

The Impact of COVID-19 on Youth Enrolled in Ohio's Behavioral Health Juvenile Justice (BHJJ) Initiative

Satabdi Samtani, PhD, Jeff Kretschmar, PhD,
& Ashley Bukach, MPH



Begun Center for Violence
Prevention Research and Education



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

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Executive Summary

Background

The COVID-19 pandemic created unprecedented challenges for youth involved in the juvenile justice system. Research documented significant increases in anxiety and depression among adolescents during this period, rises in emergency department visits for suspected youth suicide attempts, and U.S. homicide rates increased approximately 30% in the first year of COVID-19, with justice-involved youth facing additional losses of school, peer relationships, and community-based protective factors. Despite these pressures, community-based diversion programs demonstrated relative continuity, though the pandemic-driven behavioral health workforce shortage further strained service capacity.

Ohio's Behavioral Health Juvenile Justice (BHJJ) initiative diverts youth with mental health and substance use needs away from detention and into community-based treatment programs. COVID-19 significantly disrupted BHJJ operations: courts slowed, in-home services were temporarily paused, and families were reluctant to allow staff into their homes. Unfortunately, established BHJJ data collection processes were also significantly disrupted during the pandemic, resulting in data that were deemed to be incomplete and unreliable and which were therefore excluded from this analysis.

This report compares 1,894 youth across 15 Ohio counties: 1,280 in the pre-COVID cohort (January 2016–October 2019) and 614 in the post-COVID cohort (January 2021–November 2024). **Part I** seeks to shed light on whether the pandemic resulted in significant changes in the BHJJ population needs by comparing pre- and post-COVID youth at intake across variables related to demographics, clinical characteristics, trauma, substance use, delinquency, resiliency, and caregiver satisfaction. **Part II** addresses the question of whether BHJJ services continued to effectively address the needs of the population by examining program outcomes for the post-COVID cohort from intake to termination, including behavioral health functioning, academic performance, and placement stability.

Part I: Pre- and Post-COVID Intake Comparisons

Demographics

- In both periods, approximately two-thirds of the youth were male; average age was 15 years.
- Post-COVID, Black youth made up a larger share of enrollees (44% to 48%) and White youth a smaller share (45% to 38%); Hispanic youth increased from 5% to 7%.
- The proportion of families earning below \$25,000 decreased from 62% pre-COVID to 46% post-COVID, while the proportion earning \$75,000 or more doubled (6% to 13%).

Youth and Family History

- Females showed significant increases in domestic violence exposure (34% to 47%) from pre- to post-COVID.

- Males showed a significant increase in having a caregiver with a mental illness other than depression (36% to 46%) from pre- to post-COVID.

DSM Diagnoses

- Over 80% of youth in both cohorts presented with at least one behavioral health diagnosis.
- Youth with Anxiety Disorders (6% to 18%), PTSD (9% to 19%), and Trauma and Stressor-Related Disorders (2% to 9%) all increased significantly post-COVID.
- The proportion of youth with Oppositional Defiant Disorder (36% to 25%), co-occurring disorders (35% to 25%), and any substance use disorder (36% to 26%) all decreased post-COVID.

Trauma Symptoms

- Compared to pre-COVID females, post-COVID females reported increased trauma symptomatology, with the largest increases in Anger and Posttraumatic Stress.
- For males, Posttraumatic Stress and Dissociation increased significantly in the post-covid group.
- Loneliness increased significantly among post-COVID males (37% to 46%); suicidal ideation was stable across both genders pre- and post-COVID.

Ohio Scales

- At post-COVID intake, Black youth showed lower problem severity and higher functioning than White youth, who showed the opposite pattern.
- Problem severity decreased and functioning increased significantly for Black males between the pre- and post-COVID periods.

Violence and Delinquency

- Theft, witnessing physical attacks, and verbal bullying all declined significantly post-COVID.
- Reports of someone close to the youth being murdered increased slightly (22% to 26%), consistent with national homicide trends during the pandemic.

Substance Use

- Although the presence of any substance use disorder decreased post-COVID (36% to 26%), youth reported increased use of some substances but decreased use of others, with different patterns emerging for males and females.
- Cannabis use increased (67% to 75%), hallucinogen use rose (7% to 10%), and sedative use declined (10% to 6%) in the post-COVID group.
- Among females, cannabis (58% to 73%), alcohol (53% to 64%), and hallucinogens (4% to 11%) all increased significantly; no significant substance use change was detected for males.

Resiliency

- Male resiliency scores were stable across both periods.
- Post-COVID females showed decreases in multiple interpersonal and peer support items.

Caregiver Satisfaction

- Satisfaction with the program remained positive in both periods, though many items that were "Strongly Agree" pre-COVID shifted to "Agree" post-COVID.
- The largest shifts were in response to questions about receiving adequate help, having someone for the child to talk to, and services being right for the family.
- Ratings for staff respect, cultural sensitivity, and caregiver participation remained relatively stable and positive.

Part II: Key Program Outcomes at Termination: Post-COVID Cohort

This section of the report examines program outcomes within the post-COVID cohort (2021–2024), assessing changes from intake to termination on youth behavioral health indicators.

Trauma Symptoms: Intake to Termination

- Both males and females reported significant improvements across all trauma domains from intake to termination.
- The largest areas of improvement for males: Anger and Posttraumatic Stress. For females: Anger, Posttraumatic Stress, and Depression.

Ohio Scales (Worker Rating)

- Workers indicated that Problem Severity and Functioning improved significantly at termination for both males and females.

Academic Performance

- Grades improved significantly from intake to termination, with more than twice as many youth improving their grades as worsening.

Out-of-Home Placement Risk

- The proportion of youth at risk for out-of-home placement decreased by 44% from intake to termination. Most youth (77%) who remained at risk of out-of-home placement at termination did not successfully complete the program.

Program Completion

- Approximately 3 out of 4 youth (74%) successfully completed BHJJ post-COVID, up from 70% pre-COVID.
- Successful program completion among Black youth improved significantly from 62% pre-COVID to 71% post-COVID. No change in successful completion rate was observed for White youth (77.7% pre-COVID to 76.9% post-COVID).

Juvenile Justice Outcomes

- Workers indicated 73% of post-COVID youth reduced their police contact since starting BHJJ services, with males showing the highest rate of reduction (75%).
- At any time after their BHJJ enrollment, 3.7% (n = 22) of youth were committed to an ODYS facility while 3.3% (n = 20) were committed to a CCF.

The Impact of COVID-19 on Youth Enrolled in Ohio's Behavioral Health Juvenile Justice (BHJJ) Initiative

Background

The COVID-19 pandemic created unprecedented challenges for youth involved in the juvenile justice system, presenting a "*perfect storm*" of increased stressors and diminished support systems (Reid et al., 2021). Research across general youth populations documented significant increases in anxiety, depression, and externalizing behaviors during the pandemic, with systematic reviews reporting anxiety symptoms in up to 49.5% of children and adolescents and depression symptoms in up to 63.8% (Panchal et al., 2023; Bussières et al., 2021). These risks were compounded for justice-involved youth, who faced the additional loss of school, peer relationships, and community-based supports that had served as protective factors (Reid et al., 2021). During this crisis, diversion programs, which direct youth away from formal court processing and detention into community-based interventions, emerged as both a protective strategy and a resilient alternative to traditional justice responses. Understanding how these programs functioned during the pandemic reveals critical insights about the future of youth justice reform.

The Crisis Context: Amplified Vulnerabilities

Justice-involved youth experienced significant psychological distress during the pandemic that underscored the urgency of maintaining community-based alternatives to detention. A longitudinal study of Florida youth on probation documented statistically significant increases in aggressive behavior, poor frustration tolerance, and suicidal ideation when comparing post-COVID conditions to pre-COVID baselines, partly driven by the loss of positive connections such as school, recreational activities, and peer relationships that had previously served as protective factors (Reid et al., 2021).

Beyond justice-involved populations, research consistently documented increases in internalizing behaviors such as anxiety and depression, externalizing behaviors including conduct disorder and hyperactivity, and sleep disturbances among children and adolescents during the pandemic, with young people found to be at higher risk than adults (Bussières et al., 2021; Panchal et al., 2023). This distress occurred against a backdrop of rising levels of community violence, with homicide rates in the United States increasing approximately 30% during the first year of the pandemic across both urban and rural areas (Kegler et al., 2022).

For youth confined in secure facilities, responses to the pandemic often involved the adoption of practices known to induce trauma. COVID-19 safety policies such as "medical isolation" and mandatory social distancing often replicated the conditions of solitary

confinement, a practice known to cause severe psychological damage including paranoia, psychosis, and obsessive thoughts (Vivrette et al., 2020). Research in male prisons found that anxiety and depression were significantly associated with feeling unsafe at night and experiencing staff harassment, factors unrelated to virus transmission but exacerbated by the restricted conditions of pandemic-era detention (Fix et al., 2024).

Specific studies focusing on clinical and high-risk youth populations found a more concerning story. Emergency department visits for suspected suicide attempts among youth aged 12–25 rose during portions of the pandemic period (Yard et al., 2021), and research with clinical adolescent populations documented shifts in the severity of attempts and the nature of precipitating factors, particularly social stressors following return to school (Gracia-Liso et al., 2024). Some national surveillance data from early in the pandemic (mostly 2020); however, were unable to reflect the same pattern, with rates of serious suicidal ideation and attempts among high school students appearing comparable to pre-pandemic levels (Jones et al., 2021; CDC, 2020).

Diversion Programs: Demonstrated Resilience During Crisis

Despite systemic disruptions, court-mandated diversion programs proved resilient during the COVID-19 crisis. An examination of a post-arrest diversion program in Miami-Dade County found that completion rates averaged 88% across both 2019 and 2021 (McBurney, 2024), demonstrating the adaptability of community-based interventions amid unprecedented challenges.

Maintaining program effectiveness required significant adaptations in service delivery. Substance use treatment faced severe disruptions as facilities closed, evidence-based programs were terminated, and the number of people on waitlists grew (Lockwood et al., 2021). Telehealth emerged as a critical innovation, allowing programs to maintain family-based treatment during physical distancing. Video conferencing in youth courts surged from 40% to 91% during the pandemic, enabling youth to maintain connections with families, legal counsel, and treatment providers (Tolou-Shams et al., 2022). However, youth in low-income and rural families often lacked reliable internet access or devices, meaning virtual service delivery benefits were unevenly distributed (Tolou-Shams et al., 2022).

While diversion programs demonstrated resilience, pre-existing racial disparities in access to diversion remained a critical concern. Nationally, delinquency cases involving White youth were diverted at a rate of 52%, compared to 40% for Black youth (Mendel, 2022). This gap represents thousands of Black youth processed through formal court systems and potentially detained rather than redirected to community-based interventions. The pandemic did little to close these gaps; if anything, disruptions to court operations and community-based services during COVID-19 risked further limiting diversion access for

youth who were already least likely to be redirected away from formal processing (Mendel, 2022).

Lessons Learned and Path Forward

The pandemic experience offers important lessons for juvenile diversion programming. First, it demonstrated that community-based interventions can maintain effectiveness even during unprecedented disruptions, provided they receive adequate support and flexibility to adapt. Robust completion rates during a global crisis should strengthen confidence that diversion programs can serve the vast majority of youth referred to the justice system (McBurney, 2024).

Second, the pandemic accelerated a pre-existing behavioral health workforce shortage, resulting in fewer available providers, longer wait times, and reduced capacity to serve justice-involved youth at the precise moment demand for services was increasing (Lockwood et al., 2021). The rapid adoption of telehealth emerged as one promising response, offering tools for maintaining continuity of care and increasing access for geographically isolated families. While virtual service delivery cannot fully replace in-person therapeutic relationships, the challenge moving forward is preserving these innovations while addressing the digital divide that limits their reach.

Finally, the increases in anxiety, depression, and suicidal ideation documented across multiple studies in both general youth populations (Samji et al., 2022; Panchal et al., 2023; Viner et al., 2022) and justice-involved youth specifically (Reid et al., 2021; Fix et al., 2024) call for moving services "*upstream*" toward early intervention, preventing youth from ever entering the justice system rather than merely diverting them after arrest (Hoagwood et al., 2021). The pandemic's outcomes, combined with the documented trauma experienced by detained youth, strengthen the argument for expanding community-based alternatives to detention.

The challenges documented at the national level during the pandemic were reflected in Ohio, where the **Behavioral Health Juvenile Justice (BHJJ)** initiative continued to serve some of the state's most vulnerable justice-involved youth amid significant operational disruptions and changing behavioral health needs.

Ohio's Behavioral Health Juvenile Justice (BHJJ) Initiative

Over two decades ago, juvenile court judges across Ohio recognized an urgent problem when meeting with officials from the Ohio Department of Behavioral Health (ODBH) and the Ohio Department of Youth Services (ODYS). A significant number of youth entering the court system exhibited severe mental health and substance use disorders. Judges found themselves ill-equipped to properly identify, assess, and provide services to these youth, while viable community-based alternatives to detention remained scarce.

The state responded by supporting pilot initiatives in three Ohio counties designed to redirect youth requiring behavioral health services away from incarceration and toward community treatment programs. Though limited in scale, these pilots achieved measurable success in decreasing the number of youth with behavioral health needs committed to ODYS.

Recognizing the pilot's effectiveness, the ODBH and ODYS expanded funding in 2005 to launch the Behavioral Health Juvenile Justice (BHJJ) initiative across multiple Ohio counties. The expanded initiative sought to fundamentally improve how local systems identified, assessed, evaluated, and treated youth and families involved with multiple systems, while simultaneously evaluating the effectiveness of the model. Like its predecessor, BHJJ aimed to divert justice-involved youth experiencing mental health or substance use challenges from detention facilities into evidence-based community treatment programs.

To guide county implementation, the state developed eligibility parameters that counties could apply when screening youth for BHJJ services. These parameters included: documented DSM diagnosis, age range of 10-18 years, significant impairment in mental status, co-occurring substance abuse issues, established pattern of criminal activity, delinquency charges or adjudication, risk to community safety, history of trauma or domestic violence exposure, and involvement across multiple service systems. Counties maintained authority to determine which eligibility parameters to apply and how many parameters youth must satisfy for program admission.

From 2006 forward, 24 counties across Ohio have implemented BHJJ programs representing diverse geographic settings including urban centers, suburban areas, and rural communities. During the evaluation period, 15 unique counties participated across both cohorts: 12 in the pre-COVID cohort (2016–2019) and 14 in the post-COVID cohort (2021–2024), with 11 counties participating in both periods (Table 3). While mandated to deliver evidence-based or evidence-informed interventions, counties retained discretion in choosing treatment approaches appropriate for their specific populations. Treatment approaches utilized within BHJJ programs 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).

Though specific procedures differ across counties, juvenile court generally functions as the primary gateway into BHJJ. Youth facing criminal charges receive psychological evaluations to assess their suitability for the program. When youth satisfy program eligibility requirements and both the youth and family consent to involvement, a BHJJ recommendation is submitted to the court. Upon receiving judicial authorization, youth enter the program and receive referrals to designated treatment providers. The majority of participants continue under probation oversight while receiving BHJJ services. BHJJ operates under the principle of providing care in the least restrictive environment - consistent with community safety, which results in most services being delivered through home-based or outpatient modalities.

Impact of COVID-19 on BHJJ Operations

COVID-19 had a significant impact on the BHJJ program. For example, many courts halted or slowed operations and several of the in-home behavioral health services, such as MST and FFT, were impacted until safety protocols could be established. Some families were reluctant or refused to have agency staff in their homes. Several evidence-based practices (EBP's) transitioned to, or more fully embraced, telehealth services. The pandemic aggravated the already existing behavioral health workforce shortage, resulting in fewer behavioral healthcare workers, longer wait times, and fewer youth receiving services.

Historically, BHJJ data collection was done in person via paper and pencil surveys, which meant that data collection was also impacted by COVID-19. Since many court and agency staff had limited or no contact with youth and families during this time, data collection suffered. Eventually, fillable pdf versions of all existing data collection forms were created, which allowed providers to email surveys to clients and their caregivers. However, the poor quality and incomplete nature of the BHJJ data collected during the initial and follow-up waves of COVID-19 necessitated its removal from this report. Therefore, all BHJJ survey data collected in 2020 was removed from the analyses.

BHJJ Evaluation

Ongoing outcome evaluation of the BHJJ program is conducted by the Begun Center for Violence Prevention Research and Education at the Jack, Joseph and Morton Mandel School of Applied Social Sciences at Case Western Reserve University. The current BHJJ evaluation team includes Jeff Kretschmar (Principal Investigator), Ashley Bukach (Research Associate), and Satabdi Samtani (Senior Research Associate). Those seeking additional information or past evaluation reports may contact Dr. Jeff Kretschmar at jeff.kretschmar@case.edu or access <http://begun.case.edu/research/juvenile-justice/bhjj/>.

Reading This Report



Colored text is used throughout this report to **highlight** important information and guide readers to key details. **Tables** present mean values, response %, and significance levels. **Figures**, including comet graphs, slope graphs, and dumbbell plots, capture trends by gender, race, and cohort (pre- and post-COVID), as well as post-COVID outcomes from intake to termination.

Evaluation Overview and Objectives

Justice-involved youth experience significantly higher rates of mental health and substance use disorders than their non-involved peers (Shufelt & Coccozza, 2006; Tolou-Shams et al., 2022). Research consistently demonstrates that community-based, evidence-based interventions produce better outcomes for justice-involved youth than either detention or incarceration, particularly when interventions address co-occurring behavioral health needs (Mendel, 2022; Hoagwood et al., 2021). The BHJJ initiative works from this knowledge base to systematically identify and divert youth with mental health and substance use challenges into therapeutic community-based programs.

The primary goal of this evaluation report is to explore whether there are significant differences in the characteristics and needs of youth entering the BHJJ diversion program across two time periods: **a pre-COVID cohort (January 2016–October 2019)** and **a post-COVID cohort (January 2021–November 2024)**. Data from 2020 were excluded due to inconsistent collection during the acute pandemic phase.

This evaluation focuses predominantly on comparing youth at program entry across various demographic factors, presenting characteristics, and needs. Specifically, the analysis examines whether youth demographics, mental health symptoms, trauma exposure, substance use patterns, victimization experiences, and delinquency behaviors differed between the pre- and post-COVID cohorts at intake. Understanding these differences is critical for informing program planning, resource allocation, and service delivery approaches as the needs and characteristics of justice-involved youth may shift over time.

Additionally, this report includes a limited set of intake to termination outcome analyses for the post-COVID cohort of youth. This section is reminiscent of many of the previous BHJJ evaluation reports designed to examine program impact on youth behavioral health. These analyses provide context for understanding the impact of COVID-19 on program effectiveness.



Through this **comparative analysis**, the evaluation aims to document how the **population served by BHJJ may have changed over time** and to provide data-informed recommendations for ongoing program development and policy considerations.

Measures and Instrumentation

All instruments used in the BHJJ evaluation were administered either in TeleForm® format, a software program that enables data transmission via fax machine or scanner, or via fillable PDFs.

Ohio Youth Problems, Functioning, and Satisfaction Scales (Ohio Scales)

The Ohio Scales (Ogles, Melendez, Davis, & Lunnen, 2001) assess clinical outcomes for children with severe emotional and behavioral disorders and were developed to track service effectiveness. The measure evaluates four primary outcome domains through corresponding subscales: Problem Severity, Functioning, Hopefulness, and Satisfaction with services.

Three versions of the tool collect information about the youth from the caregiver, the youth, and the worker assigned to the case. For purposes of this report, worker-completed Ohio Scales were utilized. The Worker version includes the Problem Severity and Functioning scales but excludes the Satisfaction and Hopefulness scales. Each subscale generates an individual score, with a total score calculated by summing all items.

Trauma Symptom Checklist for Children (TSCC)

The Trauma Symptom Checklist for Children (TSCC) (Briere, 1996) is a 54-item self-report questionnaire containing six subscales that measure anxiety, anger, depression, posttraumatic stress, dissociation, and sexual concerns. Youth respond to questions about the frequency of specific thoughts, events, or behaviors using a 4-point Likert scale (0 = "never" to 3 = "almost all the time").

Substance Use Survey – Revised (SUS-R)

The Substance Use Survey Revised (SUS-R) was adapted from the SAMHSA-funded Tapestry Project, a demonstration and research initiative serving youth and families with significant behavioral and mental health needs in Cuyahoga County, Ohio. This measure collects youth-reported information about frequency of substance use across multiple categories, including tobacco, alcohol, marijuana, cocaine, painkillers, and additional substances.

Enrollment and Demographics Form (EDIF)

This form captures essential information at program entry, including enrollment date, reasons for BHJJ services, and DSM diagnoses. Additional data collected include out-of-home placement status, placement risk, and educational and vocational information.

Child Information Update Form (Termination Form)

Completed by treatment staff at program termination (i.e., discharge), this form documents DSM diagnoses, termination date and reasons, and out-of-home placement risk. The form also captures educational and vocational data and information regarding police contacts.

Victimization and Delinquency Questionnaire (VDQ)

The Victimization and Delinquency Questionnaire is a 33-item self-report survey that gathers information on childhood victimization (as witness or victim), delinquency, and negative peer interactions. Items are rated on a 5-point scale ranging from 0 (Never) to 4 (Almost every day). The instrument incorporates items adapted from multiple sources, including the Juvenile Victimization Questionnaire (Finkelhor, Hamby, Ormrod, & Turner, 2005). This survey is administered at intake and termination; for purposes of this report the intake responses have been used.

Caregiver Information Questionnaire (Intake and Termination)

Adapted from SAMHSA/Center for Mental Health Services (2005), this questionnaire records comprehensive information including demographics, risk factors, family composition, physical custody arrangements, abuse history, family mental health history, socioeconomic status, and presenting problems. This report utilizes CIQ intake information.

Youth Services Survey for Families (YSSF)

The Youth Services Survey for Families (YSSF) (SAMHSA) assesses caregiver satisfaction with services received by the youth and evaluates whether these services resulted in improved youth functioning. This measure is collected at termination from the program and administration was optional.

Resiliency Survey

The California Healthy Kids Survey - Resilience module is a 16-item self-report survey that measures external and internal assets associated with positive youth development. Youth complete the survey at both program intake and termination. Items are rated on a 4-point Likert scale ranging from "Not at all True" to "Very Much True." For this report, intake resiliency data were used.

Data Collection Schedule

The evaluation contains both required and optional questionnaires (see Table 1 and Table 2).

Table 1. **Required BHJJ Questionnaires**

Survey 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**

Survey 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

For this evaluation report, we focused only on the surveys and administration timepoints indicated in orange text in Tables 1 and 2.

Data Analysis Plan



This evaluation report examines **differences in youth characteristics and outcomes** across two time periods: a **pre-COVID cohort (January 2016–October 2019)** and a **post-COVID cohort (January 2021–November 2024)**. These time periods were specifically chosen to provide approximately equal durations for comparison, with each period spanning roughly 3.5 to 4 years. Note that neither 2019 nor 2024 represent full calendar years, as data collection ended in October 2019 and November 2024 respectively. Data from 2020 were excluded from the analysis due to incomplete surveys and high rates of missing data from disruptions to data collection during the early phase of the pandemic.

Analytical Approach

The analysis primarily utilizes descriptive statistics to characterize youth at program intake and to compare cohorts across the two time periods. Percentages were calculated based on available data, excluding missing responses.

Note: Due to rounding, percentages may not always total 100%

Description of the Analyses Used in the Report

Several types of statistical analyses are employed throughout this report to examine differences between groups and across time points.

Chi-square analysis is used to test relationships between categorical variables to determine if significant differences exist. For example, if we are interested in whether the proportion of youth reporting substance use differs between the pre- and post-COVID cohorts, a chi-square test is conducted. A statistically significant result indicates that the observed difference between cohorts is unlikely to have occurred by chance. Chi-square analyses are also used to examine differences across demographic groups, such as whether there are race differences in program completion.

Independent samples t-tests are used to compare mean scores on continuous measures between the pre-COVID and post-COVID cohorts. For instance, if we are interested in whether youth in the two cohorts differ in their levels of trauma symptoms, Problem Severity, or Functioning at intake, an independent samples t-test examines whether the corresponding means for the two groups significantly differ. A statistically significant result indicates that the average scores between cohorts represent real differences rather than those that could occur by chance. For ordinal scale items such as VDAQ responses, **Mann-Whitney U tests** were used as the appropriate non-parametric alternative, comparing mean ranks between pre- and post-COVID cohorts rather than means.

Paired samples t-tests are used to examine change within the post-COVID cohort from program intake to termination. These analyses assess whether youth demonstrated significant improvements in outcomes such as Problem Severity, Functioning, or Trauma Symptoms during their participation in BHJJ. Since paired samples t-tests compare the same individuals at two different time points, they account for individual variation and provide a more sensitive test of change over time. A statistically significant result indicates that the observed pre-post difference represents meaningful change rather than random fluctuation.

McNemar's tests are used to examine change within the post-COVID cohort from program intake to termination for outcomes that are measured as yes/no responses. In this report, McNemar's tests assess whether youth demonstrated significant changes in IEP status and risk of out-of-home placement during their participation in BHJJ. Since McNemar's test compares the same individuals at two different time points, it accounts for the paired structure of the data and provides a more sensitive test of change over time. A statistically significant result indicates that the observed difference between intake and termination represents real change rather than random fluctuation.

Wilcoxon Signed-Rank tests are used to examine change within the post-COVID cohort from program intake to termination for outcomes that are measured on an ordinal scale. In this report, a Wilcoxon Signed-Rank test assesses whether youth demonstrated significant change in academic performance during their participation in BHJJ, as reported by program workers at intake and termination. Since the Wilcoxon Signed-Rank test compares the same individuals at two different time points without assuming equal intervals between categories, it is the appropriate test for ordered categorical measures. A statistically significant result indicates that the observed shift in distribution from intake to termination represents real change rather than random fluctuation.

Organization of Findings

The report is organized into two parts. **Part I presents pre- and post-COVID intake comparisons**, beginning with descriptive characteristics of BHJJ youth at intake including demographic information and county enrollment, followed by comparisons between cohorts on key demographic variables, youth and family history, and standardized measures including the Ohio Scales, TSCC, SUS-R, VDQ, Resiliency surveys, and program satisfaction (YSSF). **Part II examines post-COVID program outcomes, assessing changes from intake to termination** within the post-COVID cohort only, including the TSCC, Ohio Scales, and termination (CIUF) survey results.

BHJJ Program Evaluation Findings

Part I: Pre- and Post-COVID Intake Comparisons

Overall Youth Characteristics

Based on enrollment data received, a total of 1,894 youth were represented across the two evaluation periods: 1,280 youth in the pre-COVID cohort (2016-2019) and 614 youth in the post-COVID cohort (2021-2024). Youth demographics at intake followed similar trends across pre- and post-COVID periods (see Figure 1).

Figure 1

Pre-COVID Group (n=1280)	Youth Demographics	Post-COVID Group (n=614)
GENDER 69.6% Male 30.4% Female		GENDER 67.9% Male 32.1% Female
RACE White 44.5% Black 44.3% Multiracial 9.4% Other 1.7%		RACE White 38.3% Black 47.9% Multiracial 10.3% Other 3.6%
ETHNICITY 5.3% Hispanic		ETHNICITY 7.2% Hispanic
AGE Ave age in years = 15.4 Minimum = 9 Maximum = 18		AGE Ave age in years = 15.4 Minimum = 11 Maximum = 18

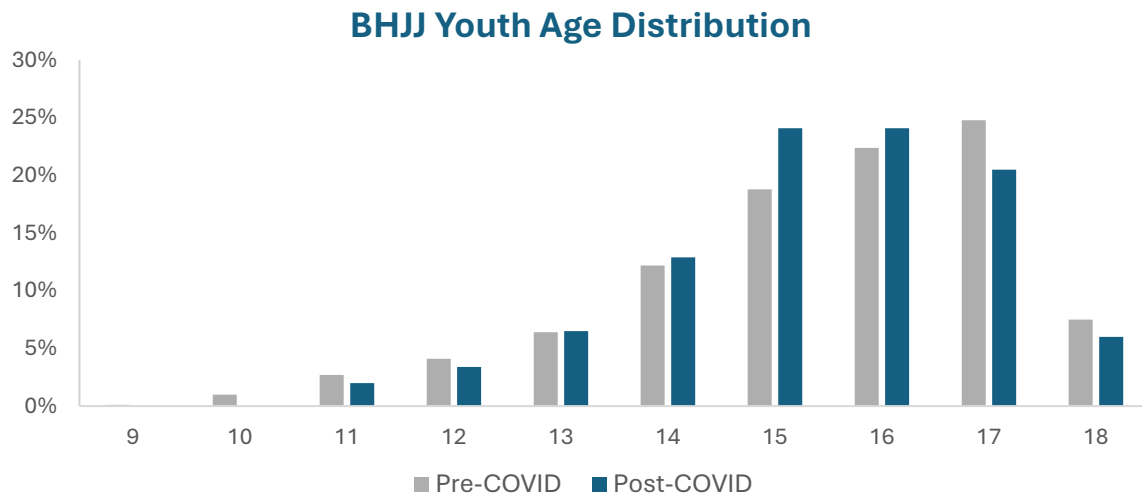
Youth Gender

Males comprised approximately **two-thirds** of the participants across both time periods (pre-COVID: 69.6%; post-COVID: 67.9%). **Females** comprised approximately **one-third** of enrolled youth in both periods (pre-COVID: 30.4%; post-COVID: 32.1%)

Youth Age

Age at enrollment was consistent across both cohorts, with a **mean age of 15.4 years** and a **median of 16 years** in both periods. Both cohorts were composed primarily of older adolescents ages 15–17, with the most common age at enrollment being 17 years in the pre-COVID cohort and 16 years in the post-COVID cohort (see Figure 2).

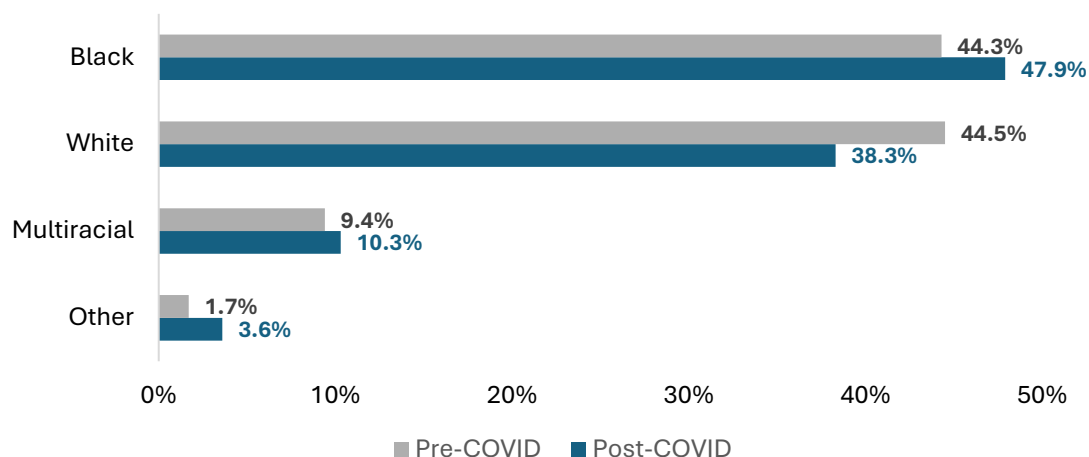
Figure 2: BHJJ Youth Age Distribution



Youth Race

As shown in Figure 3, the racial composition showed slight shifts between cohorts. In the pre-COVID cohort, **White** and **Black** youth were nearly **equally** represented (44.5% and 44.3%, respectively). In the post-COVID cohort, **Black** youth represented a slightly **larger proportion** (47.9%) compared to **White** youth (38.3%), with modest increases in multiracial and other race categories. The proportion of **Hispanic** youth **increased** from 5.3% to 7.2% across the two periods.

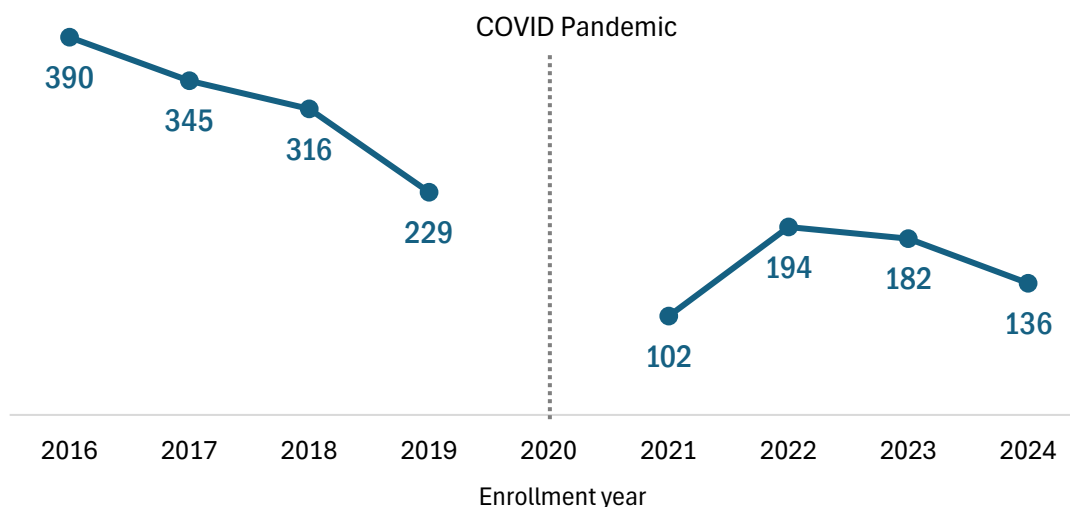
Figure 3: BHJJ Youth Race Composition



Enrollment Patterns

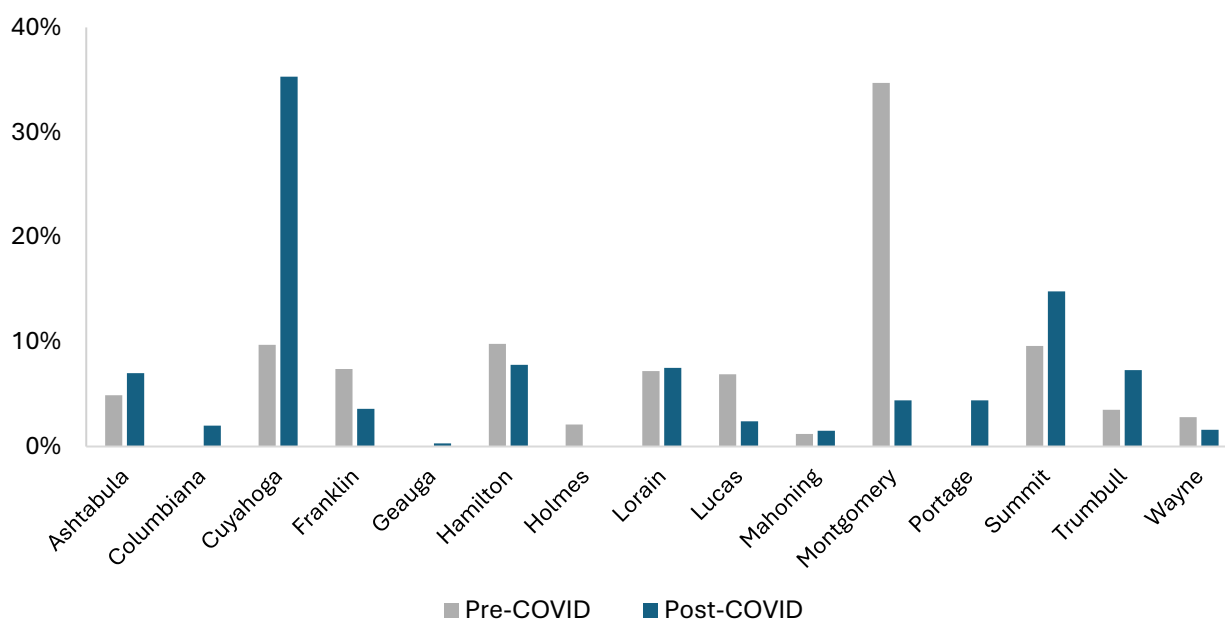
Within the pre-COVID period, the highest number of enrollments was recorded in 2016 (n=390, 30.4%), with numbers declining steadily through 2019 (n=229, 18.0%). The post-COVID cohort showed a different pattern, with enrollments increasing from 2021 (n=102, 16.6%) to peak in 2022 (n=194, 31.6%) before declining slightly in subsequent years.

Figure 4: **BHJJ Youth Enrollment by Year (2016–2024)**



As shown in Figure 5, BHJJ county representation varied across cohorts, reflecting differences in program participation across the pre-COVID and post-COVID periods.

Figure 5: **Youth Served Across BHJJ Counties: Pre- and Post COVID**



As shown in Table 3, 15 counties participated in BHJJ across both cohorts, though the distribution of youth served shifted considerably between periods. Montgomery County served the largest number of pre-COVID youth (n = 444), while Cuyahoga County served the largest number in the post-COVID cohort (n = 217).

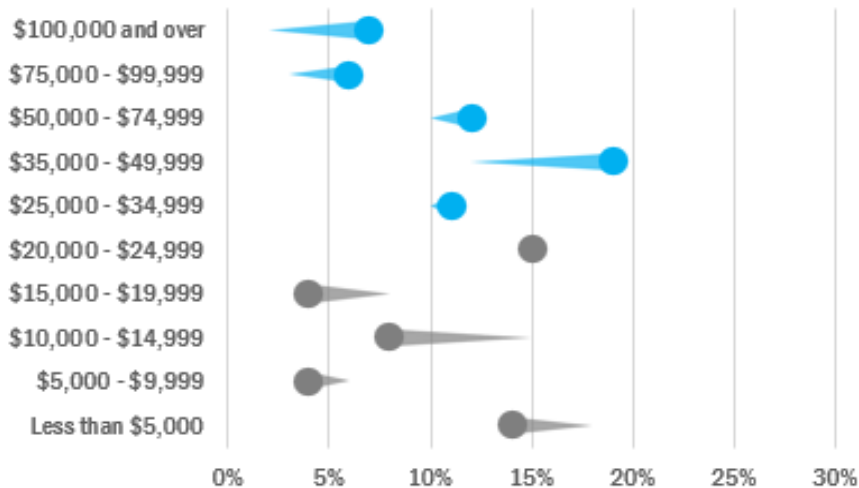
Table 3: BHJJ Youth Enrollment by County: Pre- and Post-COVID

BHJJ County	Pre-COVID (% , n)	Post -COVID (% , n)
Ashtabula	4.9% (n=63)	7.0% (n=43)
Columbiana	N/A	2.0% (n=12)
Cuyahoga	9.7% (n=124)	35.3% (n=217)
Franklin	7.4% (n=95)	3.6% (n=22)
Geauga	N/A	0.3% (n=2)
Hamilton	9.8% (n=126)	7.8% (n=48)
Holmes	2.1% (n=27)	N/A
Lorain	7.2% (n=92)	7.5% (n=46)
Lucas	6.9% (n=89)	2.4% (n= 15)
Mahoning	1.2 % (n=16)	1.5% (n=9)
Montgomery	34.7% (n=444)	4.4% (n=27)
Portage	N/A	4.4% (n=27)
Summit	9.6% (n=123)	14.8% (n=91)
Trumbull	3.5% (n=45)	7.3% (n=45)
Wayne	2.8% (n=36)	1.6% (n=10)
Total	100% (n=1280)	100% (n=614)

**Note: Due to rounding, percentages may not always total 100%*

How to read a Comet Graph? Comet graphs are a **visual tool** used to **compare two data points** across categories, making it easy to see both the direction and size of change at a glance. In the comet graph shared below, the **circular head** of each "comet" marks the post-COVID % for that income bracket, **while the tail** extends back toward the pre-COVID %, showing both the direction and level of change. **Blue comets** indicate income brackets that **increased** in the post-COVID period while **gray comets** indicate brackets that **decreased**. The **length of each tail** reflects how much the **% changed** between the two periods, with **longer tails signaling larger shifts**. Income brackets represented by a **dot** with no tail saw little to no change between the two time periods.

ALL FAMILIES



Family Income Trends for BHJJ Families

BHJJ has traditionally served families from lower-income households; however, **shifts in income distribution** were observed in the **post-COVID cohort**. Figure 6 illustrates these shifts visually across all families and by race, comparing the pre-COVID (2016–2019) and post-COVID (2021–2024) periods. The circular heads of each "**comet**" show where the post-COVID percentages landed, while the **tails** show the **direction and magnitude of change** from the pre-COVID period. **Blue comets** indicate income brackets that **increased** in the post-COVID period, while **gray comets** indicate brackets that **decreased**. The length of each tail represents how much the % changed between the two time periods.

Overall, a clear **downward shift** was observed in the proportion of families at the **lowest income levels**: 61.7% of pre-COVID families reported household incomes **below \$24,999**, compared to 45.8% post-COVID. At the same time, the proportion of families earning **\$75,000 or over** more than **doubled** from 5.7% to 12.8%. It is worth noting that some upward shift in reported income is expected over time given general wage growth across the comparison periods. For a **detailed breakdown of income distributions by race**, refer to **Appendix A**.

Across racial groups, **White families** showed the **sharpest upward shift**, with the proportion earning **\$100,000 or more** **increasing** from 4.0% to 14.0%, and the proportion earning less than **\$24,999** **dropping** from 50.1% to 32.5%. **Black families** saw **growth** in the **\$35,000–\$49,999** bracket (10.4% to 18.6%) and a **decrease** in the proportion earning less than **\$24,999** (73.1% to 55.8%), though **Black** families continued to have the **highest share** of **low-income** households among all racial groups. **Multiracial families** showed the **largest single-bracket shift**, with the proportion in the **\$35,000–\$49,999** bracket **more than doubling** from 12.1% to 27.3%.

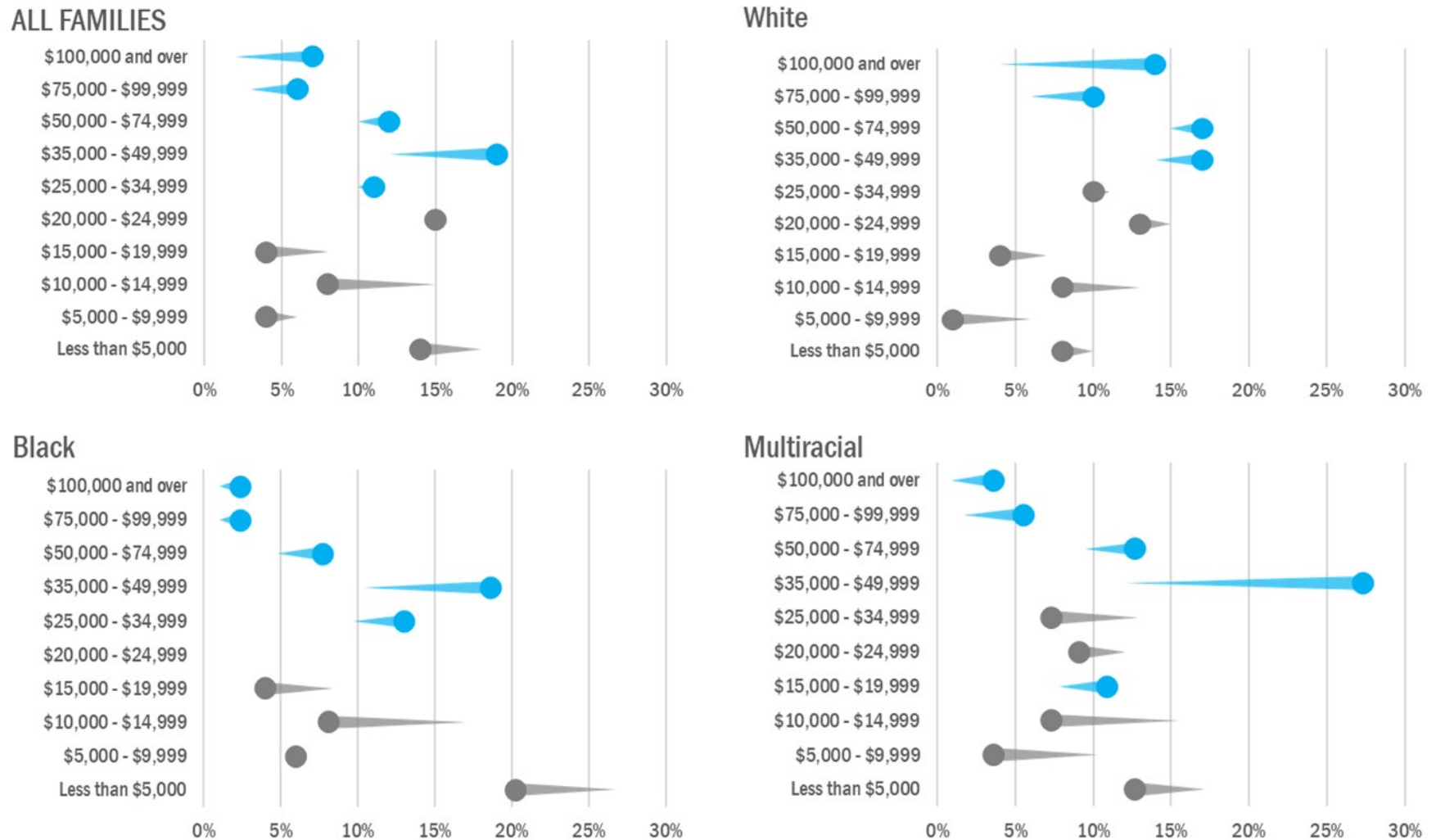


While some increase in income levels is expected over time, families entering BHJJ in the post-COVID period showed a **clear shift away** from the **lowest income brackets** across **all racial groups**, with proportionally more families reporting **moderate** to **higher** household incomes **compared** to the **pre-COVID period**.

Family Income Comparisons by Race

Post-COVID, families were **less concentrated** in the **lowest** income brackets and **more** represented in **higher** brackets across racial groups.

Figure 6



Youth and Family History



The Youth and Family History section examines trauma exposure, behavioral risk factors, and household characteristics reported by the caregiver at program intake. These indicators provide insight into the adversity and family context youth experienced prior to receiving BHJJ services. Youth entering the program exhibited a range of experiences including exposure to domestic violence, family mental health challenges, and histories of suicidal ideation and attempts.

Table 4 presents key youth and family history characteristics by gender across pre- and post-COVID periods. Rates of suicidal ideation and attempts remained relatively stable across periods for both genders, with females reporting higher rates than males at both time points. Among post-COVID **females**, a **statistically significant increase** was observed in **domestic violence exposure**. Among post-COVID **males**, a **statistically significant increase** was observed in **having a caregiver with mental illness (other than depression)**. A full summary of youth and family history characteristics by gender is provided in **Appendix B**.

Table 4: Selected Youth and Family History Characteristics by Gender and COVID Period

Characteristic	Males Pre-COVID	Males Post-COVID	Females Pre-COVID	Females Post-COVID
Child ever talked about suicide	33.6% (n=283)	35.6% (n=124)	52.3% (n=196)	59.4% (n=100)
Child ever attempted suicide	11.7% (n=98)	13.0% (n=46)	25.2% (n=92)	25.0% (n=43)
Child exposed to domestic violence	35.8% (n=303)	33.1% (n=117)	34.4% (n=129)	47.1% (n=80) **
Child's biological family member diagnosed with depression	62.8% (n=521)	64.5% (n=225)	67.0% (n=250)	71.4% (n=125)
Child's caregiver diagnosed with mental illness, other than depression	36.0% (n=141)	45.7% (n=91) *	39.4% (n=69)	41.2% (n=42)

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

Post-COVID, caregivers of females reported higher percentages across most items related to trauma exposure and household risk factors. Figure 7 illustrates shifts in caregiver-reported youth and family history indicators for **females** between pre- and post-COVID cohorts, while Table 4 above indicates the items that were statistically significant between the two periods. **Orange** comets indicate **increases** while **blue** comets indicate **decreases**, and the **grey** dot indicates **no change** between periods. Among **females**, the largest increases were observed in domestic violence exposure, **suicide ideation**, and substance use problems, while **suicide attempts in the last six months decreased** in the post-COVID period. Physical and sexual abuse rates showed smaller increases relative to other indicators. Physical and sexual abuse rates showed smaller increases relative to other indicators.

Caregiver Perceptions of Youth and Family History

Post-COVID, caregivers reported **higher** rates on most **trauma exposure** and some **household risk factors** for **females**.

Figure 7

Females

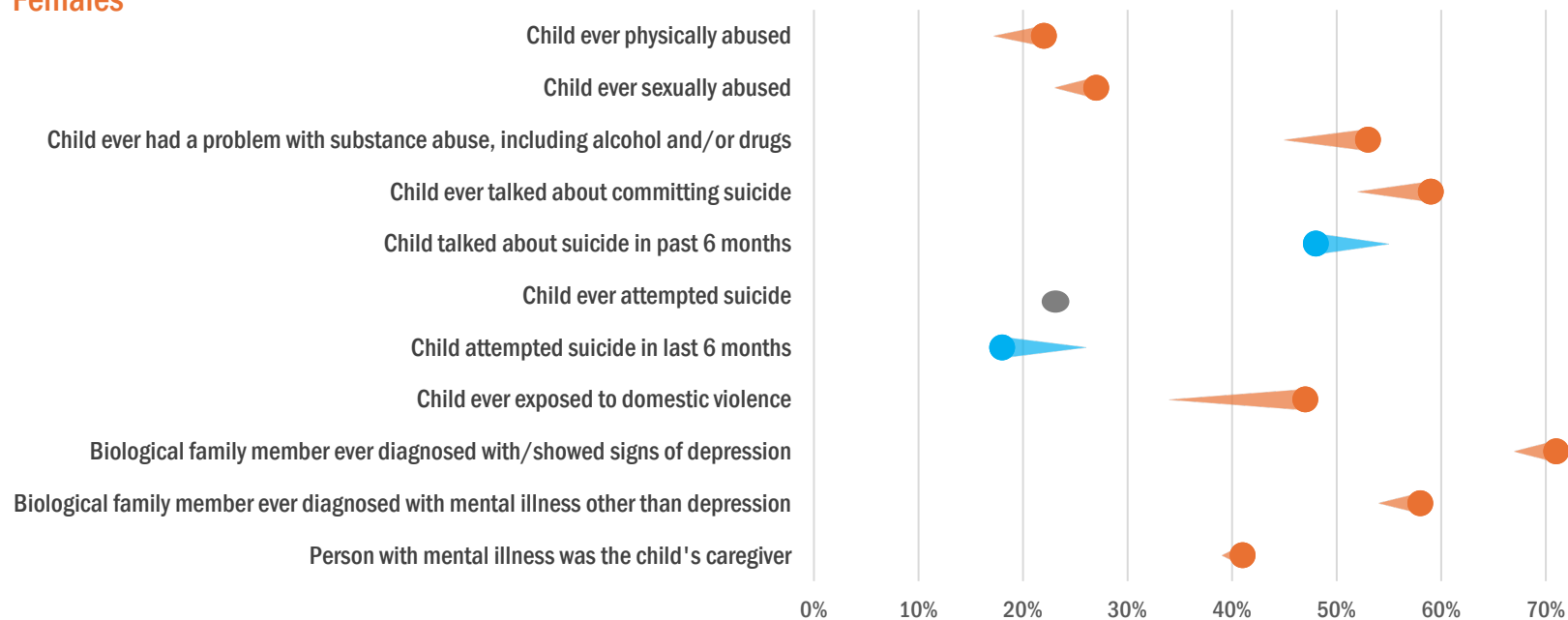
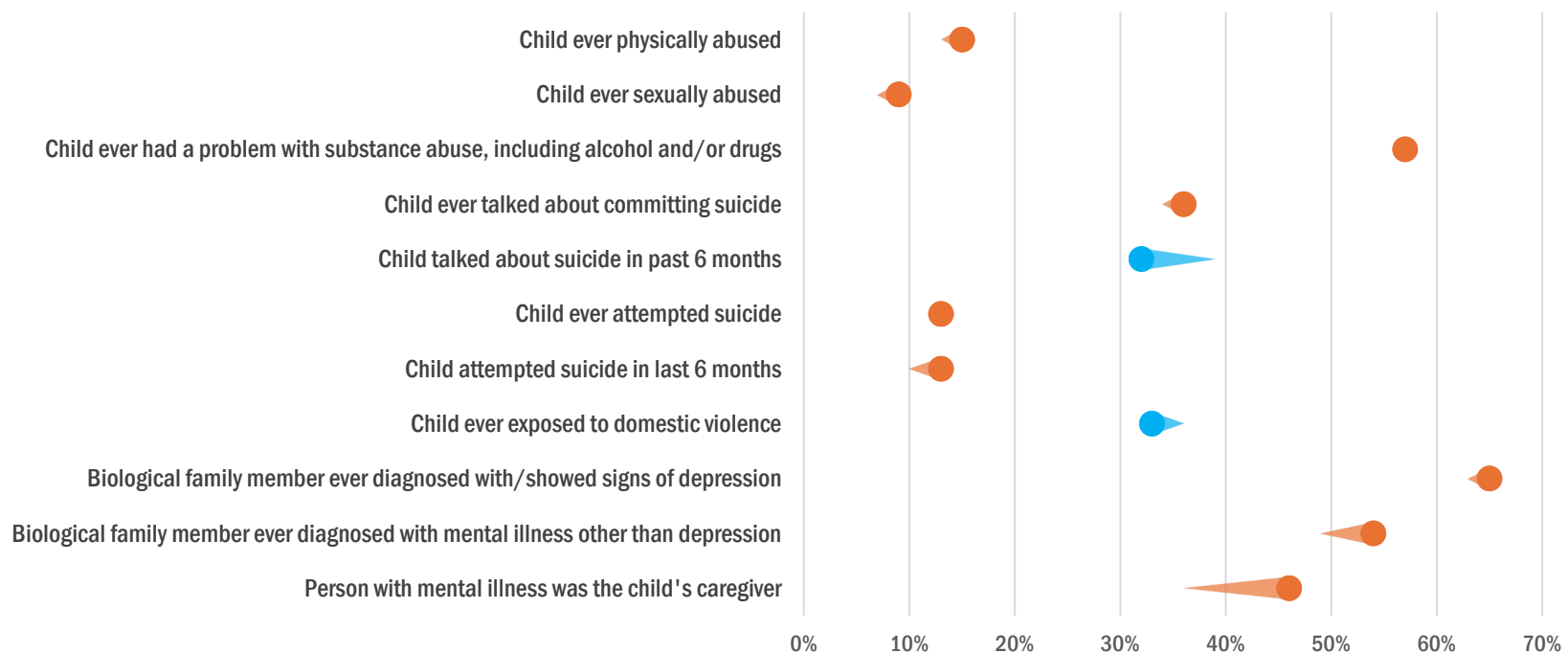


Figure 8 illustrates shifts in caregiver-reported youth and family history indicators for **males** between pre- and post-COVID cohorts, with Table 4 above indicating the items that were statistically significant between the two periods. Unlike reports for **females**, indicators for **males remained largely stable** across most items, as reflected by the **lack of comet tails** across most indicators. **Small increases** were observed in **biological family mental illness** and **caregiver mental illness**. **Domestic violence exposure** and **suicide talk in the past six months** showed **slight decreases** in the post-COVID period.

Post-COVID, caregivers reported **consistent trends** in trauma exposure and household risk factors for **males**.

Figure 8

Males

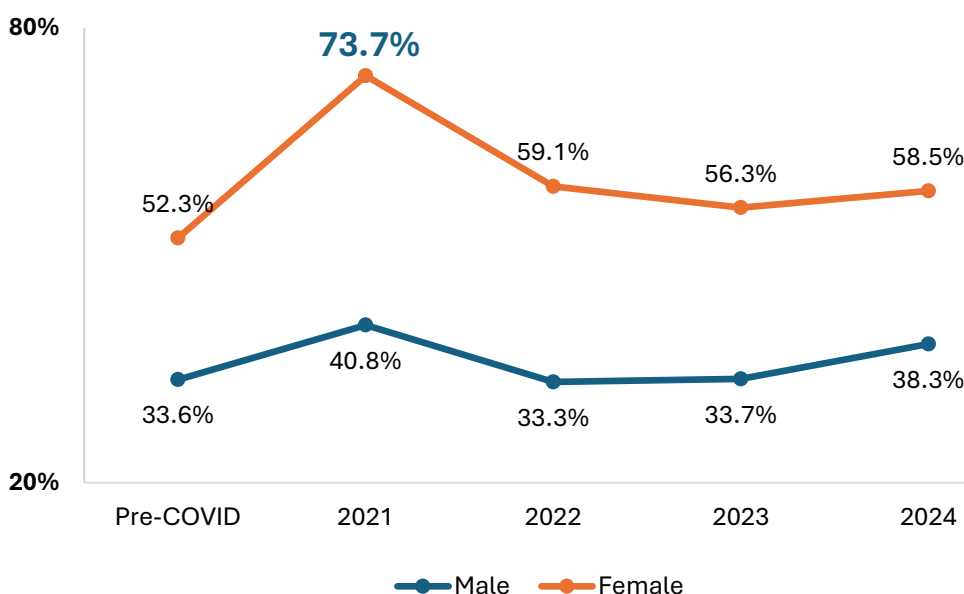


Gender Differences in Suicidal Ideation Across the Post-COVID Period

Research indicates that youth suicide risk and suicidal ideation increased during the COVID-19 pandemic, particularly among adolescents, as evidenced by rising emergency department visits for suspected suicide attempts and documented increases in suicidal ideation among justice-involved youth (Yard et al., 2021; Reid et al., 2021). Using the pre-COVID average as a reference point, Figure 9 displays caregiver-reported rates of **youth ever talking about suicide** year by year across the post-COVID period (2021–2024) by gender. **Male and female ratings rose in 2021**, before returning to levels close to the pre-COVID average in subsequent years.

Among **females**, caregiver-reported rates of the youth ever talking about suicide **peaked in 2021** at 73.7%, **declining** in subsequent post-COVID years.

Figure 9: Caregiver Reports of “Has Your Child Ever Talked About Suicide?”



Caregiver-reported **intake** indicators of trauma exposure and household risk factors were **higher** among post-COVID **females** across most items, with **statistically significant increases** in **domestic violence exposure** and **biological family depression diagnosis**. **Male** indicators remained **largely stable** across periods. **Suicide ideation** at intake **peaked in 2021** among **females**, consistent with national trends reported in the literature, before **declining** to levels slightly above the pre-COVID average in subsequent years.

DSM Diagnoses

Workers were asked to report any **DSM diagnoses** for youth 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 close to a youth's enrollment date in BHJJ. Table 5.1 presents the most common DSM diagnoses among BHJJ enrollees, comparing pre- and post-COVID cohorts.

Comparing worker-reported DSM diagnoses at intake, **shifts in diagnostic patterns** were observed between the two cohorts. **Anxiety Disorder** showed the **largest increase**, rising from **6.2% to 17.6%**, followed by **PTSD** from **8.5% to 19.4%**, and **Trauma and Stressor Related Disorder** from **2.3% to 9.0%**. Conversely, **Oppositional Defiant Disorder** showed the **largest decrease**, declining from **35.8% to 24.6%**, followed by **Cannabis-related Disorders** from **33.3% to 24.4%**. All differences noted above were **statistically significant** as indicated in Table 5.1.

Table 5.1: **Most Common DSM Diagnoses**

DSM Diagnosis	Pre-COVID (n = 1280)	Post-COVID (n = 614)
Adjustment Disorder	4.1% (n=52)	2.9% (n=18)
Alcohol-related Disorders	2.7% (n=35)	1.8% (n=11)
Anxiety Disorder	6.2% (n=80)	17.6% (n=108) ***
Attention Deficit Hyperactivity Disorder	30.4% (n=389)	26.9% (n=165)
Bipolar Disorder	2.0% (n=26)	1.5% (n=9)
Cannabis-related Disorders	33.3% (n=427)	24.4% (n=150) ***
Conduct Disorder	9.4% (n=121)	9.0% (n=55)
Depressive Disorders	18.1% (n=232)	20.0% (n=123)
Disruptive Mood Dysregulation Disorder	8.0% (n=103)	9.9% (n=61)
Oppositional Defiant Disorder	35.8% (n=458)	24.6% (n=151) ***
Post-traumatic Stress Disorder	8.5% (n=109)	19.4% (n=119) ***
Trauma and Stressor Related Disorder	2.3% (n=29)	9.0% (n=55) ***

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

Over **80% of youth in both cohorts** presented with at least **one mental health diagnosis** at intake, consistent with research documenting elevated rates of mental health disorders among justice-involved youth (Shufelt & Coccozza, 2006). Youth with **any substance use disorder significantly decreased** from **36.2% to 25.7%**; therefore, the percentage of youth with a **co-occurring disorder**, defined as the presence of both a mental health and a substance use disorder, also **declined significantly** from **34.8% to 25.1%**.

Table 5.2: **DSM Diagnosis Summary for Youth**

DSM Diagnosis Summary	Pre-COVID (n = 1280)	Post-COVID (n = 614)
Any Substance Use Disorder	36.2% (n=464)	25.7% (n=158) ***
Any Mental Health Disorder	86.5% (n=1107)	84.0% (n=516)
Co-Occurring Disorder	34.8% (n=446)	25.1% (n=154) ***
Any Disorder	87.9% (n=1125)	84.7% (n=520)

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



A pattern that remained consistent across both pre- and post-COVID periods was that **over 4 out of 5** youth entering the BHJJ program presented with a **diagnosable mental health disorder at intake**. The stability of this finding **aligns with existing research** that identifies significant behavioral health needs in the justice-involved youth population.

Trauma Symptom Checklist for Children (TSCC)

Youth completed the TSCC at **intake** to assess trauma-related symptoms across six domains. Higher scores on each subscale indicate greater symptom severity. **Females** consistently reported **higher** mean scores than **males** across all subscales **in both time periods**. Post-COVID **females** showed **significant increases** on **four** of six subscales, with the most notable rises in **Anger** (8.5 to 10.0), **Posttraumatic Stress** (7.3 to 8.5), and **Dissociation** (6.7 to 7.9). For **males**, most subscales showed **slight increases** post-COVID, with **Posttraumatic Stress** (4.9 to 6.0) and **Dissociation** (4.9 to 5.5) reaching **statistical significance**. **Sexual Concerns** remained stable for males but **increased significantly** for **females** post-COVID (3.0 to 3.8).

Table 6: Trauma Symptom Comparisons by Gender at Intake

Sub-Scale Item	Male (mean, n) Pre-COVID	Male (mean, n) Post-COVID	Female (mean, n) Pre-COVID	Female (mean, n) Post-COVID
Anxiety	3.1 (n=772)	3.3 (n = 349)	5.2 (n = 346)	6.1 (n = 172)
Depression	4.0 (n = 772)	4.3 (n = 349)	7.5 (n = 346)	8.0 (n = 172)
Anger	7.0 (n = 772)	6.4 (n = 349)	8.5 (n = 346)	10.0 (n = 172) *
Posttraumatic Stress	4.9 (n = 770)	6.0 (n = 350) ***	7.3 (n = 346)	8.5 (n = 172) *
Dissociation	4.9 (n = 767)	5.5 (n = 348) *	6.7 (n = 344)	7.9 (n = 169) *
Sexual Concerns	2.9 (n = 771)	2.8 (n = 349)	3.0 (n = 345)	3.8 (n = 170) *

* ≤.05, **≤.01, *** ≤ .001

The slope graphs in Figure 10 illustrate these patterns visually. **Posttraumatic Stress** showed the largest absolute increase for both genders, with **average scores for males** rising from 4.9 to 6.0 (a **22.4% increase**) and **females** from 7.3 to 8.5 (a **16.4% increase**). **Anger** was the one subscale where **males** and **females moved in opposite directions**, **decreasing** slightly for **males** (7.0 to 6.4) while **increasing sharply** for **females** to the highest score of any subscale (8.5 to 10.0). Across nearly all other subscales, the **steeper lines for females** compared to **males** highlight a **widening gender gap** in trauma symptoms at **intake** among post-COVID **youth** entering the program, meaning that in the time after the pandemic females presented with increasingly greater trauma-related needs compared to males.

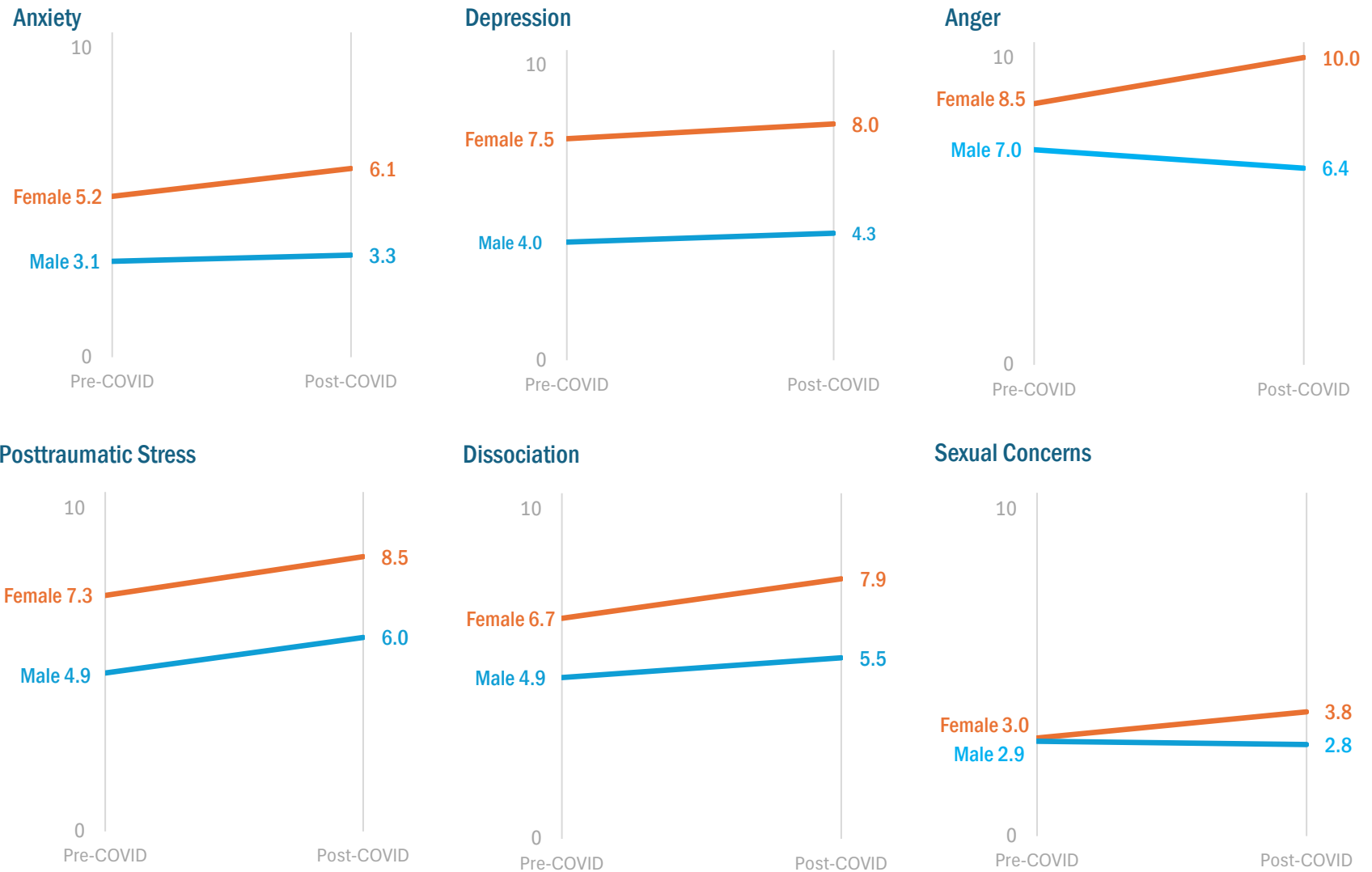


Post-COVID **females** reported **higher trauma symptoms** at intake across all **six subscales**, with **Anger** being the **highest** reported symptom. **Posttraumatic stress** showed the most **consistent** and **statistically significant** increase across **both genders** from pre- to post-COVID (males: +1.1, females: +1.2). These patterns reflect **higher trauma-related needs** at intake among post-COVID youth, particularly among **females**.

Youth Self-Reported Trauma Symptoms at Intake: Pre- and Post-COVID Comparison

While **two** trauma symptom subscales **decreased** post COVID for **males**, all **six** increased for **females**.

Figure 10: Trauma Symptoms at Intake by Gender and COVID Period



Trauma Symptoms Across the Post-COVID Period

Most **trauma symptoms** post-COVID **peaked in 2023** for both **males** and **females**. Figures 11 and 12 illustrate the post-COVID year comparisons in reference to pre-COVID averages. Among **females**, most TSCC subscale averages increased from pre-COVID levels through 2023, with **Anger** demonstrating the most notable rise, followed by **Posttraumatic Stress, Dissociation**, and **Depression**. **Depression** scores showed a **slight decline** in **2021** before rising in subsequent years. **Males** showed similar patterns with more modest increases, particularly in **Anger, Dissociation**, and **Posttraumatic Stress**. Both genders demonstrated **declines** from **2023 to 2024**, with 2024 scores returning to levels closer to pre-COVID averages across most subscales.

Figure 11: TSCC Subscale Score Comparisons for Females

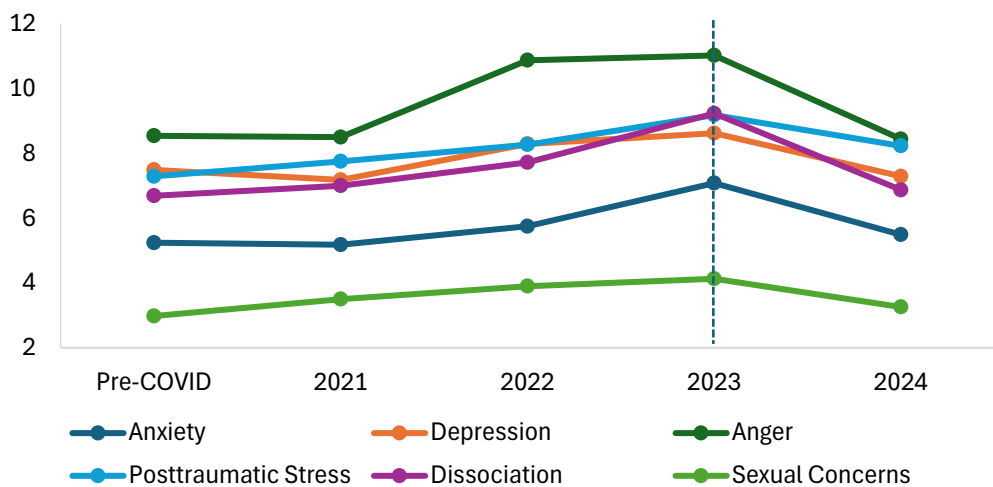
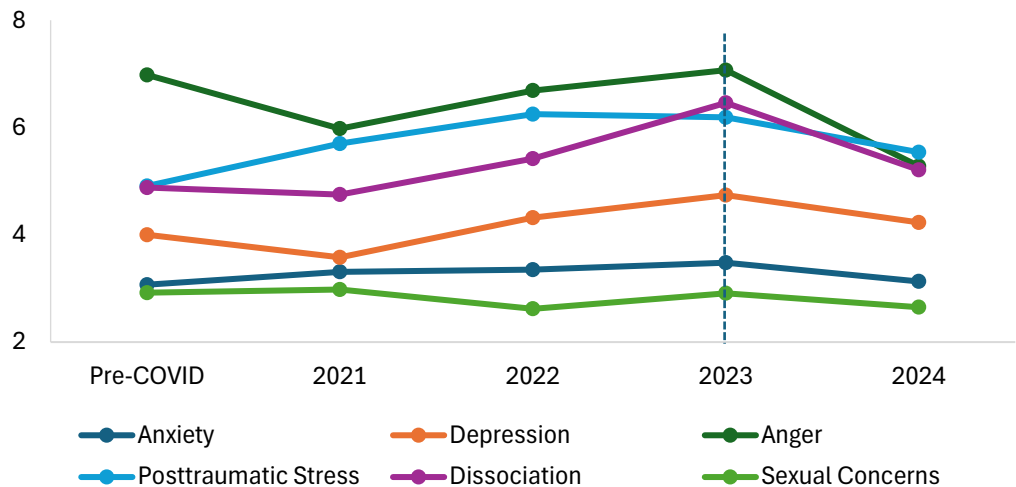


Figure 12: TSCC Subscale Score Comparisons for Males



The **TSCC items** presented in Table 7 were selected **based on research** indicating that feelings of loneliness, self-harm ideation, fear, and anxiety showed elevated rates among justice-involved youth during and following the COVID-19 pandemic (Reid et al., 2021). When looking at specific trauma symptoms, one finding showed a statistically significant difference: **males enrolled post-COVID reported feeling lonely significantly more often than those enrolled pre-COVID**. Nearly half (46.1%) of post-COVID **males** said they felt lonely at least sometimes, compared to 37.2% of pre-COVID males.

This **increase** is consistent with research showing that justice-involved youth experienced significant psychological distress during the pandemic, partly due to the loss of positive connections like school, recreational activities, and peer relationships (Reid et al., 2021). **Females showed a similar pattern**, with loneliness increasing from 63.3% to 70.8% post-COVID, though this difference was not statistically significant. Across **both genders, self-reported suicidal ideation by youth** remained **relatively stable** between the two enrollment periods, with approximately 11.0% of males and 25.0% of females reporting such thoughts.

Table 7: TSCC Item Level Comparisons

TSCC Individual Scale Item	Male (% , n) Pre-COVID	Male (% , n) Post-COVID	Female (% , n) Pre-COVID	Female (% , n) Post-COVID
Feeling Lonely	37.2% (n=814)	46.1% (n=347) *	63.3% (n=362)	70.8% (n=171)
Wanting to hurt myself	12.0% (n=811)	14.4% (n=353)	28.2% (n=362)	31.6% (n=171)
Feeling nervous or jumpy inside	36.1% (n=815)	43.7% (n=349)	54.3% (n=361)	54.8% (n=168)
Feeling afraid	26.1% (n=815)	29.5% (n=349)	45.7% (n=361)	52.0% (n=171)
Wanting to kill myself	10.8% (n=813)	10.9% (n=349)	25.7% (n=362)	25.3% (n=173)

* ≤.05, **≤.01, *** ≤ .001 Note: All responses are a combination of youth who reported that they felt these feelings sometimes, lots of times, and all the time.



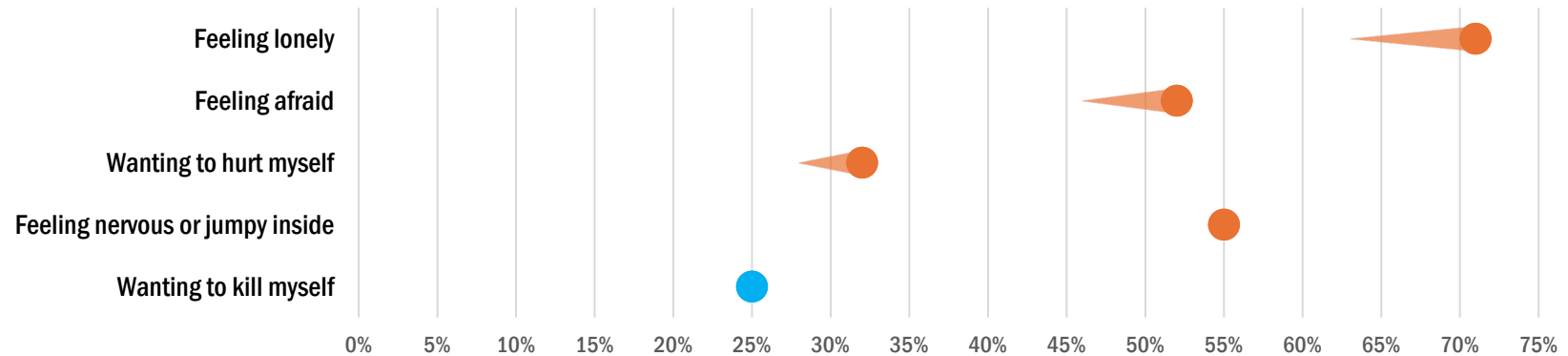
Overall, **post-COVID** youth reported **higher trauma symptoms** at intake, particularly **females**. These elevations **peaked** in **2023**, with 2024 scores returning to levels closer to pre-COVID averages across most subscales. **Loneliness** was a notable concern, **increasing significantly** among post-COVID **males**, while **suicidal ideation** remained **stable** across both periods.

TSCC Selected Item Comparisons at Intake

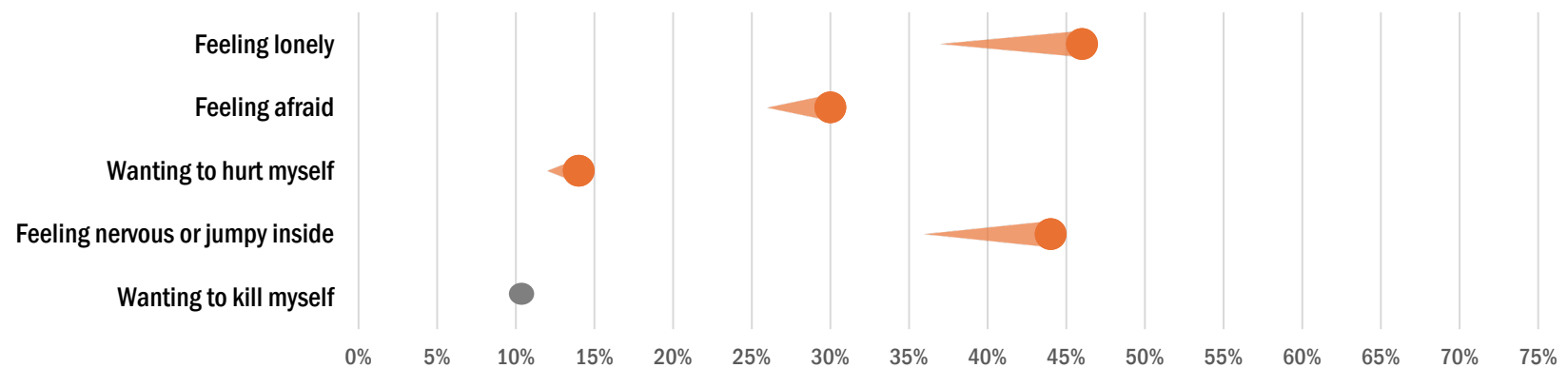
Feeling lonely was the trauma symptom that had the greatest **increase** post-COVID for both genders.

Figure 13

Females



Males



Ohio Scales

The Ohio Scales are completed by the youth, caregiver, and worker at intake and then every three months following intake until termination from services. This is the only assessment tool in BHJJ where youth, caregiver, and worker all respond to the same scale dimensions, providing multiple perspectives on the youth's functioning across domains including Problem Severity, Functioning, Satisfaction, and Hopefulness. For this analysis, the **worker-completed Ohio Scales** at **intake** were examined, which include two subscales: **Problem Severity** and **Functioning**. These two scales are scored in opposite directions, higher Problem Severity scores indicate greater behavioral difficulties, while lower Functioning scores indicate worse day-to-day Functioning. Here, we additionally consider race alongside gender, as race revealed differences not apparent when examining gender alone.

Worker-reported Ohio Scales at intake revealed **significant differences** only for **Black male** enrollees between pre-COVID and post-COVID periods (see Table 8). **Post-COVID Black males** were rated as having **significantly lower Problem Severity** (25.3 to 19.9) and **significantly higher Functioning** (42.9 to 47.7) compared to their pre-COVID counterparts. No statistically significant differences were found for White males, White females, or Black females between enrollment periods.

Table 8: Ohio Scale Worker Ratings at Intake by Race and Gender

Ohio Scale-Worker	Time Point	Black Male (Mean, n)	White Male (Mean, n)	Black Female (Mean, n)	White Female (Mean, n)
Problem Severity Scale	Pre-COVID	25.3 (n = 405)	27.7 (n = 349)	27.6 (n = 134)	29.7 (n = 195)
	Post-COVID	19.9 (n = 191) ***	29.0 (n = 121)	23.9 (n = 76)	33.1 (n = 70)
Functioning Scale	Pre-COVID	42.9 (n = 403)	40.5 (n = 349)	43.0 (n = 134)	40.2 (n = 195)
	Post-COVID	47.7 (n = 192) ***	40.7 (n = 125)	45.5 (n = 75)	39.0 (n = 70)

* ≤ .05, ** ≤ .01, *** ≤ .001

Figure 14 displays worker ratings of Problem Severity and Functioning at intake, comparing pre-COVID and post-COVID enrollees across four groups: Black males, Black females, White males, and White females. Downward slopes on Problem Severity indicate improvement, while upward slopes on Functioning indicate improvement. Notably, **White females** showed **lower Functioning** and **higher Problem Severity** post-COVID.

Worker Perceptions of Youth Problem Severity and Functioning at Intake

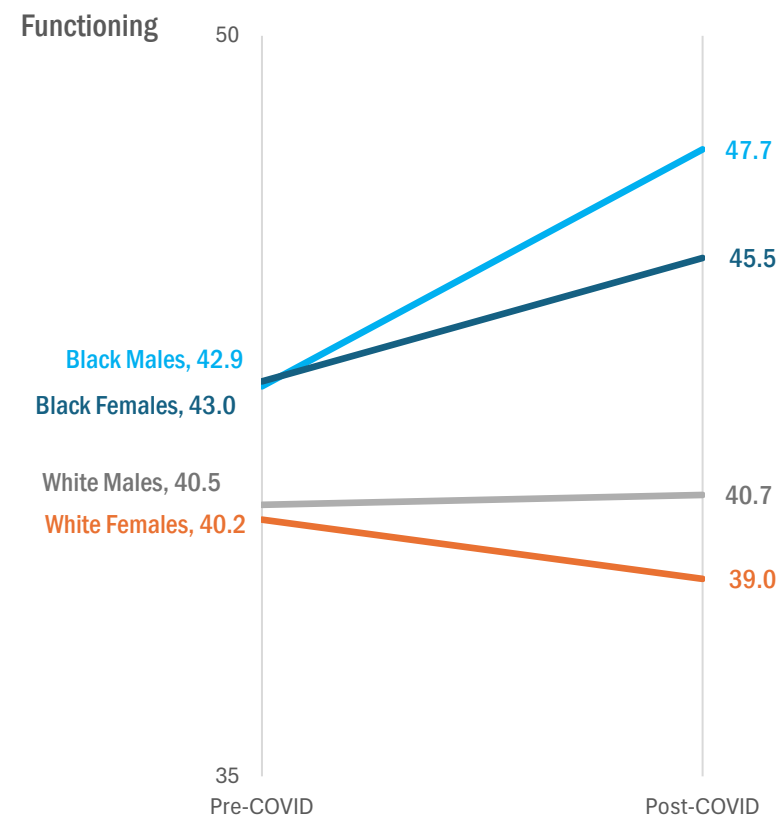
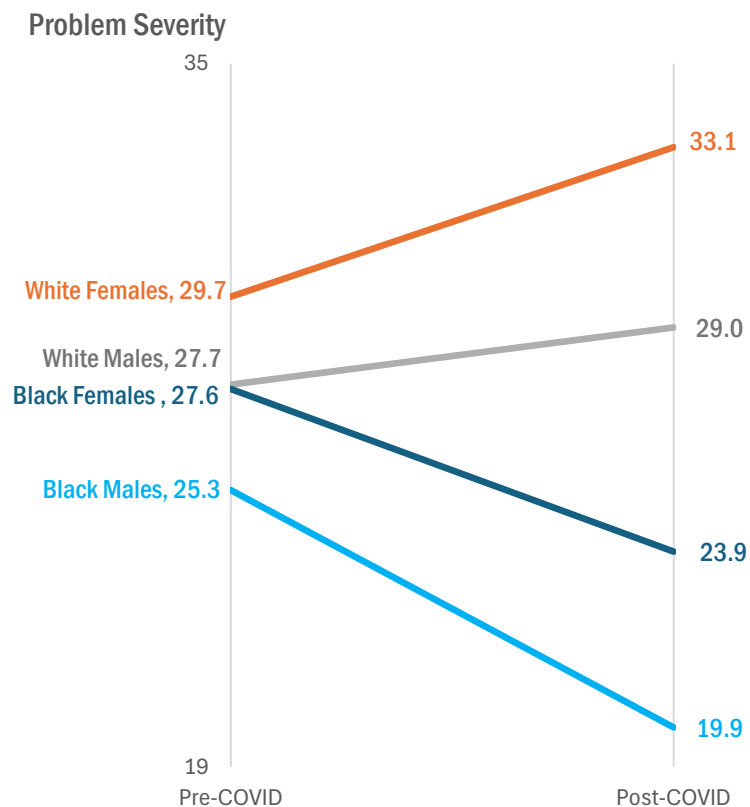
Figures 14

Pre- and post-COVID, workers reported **lower** Problem Severity for **Black youth** (male and female) as compared to **White youth**. The gap in ratings between **Black** and **White** males **widened** from 2.4 to 9.1 points while the gap between **Black** and **White** females **increased** from 2.1 to 9.2 points.

Overall, workers reported lower Problem Severity for **Black** youth at intake post-COVID.

Pre- and post-COVID, workers reported **higher** Functioning for **Black youth** (male and female) as compared to **White youth**. The gap in ratings between **Black** and **White** males **widened** from 2.4 to 7.0 points while the **Black** and **White** female gap **increased** from 2.8 to 6.5 points.

Overall, workers reported higher Functioning in **Black** youth at intake post-COVID.



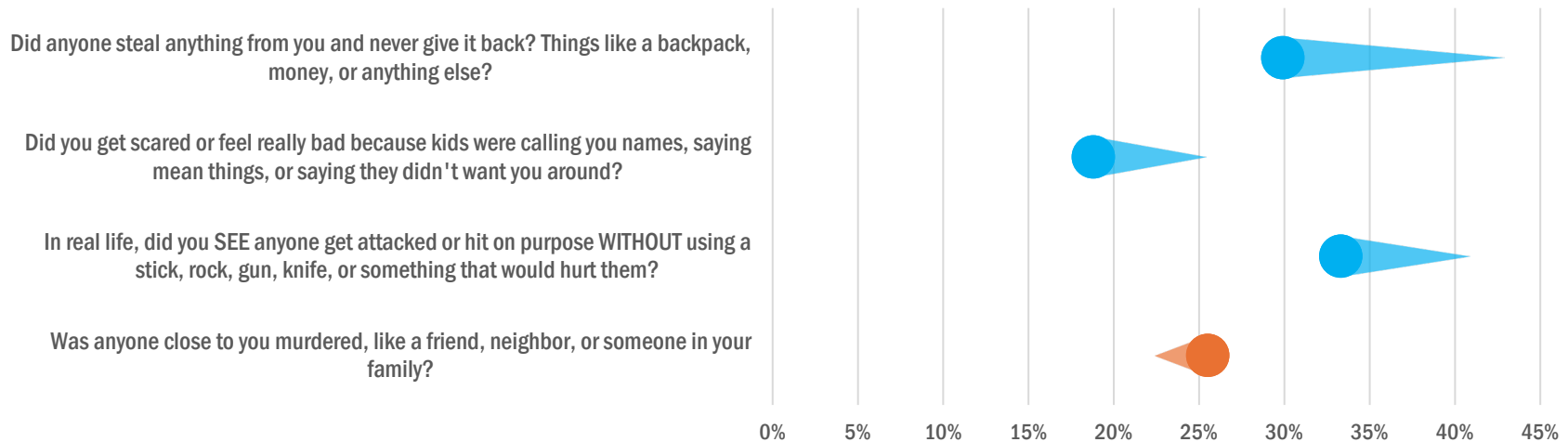
Violence and Delinquency Questionnaire (VDQ)

The Violence and Delinquency Questionnaire (VDQ) is a self-report, 33-item Likert-style survey that assesses three domains: **exposure to violence**, **violence perpetration**, and **peer delinquency**. The VDQ is administered at intake and termination; for this analysis, only intake data were examined, where youth responded about their experiences within the past year. The four items presented reflect the greatest shifts observed across all VDQ items between cohorts.

Figure 15 presents intake comparisons between pre-COVID (n = 995) and post-COVID (n = 260) cohorts on **four** violence exposure items. **Theft declined** from **42.9% to 29.9%** ($p < .001$), **witnessing physical attacks without weapons decreased** from **40.9% to 33.3%** ($p < .01$), and **name calling or social exclusion decreased** from **25.4% to 18.8%** ($p < .05$), **all statistically significant decreases** in the post-COVID period. The proportion of youth reporting having **someone close to them murdered increased** slightly from **22.4% to 25.5%**, though this difference was not statistically significant. This increase may reflect the broader rise in homicide rates nationally during the first year of the COVID-19 pandemic (Kegler et al., 2022).

Figure 15: **VDQ Selected Item Comparisons at Intake**

In the last year...



Substance Use Survey Revised (SUS-R)

Youth reported changes in lifetime substance use between the pre-COVID and post-COVID periods. Table 9 presents the most commonly used substances along with those showing statistically significant differences across cohorts. Among substances with statistically significant differences, **cannabis use increased** from **66.7% to 75.2%**, **hallucinogen use increased** from **6.8% to 10.3%**, and **sedative use decreased** from **9.7% to 6.3%**. Changes in other substances (including tobacco, caffeine, stimulants, and opioids) were not statistically significant. Age of first use remained relatively stable across most substances. Complete substance use data are included in **Appendix C**.

Table 9: Youth Substance Use Comparisons between Pre- and Post-COVID Groups

Substances	Overall Substance Use (Pre-COVID)		Overall Substance Use (Post-COVID)	
	Ever Used (% , n)	Age of First Use (yrs)	Ever Used (% , n)	Age of First Use (yrs)
Cannabis	66.7% (n=345)	13.2	75.2% (n=400) **	13.0
Alcohol	52.2% (n=271)	13.5	56.4% (n=300)	13.4
Hallucinogens	6.8% (n=35)	14.6	10.3% (n=54) *	14.4
Sedatives	9.7% (n=50)	14.5	6.3% (n=33) *	13.5
Tobacco	48.0% (n=249)	13.2	46.2% (n=246)	13.0

* < .05, ** < .01.

Gender Differences in Substance Use

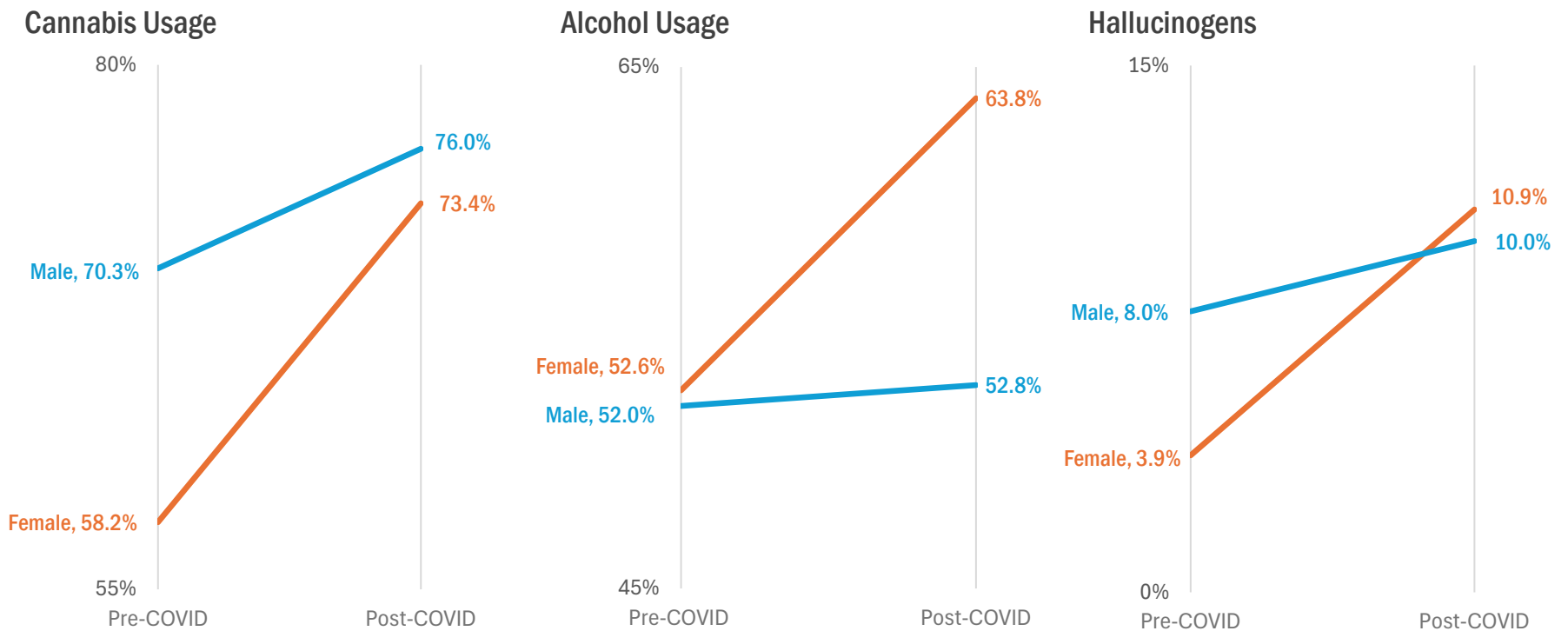
Analyses revealed different patterns in substance use across COVID periods for females and males. Among **females**, **three** substances showed **statistically significant increases**: **cannabis (58.2% to 73.4%)**, **alcohol (52.6% to 63.8%)**, and **hallucinogens (3.9% to 10.9%)**. Among **males**, no substances showed statistically significant changes between the two time periods. **Cannabis increased** from **70.3% to 76.0%**, alcohol remained stable (52.0% to 52.8%), and tobacco usage decreased minimally from 51.5% to 49.7%, but none of these changes reached statistical significance.

Figure 16 shows the trend lines for cannabis, alcohol, and hallucinogens use by gender from pre-COVID to post-COVID. The slope of each line indicates the direction and magnitude of change, with steeper lines indicating larger changes in usage.

Changes in other substances (sedatives, tobacco, caffeine, and opioids) were **not statistically significant** for **either gender**. Age of first use patterns were similar across genders for most substances. Detailed tables of overall substance use and age of first use by gender are included in **Appendix D**.

Figure 16: Substance Use at Intake by Gender and COVID Period

Females showed large increases in Cannabis and Alcohol use post-COVID, while males showed minimal change.



Cannabis and hallucinogen use increased significantly during the post-COVID period, while sedative use decreased. Among females, cannabis, alcohol, and hallucinogen use all increased significantly, while no substances showed statistically significant changes among males.

Resiliency Survey

The California Healthy Kids Survey - Resilience module is a 16-item self-report measure assessing **internal assets** (self-efficacy, self-awareness, empathy) and **external assets** (support from family, peers, and other adults). Resilience is defined as a set of factors both within the individual and external to the individual that help to insulate youth from adversity (Dray et al., 2017). Measuring resilience at intake provides important context for **understanding youth strengths** in the context of their behavioral and mental health needs.

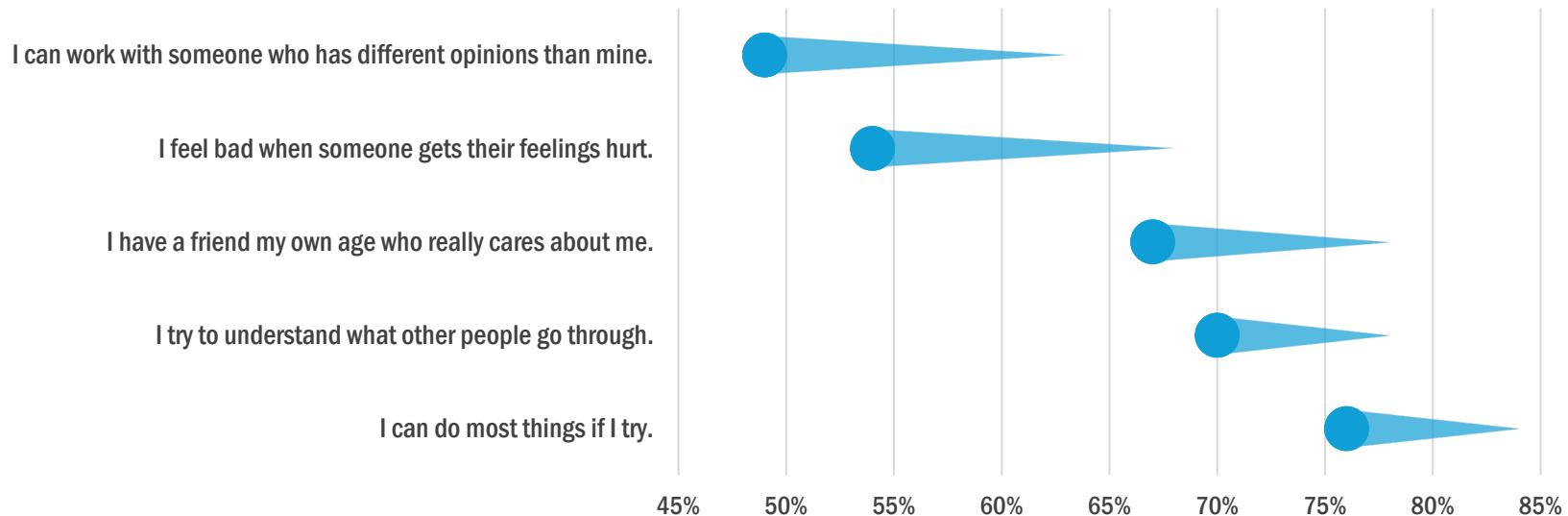
Resilience data at intake were available for **males** (n = 368; n = 348) and **females** (n = 153; n = 172) across both cohorts. The Resiliency scale showed **minimal change** between pre- and post-COVID for **males**, and as such no figure is presented for this group. The only exception was the item, "*I have a parent or other adult who listens to me when I have something to say*" where post-COVID **males** reported **higher agreement** (72.9% vs. 66.1%).

In contrast, **females** showed **decreases** across multiple resilience items, as illustrated in Figure 17. For each **comet**, the end point of the **tail** represents the **pre-COVID** response, and the **head of the comet** represents the **post-COVID** response. The **longer** the tail, the greater the change from pre- to post-COVID. The **largest declines** were in **feeling bad when someone gets their feelings hurt** (68.0% to 53.5%), in their ability to **work with others who hold different opinions** (62.7% to 48.9%) and having a **friend their own age who really cares about them** (77.5% to 67.4%). **Decreases** were observed across **multiple interpersonal** and **peer support** items in resilience among post-COVID females at intake. These findings are consistent with research documenting that adolescents broadly reported feelings of disconnection from peers and reduced social support during the pandemic (Rogers et al., 2021).

Figure 17: Resiliency Items at Intake: Females

While resiliency remained stable for **male** BHJJ participants post-COVID, **female** resiliency decreased for many items.

Females



Resiliency scores at intake were **largely stable** for **males** across both cohorts. However, post-COVID **females** showed **drops** across **multiple interpersonal** and **peer support** items, consistent with research documenting that adolescents **broadly reported** feelings of **disconnection** from peers and **reduced social support** during the pandemic (Rogers et al., 2021).

Caregiver Satisfaction with BHJJ Services

Caregiver satisfaction data were collected at termination, with responses available for pre-COVID (n = 247) and post-COVID (n = 103) caregivers. Across all satisfaction indicators, a **consistent pattern emerged**: **while the majority of caregivers expressed satisfaction with BHJJ services in both periods**, the **intensity of that satisfaction shifted downward** from pre- to post-COVID. The proportion of caregivers endorsing "Strongly Agree" decreased across most items, with the largest drops seen in getting as much help as needed (-14 points), having someone for the child to talk to (-14 points), and perceptions that services were right for the family (-15 points). Items related to **staff respect**, **cultural sensitivity**, and **caregiver participation in treatment** showed the smallest shifts, remaining **relatively stable** across periods. Figure 18 displays the change in percentage points for four satisfaction items where shifts were most pronounced; **orange** bars indicate **decreases** and **blue** bars indicate **increases** from pre- to post-COVID. The overall pattern reflects a **downward shift** in the strength of **caregiver ratings** from pre- to post-COVID, while **general satisfaction** remained **positive across both periods**. (Note: The caregiver satisfaction survey is an optional measure for BHJJ caregivers.)

A **similar pattern** was observed for items assessing perceived improvements in **youth functioning** and **social support**. "Strongly Agree" responses **declined** across all functioning items, with the largest decreases seen in **satisfaction with family life** (-5 points on "Strongly Agree", with "Strongly Disagree" rising from 3.2% to 10.9%), **perceived improvements in daily functioning** (-14 points), and **school or work performance** (-8 points). "Undecided" responses increased notably across functioning items post-COVID. **Social support** items showed **smaller** but consistent shifts, with "Strongly Agree" declining across all four items while "Agree" responses remained relatively stable. Figure 19 displays the change in percentage points for four items with pronounced shifts with **orange** bars indicating **decreases** and **blue** bars indicating **increases** from pre- to post-COVID.



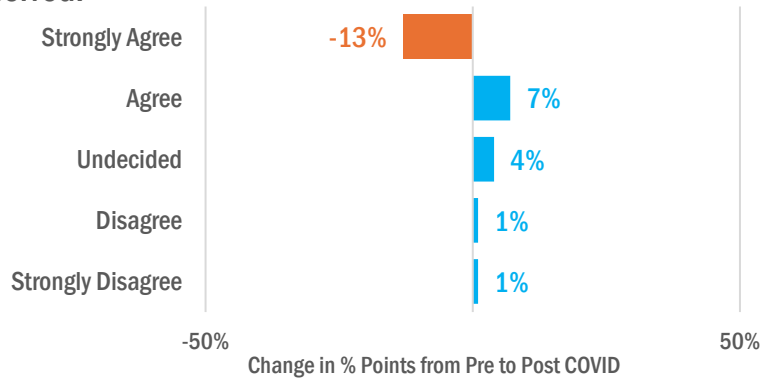
These findings indicate that the pandemic affected caregiver perceptions of BHJJ services on some items more than others. **Ratings shifted** from "Strongly Agree" to "Agree" **post-COVID**, with the **largest decreases** in items related to getting as much help as needed, having someone for the child to talk to, and perceived improvements in daily functioning and school performance. Items related to staff respect, cultural sensitivity, and caregiver participation remained relatively stable across periods.

Caregiver Satisfaction with the BHJJ Program

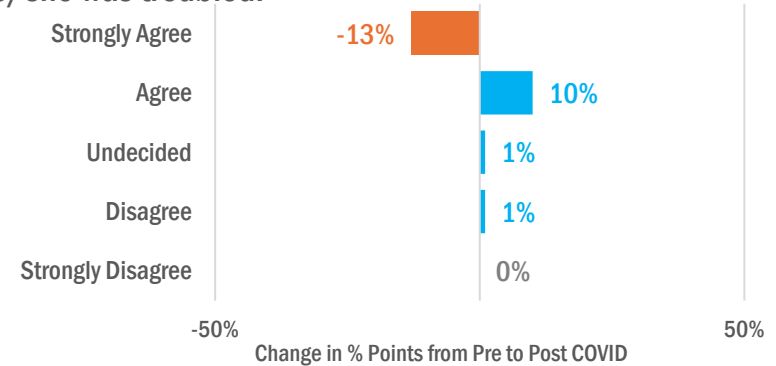
The majority of caregivers reported **satisfaction** with the BHJJ program pre- and post-COVID. Many satisfaction items rated “**Strongly Agree**” pre-COVID were rated “**Agree**” post-COVID. The change in pre- to post-COVID ratings is presented for selected items.

Figure 18:

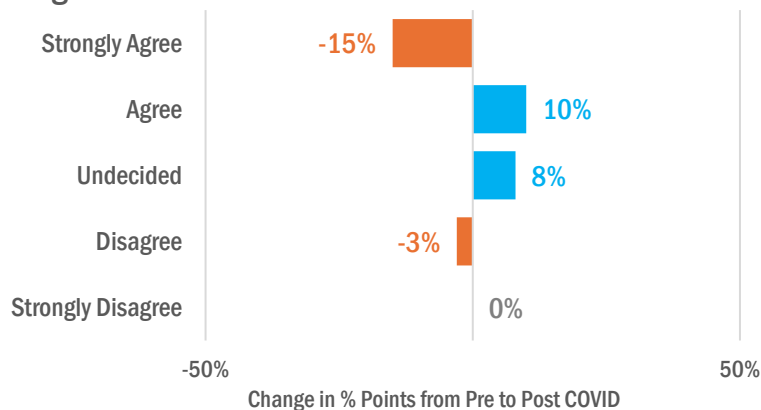
Overall I am satisfied with the services my child received.



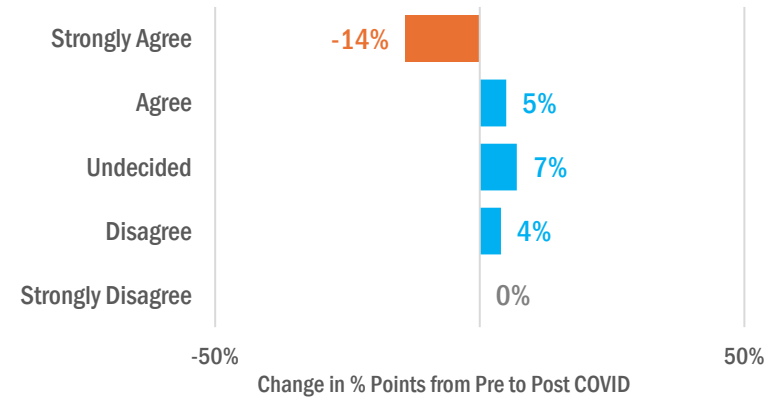
I felt my child had someone to talk to when he/she was troubled.



The services my child and/or family received were right for us.



My family got as much help as we needed for my child.



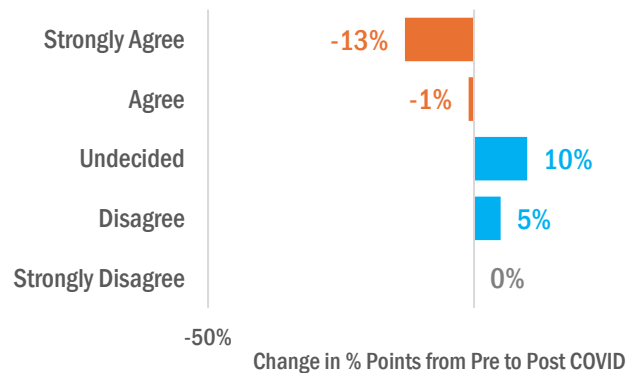
Caregiver Perceptions of BHJJ Impact on Functioning and Social Support

Caregivers reported **improved functioning** and **social support** following BHJJ services in both pre- and post-COVID periods. Many items rated “**Strongly Agree**” pre-COVID were rated **lower** post-COVID. The change is presented for selected items.

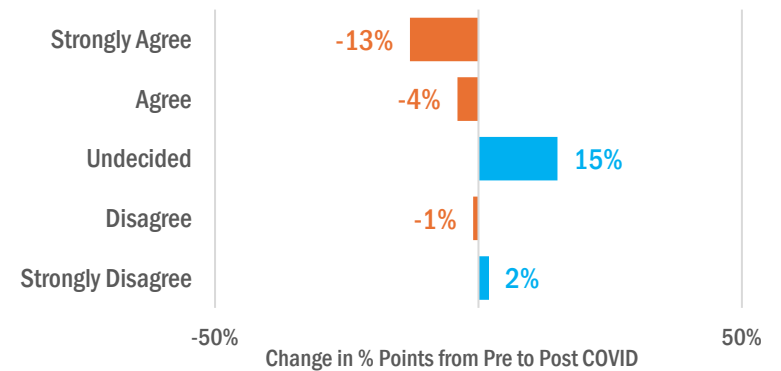
Figure 19:

As a result of BHJJ services...

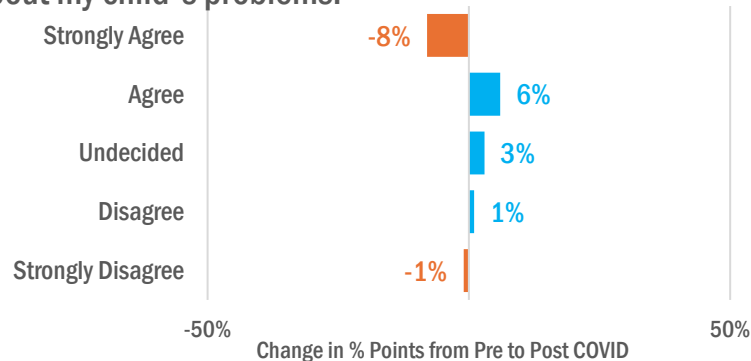
My child is better at handling daily life.



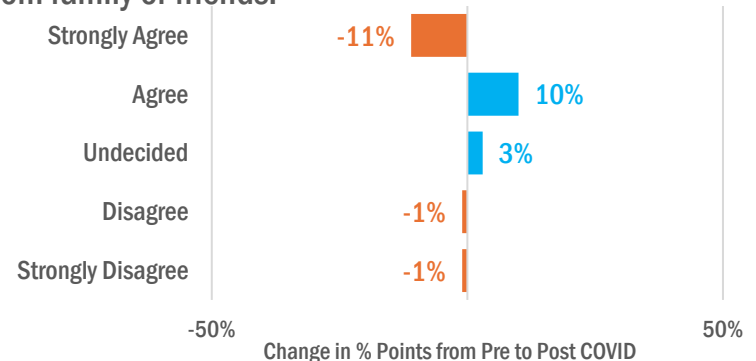
My child gets along better with family members.



I have people I am comfortable talking with about my child's problems.



In a crisis, I would have the support I need from family or friends.



Part II: Key Program Outcomes at Termination: Post-COVID

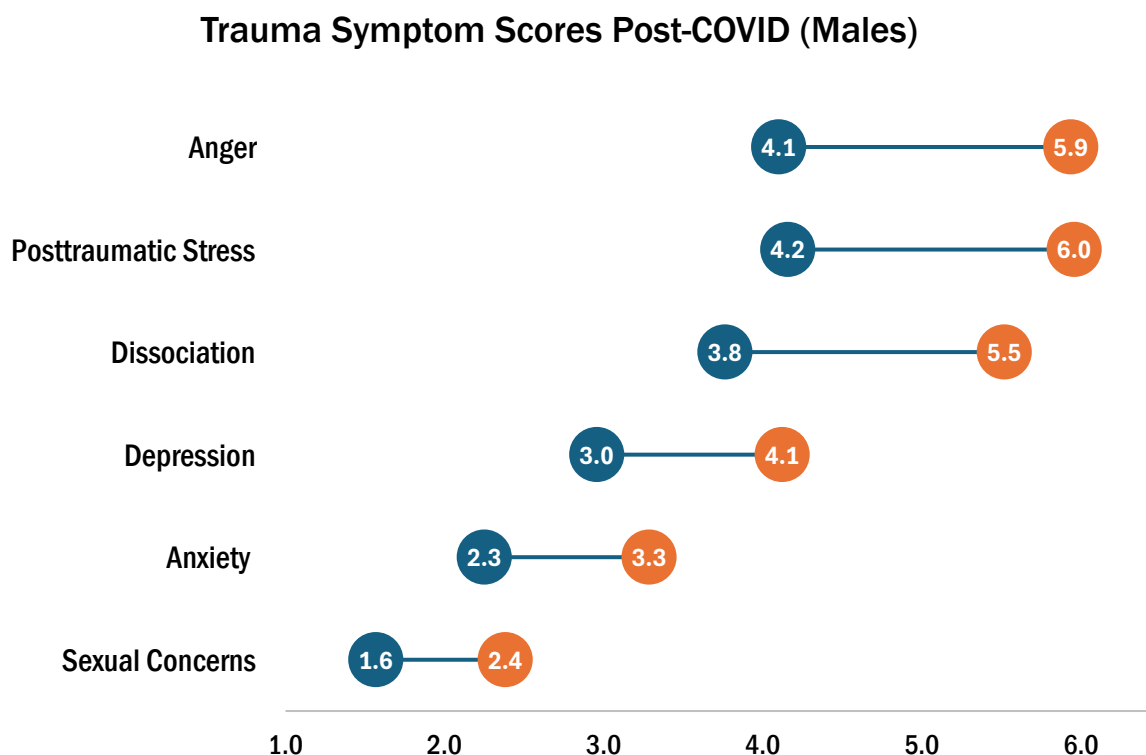
Part II of the report examines program outcomes within the post-COVID cohort (2021–2024), assessing changes from intake to termination on youth behavioral health indicators including the TSCC, Ohio Scales, and key program completion measures.

Trauma Symptoms (TSCC): Intake to Termination

Having examined TSCC scores at intake across pre- and post-COVID cohorts in Part I, **Part II** examines **change from intake to termination among post-COVID youth**. Results indicated **significant improvements** in **trauma symptoms** following BHJJ services for youth in the post-COVID cohort with matched intake and termination data (**males**: n = 140, **females**: n = 80).

Males showed **reductions** across all **trauma domains**, reflecting **improvement**, with the **largest changes** in **Anger** (5.9 to 4.1) and **Posttraumatic Stress** (6.0 to 4.2) (see Figure 20). Paired samples t-tests indicated all changes were **statistically significant** ($p < .001$).

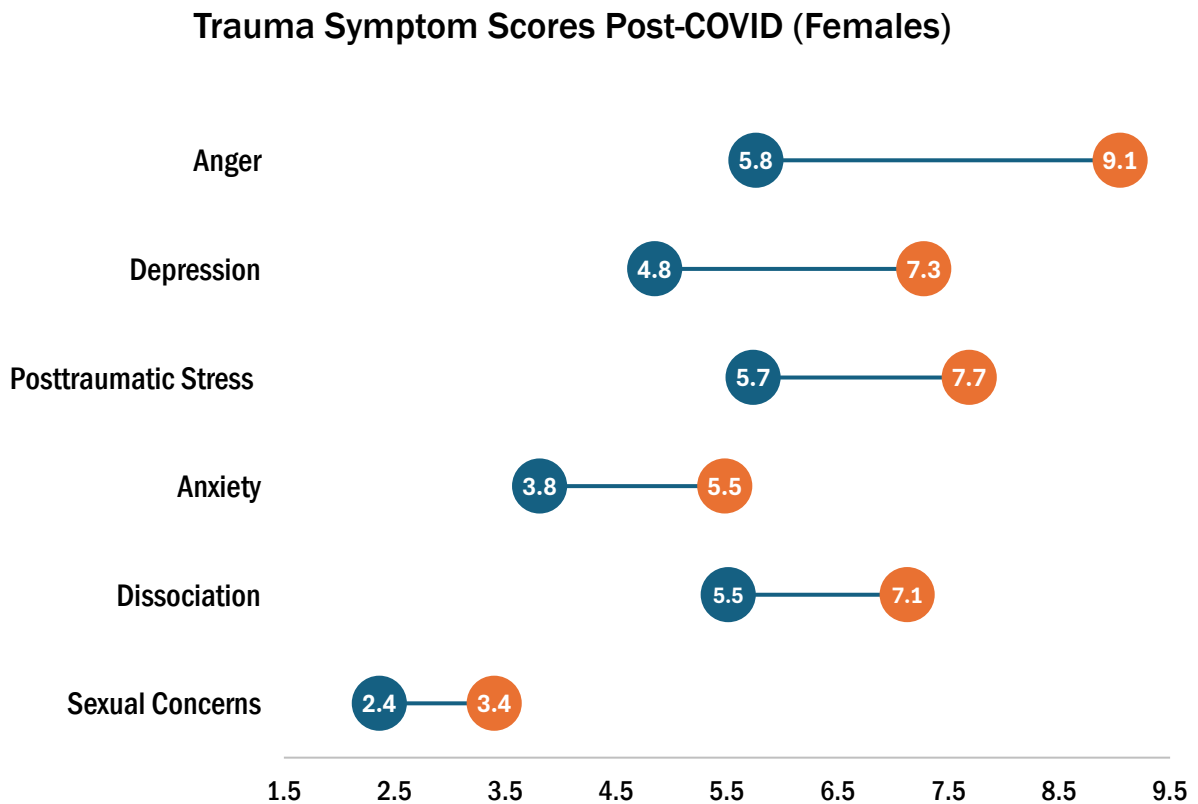
Figure 20: Trauma Symptom Scores from Intake to Termination Post-COVID (Male)



Blue dots represent Termination, Orange dots represent Intake. Lower trauma symptom scores indicate less trauma symptomatology.

Females showed **reductions** across **all trauma domains**, reflecting **improvement**, with the **largest changes** in **Anger** (9.1 to 5.8), **Posttraumatic Stress** (7.7 to 5.7), and **Depression** (7.3 to 4.8). Paired samples t-tests indicated all changes were **statistically significant** ($p < .001$) (see Figure 21).

Figure 21: **Trauma Symptom Scores from Intake to Termination Post-COVID (Female)**



Blue dots represent Termination, Orange dots represent Intake. Lower trauma symptom scores indicate less trauma symptomatology.

Improvements in trauma symptoms across all **six subscales** (reductions) for both **males** and **females** at **program completion** are consistent with **prior BHJJ evaluation findings** documenting trauma symptom improvement for justice-involved youth receiving community-based services (Kretschmar et al., 2016).

Ohio Scales (Worker): Intake to Termination

Part I of the report examined **Ohio Scales Worker** scores at intake across pre- and post-COVID cohorts. Part II presents changes from intake to termination among post-COVID youth.

Figure 22 displays Ohio Scales Worker **Problem Severity** scores by **gender** from intake to termination among post-COVID youth (**males**: n = 206, **females**: n = 91). **Lower Problem Severity scores indicate improvement** in youth outcomes. **Problem Severity** scores **decreased**, reflecting **improvements** for both **males** and **females** from **intake to termination**, with **females** entering with **higher Problem Severity** scores at intake while **males** showed a **higher percentage of change relative** to their starting scores. Paired samples t-tests indicated these reductions were **statistically significant** for both **males** and **females** ($p < .001$).

Figure 22: Ohio Scales Worker Ratings of Youth Problem Severity Outcomes from Intake to Termination Post-COVID

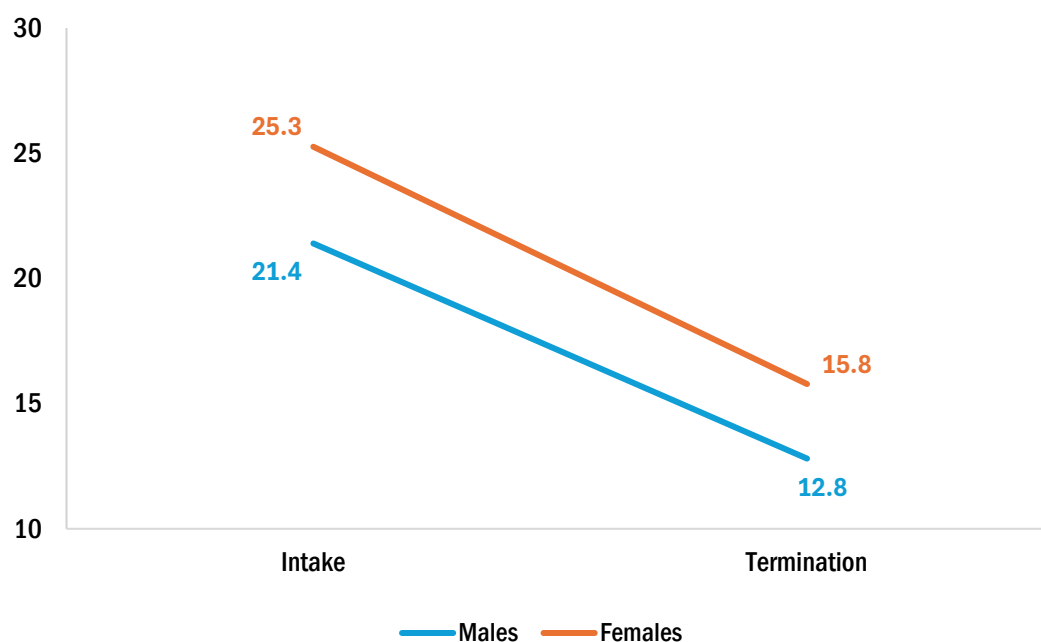
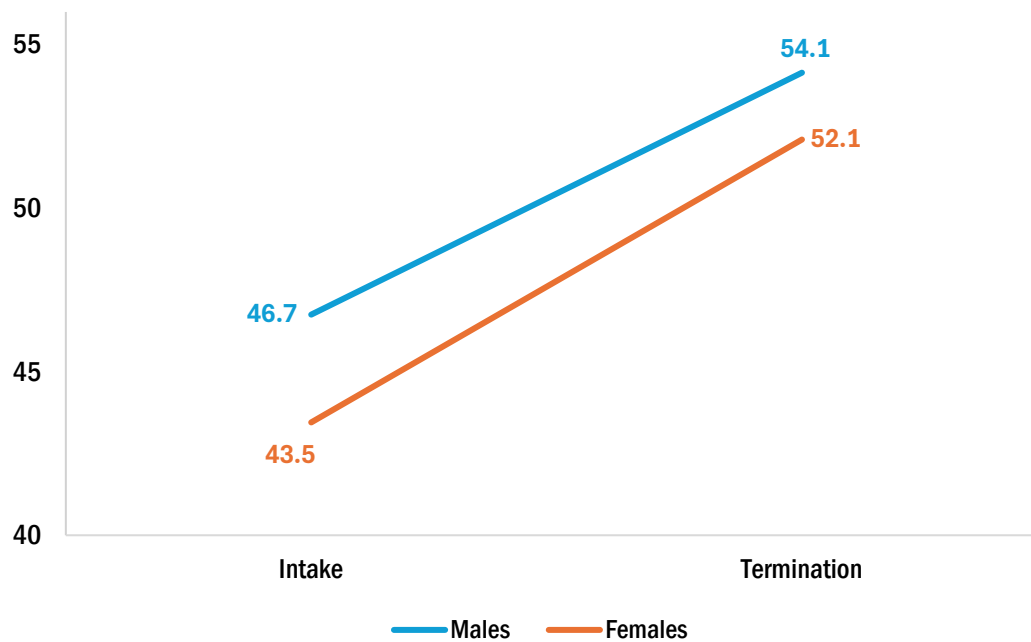


Figure 23 displays Ohio Scales Worker **Functioning** scores by gender from intake to termination among post-COVID youth (**males**: n = 209, **females**: n = 91). **Higher Functioning scores indicate improvement in youth outcomes. Functioning improved** for both **males** and **females** from intake to termination, with **males** entering with **higher Functioning** scores at intake and both groups showing **comparable increases** by termination. Paired samples t-tests indicated these improvements were **statistically significant** for both genders (p < .001).

Figure 23: Ohio Scale Worker Ratings of Youth Functioning Outcomes from Intake to Termination Post-COVID



Improvements in both **Problem Severity** and **Functioning** scores from intake to termination across **genders** reflect patterns consistent with **prior BHJJ evaluation findings** documenting positive outcomes for justice-involved youth receiving community-based services (Kretschmar et al., 2016).



Post-COVID youth demonstrated **statistically significant improvements** across **all trauma symptom subscales** from intake to termination for both genders. The **biggest improvements were** in **Anger**, **Posttraumatic Stress**, and **Depression**. **Ohio Scales Worker** ratings similarly showed **significant improvements** in both **Problem Severity** and **Functioning** scores from intake to termination.

Program Completion (Post-COVID)

Program completion is a **key indicator of program effectiveness**, reflecting the extent to which post-COVID youth successfully engaged with and finished BHJJ services. Among the **300** youth with termination data, **74.3%** of youth **successfully completed treatment** during the **post-COVID period** (see Table 10). The remaining youth exited for a range of reasons, including system-involved outcomes such as incarceration (5.7%, n = 17) and out of home placement (5.3%, n = 16).

Table 10: Termination Status for Youth in the Post-COVID Group

Termination Reason	%, n
Successfully completed treatment	74.3% (n = 223)
Out-of-home placement	5.3% (n = 16)
Moved	0.3% (n = 1)
Withdrawn from program	3.7% (n = 11)
AWOL	2.3% (n = 7)
Incarcerated	5.7% (n = 17)
Other termination reasons	8.3 % (n = 25)

Termination Status: Pre- and Post-COVID Comparisons

While Part II focuses on post-COVID program outcomes, **successful completion rates** are examined here across both pre- and post-COVID periods to provide context for how **program completion trends shifted over time** by **gender** and **race**. Overall, successful completion rates **increased** from **69.8%** pre-COVID to **74.3%** post-COVID.



Approximately **3 out of 4 youth** successfully completed the BHJJ program in the **post-COVID period, representing an increase over pre-COVID rates**. Compared to pre-COVID, post-COVID completion rates remained **stable** across **gender** but **significantly improved** among **Black** youth.

While the **successful completion rate for White youth remained stable**, the **successful completion rate for Black youth significantly increased from 61.8% pre-COVID to 71.4% post-COVID**.

Figure 24: Termination Status: Pre-to Post-COVID Comparison by Race

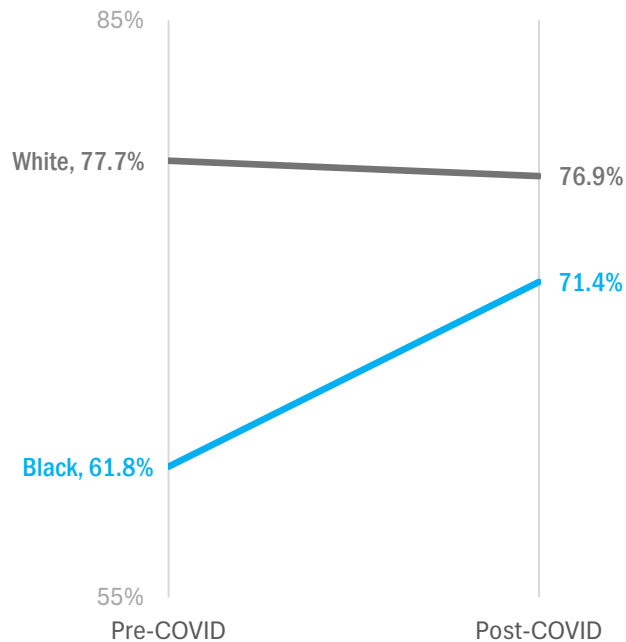


Figure 24 displays **successful completion** rates by **race** across pre- and post-COVID periods. The **steeper upward trajectory** of the line for **Black youth** compared to the **relatively flat line** for **White youth** reflects a **narrowing of the gap in successful completion rates** from **15.9 percentage points** pre-COVID to **5.4 percentage points** post-COVID. The change in the successful completion rate for **Black youth** was **statistically significant**.

Successful completion rates showed similar gains for males and females from pre- to post-COVID.

Figure 25: Termination Status: Pre-to Post-COVID Comparison by Gender

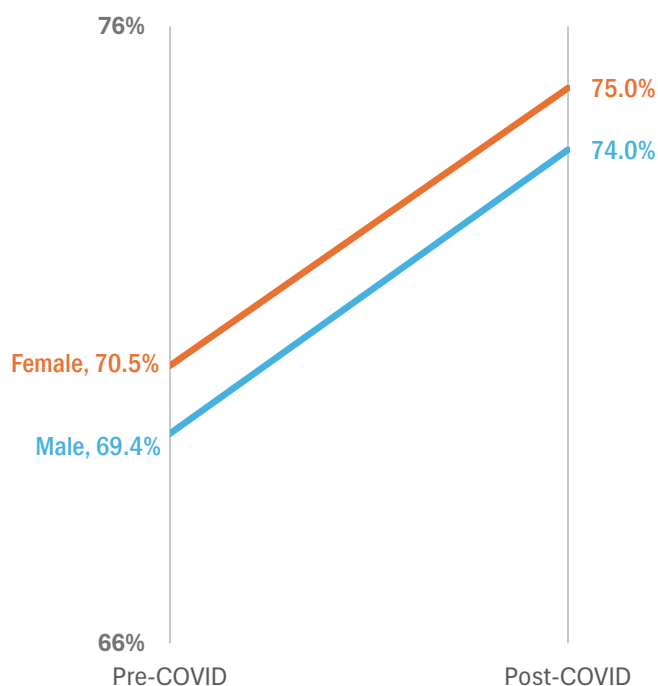


Figure 25 displays **successful program completion** rates by **gender** across pre- and post-COVID periods. **Completion rates increased** for both **males** and **females** from pre- to post-COVID although these improvements were not statistically significant.

Education and Placement Risk at Termination

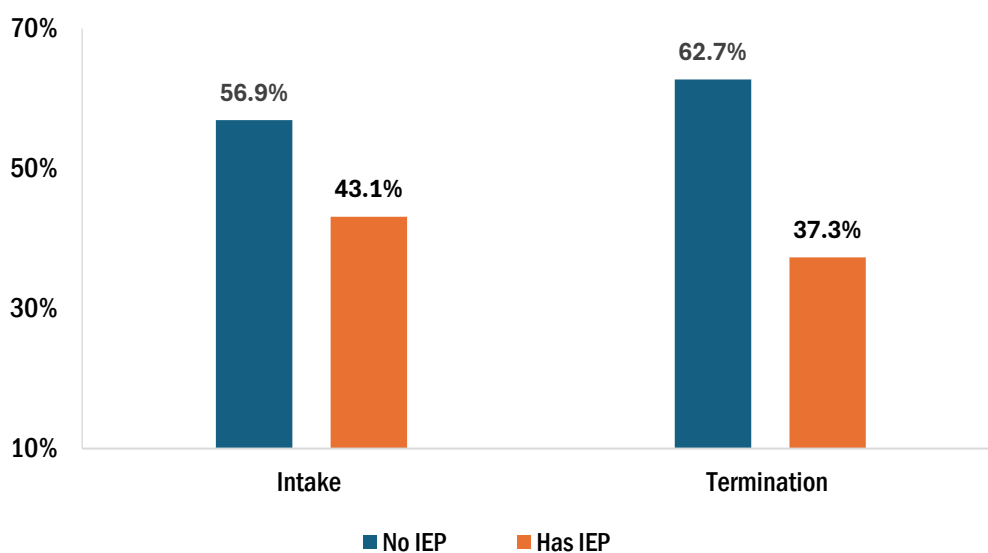
The following section examines **educational and out of home placement outcomes** at termination among post-COVID youth, including **IEP status**, **worker-reported grades**, and **risk of out-of-home placement**.

Youth Individualized Education Program (IEP)



Figure 26 displays **IEP status** at intake and termination among post-COVID youth with data at both intake and termination (**n = 255**). While the proportion of youth with an IEP **decreased** from **43.1%** (n = 110) at intake to **37.3%** (n = 95) at termination, McNemar's test indicated this change was not statistically significant.

Figure 26: **Youth IEP Status in Post-COVID Group**



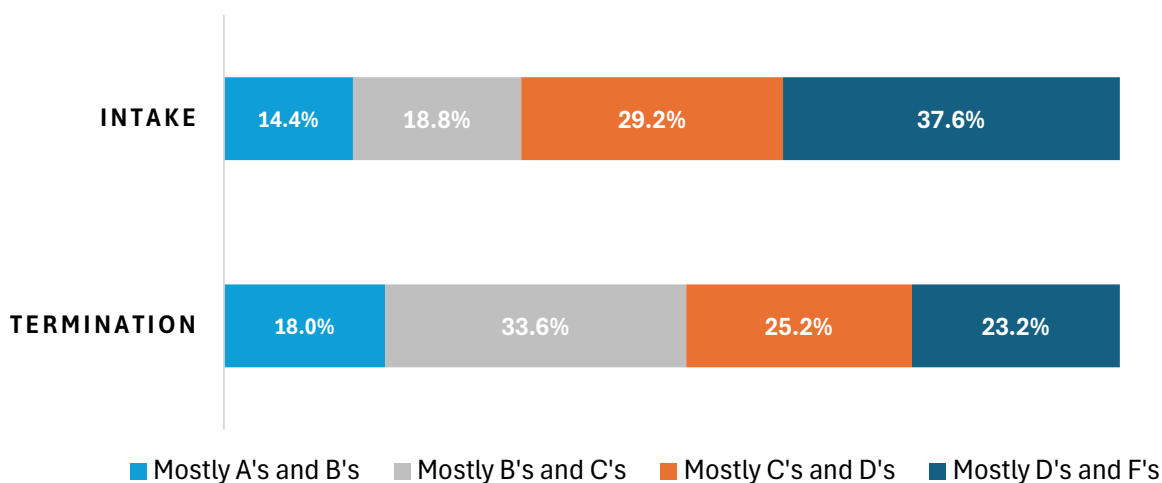
Youth Academic Performance

Figure 27 shows an **upward shift** in worker-reported **grade distribution** from intake to termination among post-COVID youth (n = 250). Youth who received mostly D's and F's **decreased** from **37.6%** at intake to **23.2%** at termination, while those reporting mostly B's and C's **increased** from **18.8% to 33.6%**. Overall, **102** youth (40.8%) **improved their grades**, **46 worsened** (18.4%), and 102 (40.8%) showed no change.



A Wilcoxon Signed-Rank test indicated a **statistically significant improvement** in worker-reported **grades** over the duration of youth participation in the BHJJ program, with more than **twice** as many youth **improving their grades** than worsening.

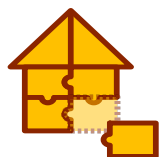
Figure 27: Academic Performance from Intake to Termination in Post-COVID Group



Youth at Risk of Out-of-Home Placement

Youth at risk of out-of-home placement refers to youth identified by workers as being at imminent risk of being removed from their home and placed in a foster care, group home, residential facility, or other out-of-home setting.

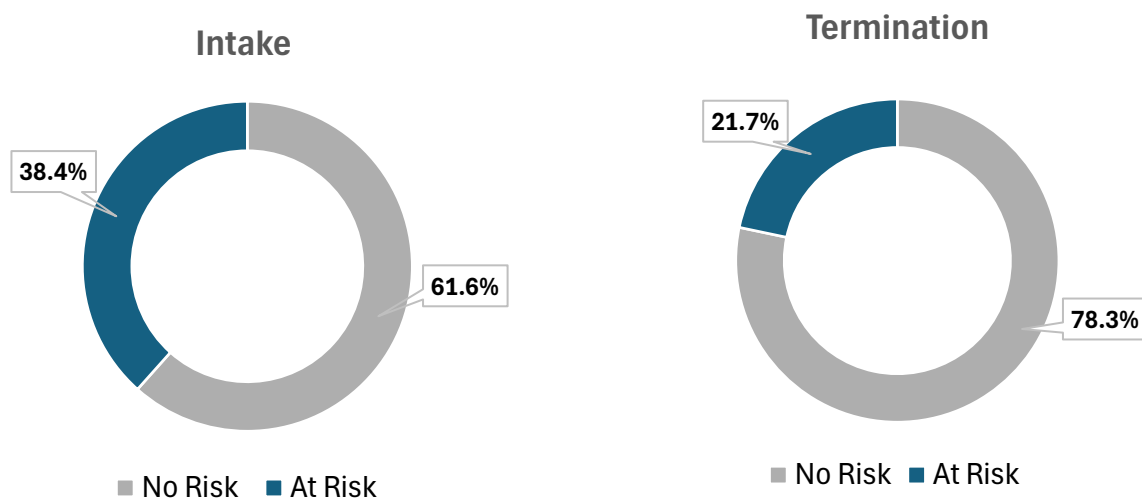
Figure 28 displays risk of imminent out-of-home placement among post-COVID youth with data at both intake and termination (n = 263). The proportion of youth identified as **at risk for out-of-home placement significantly decreased** from **38.4%** (n = 101) at intake to **21.7%** (n = 57) at termination.



A McNemar's test indicated a **statistically significant reduction** in risk of out-of-home placement from **intake** to **termination**, with **43.5% fewer youth** at risk by termination.

Figure 28: **Risk of Out-of-Home Placement for Post-COVID BHJJ Youth**

Risk of out-of-home placement decreased from intake to termination among post-COVID youth.



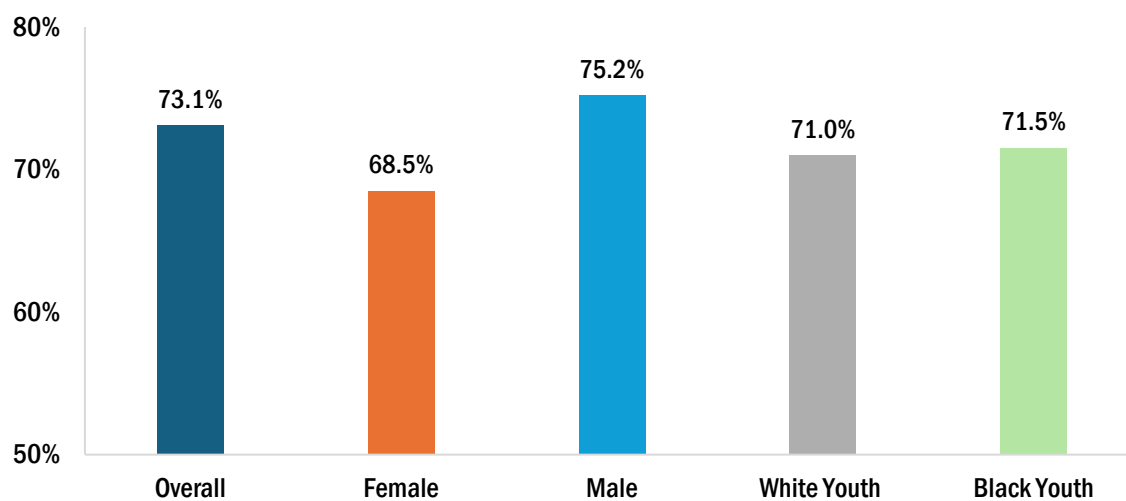
Most of the youth judged to be at risk of out-of-home placement at termination **failed to complete** BHJJ successfully, an association that was found to be **statistically significant**. Of the **57 youth at risk of out-of-home placement** at termination, **44 (77.2%)** did **not successfully complete** the program.

Juvenile Justice Outcomes

Contact with Police

At termination, program staff reported how the **youth's encounters with the police changed** since beginning BHJJ services. In the post-COVID cohort, **73.1%** of all youth were reported to have had **reduced police contact** since starting services (see Figure 29). The subgroup with the highest percentage of youth with reduced police contacts were **males** (75.2%, n = 152).

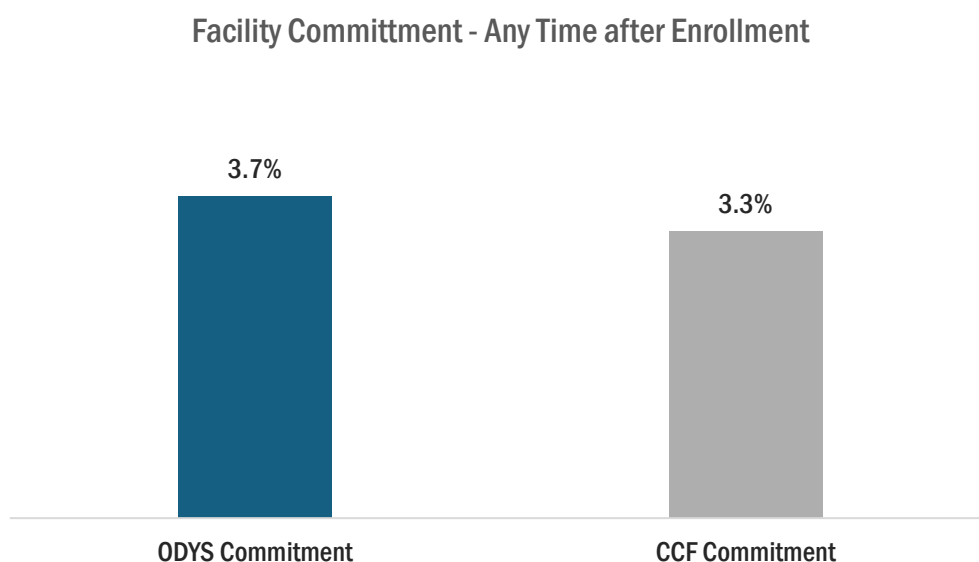
Figure 29: **Reduced Police Contact at Termination in Post-COVID Group**



Commitment to CCF & DYS

Each project provided information on the number of youth enrolled in BHJJ between January 2021 and November 2024 who were committed to a Community Correctional Facility (CCF) or an ODYS facility at **any time after their enrollment**. These data were gathered in the Spring of 2026; therefore, youth who enrolled in BHJJ in January 2021 could have potentially been tracked for over five years. Of the 601 youth for whom we received data, 3.7% (n = 22) were committed to an ODYS facility while 3.3% (n = 20) were committed to a CCF. The 42 facility commitments represented 32 unique youth (5.3% of 601), as 10 youth were committed to both an ODYS facility and a CCF after their BHJJ enrollment.

Figure 30: **Commitment to an ODYS Facility or CCF in Post-COVID Group**



Conclusion

Part I: Pre- and Post-COVID Intake Comparisons

In a comparison of pre- and post-COVID youth at intake, post-COVID families reported higher incomes overall, with low-income households **declining to less than half** of families served (62% to 46%) and the **highest income bracket doubling** (6% to 13%). Post-COVID youth generally entered BHJJ with **greater clinical complexity** than their pre-COVID counterparts. There was a significant increase in several DSM diagnoses, including **Anxiety Disorder, PTSD**, and **Trauma and Stressor-Related Disorders**, reflecting greater mental health needs among youth served. Trauma symptoms were elevated at intake across both genders, with **females** showing the largest increases in **Anger** and **Posttraumatic Stress**. Among **females**, **cannabis**, **alcohol**, and **hallucinogen** use **all increased significantly** post-COVID. Among **males**, **loneliness increased** significantly, consistent with research documenting pandemic-related disruptions to peer connection and community-based activities. **Resilience** at intake was largely **stable** for **males** but **declined** across multiple interpersonal and peer support items for **females**. Caregiver **satisfaction** ratings for **BHJJ services** remained **positive** across both periods, though the intensity of endorsement shifted **downward** post-COVID across most items.

Part II: Key Program Outcomes at Termination: Post-COVID

Despite entering the program with higher levels of need, post-COVID youth showed **meaningful** and **consistent improvements** across **all outcome** domains at termination. **Trauma symptoms decreased significantly** across **all six** domains for both **males** and **females**, and workers reported **significant reductions** in **Problem Severity** alongside **improvements** in **Functioning**. Approximately **3 out of 4 (74%)** youth **successfully** completed the program, with completion rates among **Black** youth improving from **62% to 71%**, narrowing the successful completion rate gap with **White** youth. Educational and placement outcomes at termination reflected **positive shifts** across most indicators. **Academic performance** showed a **statistically significant upward shift**, with fewer youth reporting lower grades and more reporting higher grades at termination compared to intake. **Risk of out-of-home placement decreased significantly** from intake to termination, with **nearly half** as many youth identified as at risk by program completion. Youth at **risk of out-of-home placement** at termination were significantly **less** likely to **complete** the **program successfully**. Nearly three-quarters of all youth had reduced law enforcement contact while in the program and few youth were placed in an ODYS facility (3.7%) or CCF (3.3%) at any time after their BHJJ enrollment. Overall, the BHJJ program continued to produce positive outcomes for justice-involved youth with behavioral health concerns.

References

- Bussi res, E. L., Malboeuf-Hurtubise, C., Meilleur, A., Mastine, T., H rault, E., Chadi, N., Montreuil, M., G n reux, M., Camden, C., & PRISME-COVID Team. (2021). Consequences of the COVID-19 pandemic on children's mental health: A meta-analysis. *Frontiers in Psychiatry*, 12, 691659. <https://doi.org/10.3389/fpsy.2021.691659>
- Centers for Disease Control and Prevention. (2020). *Youth Risk Behavior Survey: Data summary & trends report 2009-2019*. U.S. Department of Health and Human Services. <https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBSDataSummaryTrendsReport2019-508.pdf>
- Dray, J., Bowman, J., Campbell, E., Freund, M., Wolfenden, L., Hodder, R. K., McElwaine, K., Tremain, D., Bartlem, K., Bailey, J., Small, T., Palazzi, K., Oldmeadow, C., & Wiggers, J. (2017). Systematic review of universal resilience-focused interventions targeting child and adolescent mental health in the school setting. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(10), 813–824. <https://doi.org/10.1016/j.jaac.2017.07.780>
- Fix, R. L., Thompson, K. R., & Doan, B. (2024). Is there a mental health wake following the COVID-19 pandemic on adolescents in a male juvenile prison? *Journal of Research on Adolescence*, 1–14. <https://doi.org/10.1111/jora.12943>
- Gracia-Liso, R., Portella, M. J., Pujals-Alt s, E., Punt -Vidal, J., Llorens, M., P mias, M., Fradera Jim nez, M., Montalvo Aguirrezabala, I., & Palao, D. J. (2024). Adolescent suicide attempters pre- and during COVID-19 pandemic. *BMC Psychiatry*, 24, 373. <https://doi.org/10.1186/s12888-024-05823-y>
- Hoagwood, K. E., Gardner, W., & Kelleher, K. J. (2021). Promoting children's mental, emotional, and behavioral (MEB) health in all public systems, post-COVID-19. *Administration and Policy in Mental Health and Mental Health Services Research*, 48, 379–387. <https://doi.org/10.1007/s10488-021-01115-5>
- Jones, S. E., Ethier, K. A., Hertz, M., DeGue, S., Le, V. D., Thornton, J., Lim, C., Dittus, P. J., & Geda, S. (2021). Mental health, suicidality, and connectedness among high school students during the COVID-19 pandemic. *MMWR Supplements*, 71(3), 16–21. <https://doi.org/10.15585/mmwr.su7103a3>
- Kegler, S. R., Simon, T. R., Zwald, M. L., Chen, M. S., Mercy, J. A., Jones, C. M., Ortiz, R. R., Crosby, A. E., & Kresnow, M. (2022). Vital signs: Changes in firearm homicide and suicide rates—United States, 2019–2020. *MMWR Morbidity and Mortality Weekly Report*, 71(19), 656–663. <https://doi.org/10.15585/mmwr.mm7119e1>

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(3), 302–325. <https://doi.org/10.1177/0887403414560885>

Lockwood, A., Viglione, J., & Peck, J. H. (2021). COVID-19 and juvenile probation: A qualitative examination of emergent challenges and useful strategies. *Criminal Justice and Behavior*, 50(1), 56–75. <https://doi.org/10.1177/00938548211050618>

McBurney, A. (2024). *Reducing disproportionate minority contact in the juvenile justice system: Is there hope in diversion?* [Doctoral dissertation, Saint Leo University]. ProQuest Dissertations and Theses Global.

Mendel, R. A. (2022). *Diversion: The hidden key to combating racial and ethnic disparities in juvenile justice*. The Sentencing Project.

Panchal, U., Salazar de Pablo, G., Franco, M., Moreno, C., Parellada, M., Arango, C., & Fusar-Poli, P. (2023). The impact of COVID-19 lockdown on child and adolescent mental health: Systematic review. *European Child & Adolescent Psychiatry*, 32, 1151–1177. <https://doi.org/10.1007/s00787-021-01856-w>

Reid, J. A., Chenneville, T., Gardy, S. M., & Baglivio, M. T. (2021). An exploratory study of COVID-19's impact on psychological distress and antisocial behavior among justice-involved youth. *Crime & Delinquency*, 68(8), 1271–1291. <https://doi.org/10.1177/00111287211035951>

Rogers, A. A., Ha, T., & Ockey, S. (2021). Adolescents' perceived socio-emotional impact of COVID-19 and implications for mental health: Results from a US-based mixed-methods study. *Journal of Adolescent Health*, 68(1), 43–52.

Samji, H., Wu, J., Ladak, A., Vossen, C., Stewart, E., Dove, N., Long, D., & Snell, G. (2022). Review: Mental health impacts of the COVID-19 pandemic on children and youth – A systematic review. *Child and Adolescent Mental Health*, 27(2), 173–189. <https://doi.org/10.1111/camh.12501>

Shufelt, J. L., & Cocozza, J. J. (2006). *Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study*. National Center for Mental Health and Juvenile Justice.

Tolou-Shams, M., Bath, E., McPhee, J., Folk, J. B., Porche, M. V., & Fortuna, L. R. (2022). Juvenile justice, technology and family separation: A call to prioritize access to family-based telehealth treatment for justice-involved adolescents' mental health and well-being. *Frontiers in Digital Health*, 4, 867366. <https://doi.org/10.3389/fdgth.2022.867366>

Viner, R., Russell, S., Saulle, R., Croker, H., Stansfield, C., Packer, J., Nicholls, D., Goddings, A.-L., Bonell, C., Hudson, L., Hope, S., Ward, J., Schwalbe, N., Morgan, A., & Minozzi, S. (2022). School closures during social lockdown and mental health, health behaviors, and well-being among children and adolescents during the first COVID-19 wave: A systematic review. *JAMA Pediatrics*, 176(4), 400–409.

Vivrette, R., Hebert, A., & Liberman, A. (2020). *Trauma-informed strategies for supporting youth in the juvenile justice system during COVID-19*. Child Trends.

Yard, E., Radhakrishnan, L., Ballesteros, M. F., Sheppard, M., Gates, A., Stein, Z., Hartnett, K., Kite-Powell, A., Rodgers, L., Adjemian, J., Ehlman, D. C., Holland, K., Idaikkadar, N., Ivey-Stephenson, A., Martinez, P., Law, R., & Stone, D. M. (2021). Emergency department visits for suspected suicide attempts among persons aged 12–25 years before and during the COVID-19 pandemic — United States, January 2019–May 2021. *MMWR Morbidity and Mortality Weekly Report*, 70(24), 888–894. <https://doi.org/10.15585/mmwr.mm7024e1>

Appendices

Appendix A: Income Tables

Pre-COVID 2016-2019

Household Income	Overall	White	Black	Multiracial
Less than \$5,000	18.2% (n = 215)	9.6% (n = 51)	26.7% (n = 138)	17.2% (n = 20)
\$5,000 - \$9,999	6.3% (n = 75)	5.6% (n = 30)	6.0% (n = 31)	10.3% (n = 12)
\$10,000 - \$14,999	15.1% (n = 179)	13.0% (n = 69)	17.0% (n = 88)	15.5% (n = 18)
\$15,000 - \$19,999	7.6% (n = 90)	7.2% (n = 38)	8.3% (n = 43)	7.8% (n = 9)
\$20,000 - \$24,999	14.5% (n = 172)	14.7% (n = 78)	15.1% (n = 78)	12.1% (n = 14)
\$25,000 - \$34,999	10.4% (n = 123)	10.7% (n = 57)	9.7% (n = 50)	12.9% (n = 15)
\$35,000 - \$49,999	12.3% (n = 146)	14.3% (n = 76)	10.4% (n = 54)	12.1% (n = 14)
\$50,000 - \$74,999	9.9% (n = 117)	14.9% (n = 79)	4.8% (n = 25)	9.5% (n = 11)
\$75,000 - \$99,000	3.3% (n = 39)	6.0% (n = 32)	1.0 (n = 5)	1.7% (n = 2)
100,000 and over	2.4% (n = 28)	4.0% (n = 21)	1.0% (n = 5)	0.9% (n = 1)

Aggregated income table (Pre-COVID 2016-2019)

Household Income	Overall	White	Black	Multiracial
Less than \$24,999	61.7% (n = 731)	50.1% (n = 266)	73.1% (n = 378)	63.8% (n = 74)
\$25,000 - \$49,999	22.7% (n = 269)	25.0% (n = 133)	20.1% (n = 104)	25.0% (n = 29)
\$50,000 - \$74,999	9.9% (n = 117)	14.9% (n = 79)	4.8% (n = 25)	9.5% (n = 11)
\$75,000 and over	5.7% (n = 67)	10.0% (n = 53)	2.0% (n = 10)	2.6% (n = 3)

Post-COVID 2021-2024

Household Income	Overall	White	Black	Multiracial
Less than \$5,000	14.3% (n=74)	7.5 % (n=15)	20.2 % (n=50)	12.7 % (n = 7)
\$5,000 - \$9,999	3.9% (n=20)	1.0 % (n=2)	6.1 % (n=15)	3.6 % (n = 2)
\$10,000 - \$14,999	8.1% (n=42)	7.5 % (n=15)	8.1 % (n=20)	7.3 % (n = 4)
\$15,000 - \$19,999	4.4% (n=23)	3.5 % (n=7)	4.0 % (n=10)	10.9 % (n = 6)
\$20,000 - \$24,999	15.1% (n=78)	13.0 % (n=26)	17.4 % (n=43)	9.1 % (n = 5)
\$25,000 - \$34,999	10.8% (n=56)	10.0 % (n=20)	13 % (n=32)	7.3 % (n = 4)
\$35,000 - \$49,999	19.0% (n=98)	16.5 % (n=33)	18.6 % (n=46)	27.3 % (n = 15)
\$50,000 - \$74,999	11.6% (n=60)	17.0% (n=34)	7.7 % (n=19)	12.7 % (n = 7)
\$75,000 - \$99,000	5.8% (n=30)	10.0 % (n=20)	2.4 % (n=6)	5.5 % (n = 3)
100,000 and over	7.0% (n=36)	14.0 % (n=28)	2.4 % (n=6)	3.6 % (n = 2)

Aggregated income table (Post-COVID 2021-2024)

Household Income	Overall	White	Black	Multiracial
Less than \$24,999	45.8% (n = 237)	32.5% (n = 65)	55.8% (n = 138)	43.6% (n = 24)
\$25,000 - \$49,999	29.8% (n = 154)	26.5% (n = 53)	31.6% (n = 78)	34.6% (n = 19)
\$50,000 - \$74,999	11.6% (n = 60)	17.0% (n = 34)	7.7% (n = 19)	12.7% (n = 7)
\$75,000 and over	12.8% (n = 66)	24.0% (n = 48)	4.8% (n = 12)	9.1% (n = 5)

Appendix B: Youth and Family History

Question	Males (% (Pre-COVID))	Males (% (Post-COVID))	Females (% (Pre-COVID))	Females (% (Post-COVID))
Has the child ever been physically abused?	12.9% (n=108)	15.3% (n=53)	17.1% (n=63)	22.2% (n=38)
Has the child ever been sexually abused?	6.8% (n=57)	9.4% (n=32)	23.0% (n=83)	26.7% (n=44)
Has the child ever run away?	44.6% (n=378)	50.6% (n=176)	58.4% (n=218)	53.7% (n=89)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	56.4% (n=477)	57.1% (n=197)	44.5% (n=165)	52.6% (n=90)
Has the child ever talked about committing suicide?	33.6% (n=283)	35.6% (n=124)	52.3% (n=196)	59.4% (n=100)
Suicide talk, last 6 months	39.0% (n=156)	32.4% (n=56)	54.6% (n=112)	48.0% (n=60)
Has the child ever attempted suicide?	11.7% (n=98)	13.0% (n=46)	25.2% (n=92)	25.0% (n=43)
Suicide attempt, last 6 months	9.6% (n=32)	13.4% (n=20)	25.7% (n=44)	17.6% (n=16)
Average # suicide attempts	1.5	2.5	2.9	2.4
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	35.8% (n=303)	33.1% (n=117)	34.4% (n=129)	47.1% (n=80) **
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	62.8% (n=521)	64.5% (n=225)	67.0% (n=250)	71.4% (n=125) **
Lived in a household with depression, last 6 months	44.3% (n=259)	45.0% (n=118)	51.9% (n=139)	57.8% (n=78)
Was the person with depression the caregiver	57.1% (n=267)	54.8% (n=125)	63.3% (n=131)	60.7% (n=74)
Has anyone in the child's biological family had a mental illness, other than depression?	48.9% (n=395)	54.4% (n=184)	54.0% (n=196)	57.6% (n=98)
Lived in a household with mental illness, last 6 months	28.5% (n=133)	33.6% (n=74)	35.5% (n=78)	36.7% (n=44)
Was the person with MI the caregiver	36.0% (n=141)	45.7% (n=91) *	39.4% (n=69)	41.2% (n=42)
Has the child ever lived in a household in which someone was convicted of a crime?	38.3% (n=315)	36.1% (n=122)	41.2% (n=149)	44.4% (n=75)
Has anyone in the child's biological family had a drinking or drug problem?	49.7% (n=413)	50.0% (n=174)	55.3% (n=207)	54.0% (n=95)
Ever lived in a house with a family member with SA	39.8% (n=296)	43.0% (n=130)	46.8% (n=154)	45.6% (n=72)
Was the SA family member a caregiver?	31.3% (n=125)	38.7% (n=67)	38.0% (n=65)	38.5% (n=40)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	33.7% (n=280)	37.6% (n=132)	41.0% (n=152)	44.3% (n=77)

Note: * < .05, ** < .01, *** < .001

Appendix C: Youth Substance Use Pre & Post-COVID Comparisons

All Substance Use Measures at Intake: Comparing Pre- and Post-COVID Cohorts

Substance	Overall Substance Use (Pre-COVID)		Overall Substance Use (Post-COVID)	
	Ever Used (%, n)	Age of First Use (yrs, SD)	Ever Used (%, n)	Age of First Use (yrs, SD)
Alcohol	52.2% (n=271)	13.5 (SD=1.94)	56.4% (n=300)	13.4 (SD=2.02)
Tobacco	48% (n=249)	13.2 (SD=2.05)	46.2% (n=246)	13 (SD=1.94)
Cannabis	66.7% (n=345)	13.2 (SD=1.84)	75.2% (n=400) **	13(SD=1.75)
Hallucinogens	6.8% (n=35)	14.6 (SD=1.85)	10.3%(n=54) *	14.4 (SD=1.36)
Inhalants	2.1% (n=11)	12.6 (SD=3)	2.1% (n=11)	13.1(SD=2.23)
Opioids	6.4% (n=33)	14.2 (SD=1.89)	6.3% (n=33)	13.4 (SD=1.95)
Sedatives	9.7% (n=50)	14.5 (SD=1.57)	6.3% (n=33) *	13.5 (SD=1.74)
Caffeine	34.4% (n=178)	12 (SD=2.52)	36.6% (n=192)	11.7 (SD=2.23)
Stimulants	6.8% (n=35)	14.6 (SD=1.78)	5% (n=26)	13.8 (SD=2.05)
Over the counter medications	9.7% (n=50)	14.2 (SD=1.53)	7.8% (n=41)	14.2 (SD=1.54)
Other prescription drugs	6.4% (n=33)	12.9 (SD=2.48)	8.4% (n=44)	12.8 (SD= 2.07)
Herbs/Flowers	0.8% (n=4)	14.3 (SD=0.58)	1% (n=5)	12.8 (SD=3.31)

Note: * $\leq .05$, ** $\leq .01$; Youth could report use of multiple substances; hence responses are not exclusive.

Appendix D: Youth Substance Use Pre & Post-COVID Comparisons by Gender

Substance (SUS-R)	Males (Pre-COVID)		Males (Post-COVID)		Difference in Usage (%)
	Ever Used (% , n)	Age of First Use (yrs, SD)	Ever Used (% , n)	Age of First Use (yrs, SD)	
Alcohol	52% (n=190)	13.5 (SD=2)	52.8% (n=189)	13.5 (SD=2.19)	0.8
Tobacco	51.5% (n=188)	13.3 (SD=2.08)	49.7% (n=178)	13.1 (SD=1.96)	-1.8
Cannabis	70.3% (n=256)	13.1 (SD=1.88)	76.0% (n=273)	13.0 (SD=1.78)	5.7
Hallucinogens	8.0% (n=29)	14.6 (SD=1.78)	10.0% (n=35)	14.6 (SD=1.37)	2.0
Inhalants	2.2% (n=8)	13.1 (SD=2.85)	2.0% (n=7)	13.5 (SD=1.97)	-0.2
Opioids	7.1% (n=26)	14.3 (SD=1.41)	6.3 % (n=22)	13.6 (SD=1.81)	-0.8
Sedatives	10.4% (n=38)	14.4 (SD=1.46)	6.3 % (n=22)	13.9 (SD=1.71)	-4.1
Caffeine	33.4% (n=122)	12.0 (SD=2.52)	36.6% (n=129)	11.5 (SD=2.21)	3.2
Stimulants	6.9% (n=25)	14.6 (SD=1.47)	4.2% (n=15)	14.1 (SD=1.60)	-2.7
Over the counter medications	11.0% (n=40)	14.2 (SD=1.22)	8.2% (n=29)	14.4 (SD=1.41)	-2.8
Other prescription drugs	6.6% (n=24)	12.8 (SD=2.66)	7.1% (n=25)	13.2 (SD=2.15)	0.5
Herbs/Flowers	0.6% (n=2)	14.3 (SD=0.58)	0.9% (n=3)	11.5 (SD=2.65)	0.3

Substance (SUS-R)	Females (Pre-COVID)		Females (Post-COVID)		Difference in Usage (%)
	Ever Used (% , n)	Age of First Use (yrs, SD)	Ever Used (% , n)	Age of First Use (yrs, SD)	
Alcohol	52.6% (n=81)	13.5 (SD=1.80)	63.8% (n=111) *	13.3 (SD=1.71)	11.2
Tobacco	39.6% (n=61)	12.7 (SD=1.89)	39.1% (n=68)	12.8 (SD=1.89)	-0.5
Cannabis	58.2% (n=89)	13.3 (SD=1.73)	73.4% (n=127) **	13.0 (SD=1.68)	15.2
Hallucinogens	3.9% (n=6)	14.5 (SD=2.27)	10.9% (n=19) *	14.0 (SD=1.27)	7.0
Inhalants	2.0% (n=3)	10.5 (SD=3.53)	2.3% (n=4)	12.7 (SD=2.58)	0.3
Opioids	4.6% (n=7)	13.8 (SD=3.06)	6.4% (n=11)	12.9 (SD=2.21)	1.8
Sedatives	7.9% (n=12)	14.8 (SD=2)	6.4% (n=11)	12.9 (SD=1.68)	-1.5
Caffeine	36.6% (n=56)	12.1 (SD=2.55)	36.6% (n=63)	12.0 (SD=2.26)	0
Stimulants	6.7% (n=10)	14.3 (SD=2.65)	6.4% (n=11)	13.4 (SD=2.5)	-0.3
Over the counter medications	6.6% (n=10)	13.9 (SD=2.7)	7.0% (n=12)	13.7 (SD=1.72)	0.4
Other prescription drugs	5.9% (n=9)	13.1 (SD=2.1)	11.1% (n=19)	12.3 (SD=1.94)	5.2
Herbs/Flowers	1.3% (n=2)	—	1.2% (n=2)	15.5 (SD=3.54)	-0.1

Note: * < .05, ** < .01, *** < .001