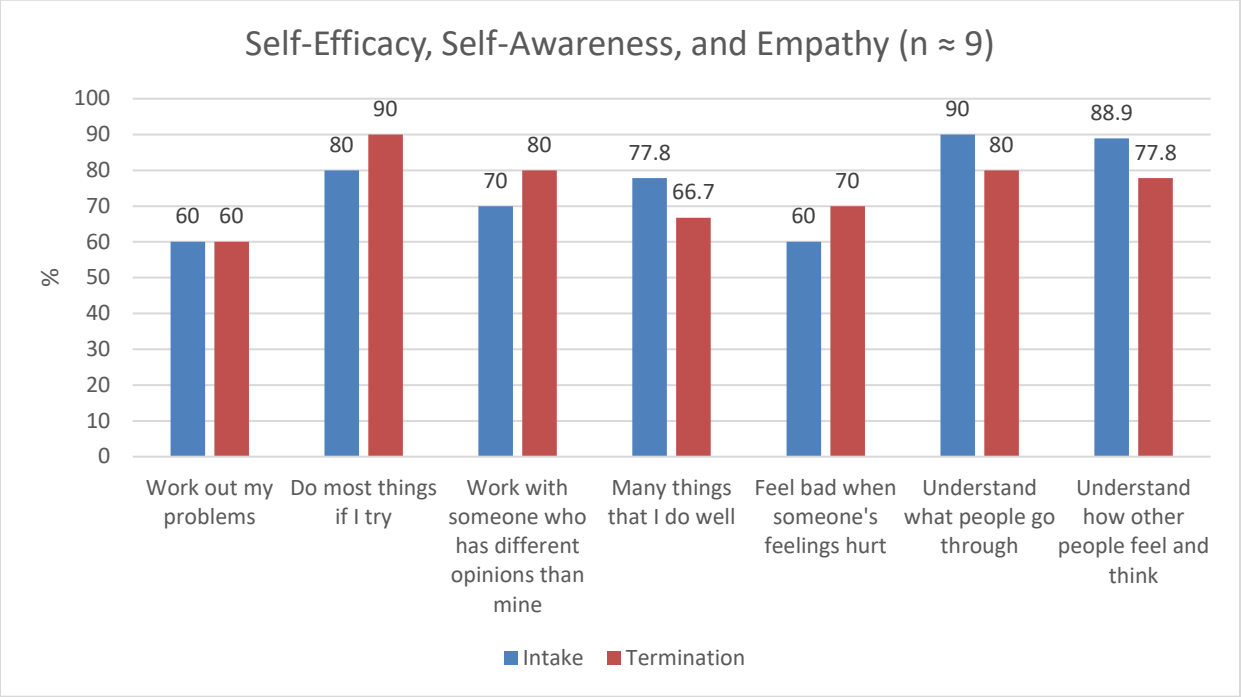


Figure 247 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring peer support. There was either an increase or no change in the proportion of positive responses from intake to termination for all three items.

Figure 247.

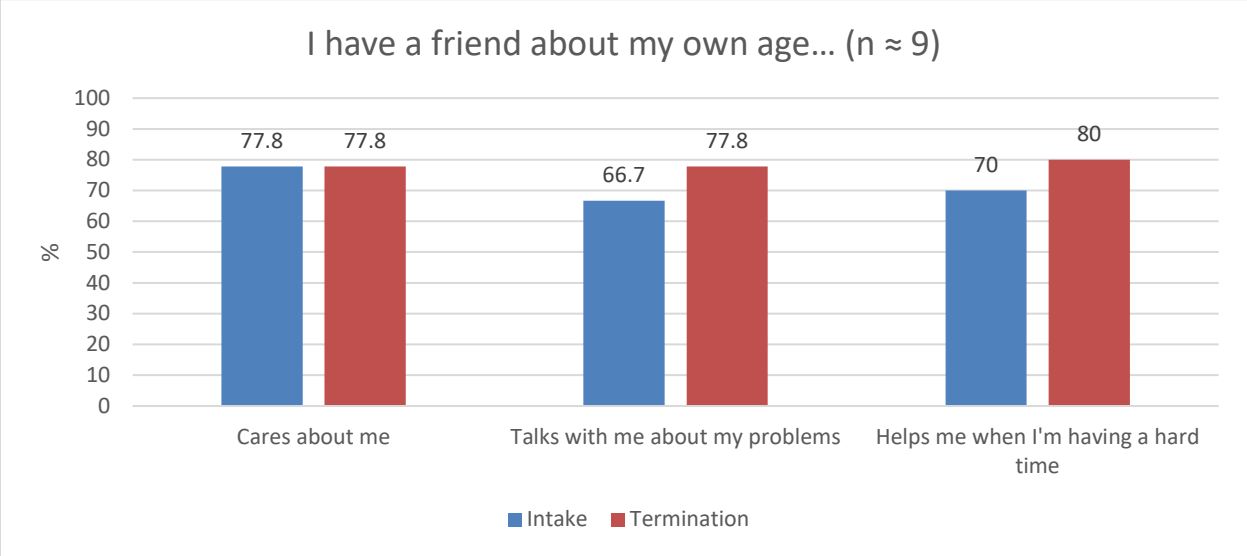
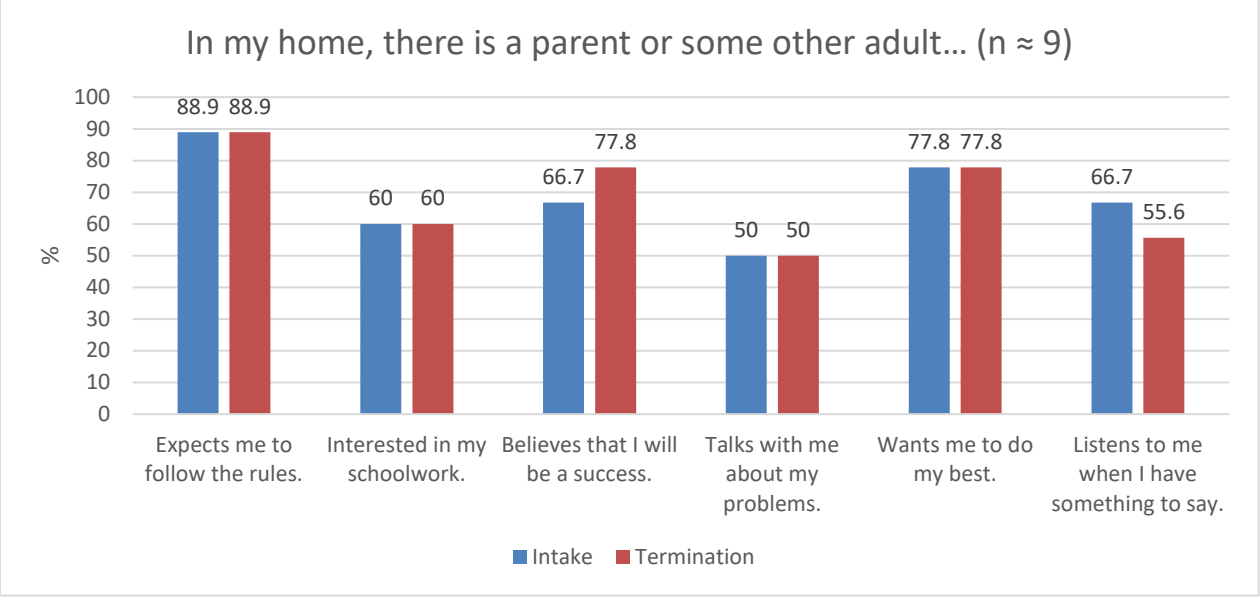


Figure 248 shows the proportion of youth who responded either pretty much or very much true to each of the items measuring parental support or support from other adults in the home. The proportion of positive responses increased slightly for the item "believes that I will be a success" and decreased slightly for "listens to me when I have something to say".

Figure 248.



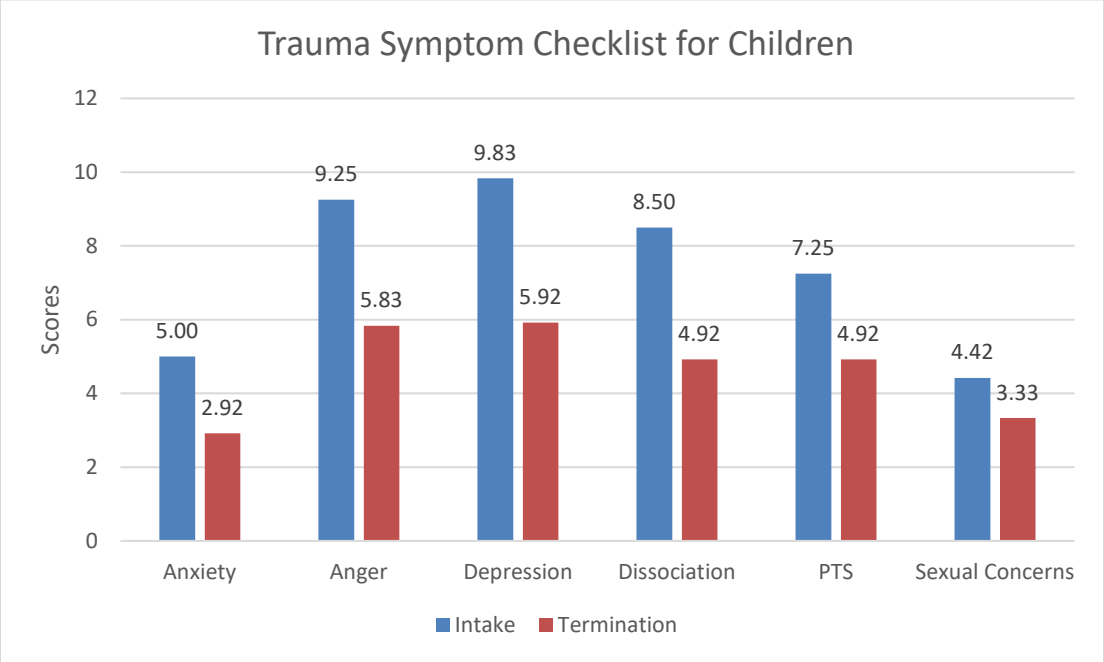
TSCC

The TSCC was administered at intake and termination from BHJJ. Paired-samples t-tests were conducted to show whether means at intake and termination on each TSCC subscale differed significantly. We were unable to examine gender effects due to the low sample size of both males (n = 4) and females (n = 8). Paired samples t-tests revealed significant improvements in trauma symptoms for the Dissociation domain from intake to termination (see Table 315).

Table 315. TSCC Subscales from Intake to Termination among all Participants

	Intake	Termination	t	d
Anxiety	5.00 (SD = 4.33; n = 12)	2.92 (SD = 2.07; n = 12)	2.08	.60
Depression	9.83 (SD = 5.84; n = 12)	5.92 (SD = 5.93; n = 12)	1.93	.55
Anger	9.25 (SD = 5.72; n = 12)	5.83 (SD = 5.72; n = 12)	1.53	.44
Posttraumatic Stress	7.25 (SD = 4.07; n = 12)	4.92 (SD = 3.90; n = 12)	2.04	.59
Dissociation	8.50 (SD = 4.96; n = 12)	4.92 (SD = 4.60; n = 12)	3.00*	.86
Sexual Concerns	4.42 (SD = 4.44; n = 12)	3.33 (SD = 3.47; n = 12)	1.01	.29

Figure 249.



Substance Use Survey

The Substance Use Survey was revised for this current evaluation covering the 2017-2019 period to combine and add substances that were not covered in the previous survey and to add general questions regarding youth's perceptions of the ways in which alcohol and drug use has affected their physical health and social functioning. For example, the revised instrument includes opioids as its own category inclusive of heroin, oxycodone, Percocet, opium, and synthetic opioids which were previously represented across multiple categories. In this example, Percocets and Oxycodone were included in the previous instrument with other non-opioid pain killers. Given that there were several categories of substances where there was not an exact match from the previous instrument to the current one, we present data only for the most current evaluation period in this section.

Table 316 shows the proportion of youth in the BHJJ program who reported ever having used alcohol or drugs and the average age of first use by gender in Ashtabula County. For both females and males, alcohol, tobacco, and marijuana were the most commonly used substances. Chi-squared tests revealed that a significantly higher proportion of males reported ever having used marijuana than females ($\chi^2(1) = 3.99$, $p < .05$).

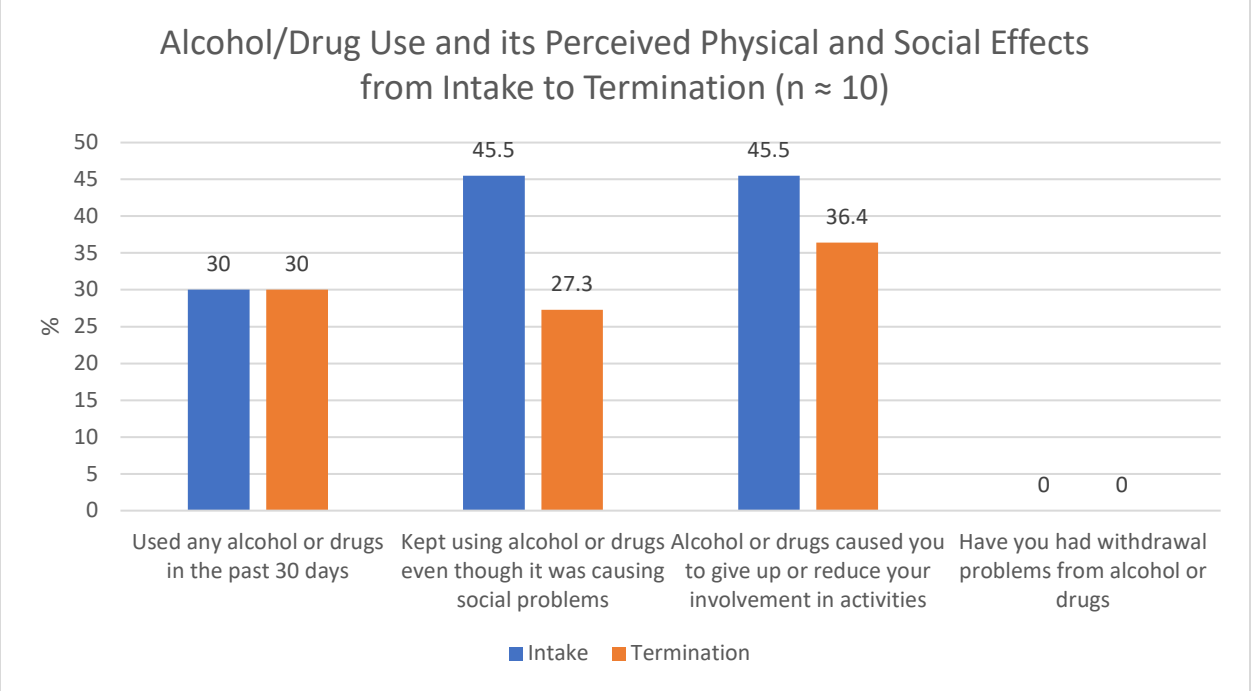
Table 316. Self-Reported Substance Use at Intake by Gender – Ashtabula County

	Male		Female	
	% Ever Used	Age of First Use	% Ever Used	Age of First Use
Alcohol	46.2% (n = 6)	12.50 (SD = 2.74)	53.8% (n = 7)	12.50 (SD = 1.64)
Tobacco	61.5% (n = 8)	13.25 (SD = 2.19)	61.5% (n = 8)	12.57 (SD = 2.76)
Cannabis	53.8% (n = 7)	12.00 (SD = 2.58)	38.5% (n = 5)	14.00 (SD = 2.16)
Hallucinogens	15.4% (n = 2)	15.00 (SD = 1.41)	0.0% (n = 0)	
Inhalants	7.7% (n = 1)		0.0% (n = 0)	
Opioids	0.0% (n = 0)		0.0% (n = 0)	
Sedatives	0.0% (n = 0)		0.0% (n = 0)	
Caffeine	28.6% (n = 4)	9.50 (SD = 6.24)	38.5% (n = 5)	9.25 (SD = 6.80)
Stimulants	7.1% (n = 1)	14.00[a]	0.0% (n = 0)	
Over the counter medications	0.0% (n = 0)		0.0% (n = 0)	
Other prescription drugs	7.1% (n = 1)	13.00[a]	15.4% (n = 2)	
Herbs/Flowers	0.0% (n = 0)		0.0% (n = 0)	

[a] No Standard Deviations are calculated.

In addition to questions pertaining to the use of specific substances, youth were asked questions around general alcohol/drug use and its perceived effects on physical health and social functioning. The proportion of youth who indicated that they had used any alcohol or drugs in the past 30 days remained at 30% from intake to termination (see Figure 250). From intake to termination, the proportion of youth who indicated that they had continued to use alcohol/drugs even though it was causing social problems and the proportion of youth who indicated that alcohol/drugs caused them to give up or reduce involvement in activities at work, school, home, and social events declined. No youth indicated that they had withdrawal problems from alcohol or drugs. While none of these differences were statistically significant, it is likely a function of low cell sizes.

Figure 250.



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.

Between July 1, 2015 and June 30, 2019, there have been 23 youth terminated from the BHJJ program in Ashtabula County. Ninety-one percent (91.3%, n = 21) of the youth terminated from the BHJJ program were identified as successful treatment completers. Table 317 presents all of the reasons for termination from BHJJ.

Table 317. Reasons for Termination from BHJJ

Termination Reason	All Youth Enrolled between July 2015 and June 2019
Successfully Completed Services	91.3% (n = 21)
Client Did Not Return/Rejected Services	0
Out of Home Placement	0
Client/Family Moved	0
Client Withdrawn	0
Client AWOL	0
Client Incarcerated	0
Other	8.7% (n = 2)

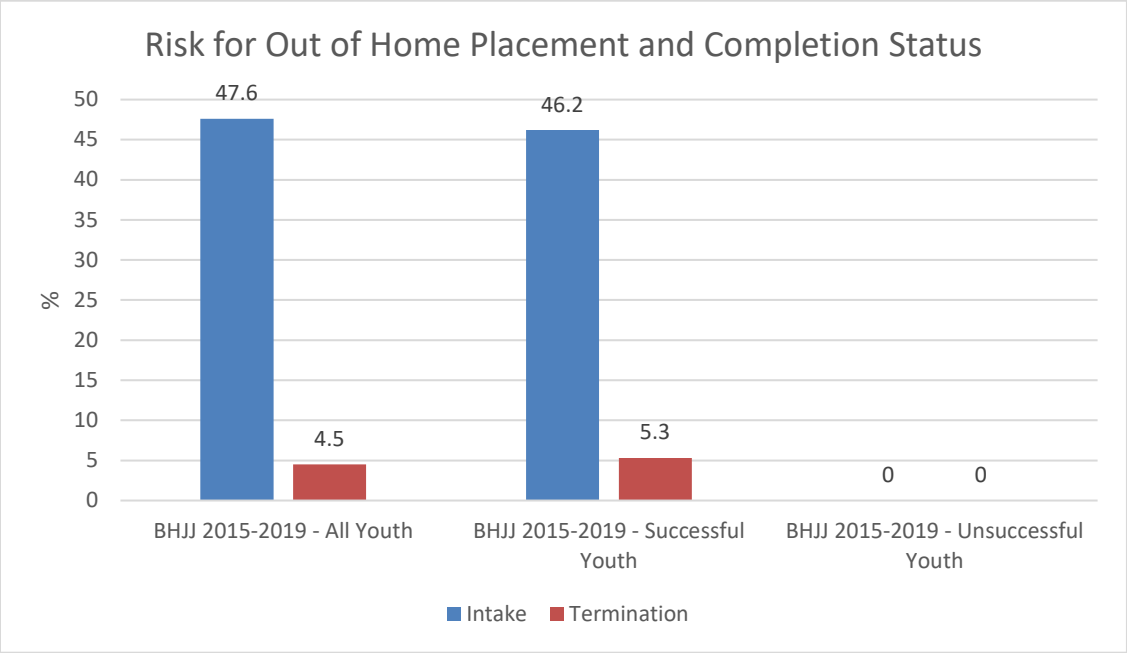
Average Length of Stay

Since the start of BHJJ, the average length of stay (ALOS) in the program was 130.5 days. For youth identified as successful treatment completers, the ALOS was 134.3 days while for unsuccessful treatment completers, the ALOS was 49.0 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, 47.6% of the youth (n = 20) were at risk for out of home placement. At termination, 4.5% (n = 1) of youth were at risk for out of home placement (see Figure 251). Of those youth who successfully completed BHJJ treatment, 5.3% (n = 1) were at risk for out of home placement at termination while 0% of youth who completed unsuccessfully were at risk for out of home placement (see Figure 251).

Figure 251.



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 services through BHJJ. Workers reported that police contacts had been reduced for 70.8% (n = 17) of the youth and had stayed the same for 8.3% (n= 2) of the youth. Police contacts increased for 8.3% of youth (n = 2) of the youth and the worker was unable to estimate for 12.5% (n = 3) of the youth.

YSSF

Upon completion of the BHJJ program, the caregiver was asked about their overall satisfaction with the services they received through the BHJJ program in Ashtabula County as well as how services impacted their children and family. At termination from the BHJJ program, 95.1% (n =39) of caregivers either strongly agreed or agreed that the BHJJ staff were sensitive to their cultural/ethnic background and 92.7% (n = 38) either strongly agreed or agreed that the location of the services was convenient (see Figure 252). Over forty-seven percent (47.6%, n = 20) of caregivers reported that as a result of the services their child/family received, their child gets along better with family members and 57.2% (n = 24) reported their child is doing better with school/work (see Figure 253).

Figure 252.

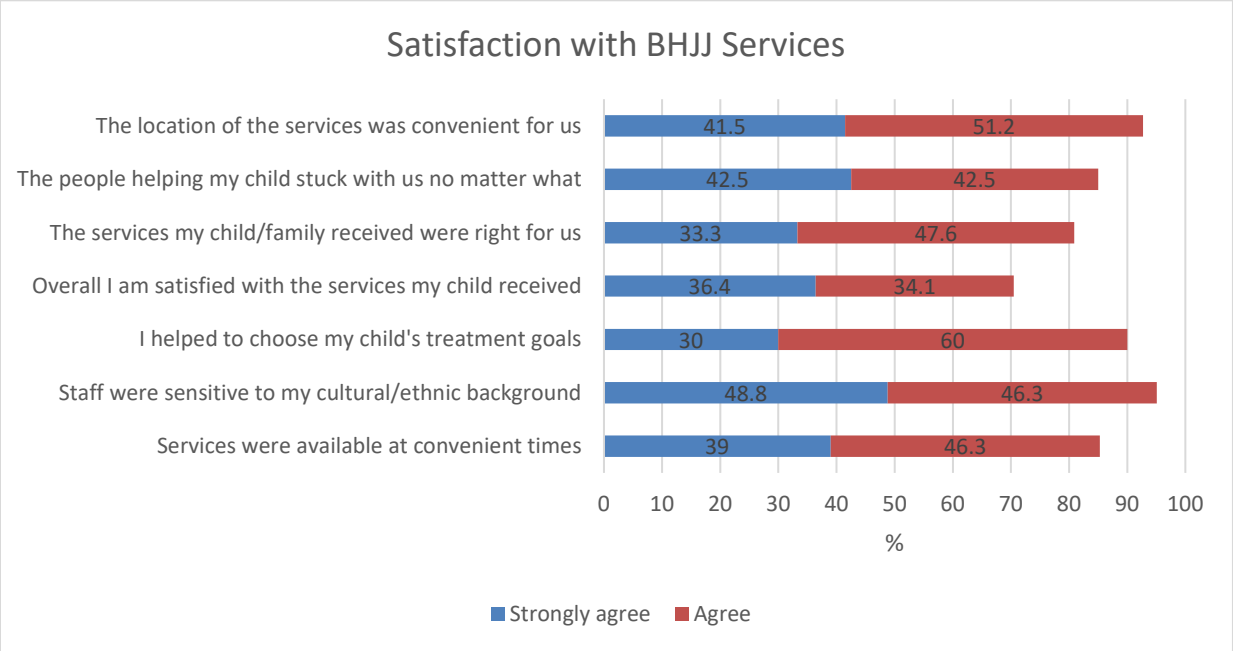
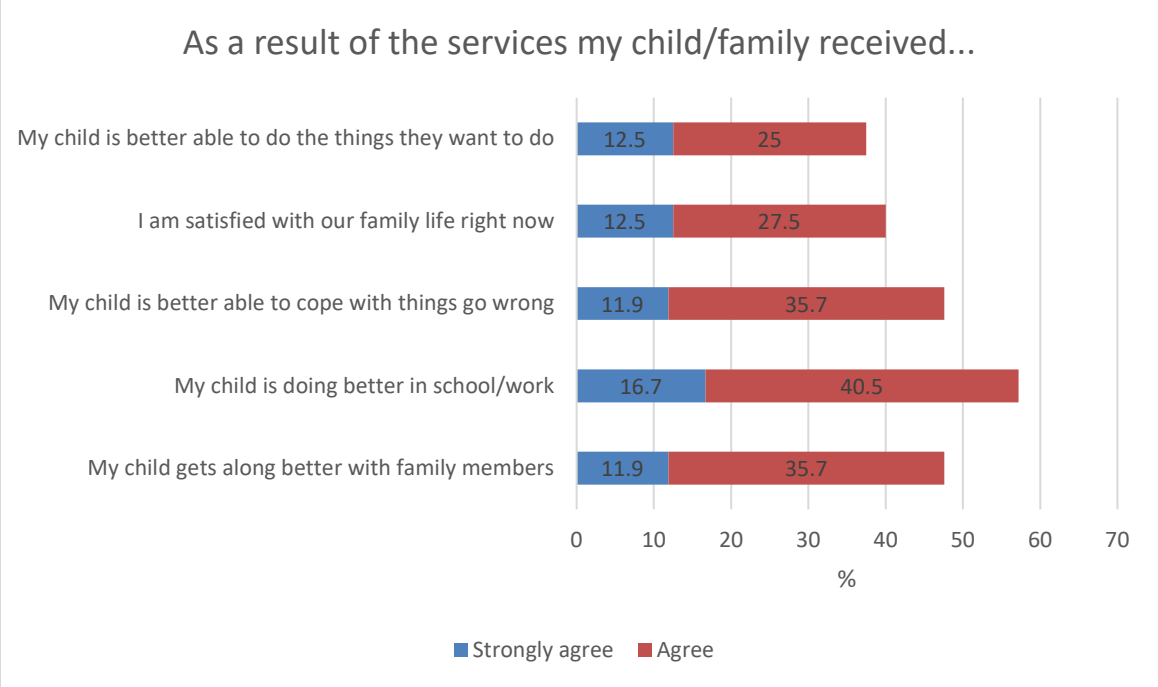


Figure 253.



Recidivism (July 1, 2015 – June 30, 2019)

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 misdemeanor and felony charges are presented in the following sections. Juvenile court history and recidivism information are presented at 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 (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 six months after termination from BHJJ we chose to include only those youth who had been terminated from BHJJ for at least six months prior to the end of the data collection period, June 30, 2019. 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 six month after termination analyses, a youth had to have been 17.5 years old or younger at the time of termination and must have been terminated at least six months prior to the end of the data collection period. The same criteria were applied to the intervals following enrollment in BHJJ. When examining new charges occurring within 12 months after enrollment, youth must be 17 years old or younger at the time of enrollment and the enrollment date must be at least twelve months prior to the end of the data collection period for inclusion in the analysis. Due to a small number of youth who terminated unsuccessfully, we were not able to separate out these data by completion status. These data focus on youth who were enrolled between July 1, 2015 and June 30, 2019.

Results

Previous Juvenile Court Involvement

Overall, 69.4% (n = 43) of BHJJ youth in Ashtabula county enrolled between July 1, 2015 and June 30, 2019 had a misdemeanor charge, 6.5% (n = 4) had a felony charge, and 58.1% (n = 36) were adjudicated delinquent in the 12 months prior to enrollment (see Table 318).

Table 318. Charges Prior to Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 62)	54.8% (n = 34)	6.5% (n = 4)	43.5% (n = 27)
12 months (n = 62)	69.4% (n = 43)	6.5% (n = 4)	58.1% (n = 36)
18 months (n = 62)	72.6% (n = 45)	6.5% (n = 4)	58.1% (n = 36)

Recidivism after Enrollment

We defined recidivism after enrollment as receiving a new charge or adjudication at 6, 12, and/or 18 months after a youth's BHJJ enrollment date (see Table 319). In the 12 months after enrollment in BHJJ, 50.9% (n = 28) of participants were charged with at least one new misdemeanor, 7.3% (n = 4) were charged with at least one new felony, and 76.4% (n = 42) were adjudicated delinquent.

Table 319. Recidivism after BHJJ Enrollment

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 60)	31.7% (n = 19)	5.0% (n = 3)	61.7% (n = 37)
12 months (n = 55)	50.9% (n = 28)	7.3% (n = 4)	76.4% (n = 42)
18 months (n = 40)	50.0% (n = 20)	7.5% (n = 3)	72.5% (n = 29)

Recidivism after BHJJ Termination

We defined recidivism after termination as receiving a new charge or adjudication in the 6, 12, and 18 months after a youth's BHJJ termination date (see Table 320). In the 12 months after termination from BHJJ, 41.9% (n = 18) of youth were charged with at least one new misdemeanor, 2.3% (n = 1) were charged with at least one felony, and 48.8% (n = 21) were adjudicated delinquent.

Table 320. Recidivism after BHJJ Termination

	% of Youth with Misdemeanors	% of Youth with Felonies	% of Youth Adjudicated Delinquent
6 months (n = 54)	29.6% (n = 16)	3.7% (n = 2)	40.7% (n = 22)
12 months (n = 43)	41.9% (n = 18)	2.3% (n = 1)	48.8% (n = 21)
18 months (n = 39)	48.7% (n = 19)	2.6% (n = 1)	56.4% (n = 22)

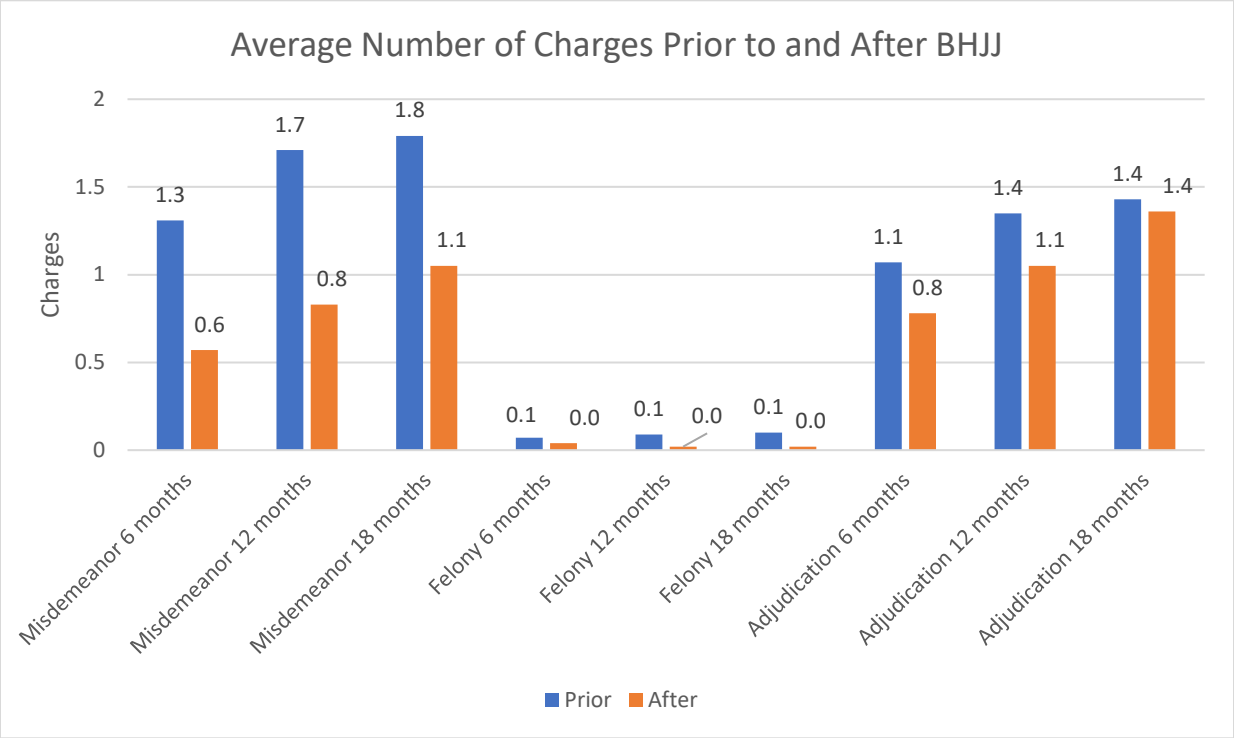
ODYS Commitments

None of the 62 youth who enrolled since July 1, 2015 were sent to an ODYS facility at any time following their enrollment in BHJJ, including after a youth's termination from BHJJ.

Average Numbers of Charges and Adjudications

In addition to whether a youth was charged or adjudicated delinquent, we examined whether there were differences in the average number of charges and adjudications in equivalent periods of time prior to enrollment and after termination. We conducted paired samples *t*-tests to examine whether there were statistically significant differences in the mean number of charges and adjudications at each time period prior to and after BHJJ participation. Figure 254 shows the average number of charges for youth who had data at both time periods. This restriction resulted in a sample of 54 youth at 6 months, 42 youth at 12 months, and 39 youth at 18 months. **Paired samples *t*-tests revealed statistically significant declines in the average number of misdemeanor charges at each of the time periods we examined.** For example, the average number of misdemeanor charges 12 months prior to BHJJ enrollment was 1.71 while the average number of misdemeanor charges 12 months after BHJJ termination was 0.83.

Figure 254.



Note. The average number of felony charges 6 months after BHJJ was 0.04 and the average number of felony charges at 12 and 18 months after BHJJ was 0.02.

References

Abram, K. M., Teplin, L. A., McClelland, G. M., & Dulcan, M. K. (2003). Comorbid psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 60*(11), 1097-1108.

Briere, J. (1996). *Trauma Symptom Checklist for Children (TSCC) Professional Manual*. Odessa, FL: Psychological Assessment Resources.

Cocozza, J. & Skowyra, K. (2000). Youth with mental health disorders: Issues and emerging responses. *Office of Juvenile Justice and Delinquency Prevention Journal, 7*(1), 3-13.

Cuellar, A.E., McReynolds, L., & Wasserman, G. (2006). A cure for crime: Can mental health treatment diversion reduce crime among youth? *Journal of Policy Analysis and Management, 25*(1), 197-214.

Feinstein, R. A., Lampkin, A., Lorish, C. D., Klerman, L. V., Maisiak, R., & Oh, M. K. (1998). Medical status of adolescents at time of admission to a juvenile detention center. *Journal of Adolescent Health, 22*(3), 190-196.

Friedman, R., Katz-Levy, J., Manderscheid, R., & Sondheimer, D. (1996). Prevalence of serious emotional disturbance in children and adolescents. In R. Manderscheid & M. A. Sonnenschein (Eds.), *Mental health in the United States* (pp. 71-89). Rockville, MD: U.S. Department of Health and Human Services.

Goldstrom, I., Jaiquan, F., Henderson, M., Male, A., & Manderscheid, R.W. (2000). The availability of mental health services to young people in juvenile justice facilities: A national survey. In R.W. Manderscheid and M.J. Henderson (Eds.) *Mental Health, United States, 2000* (DHHS Publication No. SMA-01-3537, pp.248-268). Washington, DC: U.S. Government Printing Office.

Hoge, R. D. (2002). Standardized instruments for assessing risk and need in youthful offenders. *Criminal Justice and Behavior, 29*, 380-396.

Kretschmar, J.M., Butcher, F., Flannery, D.J., & Singer, M.I. (2016). Diverting juvenile justice-involved youth with behavioral health issues from detention: Preliminary findings from Ohio's Behavioral Health Juvenile Justice (BHJJ) Initiative. *Criminal Justice Policy Review, 27,* 302-325.

Kretschmar, J.M., Butcher, F., Kanary, P.K., & Devens, R. (2015). Responding to the mental health and substance abuse needs of youth in the juvenile justice system: Ohio's Behavioral Health/Juvenile Justice Initiative. *American Journal of Orthopsychiatry, 85,* 515-521.

Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K.,

& Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry, 49*(10), 980-989.

Nordess, P., Grummert, M., Banks, D., Schindler, M., Moss, M., Gallagher, K., & Epstein, M. (2002). Screening the mental health needs of youths in juvenile detention. *Juvenile & Family Court Journal, 53*(2), 43-50.

Novins, D. K., Duclos, C. W., Martin, C., Jewett, C. S., & Manson, S. M. (1999). Utilization of alcohol, drug, and mental health treatment services among American Indian adolescent detainees. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*, 1102-1108.

Ogles, B. M., Melendez, G., Davis, D. C., & Lunnen, K. M. (2001). The Ohio Scales: Practical outcome assessment. *Journal of Child and Family Studies, 10*(2), 199-212.

Otto, R.K., Greenstein, J.J., Johnson, M.K., & Friedman, R.M. (1992). Prevalence of mental disorders among youth in the juvenile justice system. In J.J. Cocozza (Ed.), Responding to the mental health needs of youth in the juvenile justice system. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System.

Schwalbe, C. S., Gearing, R. E., McKenzie, M. J., Brewer, K. B., Ibrahim, R. (2012). A meta-analysis of experimental studies of diversion programs for juvenile offenders. *Clinical Psychology Review, 32*, 26-33.

Shufelt, J. L. & Cocozza, J. J. (2006). Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study. Delmar, NY: National Center for Mental Health and Juvenile Justice.

Singer, M. I., Anglin, T. M., Song, L. y. & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. *Journal of the American Medical Association,* 273(6), 477-482.

Skowrya, K. & Powell, S. (2006). Juvenile diversion: Programs for justice-involved youth with mental health disorders. Delmar, NY: National Center for Mental Health and Juvenile Justice.

Soler, M. (2002). Health issues for adolescents in the justice system. *Journal of Adolescent Health, 31,* 321-333.

Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 59*(12), 1133-1143.

U.S. Department of Health and Human Services. (2005). National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program. Rockville, MD: Author.

U.S. Department of Justice. (2005). Department of Justice activities under Civil Rights of Institutionalized Persons Act: Fiscal year 2004. Washington, DC: Author.

Wasserman, G. A., McReynolds, L. S., Ko, S. J., Katz, L. M., & Carpenter, J. R. (2005). Gender differences in psychiatric disorders at juvenile probation intake. *American Journal of Public Health, 95*(1), 131-137.

Wasserman, G. A., McReynolds, L., Lucas, C., Fisher, P., & Santos, L. (2002). The Voice DISC-IV with incarcerated male youths: Prevalence of disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(3), 314-321.

Wasserman, G. A., McReynolds, L. S., Schwalbe, C. S., Keating, J. M., & Jones, S. A. (2010). Psychiatric disorder, comorbidity, and suicidal behavior in juvenile justice youth. *Criminal Justice and Behavior*, 37(12), 1361-1376.