An Evaluation of the Behavioral Health/Juvenile Justice Initiative: 2005-2007

Prepared for:
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The Ohio Department of Youth Services,
&
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Executive Summary

Many children involved in the Juvenile Justice System suffer from significant mental health impairments. The Behavioral Health/Juvenile Justice (BHJJ) program was created to give Juvenile Court judges an alternative to incarceration. At its core, the BHJJ initiative is a diversion program. Children with mental health issues involved in the juvenile justice system need proper treatment, which is often difficult to provide in large correctional facilities. Instead of sending these children to an Ohio Department of Youth Services (ODYS) facility, the BHJJ program allows for treatment in the youth's community, which not only serves to improve mental and behavioral health outcomes, but also makes good financial sense.

Six project sites were funded during the current evaluation period: Cuyahoga, Fairfield, Franklin, Logan/Champaign, Montgomery, and Union Counties. Three of the sites; Cuyahoga, Fairfield, and Montgomery Counties focused on juvenile females offenders. While each program site used a different treatment model, all were evidence-based best practice models. Enrollment criteria included youth between the ages of 10-18 who had been charged and or adjudicated as delinquent. In addition, these youth must have demonstrated substantial mental status impairments in behavioral, cognitive, or affective domains. Youth with patterns of criminal or violent behavior, who demonstrated co-occurring substance abuse, or youth who were threats to public safety or themselves were also considered for inclusion.

The Institute for the Study and Prevention of Violence (ISPV) was selected to evaluate the BHJJ program. A comprehensive assessment tool was designed to measure the success of the program and included surveys covering topics such as substance use, trauma symptoms, problem severity and functioning, optimism, exposure to violence, abuse history, youth and family demographics, and satisfaction with the BHJJ program.

As of June 30th, 2007, 455 youth had been enrolled in the BHJJ program. The average age of youth at the time of enrollment was 15.21 years. Males comprised 50.3% of the sample and Caucasians (65.5%) and African Americans (28.1%) made up the majority of the sample. While over 75% of the caregivers in the program had at least a high school diploma, nearly a quarter did not graduate from high school (23.4%). Nearly two-thirds (65%) of the youth lived in a single-parent household; 54.3% lived with only the biological mother and 10.7% lived with only the biological father. The average household income for the entire sample was between $20000 and $24999. Caregivers reported that 17.1% of males and 25.7% of females were physically abused in the past. In addition, they reported that 5.5% of males and 36.4% of females had been sexually abused.

There were a total of 771 Axis I diagnoses for the 455 youth, for an average of 1.69 diagnoses per child. The most common diagnosis among females was Oppositional Defiant Disorder (ODD) and for males, the most common diagnosis was Attention Deficit Hyperactive Disorder (ADHD). Slightly over a quarter (25.9%) of the youth had co-occurring mental health and substance abuse diagnoses.

The Ohio Scales analyses indicate that the BHJJ youth improved significantly across all areas (Problem Severity, Functioning, Satisfaction, and Hopefulness) and across nearly all measurement intervals. This was measured by Youth, Parent, and Worker ratings. All three raters reported significant improvements in all four areas. Trauma symptoms, as measured by the Trauma Symptoms for Children Checklist (TSCC) also significantly improved from Intake to Discharge.

Because exposure to violence has been found to be a significant predictor of mental health impairments, regression analyses were conducted to determine if the BHJJ youth who were exposed to greater amounts of violence over the past year also reported greater trauma scores. Results indicated that youth who reported greater exposure to violence in the past year also reported greater trauma scores across all six subscales (Anxiety, Anger, Depression, Dissociation, Post-Traumatic Stress, and Sexual Concerns). In addition, youth who reported greater exposure to violence in the past year also experienced greater problem severity and lower functioning, as measured by the Ohio Scales.

Self-reported substance abuse decreased for all substances from Intake to Discharge, except for cigarettes. Cigarette use increased slightly while youth were in the program. There was also a significant reduction from Intake to Discharge on the Ohio Scales alcohol and drug item.

Over one quarter (26.2%) of the sample had been discharged from the program. Of those, 44.5% were labeled as successful completions, meaning they had successfully completed treatment and were discharged from BHJJ. Several youth moved out of county after enrolling in the BHJJ program, and were thus discharged (13.4%). Some clients simply did not attend therapy sessions or were removed from the program by a caregiver (18.5%). Three youth were stepped down *from* an ODYS facility and placed into the BHJJ program. Two of these youth were referred back to ODYS. Therefore, for the 452 youth for whom BHJJ was a true diversion program, none were referred to ODYS. The recidivism rate for the BHJJ youth, measured by new charges after enrollment into the program, was 30.8%.

As stated above, there were 455 youth enrolled during the project period at a cost of $1,800,000. The Ohio Department of Youth Services (ODYS) per diem in the 2007 fiscal year was $215.64 and the average length of institutionalization for youth was 11.5 months. At those rates, only 24 youth could have been served at ODYS during the same project period with the same amount of funding.

One major improvement from the pilot evaluation was the addition of the part-time data manager at each project site. The addition of this position is one of the reasons why the data collection process went smoothly and also why there were so much data to analyze. It is the recommendation of the Evaluation Team that this position be maintained at all current and future BHJJ sites. Another recommendation would be the introduction of a common risk assessment tool to the screening and assessment phase of

enrollment. This tool would allow for consistent screening and enrollment across project sites. A uniform risk screening tool would help to make cross-county comparisons significantly more meaningful. Overall, the BHJJ program was successful in identifying and treating juvenile justice-involved youth with mental health issues and diverting these youth from ODYS to local treatment options.

An Evaluation of the Behavioral Health/Juvenile Justice Initiative: 2005-2007

History of the Behavioral Health/Juvenile Justice Program

Over 10 years ago, Ohio's juvenile court judges met with representatives from the Ohio Department of Mental Health (ODMH) and the Ohio Department of Youth Services (ODYS) to address a growing and serious concern. Many of the youth who appeared in court demonstrated serious mental and behavioral health problems. Not only did these judges lack the resources and expertise to identify, assess, and serve these youth, but there were few alternative programs into which these youth could be placed, in lieu of a detention facility.

As a result of this meeting, the ODMH and the ODYS developed the Task Force on Mental Health Services to Juvenile Offenders, with cross system and family representation. The Task Force presented its final recommendations to State officials in the Winter of 1998. These recommendations included: developing a local continua of care in the community, promoting intersystem collaboration, and identifying legislative and funding issues around serving youth in the juvenile justice system who are in need of mental or behavioral health services. The final recommendation was to fund local pilot projects in an attempt to divert youth, who demonstrated a need for mental or behavioral health service, from an ODYS facility into a community treatment setting.

Three pilot sites were selected for inclusion into the first Behavioral Health/Juvenile Justice (BHJJ) project. The target population for these pilot sites were males and females who were under 18 years of age at the time of the offense and who were charged or adjudicated as delinquent. In addition, the youth also had to demonstrate a significant impairment in affective, behavioral, or cognitive domains. One of the main goals of the project was to reduce the referrals to the ODYS for youth involved in the juvenile justice system who showed signs of significant mental health impairment. This was to be accomplished by using community resources, evidence-based best practice models, and intersystem communication, cooperation, and collaboration to offer the youth appropriate treatment in the community and when possible, in the home.

A necessary component of these pilot projects was a program evaluation. The goals of the initial evaluation were to describe the sample, assess outcomes as a function of participation in treatment, describe the process used to identify these youth, and conduct a qualitative analysis of the program implementation. As a direct result of the BHJJ program, the number of severe mental health youth referrals to the ODYS decreased, collaboration among ODYS and local systems improved, and counties demonstrated an increased understanding of local continua of care (Flannery, Buckeye, Wester, & Singer, 2003).

As a result of a favorable evaluation, the BHJJ program received the continued support of the ODMH and the ODYS, and received additional funding to expand the project beginning in fiscal year 2005. While similar in scope, some of the target population characteristics were slightly different from the pilot project. Target criteria

included youth between the ages of 10-18 who had been charged and or adjudicated as delinquent. In addition, these youth must demonstrate substantial mental status impairments in behavioral, cognitive, or affective domains and have a DSM-IV diagnosis. Youth with patterns of criminal or violent behavior, who demonstrated co-occurring substance abuse, or youth who are threats to public safety or themselves were also considered for inclusion.

In an attempt to address the underrepresentation of young females involved in the juvenile justice and behavioral health systems, the State encouraged proposals dedicated to the female juvenile offender. Six proposals were funded, three of which focused on females. Once again, all successful proposals had to incorporate evidence-based best practices into their treatment model. The continued goal of the BHJJ program is to treat those youth who meet the target criteria locally, thus reducing the number of referrals to the ODYS and improving mental and behavioral health outcomes.

BHJJ Target Population

Several criteria were outlined in the original request for proposals distributed by the State. Youth did not have to meet all criteria to be included, but did need to meet several. The criteria were as follows:

- DSM IV diagnosis
- Aged 10 to 18
- Substantial mental status impairment in affective, behavioral, and/or cognitive domains
- Co-occurring substance abuse
- Violent and/or pattern of criminal behavior
- Charged and/or adjudicated delinquent
- Incompetent to stand trial for felony offense, misdemeanor offenses of violence, and in need of mental health treatment other than competency restoration
- Threat to public safety, community and self/others
- Substantial impairment in daily living skills and limited success in major life domains
- Exposed to/victim of trauma and/or domestic violence
- History of multi-system involvement

BHJJ Counties

Six projects were funded and seven counties participated in the BHJJ project. The counties included: Cuyahoga, Fairfield, Franklin, Logan/Champaign, Montgomery, and Union. While all counties had to use evidence based-best practice treatment models, each county was able to select the model that it felt best served its population. While the entrance to the project was almost exclusively through the juvenile court, the exact processes by which children were identified, assessed, and enrolled varied by county. The following section briefly outlines the procedures used in each of the counties.

<u>Cuyahoga</u>

The referral/decision process for Cuyahoga BHJJ begins in the juvenile court. First, a court hearing is scheduled and placement planning is ordered. Next, a referral to

a placement manager is made and a request for an alternative case plan meeting is made. The alternative case plan team consists of representatives from Probation, the County, MST therapists, direct service providers, and school personnel. The alternative case plan team meets to decide the best course of action for the youth, and recommends either traditional services and supervision or makes a referral to the BHJJ Care Coordinator. Once the decision is made to refer the child to BHJJ, additional assessments are completed by one of the local service providers. After these assessments are complete, the Care Coordinator holds a meeting with the family and the service team to develop a wrap-around plan for the family.

At the court hearing, the alternative case plan team is present to offer their recommendations to the Judge. At that time, the youth is assigned to a placement or aftercare coordinator. Some children enter short-term residential placement and are stepped down into aftercare with community-based wraparound services as part of the BHJJ program. Children who do not need short-term residential placement begin their BHJJ community-based wraparound services immediately after the court hearing. Cuyahoga County is using both Multisystemic Therapy and Integrated Co-Occuring Treatment as their evidence-based best practice models. Currently, the BHJJ project in Cuyahoga County is exclusive to female offenders.

Fairfield County

The point of entry into the BHJJ program in Fairfield is the Juvenile Court Mental Health Division. All referrals are young women and men who are currently on probation and assessed by the mental health staff to be appropriate for inclusion in the program. Many of the referrals also attend the Fairfield County Community (Alternative) School. Once assessed for mental health status and determined eligible, the referral is made to the New Horizons Home Based Therapy Supervisor. Intake is coordinated with the Family and Children First Council Multi-System Coordinator.

Care management is the responsibility of the Home Based Therapist employed by New Horizons. Parents/families are included in the Family Service Coordination Plan and managed by the Intensive Family Home-Based Therapy (IFHBT) staff. Care management occurs at the parent/family level as a part of the philosophy of home based therapy.

The selection criteria for the BHJJ IFHBT service are:

- The family is a resident of Fairfield County as determined by Medicaid residency eligibility.
- The identified client has been determined appropriate and eligible by the Juvenile Court Mental Health treatment team.
- Client cannot be actively psychotic.
- Substance abuse cannot be the only diagnosis.
- The family is available to participate in the program.
- The family agrees to comply with the Home-Based service plan.

The following steps must occur when making a referral for the Home-Based Program:

- The client is identified for IFHBT by Juvenile Court Mental Health Treatment Team.
- Juvenile Court staff must complete the Cluster Referral Form along with an Intersystem Collaboration for Youth Release of Information which is given to the Home-Based supervisor.
- A clinical staffing involving all current providers is scheduled and facilitated at New Horizons. If the case is accepted after a clinical staffing then the case will be assigned to a Home-Based Therapist/Case Manager.
- With appropriate parent/guardian authorization for release of information, home-based clinicians will provide case-specific periodic reports of clinical progress and outcomes.

Once selected for the BHJJ Intensive Family Home Based Therapy project, young women and men and their families are provided unconditional care, resulting in no ejection from the program except from the criteria listed for non-compliance that are within the control of the family/youth.

Logan/Champaign

Logan

The age range for inclusion in the BHJJ project in Logan County is between 13-17 years old. After appearing in Court, the youth is court ordered to complete a mental health/substance abuse screening. The screening includes the Teen Screen (Flynn, McGuire, & Crandall, 2003), a national mental health and suicide risk screener for youth, and the youth version of the Substance Abuse Subtle Screening Inventory (SASSI) (Miller, 1985). The SASSI is a brief screening measure that helps identify individuals who have a high probability of having a substance use disorder. If youth screens positive on one or both screening tools, an assessment with the court counselor is court ordered. An assessment with the court counselor is also ordered if the guardian, youth, or court staff asks to have an assessment completed due to specific concerns.

Enrollment into the BHJJ program in Logan County happens two ways. Youth who are currently utilizing mental health or substance abuse services at the time of screening are not formally assessed for enrollment into the program. Rather, the previous screening is used as a proxy and the child is enrolled into BHJJ. If the youth is not currently utilizing any mental health or substance abuse services, a full psychological assessment with the court counselor is conducted. Based on the results of the assessment, recommendations are made for the youth to begin counseling or substance abuse treatment. At that time, the youth is formally enrolled into the BHJJ program. The family treatment court then follows the family to make sure they are attending their sessions and meet with the families on a regular basis. If they do not follow through with orders, the family appears before the Judge once again. Logan and Champaign Counties selected Intensive Home-Based Treatment (IHBT) as their evidence-based best-practice treatment model.

Champaign

To be eligible for the BHJJ project in Champaign County, the juvenile must be between the ages of 13 to 17½. They must have a delinquent charge and/or have been adjudicated a delinquent. The juvenile is assessed by the Family Service Director. If the assessment indicates a high probability of harmful involvement with drugs and/or alcohol, an area of concern in mental health, or an ongoing case with a mental health agency; the juvenile is enrolled into the BHJJ program. The Champaign County Court also enrolls juveniles into the BHJJ program if the parent or Probation Officer requests the service and is seeking mental health intervention.

In Champaign County, unlike Logan County, the judge does not order the treatment, but strongly recommends that the family seek behavioral health counseling. The Community Resource Officer (CRO) and the Probation Officers (PO) help the family connect with proper services and the IHBT worker also works to put and keep the family in contact with the proper treatment professionals. The CRO maintains some contact with the providers during treatment and the POs also engage in follow-ups with the family. In contrast to Logan County, Champaign County rarely keeps youth on probation after successful termination of the BHJJ program. In addition, Champaign County aims to enroll higher risk youth than Logan County.

Franklin

The target population for screening and assessment is court-involved youth aged 10-18. The Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2), a best practice instrument for screening with a juvenile justice population (Grisso & Quinlan, 2005), is given to all youth coming through Pre-Sentence Investigation (PSI), as well as youth involved with Intake, Probation, and Juvenile Detention Center (JDC). A cut-off for triggering further evaluation is set as two Cautions and/or one Warning on the six clinical scales. This resulted in approximately 45% of all youth being recommended for further assessment. In addition, even if the MAYSI-2 is not triggered, youth are assessed when referred by court staff due to concerns about the youth and their families.

The assessment phase is driven by the SOQIC, the assessment tool developed by ODMH, providing a DSM-IV diagnosis, a clinical summary, a recommended level of care, and specific recommendations regarding mental health and substance abuse concerns. In addition to identifying more purely psychiatric symptoms, the assessment also addresses those criminogenic risk and protective factors that the research has identified as contributing to risk of recidivism. When warranted, youth are referred for more targeted assessments (e.g., neuropsychological, ADHD, or psychoeducational assessments).

Recommendations are provided to court personnel in advance of court hearings whenever possible, so that integrated recommendations can be formulated and presented to the bench. Care is taken to recommend the least restrictive level of care, with a focus on maintaining youth with their families within the community and providing care that best matches their behavioral health and criminogenic needs and enhanced community safety. In addition, the care coordinators are consulted and provided reports as soon as

possible, so as to expedite linkage to appropriate services. Franklin County employs Multisystemic Therapy (MST) as the treatment model for BHJJ clients.

Montgomery County

A Montgomery County Juvenile Court Traditional Probation Officer (or an MCJC Care Coordinator in the case of pre-teens who are not yet on probation) identifies a female who meets criteria established for the BHJJ Program (identified as the L.I.F.E. (Learning Independence and Family Empowerment) Program in the county) and refers the youth to Samaritan CrisisCare for a diagnostic assessment. After the assessment, the youth is referred to the Montgomery County Juvenile Court LIFE Intensive Probation Officer who coordinates the referral to South Community for treatment.

In some instances, a Samaritan CrisisCare assessment therapist may recommend the LIFE Program for a court involved female youth based on her assessment, and the referral to South Community would be coordinated through the Probation Department. In other instances, a female youth may be paroled from the Ohio Department of Youth Services and referred to the BHJJ Program after Samaritan CrisisCare has completed a diagnostic assessment. In all cases, the youth is considered enrolled in the BHJJ Program when South Community receives the referral from Montgomery County Juvenile Court and the Diagnostic Assessment from Samaritan CrisisCare.

To participate in the LIFE Program the youth must be a female between the ages of 10 and 17 with a DSM-IV diagnosis and must meet at least 4 of the following criteria:

- Substantial mental status impairment in affective, behavioral, and/or cognitive domains
- Co-occuring substance abuse
- Violent and/or pattern of criminal behavior
- Charged and/or adjudicated delinquent
- Threat to public safety, community, self, and/or others
- Substantial impairment in daily living skills and limited success in major life domains
- Exposed to and/or victim of trauma and/or domestic violence
- History of multi-system involvement
- Learning disability

` Functional Family therapy is used as the evidence-based best practice treatment model in Montgomery County.

Union County

Union County's BHJJ project is a collaborative effort that involves three key stakeholders: the Juvenile Court, the Department of Job and Family Services /Children's Services, and Consolidated Care's Intensive Home Based Treatment programs. The primary mission of Union County's BHJJ program is to intercept youth who have the highest potential for out of home placement. The program has two points of youth interception. First, youth involved with Juvenile Court and who are identified as the

highest of the high risk population are referred to BHJJ. Second, a youth may be referred even if he or she has had no prior contact with the Juvenile Justice System if he or she is identified as appropriate by an interdisciplinary team.

Union's BHJJ project incorporates a cross-disciplinary team of key stakeholders who identify and screen potential enrollees into the program. The team identifies risk factors of both the youth and the family to determine the appropriateness of enrollment into the program. The Director of the treatment program, who leads the team, then facilitates the enrollment into the BHJJ program. A total of 59% of the program participants have been directly involved with the Juvenile Court, while the remaining 41% were youth identified as high risk for delinquent behavior that could lead to Juvenile Court involvement and potential out of home placement.

Measures and Instrumentation

All of the instruments that were collected as part of the BHJJ evaluation were in TeleForm format. TeleForm is a software program that allows for data transmission via fax. Instrumants are created using this software and once completed, can be faxed or scanned directly into a database. In order to read a form created with TeleForm, you must have Teleform installed on your system. Therefore, all instrumentation was converted to .pdf form and attached as a separate .zip file to the evaluation. A description of all measures follows below.

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

The Ohio Scales (Ogles, Melendez, Davis, & Lunnen, 2001) are designed to assess clinical outcomes for children with severe emotional and behavioral disorders, and were developed primarily to track service effectiveness. The measure assesses four primary domains of outcomes: problem severity, functioning, hopefulness, and satisfaction with services. In the Ohio Scales–Caregiver version, the caregiver rates his/her child's problem severity and functioning, and the caregiver's satisfaction with services and hopefulness about caring for his or her child. In the Ohio Scales–Youth version, the youth rates his/her own problem severity and functioning, and his/her satisfaction with services and hopefulness about life or overall well-being. There is also a version completed by program staff. The Worker version does not include the Satisfaction or Hopefulness scales. A score is generated for each of the four scales, with a total score for the scale generated by summing the items.

Family Stability Factors

This measure, borrowed from Gavazzi (2005), permits Intake staff to record a variety of stressors which can affect the stability of a family. These include divorce/separation of the parents, death of a close family member, moving to a new home or neighborhood, changing schools, problems with health or mental health insurance coverage, as well as reasons for the child's out-of-home placement. The items on this scale were adapted by Gavazzi from work by Patterson, Bank and Stoolmiller (1990).

Trauma Symptom Checklist for Children (TSCC)

The Trauma Symptoms Checklist for Children (TSCC) is a 54-item Likert-type questionnaire containing six subscales designed to measure anxiety, anger, depression, posttraumatic stress, dissociation, and sexual concerns (Briere, 1996). The youth respond to a series of questions regarding the frequency of certain thoughts, events, or behaviors. Responses are made on a 4-point, 0-3 scale with "0" indicating "never" and "3" indicating "almost all the time". In addition to the subscale scores, a total trauma symptoms score can be calculated by summing the individual subscale scores for each participant.

Substance Use Survey – Revised

This measure, used in the SAMHSA-funded Tapestry Project (a demonstration and research project that identifies, serves and follows youth and families from Cuyahoga County, Ohio, with significant behavioral and mental health needs), collects information reported by the youth about the frequency of his or her substance use, including tobacco, alcohol, marijuana, cocaine and several additional substances.

Enrollment Form

This form, developed by Gavazzi (2005), permits program staff to record several important pieces of information including but not limited to date of enrollment, current custody arrangements, out-of-home placement status and behavioral health care issues.

Termination Form

This form, also shared with the evaluation team by Gavazzi (2005), is designed to update the status of the youth as determined by the *Enrollment Form*. In addition, it permits program staff to record the reason for termination.

Recent Exposure to Violence

This 26-item scale measures several youth-reported violent acts: threats, beatings, hitting, knife attacks, and shootings (Singer, Anglin, Song, & Lunghofer, 1995). Youths respond to a 6-point scale ranging from "0" (never) to "5" (almost every day). Subjects report separately on violence they have experienced directly and violence they have witnessed. For threats, slapping/hitting, and beatings, questions are specific to the setting in which the violence has occurred: at home, at school, or in the neighborhood. The remaining items do not specify the setting in which the violence occurred. This scale, which has an acceptable internal consistency (Cronbach's alpha = .86), served as our measure of victimization.

Perceived Benefit of Drinking Scale and Perceived Benefit of Drug Use Scale

The Perceived Benefit of Drinking and the Perceived Benefit of Drug Use scales were developed to assess the reasons adolescents give for drinking and drug use. These scales have been demonstrated as an efficient means of identifying adolescents who are likely to be alcohol and drug abusers. A decided advantage of these scales is that they are not dependent upon directly eliciting information about alcohol/drug use patterns or negative consequences resulting from such patterns. Such information can be particularly difficult to obtain among substance-abusing youth who are likely to deny heavy use

patterns or negative consequences of use. Scalogram analysis of the Perceived Benefit of Drinking Scale yielded a coefficient of reproducibility of .91 and a scalability coefficient of .61 (Petchers & Singer, 1987). In a separate study and analysis, the Perceived Benefit of Drug Use yielded a standardized alpha of .82 (Petchers, Singer, Chow & Angelotta, 1988).

Optimism Scale

This scale, part of the Life Orientation Test (Scheier & Carver, 1985), assess the extent to which optimism mediates the effects of previous trauma and other negative experiences. There is recent evidence in the literature (e.g., Greef & Ritman, 2005; Reivich et al., 2005) that optimism is indeed associated with resilience in youth. Including this measure will permit the evaluation team to further test this hypothesis.

Demographic and Other Descriptive Information

The evaluation team used several existing forms to collect relevant demographic and descriptive data from the BHJJ youth and families. The Enrollment and Demographic Information Form (SAMHSA/ Center for Mental Health Services, 2005), permits program staff to record basic demographic and enrollment information about the youth at Intake, such as age, gender, Global Assessment of Functioning (GAF) score, and DSM-IV diagnoses. The Caregiver Information Questionnaire-Baseline, also borrowed from SAMHSA/Center for Mental Health Services (2005), permits staff to record information including demographics, risk factors, family composition, physical custody of the child, child's mental and physical health service use history, caregiver employment status, and child's presenting problems. The Youth Information Questionnaire (SAMHSA/Center for Mental Health Services, 2005) asks the youth questions regarding social support and behavioral health treatment history. Lastly, we used portions of the Multi-Sector Service Contacts – Revised form (SAMHSA, 2005), which was designed to assess the extent to which clients have been served by multiple systems as well as their satisfaction with these systems. All these questionnaires were collected at Intake and the respective follow-ups were collected at Discharge.

Recidivism

Recidivism can be defined in many ways; as new delinquency offense, a new status offense, a violation of probation or other official contacts. Recidivism is a standard measure of program success, especially as an indicator of treatment outcomes over time. For this evaluation, recidivism was defined as a new charge after the BHJJ enrollment date.

Data Collection Timeline

The majority of all data collection occurs at Intake and Discharge. However, some measures are collected intermittently throughout the course of a youth's BHJJ participation. Table 1 outlines the instruments, the collection schedule, and the individual responsible for completing the measures.

Table 1. Data Collection Schedule for BHJJ Participants

Measure	Who Completes	When Administered
Ohio Scales	Y, C, PS	I, 3, 6, 9, 12/D
Family Stability Factors	PS w/ C	I, D
Trauma Symptom Checklist for Children	Y	I, D
Substance Use Survey - Revised	Y w/ PS	I, 6, 12/D
Enrollment Form	PS	I
Termination Form	PS	D
Recent Exposure to Violence	Y	I, D
Perceived Benefit of Drinking Scale	Y	I, 12/D
Perceived Benefit of Drug Use Scale	Y	I, 12/D
Optimism Scale from *Life Orientation Test*	Y	I, 12/D
Multi-Sector Service Contacts	C w/ PS	6, 12/D
Enrollment and Demographics Information Form (EDIF)	PS	I
Caregiver Information Questionnaire – Intake (CIQ)	C w/ PS	I
Caregiver Information Questionnaire – Follow-up	C w/ PS	D
Youth Information Questionnaire – Intake	Y w/ PS	I
Youth Information Questionnaire – Follow-up	Y w/ PS	D

Y = Youth C = Caregiver PS = Program Staff I = Intake D = Discharge

Data Analysis

The first set of analyses were performed on the combined data set and include data from all BHJJ counties. Following the main analyses, individual reports are included for each county. Paired-samples t-tests and independent samples t-tests were used to determine whether two means were significantly different from one time period to another. Regression models were used to predict the likelihood of certain outcomes from critical dependent variables.

In order to correct for the multiple tests being run on the sample, a Bonferroni correction was applied to the alpha level. This correction makes it more difficult to

commit a Type I error, finding a significant result when one is not actually there. The alpha level, which is typically set at .05, is adjusted downward to become more conservative. The amount of this adjustment depends on the number of comparisons being made in the analysis. The determination of statistical significance was made using the Bonferroni alpha levels.

Demographics

As of June 30th, 2007, 455 youth had been enrolled in the BHJJ program. Table 2 shows enrollment by county. The average age of youth at the time of enrollment was 15.21 years (SD = 1.60). Males comprised 50.3% of the sample (n = 229) and females made up 49.7% (n = 226) (see Chart 1). Caucasians (65.5%) and African Americans (28.1%) made up the majority of the sample (see Chart 2).

Table 2. BHJJ Enrollment by County

County	Youth Enrolled
Champaign	55
Cuyahoga	36
Fairfield	13
Franklin	120
Logan	143
Montgomery	67
Union	21

Chart 1. Gender of BHJJ Youth

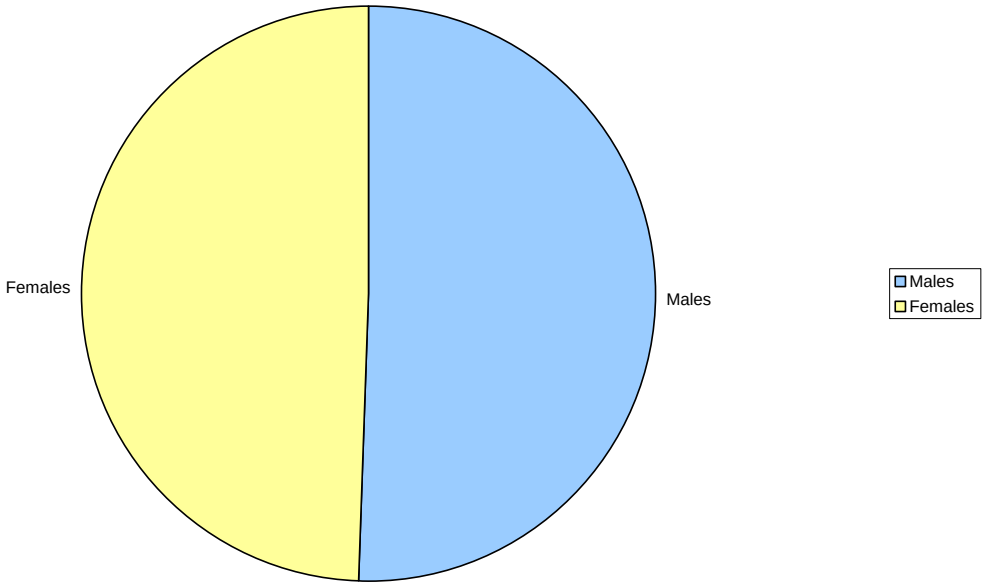
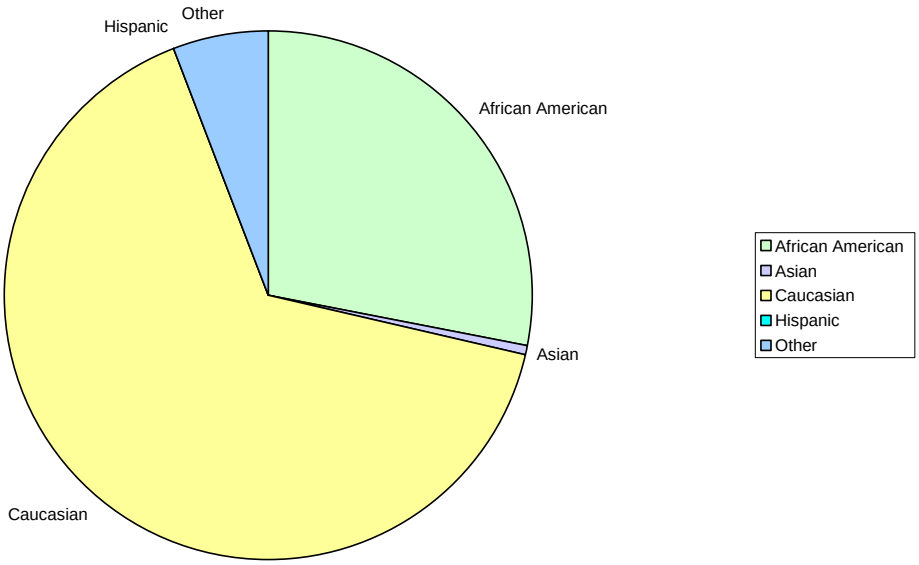


Chart 2. Ethnicity of BHJJ Youth



The average number of children in the household, including the BHJJ participant, was 2.38 (SD = 1.49), while the average number of adults in the household was 1.82 (SD = .84). Although 82.4% of the sample lived with at least one biological parent, the youth was in the custody of only the biological mother 54.3% of the time (see Table 3).

Table 3. Custody Arrangement for BHJJ Youth

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	17.4% (n = 75)
Biological Mother Only	54.3% (n = 234)
Biological Father Only	10.7% (n = 46)
Adoptive Parent(s)	3.5% (n = 15)
Aunt/Uncle	2.1% (n = 9)
Grandparents	7.9% (n = 34)
Friend	0.7% (n = 3)
Ward of the State	1.4% (n = 6)
Other	1.9% (n = 8)

The average number of school years completed for the child's caregiver was 12.12, equivalent to slightly more than a high school diploma (SD = 1.9) (see Table 4). Nearly a quarter of the sample of caregivers did not graduate from high school (23.4%) and nearly another quarter had at least some college (24.8%). The average household income for the entire sample was between $20000 - $24999 (see Table 5).

Table 4. Caregiver's Education Level

Number of School Years Completed	Number of Caregivers
6	0.7% (n = 3)
7	1.0% (n = 4)
8	2.1% (n = 9)
9	4.3% (n = 18)
10	6.7% (n = 28)
11	8.6% (n = 36)
12	43.4% (n = 182)
13	8.4% (n = 35)
14	19.8% (n = 83)
15	2.6% (n = 11)
16	1.0% (n = 4)
17	1.2% (n = 5)
18	0.2% (n = 1)

Table 5. Household Income for BHJJ Families

Household Income	BHJJ Families
Less than $5000	11.7% (n = 48)
$5000 - $9999	10.5% (n = 43)
$10000 - $14999	10.2% (n = 42)
$15000 - $19999	13.2% (n = 54)
$20000 - $24999	13.2% (n = 54)
$25000 - $34999	12.2% (n = 50)
$35000 - $49999	15.6% (n = 64)
$50000 - $74999	7.1% (n = 29)
$75000 - $99999	3.2% (n = 13)
$100000 and over	3.2% (n = 13)

Caregivers reported that 17.1% of males and 25.7% of females were physically abused in the past. Results showed that 5.5% of males and 36.4% of females had been sexually abused, with 12.9% of those females abused in the past six months. More females than males were identified as having substance abuse problems in the past (44.4% and 36.4% respectively). In the six months prior to enrollment, 67.6% of females and 58.1% of males were identified by caregivers as having substance abuse problems. Caregivers reported that 9.5% of males and 24.7% of females have attempted suicide at least once. These and additional family and youth history data can be found in Table 6.

Table 6. Family and Youth Results from the Caregiver Information Questionnaire

Question	Females	Males
Has the child ever been physically abused?	25.7% (n = 53)	17.1% (n = 38)
In the last 6 months, has the child been physically abused?	13.0% (n = 9)	2.8% (n = 2)
Has the child ever been sexually abused?	36.4% (n = 75)	5.5% (n = 12)
In the last 6 months, has the child been sexually abused?	12.9% (n = 11)	2.0% (n = 1)
Has the child ever run away?	55.1% (n = 114)	30.2% (n = 67)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	44.4% (n = 91)	39.6% (n = 86)
In the last 6 months, has the child had a problem with substance abuse, including alcohol and/or drugs?	67.6% (n = 69)	58.1 (n = 68)
Has the child ever talked about committing suicide?	51.2% (n = 106)	37.2% (n = 83)
Has the child ever attempted suicide?	24.7% (n = 49)	9.5% (n = 21)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	50.5% (n = 104)	40.6% (n = 91)
In the past six months, has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	16.0% (n = 20)	5.2% (n = 7)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	69.7% (n = 140)	55.5% (n = 121)
Has the child ever lived in a household in which someone has shown signs of being depressed?	67.0% (n = 138)	50.9% (n = 113)
Was the person who showed signs of being depressed involved in providing care and supervision to the child?	81.7% (n = 94)	65.5% (n = 74)
Has anyone in the child's biological family had a mental illness, other than depression?	46.8% (n = 96)	33.6% (n = 74)
Other than depression, has the child ever lived in a household in which someone had a mental illness?	31.2% (n = 64)	22.2% (n = 49)
Has the child ever lived in a household in which someone was convicted of a crime?	46.6% (n = 96)	36.8% (n = 82)
Has anyone in the child's biological family had a drinking or drug problem?	68.6% (n = 140)	58.1% (n = 129)
Has the child ever lived in a household in which someone had a drinking or drug problem?	58.1% (n = 118)	46.8% (n = 101)
Was the person with the drinking or drug problems involved in providing care and supervision to the child?	51.2% (n = 43)	54.4% (n = 49)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	33.3% (n = 68)	27.9% (n = 62)

The case worker or another staff member assigned to the family completed the Enrollment and Demographics Questionnaire (EDIF) (SAMHSA, 2005) as part of the Intake process. One question asked the worker to identify the problems leading to the youth being referred for services as part of the BHJJ project. For both females and males, the number one problem leading to services was conduct/delinquency-related problems (94.3% and 87.6% respectively). Additional reasons for referrals are found in Table 7.

Table 7. Problems Leading to Services for All BHJJ Youth

Problems Leading to Services	Females	Males
Suicide-related problems	17.5% (n = 37)	6.6% (n = 15)
Depression-related problems	40.1% (n = 85)	18.3% (n = 42)
Anxiety-related problems	22.6% (n = 48)	5.8% (n = 13)
Hyperactive and attention-related problems	24.5% (n = 52)	19.9% (n = 45)
Conduct/delinquency-related problems	94.3% (n = 200)	87.6% (n = 198)
Substance use, abuse, dependence-related problems	42.9% (n = 91)	34.1% (n = 77)
Adjustment-related problems	23.1% (n = 49)	4.4% (n = 10)
Psychotic Behaviors	4.2% (n = 9)	1.8% (n = 4)
Pervasive development disabilities	1.9% (n = 4)	1.3% (n = 3)
Specific developmental disabilities	0.9% (n = 2)	0.9% (n = 2)
Learning disabilities	8.5% (n = 18)	12.4% (n = 28)
School performance problems not related to learning disabilities	48.1% (n = 102)	28.3% (n = 64)
Eating disorders	4.2% (n = 9)	0.0% (n = 0)

Diagnostic and Statistical Manual IV (DSM-IV) Diagnoses

In addition to reasons for referral, workers were asked to identify any Diagnostic and Statistical Manual – IV (DSM-IV) Axis I diagnoses obtained from the child's most recent multiaxial diagnostic evaluation. There were a total of 771 Axis I diagnoses for the 455 youth, for an average of 1.69 diagnoses per child. The five most common diagnoses for females and males can be found in Tables 8 and 9. Mental health diagnoses were paired with substance abuse diagnoses (co-occuring disorders) 25.9% (n = 118) of the time (20.5% for males and 31.7% for females). A total of 4.2% of the sample (n = 19) had only a substance abuse diagnosis (6.6% of males and 1.8% of females).

Table 8. Top Five DSM-IV Axis I Diagnoses for Females

Axis I Diagnosis	Frequency
Oppositional Defiant Disorder	28.8% (n = 65)
Cannabis Abuse/Dependence	23.5% (n = 53)
Major Depression	19.5% (n = 44)
Attention Deficit Hyperactivity Disorder	19.0% (n = 43)
Adjustment Disorder	15.6% (n = 35)

Table 9. Top Five DSM-IV Axis I Diagnoses for Males

Axis I Diagnosis	Frequency
Attention Deficit Hyperactivity Disorder	26.2% (n = 60)
Cannabis Abuse/Dependence	22.7% (n = 52)
Conduct Disorder	22.2% (n = 51)
Oppositional Defiant Disorder	20.5% (n = 47)
Major Depression	12.2% (n = 28)

Emotional or Behavioral Medication Use

Caregivers were asked to identify any medications that the youth was taking for emotional or behavioral health problems. Caregivers indicated that 30.4% (n = 130) of the sample was already taking emotional or behavioral medication prior to enrolling in BHJJ. The most commonly used drug was Seroquel, an atypical antipsychotic commonly used to treat schizophrenia and bipolar disorder. Caregivers reported that 5.6% (n = 26) of youth were taking Seroquel at the time of enrollment into the BHJJ program. Abilify, another atypical antipsychotic, was the second-most commonly used drug, at 5.3% (n = 24). The next most popular drug used was Concerta, a central nervous system stimulator primarily used to treat ADD and ADHD (5.1%, n = 23). Risperdal, an atypical antipsychotic (4.0%, n = 18) and Strattera, a norepinephrine reuptake inhibitor used in the treatment of ADHD (3.7%, n = 17) were the fourth and fifth most commonly used drugs in the sample.

Ohio Scales Analysis

One of the main dependant measures in the data collection packet were the Ohio Scales. The Ohio Scales were completed by the youth, caregiver, and worker at Intake and then every three months following Intake until Discharge. Tables and charts containing means, standard deviations, and sample sizes follow the summary of the statistical analyses. Because Discharge can occur at any point in time along the continuum of service, separate charts are included that display the means from Intake to Discharge. Interpretations of data points with corresponding small sample sizes must be made cautiously. For example, 12 month Ohio Scales data exists for a very small number of youth. Means based on such a small sample may not reflect the overall pattern that

may emerge with more complete data. Although these means are plotted on the graphs, they should be interpreted with care.

Problem Severity

Means for the Problem Severity scale can be found in Table 10 and are also represented in Charts 3 and 4. A One-way ANOVA was conducted to determine if the Problem Severity Scores at Intake were statistically similar for all counties. Results of the ANOVA revealed significant differences on the Problem Severity scale at Intake for both Parents: $F(6, 424) = 4.13$, $p < .001$, and Workers: $F(6, 424) = 11.25$, $p < .001$.

The follow-up post hoc Tukey's HSD test indicated that Logan County ($\bar{X}$ = 20.15) had significantly lower Parent Problem Severity Scores than Montgomery ($\bar{X}$ = 29.84), Union ($\bar{X}$ = 31.97), and Champaign ($\bar{X}$ = 28.43) Counties. No other significant differences were detected. For the Worker version, Logan County ($\bar{X}$ = 20.53) had significantly lower Problem Severity Scores than Champaign ($\bar{X}$ = 27.27), Cuyahoga ($\bar{X}$ = 31.58), Franklin ($\bar{X}$ = 33.08), Montgomery ($\bar{X}$ = 30.58), and Union ($\bar{X}$ = 33.38) Counties.

Paired samples t-tests revealed significant decreases in problem severity on the Parent version from Intake to all measurement intervals except for 12 months. Significant decreases occurred from Intake to 3 months; $t(240) = 6.99$, $p <.001$, Intake to 6 months; $t(111) = 6.90$, $p < .001$, Intake to 9 months; $t(43) = 4.61$, $p < .001$, and Intake to Discharge; $t(74) = 5.56$, $p < .001$.

There were also significant decreases on the Problem Severity scale across all measurement intervals on the Worker version. Paired samples t-tests indicated that significant positive change occurred from Intake to 3 months; $t(237) = 9.92$, $p < .001$, Intake to 6 months; $t(113) = 9.44$, $p < .001$, Intake to 9 months; $t(43) = 8.79$, $p < .001$, and Intake to Discharge; $t(82) = 10.21$, $p < .001$.

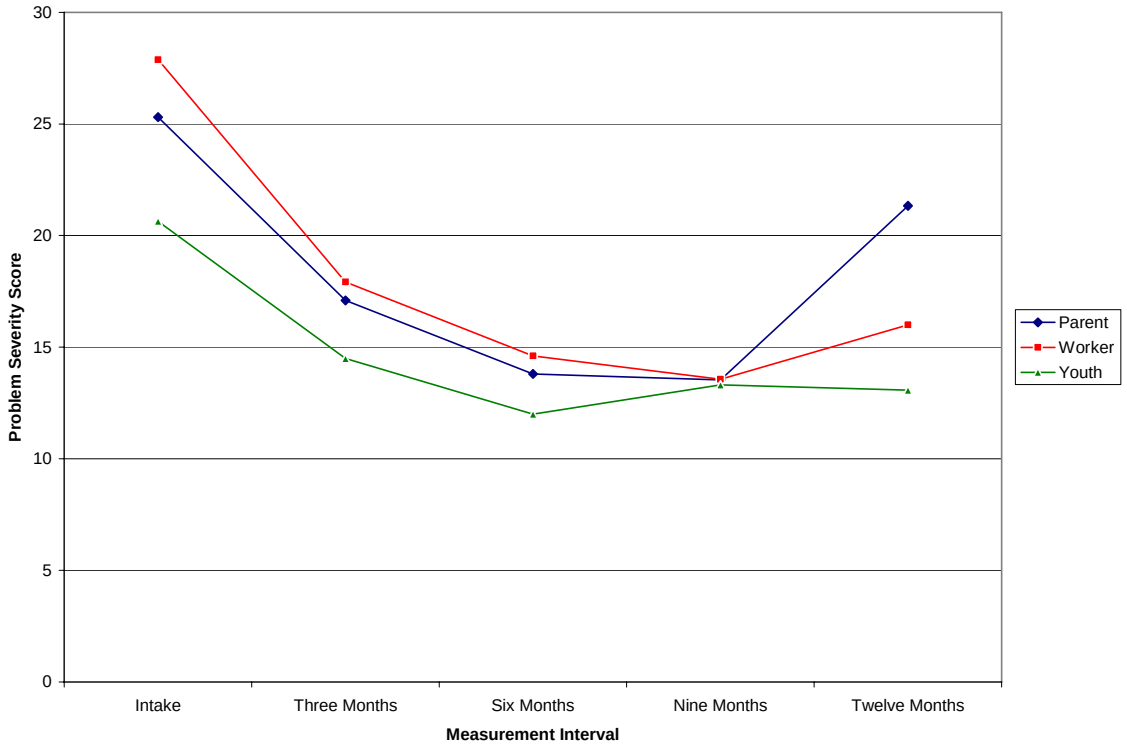
For the Youth version, similar significant decreases were observed on the Problem Severity scale. Paired samples t-tests revealed significant decreases in Problem Severity from Intake to three months; $t(243) = 6.53$, $p < .001$, Intake to 6 months; $t(115) = 6.35$, $p < .001$, Intake to 9 months; $t(48) = 4.74$, $p < .001$, and Intake to Discharge; $t(74) = 7.50$, $p < .001$.

Across all raters and all measurement intervals, problem severity scores significantly decreased.

Table 10. Problem Severity Scores Across all Measurement Intervals for All BHJJ Youth

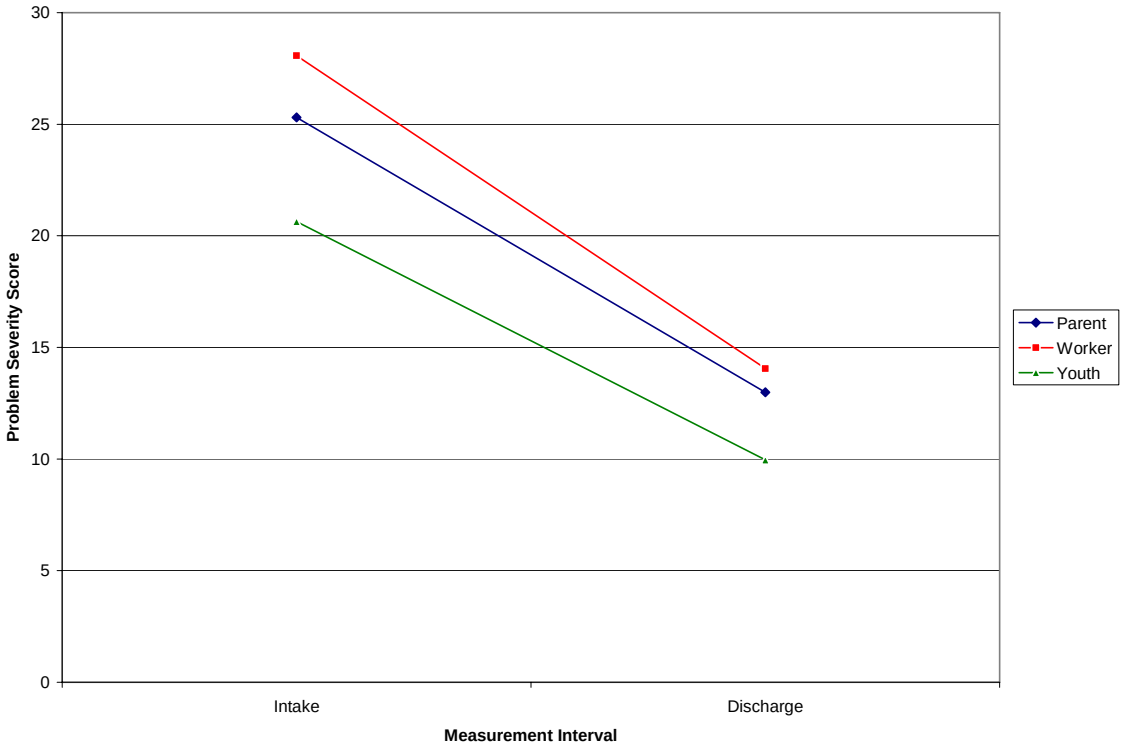
	Parent	Worker	Youth
Intake	25.31 (SD = 17.25) (n = 423)	27.88 (SD = 14.20) (n = 425)	20.64 (SD = 14.41) (n = 424)
Three Months	17.09 (SD = 14.47) (n = 248)	17.92 (SD = 11.90) (n = 250)	14.49 (SD = 12.57) (n = 250)
Six Months	13.80 (SD = 11.87) (n = 119)	14.61 (SD = 9.26) (n = 125)	12.00 (SD = 10.25) (n = 118)
Nine Months	13.54 (SD = 10.99) (n = 48)	13.56 (SD = 8.34) (n = 51)	13.31 (SD = 10.92) (n = 51)
Twelve Months	21.33 (SD = 17.26) (n = 12)	16.00 (SD = 13.34) (n = 12)	13.07 (SD = 13.70) (n = 13)
Discharge	12.29 (SD = 13.69) (n = 77)	14.06 (SD = 12.66) (n = 88)	9.96 (SD = 11.57) (n = 77)

Chart 3. Problem Severity Scores Across All Measurement Intervals for All BHJJ Youth



* Lower scores indicative of less problem severity

Chart 4. Problem Severity Scores at Intake and Discharge for All BHJJ Youth



* Lower scores indicative of less problem severity

Functioning

Means for the Functioning scale can be found in Table 11 and are also represented in Charts 5 and 6. Once again, One-Way ANOVAs were performed to determine whether Functioning scores differed significantly by county. Results indicated that Functioning Scores did differ by county for Parents: $F(6, 425) = 4.53$, $p < .001$ and Workers: $F(6, 422) = 25.85$, $p < .001$. Tukey's post hoc comparisons indicated that Logan County ($\bar{X} = 49.36$) reported significantly higher Parent Functioning scores than Champaign ($\bar{X} = 40.76$), Montgomery ($\bar{X} = 40.76$), and Union ($\bar{X} = 35.35$) Counties. For Workers, Logan County ($\bar{X} = 51.84$) reported significantly higher Functioning scores than Cuyahoga ($\bar{X} = 38.06$), Fairfield ($\bar{X} = 38.54$), Franklin ($\bar{X} = 35.15$), Montgomery ($\bar{X} = 41.15$), and Union ($\bar{X} = 33.04$) Counties.

Paired samples t-tests revealed significant increases in Functioning across all measurement intervals on the Parent version except 12 months. Statistically significant improvements were observed from Intake to 3 months; $t(242) = -6.39$, $p < .001$, Intake to 6 months; $t(113) = -5.38$, $p < .001$, Intake to 9 months; $t(43) = -4.72$, $p < .001$, and Intake to Discharge; $t(75) = -5.15$, $p < .001$.

Similar significant increases in Functioning were observed with the Worker version. Paired samples t-tests indicated significant improvement from Intake to 3

months; $t(219) = -6.69$, $p < .001$, Intake to 6 months; $t(106) = -8.49$, $p < .001$, Intake to 9 months; $t(41) = -8.36$, $p < .001$, and Intake to Discharge; $t(81) = -5.54$, $p < .001$.

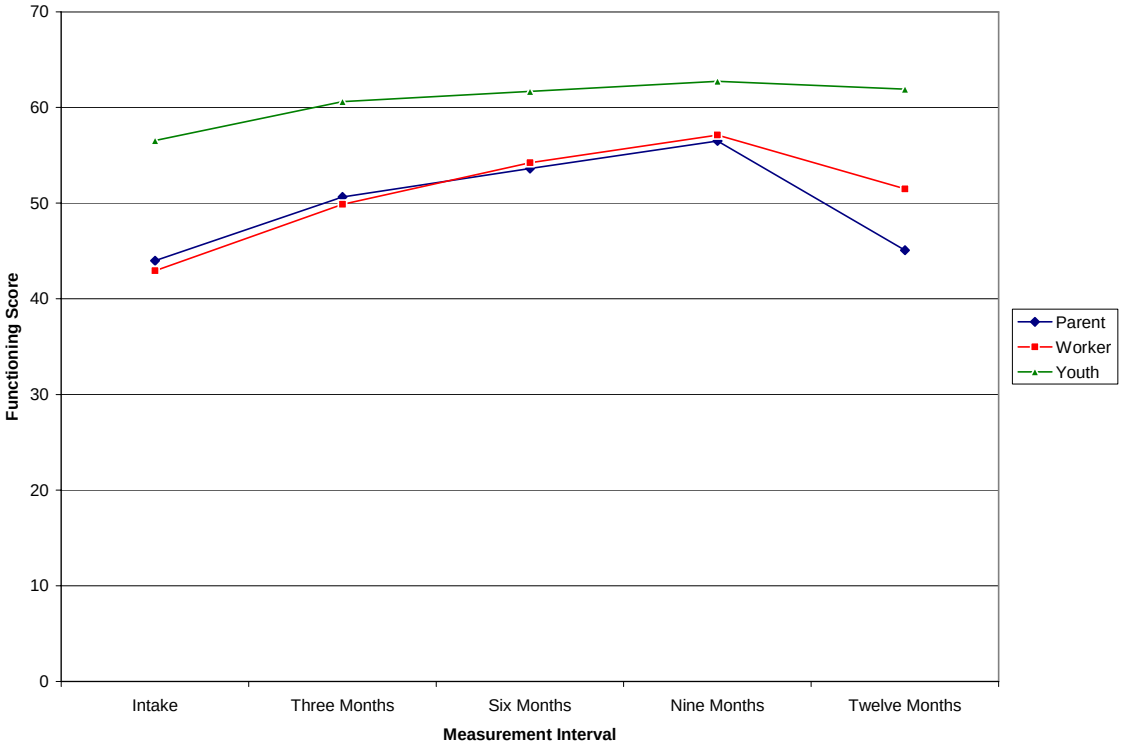
Paired samples t-tests discovered similar significant improvements in functioning on the Youth version. Significant gains in functioning were observed from Intake to 3 months; $t(244) = -4.32$, $p < .001$, Intake to 6 months; $t(114) = -4.46$, $p < .001$, Intake to 9 months; $t(49) = -3.81$, $p = .001$, and Intake to Discharge; $t(74) = -4.32$, $p < .001$.

Similar to the results for the Problem Severity Scale, significant improvements in Functioning were observed across all raters and all measurement intervals.

Table 11. Functioning Scores Across All Measurement Intervals for All BHJJ Youth

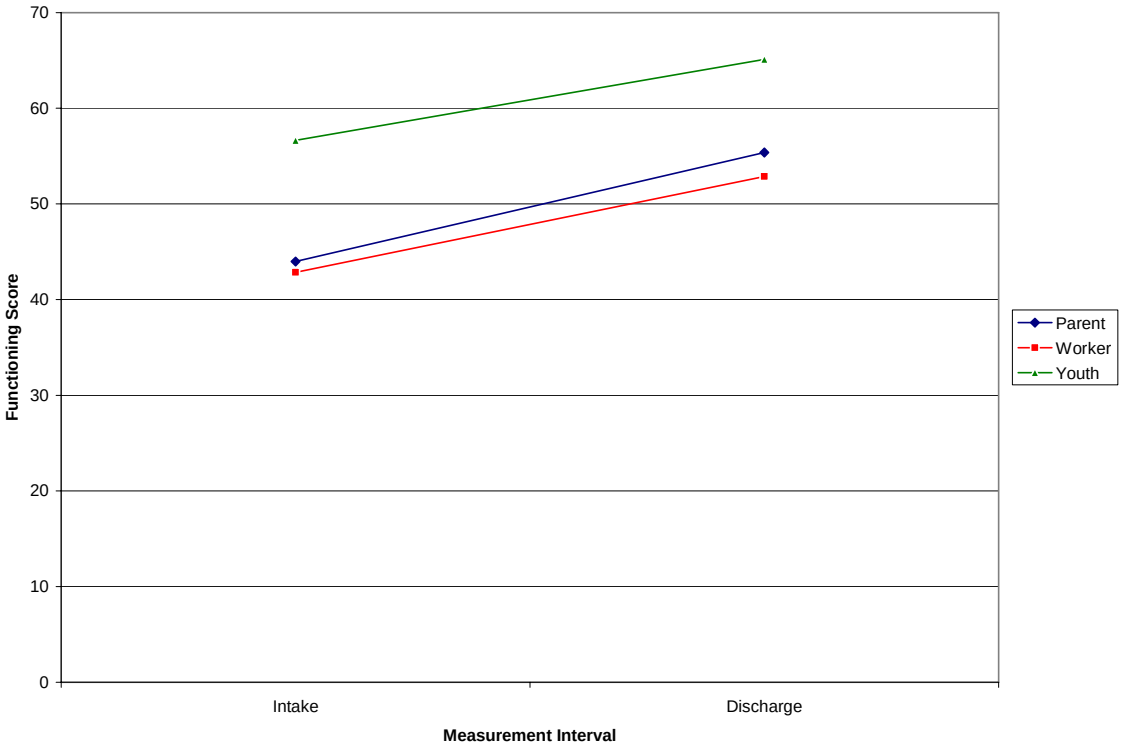
	Parent	**Worker**	**Youth**
Intake	43.98 (SD = 17.25) (n = 426)	42.94 (SD = 13.93) (n = 423)	56.54 (SD = 12.78) (n = 425)
Three Months	50.65 (SD = 17.13) (n = 248)	49.88 (SD = 14.11) (n = 251)	60.61 (SD = 12.94) (n = 251)
Six Months	53.62 (SD = 15.83) (n = 119)	54.24 (SD = 11.19) (n = 125)	61.67 (SD = 11.06) (n = 117)
Nine Months	56.51 (SD = 13.71) (n = 47)	57.11 (SD = 10.19) (n = 52)	62.75 (SD = 12.03) (n = 52)
Twelve Months	45.09 (SD = 25.66) (n = 11)	51.50 (SD = 14.89) (n = 12)	61.92 (SD = 12.28) (n = 13)
Discharge	55.38 (SD = 17.76) (n = 78)	52.88 (SD = 16.32) (n = 88)	65.12 (SD = 13.35) (n = 77)

Chart 5. Functioning Scores Across All Measurement Intervals for All BHJJ Youth



* Higher scores indicative of higher functioning

Chart 6. Functioning Scores at Intake and Discharge for All BHJJ Youth



* Higher scores indicative of higher functioning

Satisfaction

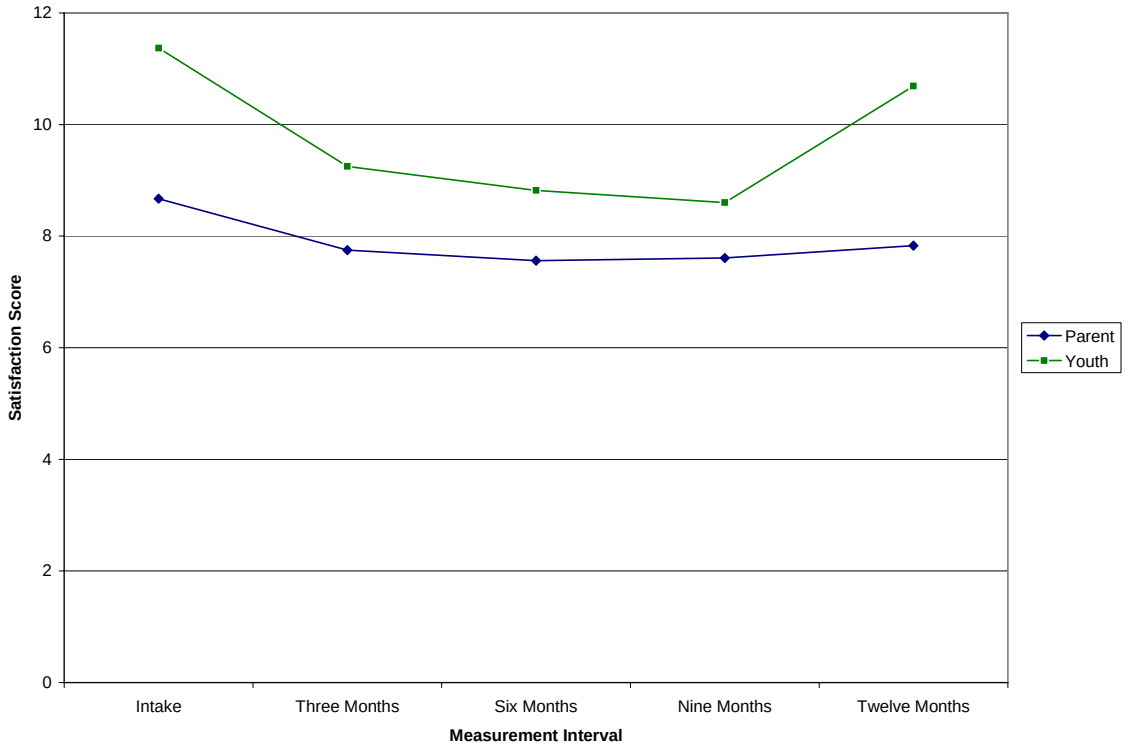
The Satisfaction scale was completed by only the parent and youth. Lower scores on the Satisfaction scale indicate greater satisfaction with mental health services. Means for the Satisfaction scale are found in Table 12 and also represented in Charts 7 and 8. Results from paired samples t-tests conducted on the Parent version indicated statistically significant improvements in satisfaction from Intake to 3 months; $t(185) = 3.66$, $p < .001$, Intake to 6 months; $t(83) = 2.89$, $p = .005$, and Intake to Discharge; $t(50) = 2.59$, $p = .01$.

For the Youth version, statistically significant improvement in Satisfaction was observed from Intake to 3 months; $t(167) = 3.61$, $p = .001$, Intake to 6 months; $t(79) = 4.32$, $p < .001$, and Intake to Discharge; $t(53) = 3.65$, $p = .001$.

Table 12. Satisfaction Scores Across All Measurement Intervals for All BHJJ Youth

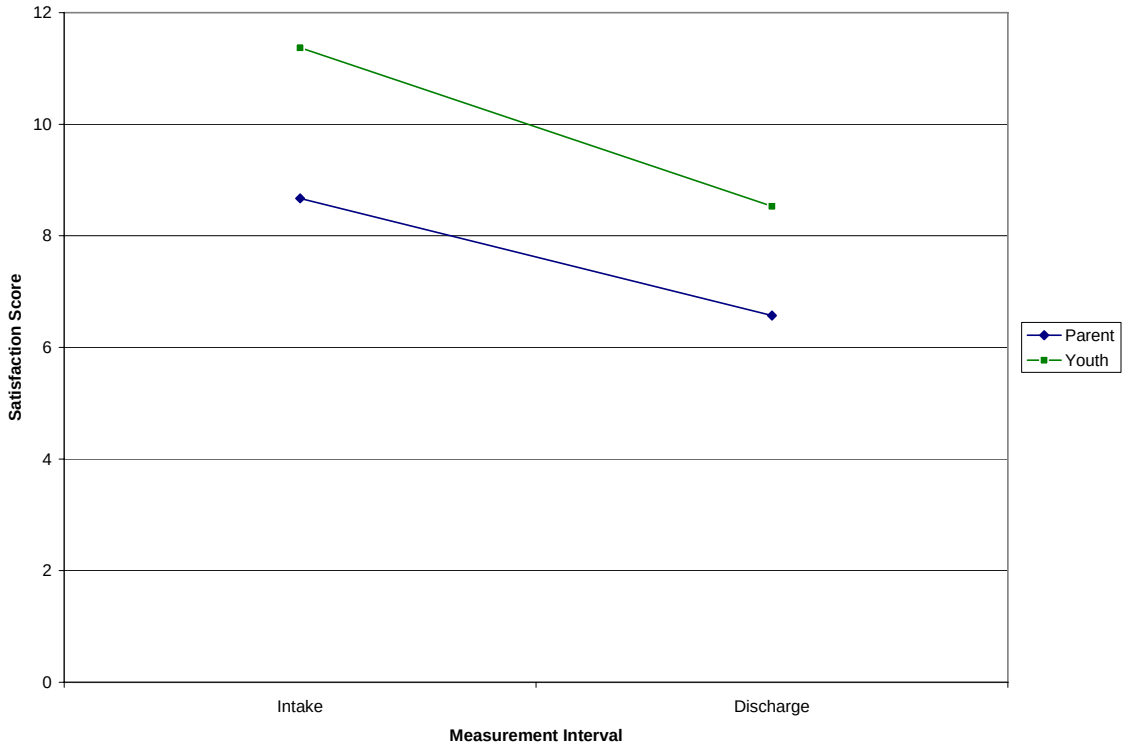
	Parent	Youth
Intake	8.67 (SD = 4.61) (n = 330)	11.37 (SD = 5.00) (n = 308)
Three Months	7.75 (SD = 4.24) (n = 233)	9.25 (SD = 5.04) (n = 230)
Six Months	7.56 (SD = 4.46) (n = 110)	8.82 (SD = 4.52) (n = 109)
Nine Months	7.61 (SD = 3.84) (n = 44)	8.60 (SD = 4.56) (n = 43)
Twelve Months	7.83 (SD = 6.11) (n = 12)	10.69 (SD = 4.88) (n = 13)
Discharge	6.57 (SD = 3.72) (n = 68)	8.53 (SD = 4.59) (n = 68)

Chart 7. Satisfaction Scale Scores Across All Measurement Intervals for All BHJJ Youth



* Lower scores indicate greater satisfaction

Chart 8. Satisfaction Scores from Intake to Discharge for All BHJJ Youth



* Lower scores indicate greater satisfaction

Hopefulness

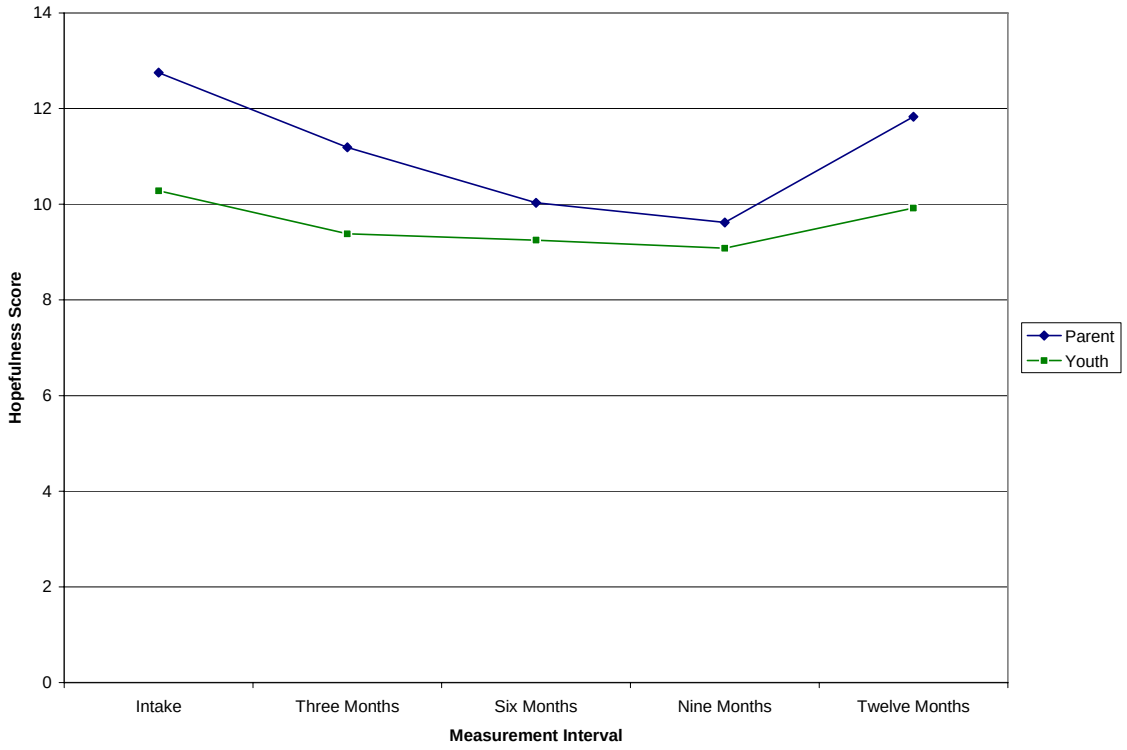
Similar to the Satisfaction scale, the Hopefulness scale was completed by only the parent and youth. Lower scores on the Hopefulness scale indicate greater hopefulness about the future. Means for the Hopefulness scale are found in Table 13 and also represented in Charts 9 and 10. Paired samples t-tests revealed significant improvements across all measurement intervals in Hopefulness for the Parent version. Significant gains were observed from Intake to 3 months; $t(239) = 4.82$, $p < .001$, Intake to 6 months; $t(112) = 4.68$, $p < .001$, Intake to 9 months; $t(45) = 3.94$, $p < .001$, and Intake to Discharge; $t(75) = 5.56$, $p < .001$.

Paired samples t-tests conducted on the Youth version of the Hopefulness scale also found significant improvements, but only from Intake to 3 months; $t(238) = 3.36$, $p < .001$ and Intake to Discharge; $t(73) = 4.09$, $p < .001$. While the comparisons from Intake to 6 months and Intake to 9 months were in the predicted direction, they failed to reach statistical significance.

Table 13. Hopefulness Scores Across All Measurement Intervals for All BHJJ Youth

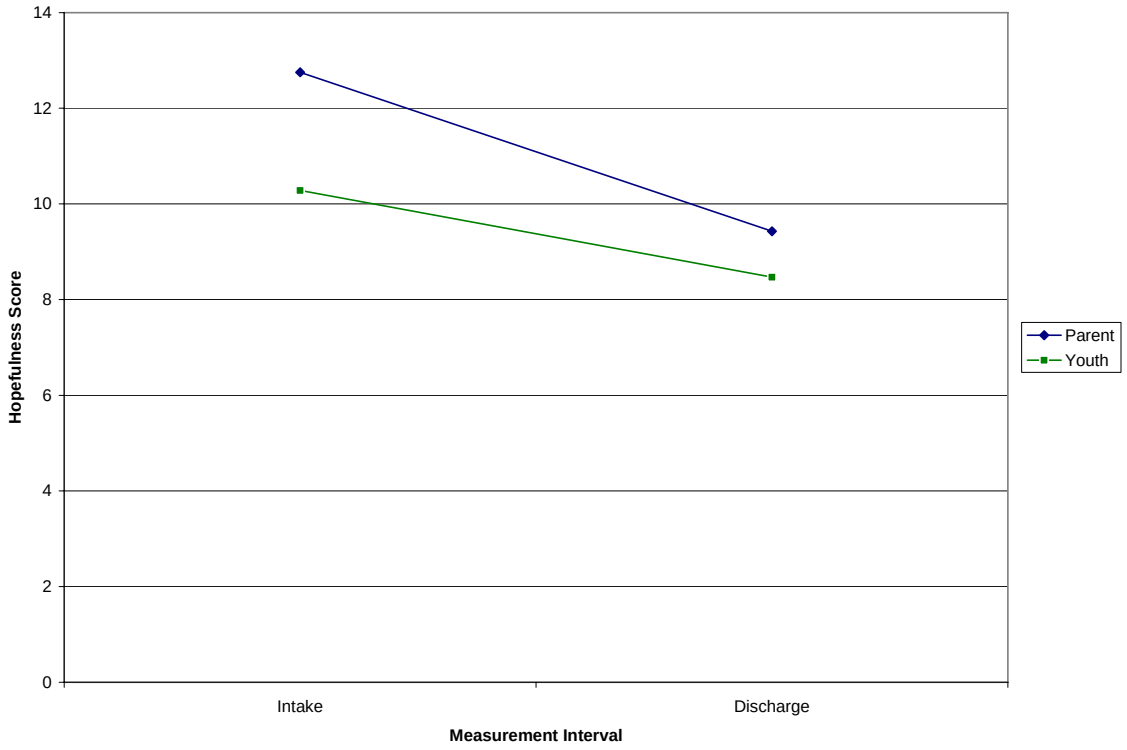
	Parent	Youth
Intake	12.75 (SD = 4.73) (n = 418)	10.28 (SD = 3.85) (n = 411)
Three Months	11.19 (SD = 4.27) (n = 247)	9.38 (SD = 3.68) (n = 250)
Six Months	10.03 (SD = 4.25) (n = 118)	9.25 (SD = 3.63) (n = 118)
Nine Months	9.62 (SD = 3.68) (n = 48)	9.08 (SD = 3.95) (n = 52)
Twelve Months	11.83 (SD = 4.91) (n = 12)	9.92 (SD = 4.07) (n = 13)
Discharge	9.43 (SD = 4.52) (n = 79)	8.47 (SD = 3.68) (n = 76)

Chart 9. Hopefulness Scores Across All Measurement Intervals for All BHJJ Youth



* Lower scores indicative of greater hopefulness

Chart 10. Hopefulness Scores from Intake to Discharge for All BHJJ Youth



* Lower scores indicative of greater hopefulness

Trauma Symptoms Checklist for Children (TSCC)

The TSCC measures trauma symptoms and is composed of six subscales: anger, anxiety, depression, dissociation, post-traumatic stress disorder, and sexual concerns. The TSCC was administered at Intake and Discharge. Although there were relatively few TSCCs at Discharge, there were enough to conduct a paired-samples t-test on the scale means. The TSCC also contains an Underresponse and Hyperresponse scale. The Underresponse scale "reflects a tendency toward denial, a general under-endorsement response set, or a need to appear unusually symptom-free (Bierre, 1996)". According to the professional manual, any child who has a t-score above a 70 on the Underresponse scale should be eliminated from further data analysis. The Hyperresponse scale "indicates a general overresponse to TSCC items, a specific need to appear especially symptomatic, or a state of being overwhelmed by traumatic stress (Bierre, 1996)". The TSCC professional manual recommends eliminating any child with a Hyperresponse t-score above 90 from further data analysis.

An examination of the Underresponse scale indicated that of the 417 complete TSCC surveys collected at Intake, 69 (16.5%) contained t-scores higher than 70. These youth were eliminated from all further data analyses conducted on the TSCC. There were no problems with youth and the Hyperresponse scale. Table 14 contains the means on all subscales for the remaining sample.

Table 14. TSCC Scores for All BHJJ Youth

	Intake	Discharge
Anger	9.68 (SD = 5.54) (n = 357)	5.69 (SD = 5.24) (n = 43)
Anxiety	5.15 (SD = 4.06) (n = 355)	2.43 (SD = 2.94) (n = 44)
Depression	6.63 (SD = 4.71) (n = 355)	3.51 (SD = 4.06) (n = 43)
Dissociation	6.92 (SD = 4.74) (n = 353)	4.13 (SD = 4.35) (n = 44)
Post-traumatic Stress	7.88 (SD = 5.36) (n = 353)	4.27 (SD = 3.99) (n = 43)
Sexual Concerns	4.05 (SD = 3.85) (n = 350)	2.70 (SD = 3.86) (n = 44)

While there were many fewer Discharges than Intakes, paired samples t-tests were conducted on the available data. Results indicated that there were significant improvements on all subscales. Statistically significant improvements were found for the Anger scale; $t(37) = 3.50$, $p = .001$, the Anxiety scale; $t(37) = 6.02$, $p < .001$, the Depression scale $t(36) = 5.67$, $p < .001$, the Dissociation scale; $t(37) = 4.81$, $p < .001$, the Post-traumatic Stress scale; $t(35) = 5.36$, $p < .001$, and the Sexual Concerns scale; $t(37) = 3.75$, $p < .001$. Although the sample size is relatively small, results point to a positive change in all subscales from Intake to Discharge.

Recent Exposure to Violence (REVS)

The responses on the 26-item REVS were summed to create a "Total Violence Exposure" score, ranging from 0 (lowest) to 78 (highest). The mean total exposure score at Intake was 8.69 (SD = 7.66) and the mean score at Discharge was 5.61 (SD = 5.89). There was no significant difference between males and females on Total Violence Exposure at Intake. However, the results of an independent sample t-test revealed that African Americans reported significantly more Total Violence Exposure than Caucasians; $t(401) = 3.58$, $p <.001$. The mean Total Violence Exposure at Intake for African Americans was 10.59 while the mean for Caucasians was 7.69. Research suggests that exposure to violence can have a significant impact on psychological trauma (Singer, Anglin, Song, & Lunghofer, 1995). In order to examine this connection in the BHJJ sample, regressions were conducted using the REVS and TSCC, and the REVS and Ohio Scales data.

<u>REVS and Ohio Scales</u>

Problem Severity

Linear regression was used to determine whether Total Violence Exposure at Intake predicted Youth Problem Severity scores at Intake. Model 1 was a zero-order regression model with Gender, Age, and Ethnicity as the independent variables and the Youth Problem Severity score at Intake as the dependent variable. Results of the regression were significant: $F(3, 401) = 5.34$, $p < .001$. The R^2 for the model was .039,

which means that 3.9% of the variability in Youth Problem Severity scores at Intake was accounted for by these demographic factors.

Total Violence Exposure at Intake was added in Model 2. The regression model for Youth Problem Severity at Intake remained significant: $F(4, 401) = 16.20$, $p < .001$. The R^2 for Model 2 was .140, therefore 14.0% of the variability in Problem Severity scores at Intake was accounted for by Total Violence Exposure at Intake and the demographic variables. This is a 10.1% increase over Model 1 and is significant: $F(1, 397) = 46.92$, $p < .001$. Controlling for the demographic variables, Total Violence Exposure accounts for 10.1% of the variability in Youth Problem Severity scores.

Table 15. Regression Table for the Influence of Gender, Ethnicity, Age, and Total Violence Exposure on Youth Problem Severity at Intake

	Model 1		**Model 2**	
	B	SE	B	SE
Female	4.80***	1.43	4.66***	1.36
African American	-3.86**	1.59	-5.46***	1.53
Age	-.01	.44	-.09	.12
Total Violence Exposure			.18***	.42
F	5.34***		16.20***	
R^2	.039		.140	
N	402		402	

* p . > 05 ** p < .01 *** p < .001

Functioning

Linear regression was used to determine whether Total Violence Exposure at Intake also predicted Youth Functioning scores at Intake. Model 1 was a zero-order regression model with Gender, Age, and Ethnicity included as the independent variables and Youth Functioning at Intake as the dependent variable. Model 1 was not significant. Total Violence Exposure at Intake was added to the regression in Model 2. Model 2 was significant: $F(4, 401) = 3.15$, $p = .014$. The R^2 for Model 2 was .031; Total Violence Exposure at Intake and the demographic variables accounted for 3.1% of the variability in Youth Functioning Scores at Intake.

Table 16. Regression Table for the Influence of Gender, Ethnicity, Age, and Total Violence Exposure on Youth Functioning at Intake

	Model 1		**Model 2**	
	B	SE	B	SE
Female	-1.79	1.30	-1.73	1.36
African American	1.34	1.44	2.01	1.53
Age	.33	.40	.36	.39
Total Violence Exposure			-.26**	.09
F	1.09		3.15*	
R^2	.008		.031	
N	402		402	

* p . > 05 ** p < .01 *** p < .001

REVS and TSCC

Once again, linear regression was used to determine the association between demographic variables (gender, ethnicity, and age), Total Violence Exposure (as measured by the REVS), and the six subscales of the TSCC (Anger, Anxiety, Depression, Dissociation, Post-traumatic Stress, and Sexual Concerns). Linear regression was used to determine the effects demographic variables (Gender, Age, and Ethnicity) and Total Violence Exposure had on Anxiety Scores as measured by the TSCC.

Anxiety

In Model 1, Gender, Age, and Ethnicity were entered as independent variables as a block. Model 1 proved to be significant and accounted for 18.0% of the variability in Anxiety scores. Being female and being Caucasian are related to higher Anxiety scores.

Model 2 contains the demographic independent variables (Gender, Ethnicity, and Age) as well as the Total Violence Exposure Score. Model 2 is significant, and accounts for 24.8% of the variability in Anxiety scores. This is a 6.8% increase over Model 1 and is statistically significant: $F(1, 342) = 31.13$, $p < .001$. Controlling for Gender, Age, and Ethnicity, Total Violence Exposure uniquely accounts for 6.8% of the variability in Anxiety scores. Not only do females and Caucasians score higher on the Anxiety scale, but youth with higher Total Violence Exposure scores also scored higher on the Anxiety scale (see Table 17).

Table 17. Regression Table for the Influence of Gender, Ethnicity, Age, and Total Violence Exposure on Anxiety Scores

	Model 1		**Model 2**	
	B	SE	B	SE
Female	3.33***	.40	3.24***	.38
African American	-1.29***	.45	-1.76***	.44
Age	-.08	.12	-.08	.12
Total Violence Exposure			.14***	.03
F	25.04***		28.21***	
R^2	.18		.248	
N	347		347	

* p . > 05 ** p < .01 *** p < .001

Depression

In Model 1, Gender, Age, and Ethnicity were entered as independent variables as a block. Model 1 proved to be significant and accounted for 15.4% of the variability in Depression scores. Being female and being Caucasian are related to higher Depression scores.

Model 2 contains the demographic independent variables (Gender, Ethnicity, and Age) as well as the Total Violence Exposure Score. Model 2 is significant, and accounts for 23.1% of the variability in Depression scores. This is an 7.7% increase over Model 1 and is statistically significant: $F(1, 342) = 34.19$, $p < .001$. Controlling for Gender, Age, and Ethnicity, Total Violence Exposure uniquely accounts for 7.7% of the variability in Depression scores. Not only do females and Caucasians score higher on the Depression scale, but youth with higher Total Violence Exposure scores also scored higher on the Depression scale (see Table 18).

Table 18. Regression Table for the Influence of Gender, Ethnicity, Age, and Total Violence Exposure on Depression Scores

	Model 1		**Model 2**	
	B	SE	B	SE
Female	3.56***	.47	3.44***	.45
African American	-1.28*	.53	-1.89***	.52
Age	.10	.14	.10	.14
Total Violence Exposure			.17***	.03
F	20.75***		25.61***	
R^2	.154		.231	
N	347		347	

* p . > 05 ** p < .01 *** p < .001

Anger

In Model 1, gender, age, and ethnicity were entered as independent variables as a block. Model 1 proved to be significant and accounted for 3.2% of the variability in Anger scores. Being female is related to higher Anger scores.

Model 2 contains the demographic independent variables (Gender, Ethnicity, and Age) as well as the Total Violence Exposure Score. Model 2 is significant and accounts for 18.2% of the variability in Anger scores. This is a 15.0% increase over Model 1 and is statistically significant: $F(1, 344) = 62.92$, $p < .001$. Controlling for Gender, Age, and Ethnicity, Total Violence Exposure uniquely accounts for 15.0% of the variability in Anger scores. Not only do females score higher on the Anger scale, but youth with higher Total Violence Exposure scores also scored higher on the Anger scale (see Table 19).

Table 19. Regression Table for the Influence of Gender, Ethnicity, Age, and Total Violence Exposure on Anger Scores

	Model 1		**Model 2**	
	B	SE	B	SE
Female	1.99**	.59	1.82**	.54
African American	.17	.67	-.80	.63
Age	-.04	.18	-.03	.17
Total Violence Exposure			.28***	.04
F	3.86*		19.14***	
R^2	.032		.182	
N	349		349	

* p . > 05 ** p < .01 *** p < .001

Post-Traumatic Stress

In Model 1, gender, age, and ethnicity were entered as independent variables as a block. Model 1 proved to be significant and accounted for 9.4% of the variability in Anger scores. Being female is related to higher Post-Traumatic Stress scores.

Model 2 contains the demographic independent variables (Gender, Ethnicity, and Age) as well as the Total Violence Exposure Score. Model 2 is significant and accounts for 18.7% of the variability in Post-Traumatic Stress scores. This is a 9.3% increase over Model 1 and is statistically significant: $F(1, 340) = 38.79$, $p < .001$. Controlling for Gender, Age, and Ethnicity, Total Violence Exposure uniquely accounts for 9.3% of the variability in Post-Traumatic Stress scores. Not only do females score higher on the Post-Traumatic Stress scale, but youth with higher Total Violence Exposure scores also scored higher on the Post-Traumatic Stress scale (see Table 20).

Table 20. Regression Table for the Influence of Gender, Ethnicity, Age, and Total Violence Exposure on Post Traumatic Stress Scores

	Model 1		**Model 2**	
	B	SE	B	SE
Female	3.16***	.55	2.99***	.52
African American	-1.13	.63	-1.92**	.61
Age	.02	.17	.02	.16
Total Violence Exposure			.22***	.04
F	11.79***		19.52***	
R^2	.094		.187	
N	345		345	

* p . > 05 ** p < .01 *** p < .001

Dissociation

In Model 1, gender, age, and ethnicity were entered as independent variables as a block. Model 1 proved to be significant and accounted for 5.1% of the variability in Dissociation scores. Being female and being Caucasian is related to higher Dissociation scores.

Model 2 contains the demographic independent variables (Gender, Ethnicity, and Age) as well as the Total Violence Exposure Score. Model 2 is significant and accounts for 13.5% of the variability in Dissociation scores. This is a 8.4% increase over Model 1 and is statistically significant: $F(1, 340) = 33.22$, $p < .001$. Controlling for Gender, Age, and Ethnicity, Total Violence Exposure uniquely accounts for 8.4% of the variability in Dissociation scores. Not only do females and Caucasians score higher on the Dissociation scale, but youth with higher Total Violence Exposure scores also scored higher on the Dissociation scale (see Table 21).

Table 21. Regression Table for the Influence of Gender, Ethnicity, Age, and Total Violence Exposure on Dissociation Scores

	Model 1		**Model 2**	
	B	SE	B	SE
Female	1.58**	.50	1.44**	.48
African American	-1.65**	.57	-2.31**	.55
Age	.09	.15	.09	.15
Total Violence Exposure			.18***	.03
F	7.05***		23.09***	
R^2	.051		.135	
N	345		345	

* p . > 05 ** p < .01 *** p < .001

Sexual Concerns

In Model 1, gender, age, and ethnicity were entered as independent variables as a block. Model 1 proved to be significant and accounted for 4.1% of the variability in Sexual Concerns scores. African Americans and older children report higher sexual concerns scores.

Model 2 contains the demographic independent variables (Gender, Ethnicity, and Age) as well as the Total Violence Exposure Score. Model 2 is significant and accounts for 21.1% of the variability in Sexual Concerns scores. This is a 17.0% increase over Model 1 and is statistically significant: $F(1, 337) = 72.84$, $p < .001$. Controlling for Gender, Age, and Ethnicity, Total Violence Exposure uniquely accounts for 17.0% of the variability in Sexual Concerns scores. For Model 2, not only do older youth score higher on the Sexual Concerns scale, but youth with higher Total Violence Exposure scores also scored higher on the Sexual Concerns scale (see Table 22).

Table 22. Regression Table for the Influence of Gender, Ethnicity, Age, and Total Violence Exposure on Sexual Concern Scores

	Model 1		**Model 2**	
	B	SE	B	SE
Female	.20	.41	.06	.38
African American	1.10*	.47	.36	.43
Age	.37**	.13	.37**	.11
Total Violence Exposure			.21***	.02
F	4.81**		22.58***	
R^2	.018		.219	
N	342		342	

* p . > .05 ** p < .01 *** p < .001

Substance Use

Every six months, beginning at Intake, the youth completed the Substance Use Survey – Revised (SUS-R) (SAMHSA, 2005). The survey is a thorough review of past and present alcohol and drug use and was included in the evaluation packet to track changes in substance use while in the BHJJ program. Table 23 provides information concerning the specific types of alcohol and drugs used by the BHJJ youth at Intake. One question on the SUS-R was "In the past six months, how often did you drink an alcoholic beverage?". Results for that question at Intake, six months, and Discharge are provided in Table 24. Finally, Chart 11 contains the results for substance use for the previous 30 days from Intake to Discharge. Substance use decreased from Intake to Discharge on all substances except for cigarettes.

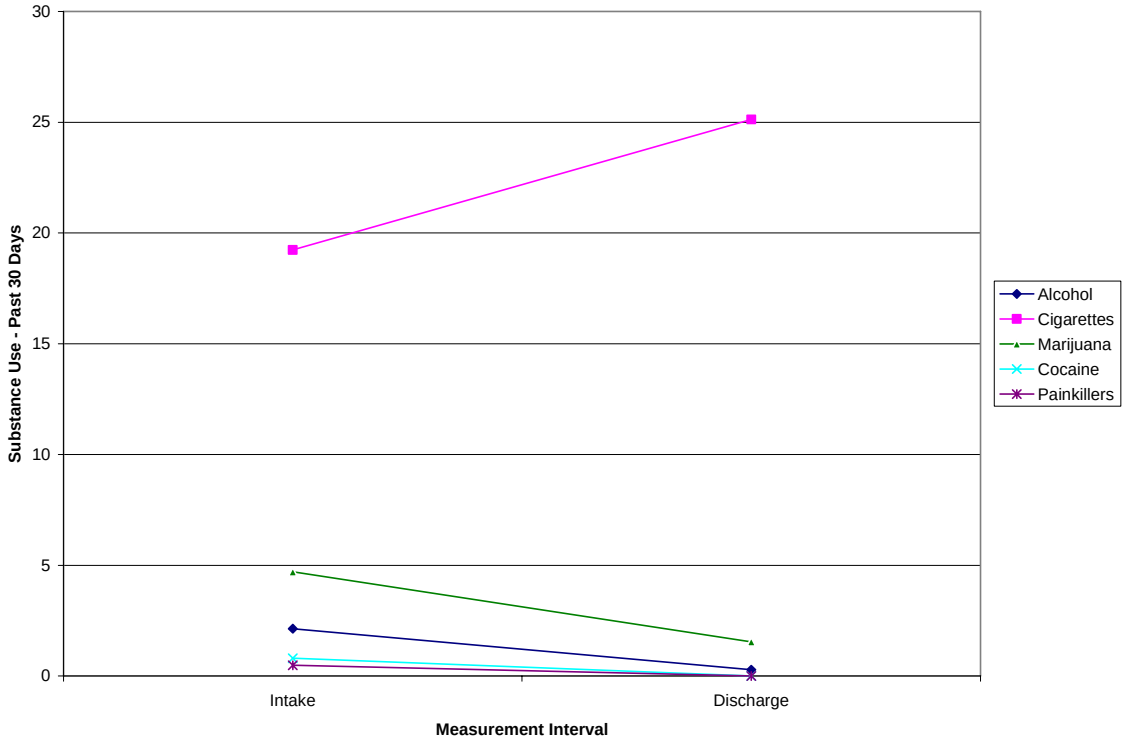
Table 23. Self-Reported Substance Use and Age of First Experience for All BHJJ Youth

Substance	Percentage of Youth Who Reported Use	Average Age of First Use
Alcohol	65.9% (n = 270)	12.98 (SD = 2.33)
Cigarettes	68.7% (n = 285)	12.09 (SD = 5.13)
Chewing Tobacco	16.4% (n = 67)	12.74 (SD = 7.27)
Marijuana	69.6% (n = 284)	12.91 (SD = 2.27)
Heroin	2.9% (n = 12)	11.31 (SD = 6.87)
Amphetamines	4.2% (n = 17)	13.26 (SD = 7.87)
Pain Killers	14.6% (n = 61)	14.67 (SD = 7.64)
Cocaine	14.0% (n = 58)	14.18 (SD = 2.93)
Hallucinogens	8.7% (n = 36)	13.84 (SD = 3.62)
Ecstasy	8.5% (n = 35)	15.64 (SD = 9.34)
Non-prescription drugs	8.8% (n = 36)	12.98 (SD = 4.66)
PCP	2.6% (n = 11)	12.50 (SD = 6.1)
Tranquilizers	7.6% (n = 31)	13.11(SD = 4.91)
Ritalin	7.8% (n = 32)	12.82 (SD = 4.34)

Table 24. Self-Reported Alcohol Use Over Time for All BHJJ Youth

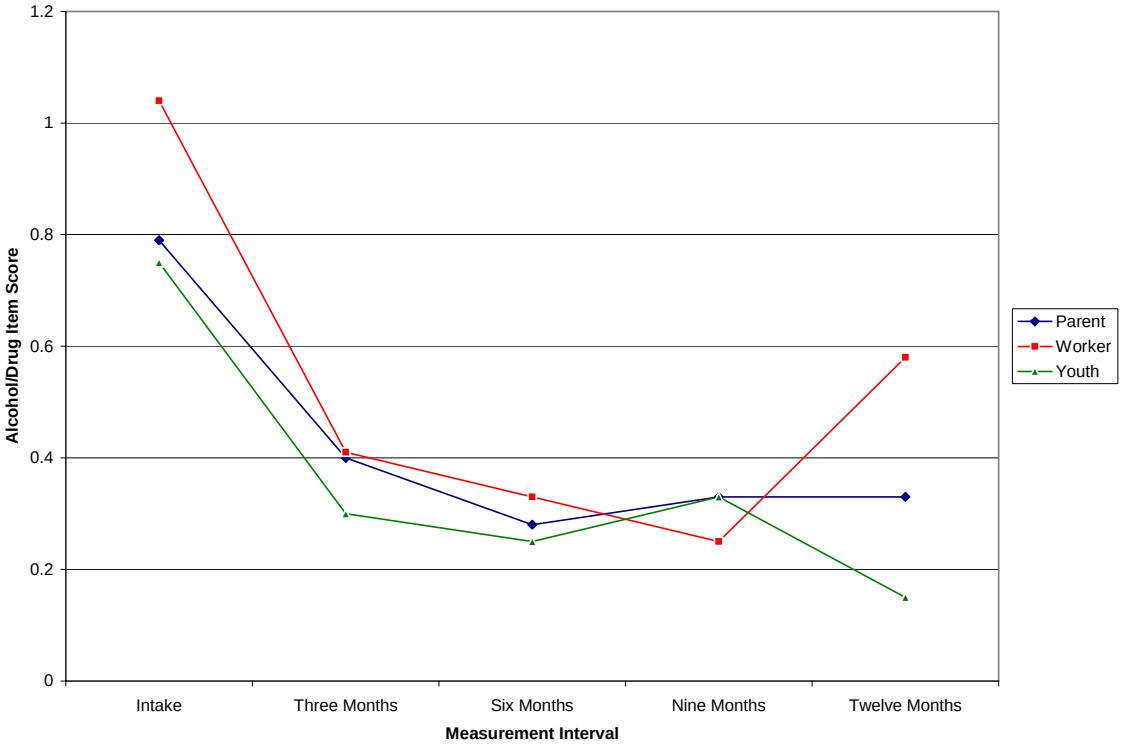
In the past six months, how often did you drink an alcoholic beverage?	Intake	Six Months	Discharge
Not at all	33.2% (n = 75)	54.0% (n = 34)	40.0% (n = 10)
Less than once a month	31.4% (n = 71)	25.4% (n = 16)	40.0% (n = 10)
1-3 times a month	20.8% (n = 47)	11.1% (n = 7)	12.0% (n = 3)
1-2 times per week	9.3% (n = 21)	9.5% (n = 6)	4.0% (n = 1)
3-6 times per week	2.7% (n = 6)	0	4.0% (n = 1)
Daily	2.7% (n = 6)	0	0

Chart 11. Self-Reported Previous 30 Day Substance Use from Intake to Discharge for All BHJJ Youth



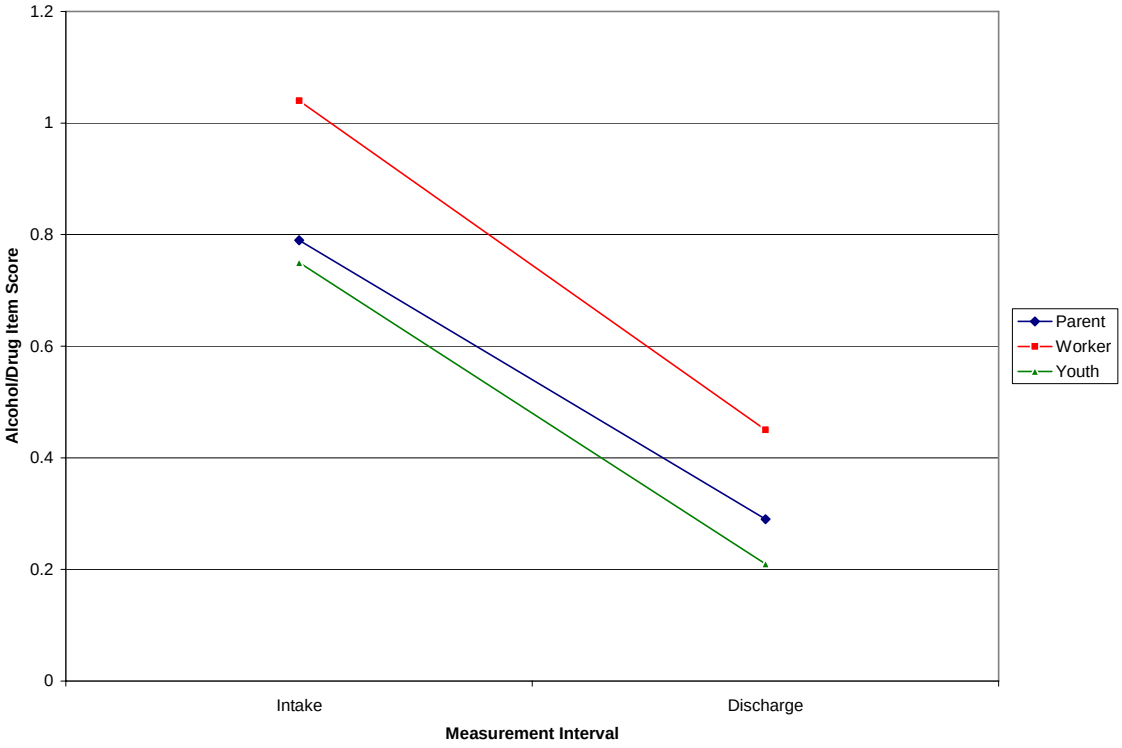
One of the 20 questions on the Ohio Scales Problem Severity scale addresses the use of drugs and alcohol. An analysis of the data for that specific question for all raters revealed a significant decrease in alcohol/drug problem severity from Intake to Discharge for Workers, and Youth; $t(92) = 3.31$, $p = .001$, and $t(80) = 4.12$, $p < .001$ respectively. Although in the predicted direction, results from Parents did not reach statistical significance. Results across all measurement intervals are found in Chart 12. Chart 13 contains these results from Intake to Discharge. Lower scores indicate lower alcohol/drug problem severity.

Chart 12. Alcohol/Drug Ohio Scales Item Across Measurement Intervals for ALL BHJJ Youth



* Lower scores indicate fewer problems

Chart 13. Alcohol/Drug Ohio Scales Item Score from Intake to Discharge for All BHJJ Youth



* Lower scores indicate fewer problems

Satisfaction with the BHJJ Program

After six and 12 months in the BHJJ program, caregivers were asked to complete the Multi-Service Sector Contacts – Revised questionnaire. This served as a measure of satisfaction with the services associated with the BHJJ program. Caregivers were presented with a list of 23 services they may have received as part of the BHJJ program. If the family received the service, the caregiver was asked to rate how well each service met the needs of the family. Rating were based on a 1 (not well at all) to 5 (extremely well) scale. Because very little data existed at 12 months, data are only reported for 6 months and Discharge. Individual service satisfaction data are found in Table 25. One additional question asked caregivers whether they would recommend the BHJJ services to a friend if the family had a similar need. At six months, only five out of a possible 127 caregivers (3.9%) said they either would absolutely or probably not recommend the BHJJ program to others. Thirteen caregivers (10.2%) said they were not sure if they would recommend BHJJ to others while 109 caregivers (85.8%) reported that they would probably or absolutely recommend the program to others. Only 7 caregivers completed the measure at 12 months, but of those, 6 (85.7%) reported that they would probably or absolutely recommend the program. Finally, at Discharge, 51 caregivers (89.4%) reported they would probably or absolutely recommend the BHJJ program to others.

Table 25. Satisfaction with BHJJ Services

BHJJ Service	6 Months	Discharge
Assessment and Evaluation	3.98 (SD = 0.99) (n = 51)	3.64 (SD = 1.15) (n = 36)
Crisis Stabilization	4.08 (SD = 1.12) (n = 13)	4.17 9SD = 1.17) (n = 6)
Family Preservation	3.74 (SD = 0.93) (n = 19)	4.15 (SD = 0.69) (n = 13)
Medical Treatment Monitoring	4.03 (SD = 0.90) (n = 32)	4.15 (D = 0.99) (n = 13)
Group Therapy	4.12 (SD = 1.24) (n = 25)	3.71 (SD = 0.49) (n = 7)
Individual Therapy	3.53 (SD = 1.09) (n = 80)	3.72 (SD = 1.06) (n = 25)
Case Management	4.11 (SD = 1.05) (n = 19)	4.36 (SD = 0.67) (n = 11)
Family Therapy	3.56 (SD = 1.10) (n = 50)	3.76 (SD = 0.96) (n = 34)
Day Treatment	4.00 (SD = 1.05) (n = 10)	4.00 (SD = 1.41) (n = 2)
Behavioral or Therapeutic Aide	NA	2.00 (SD = NA) (n = 1)
Independent Living	NA	NA
Youth Transition	NA	NA
Caregiver or Family Support	3.80 (SD = 0.84) (n = 5)	3.67 (SD = 1.37) (n = 6)
Vocational Training	4.50 (SD = 0.71) (n = 2)	NA
Recreational Activities	4.00 (SD = 1.20) (n = 8)	4.33 (SD = 0.52) (n = 6)
After-school Programs or Child Care	3.29 (SD = 1.38) (n = 7)	2.00 (SD = 0.00) (n = 3)
Transportation	4.58 (SD = 1.17) (n = 12)	4.50 (SD = 0.71) (n = 2)
Respite Care	3.75 (SD = 0.96) (n = 4)	5.00 (SD = NA) (n = 1)
Residential Therapeutic Camp or Wilderness Camp	NA	3.00 (SD = NA) (n = 1)
Inpatient Hospitalization	4.50 (SD = 0.71) (n = 2)	3.50 (SD = 0.71) (n = 2)
Residential Treatment Center	4.50 (D = 0.71) (n = 10)	3.00 (SD = NA) (n = 1)
Therapeutic Group Home	4.00 (SD = 1.00) (n = 3)	3.00 (SD = NA) (n = 1)
Therapeutic Foster Care	2.67 (SD = 1.53) (n = 3)	2.00 (SD = 1.41) (n = 2)

1 = not well at all, 2 = somewhat well, 3 = moderately well, 4 = very well, 5 = extremely well

Discharge Information

There were 119 Termination Forms completed for the BHJJ youth. Of those, 53 were identified as successful completions (44.5%). Fifteen clients (13.44%) moved out of the county while enrolled in BHJJ and 22 (18.5%) clients either rejected or did not return for services or were withdrawn from the BHJJ program. Complete Discharge information can be found in Table 26.

Table 26. Discharge Information for All BHJJ Counties

Reason for Discharge	Frequency
Successful Discharge	44.5% (n = 53)
Out of Home Placement	3.4% (n = 4)
Client Moved	13.4% (n = 16)
Client Rejected Services/Did Not Return/Withdrawn	18.5% (n = 22)
Client Incarcerated	1.7% (n = 2)
Other (AWOL, aged out of program, changes in custody, transferred to different program)	18.5% (n = 22)

Of those youth for which Termination forms were submitted, 22.3% were at risk for out of home placement upon termination from the program. At intake, 16% of the sample was already in an out of home placement and another 45% were at risk for out of home placement. Length of treatment was calculated by using the Intake and Discharge dates for the youth. If the youth was still in the program at the time of this report, the final day of the project period, June 30th 2007, was used to calculate length of treatment. The mean number of days spent in the BHJJ program for all youth was 209.75 days (SD = 95.20). For the youth who had successful terminations, the average was 208.20 (SD = 72.74). DSM-IV Axis I diagnoses were compared for youth with both the EDIF (Intake) and the CUIF (Discharge). At Intake, these 60 youth had 99 diagnoses. At Discharge, these same 60 youth had 39 diagnoses. A paired samples t-test revealed no significant difference between Global Assessment of Functioning (GAF) scores at Intake and Discharge: $t(30) = .043$, $p > .05$.

Logistic regression was used to determine whether demographic variables (Gender, Ethnicity, and Age) and length of treatment predicted successful completion of the BHJJ program. The model was not significant: $X^2(4) = 1.73$, $p > .05$. Even after controlling for demographic variables, there was no relationship between length of treatment and treatment success. The *B* coefficients for all independent variables were nonsignificnat.

Recidivism

The Juvenile Court records both prior to and after BHJJ enrollment were collected for the BHJJ youth. In any future discussion of recidivism and in all analyses, recidivism is defined as a new charge received after the BHJJ enrollment date. Prior to enrollment, 455 youth accounted for 2050 charges, for an average of 4.51 charges per youth. Of the 1934 charges for which offense code data was present, 54.8% of the charges (n = 1060) were misdemeanors and 12.2% (n = 236) were felonies. Status offenses accounted for 28.4% (n = 549) of the charges. After enrollment, 140 (30.8%) of the original 455 youth accounted for 353 new charges, for an average of 0.78 new charges per youth. Of these new charges, 59.8% (n = 211) were misdemeanors, 16.1% (n = 57) were felonies, and 19.8% (n = 70) were status offenses. Tables 27a and 27b contain the most frequent

misdemeanor and felony charges for the total sample for both before and after BHJJ enrollment.

Table 27a. Top 5 Misdemeanor or Felony Offenses Prior to Enrollment

Offense	Frequency
Assault	10.05% (n = 206)
Domestic Violence	8.24% (n = 169)
Theft	7.80% (n = 160)
Disorderly Conduct	6.24% (n = 128)
Criminal Damaging	3.37% (n = 69)

Table 27b. Top 5 Misdemeanor or Felony Offenses After Enrollment

Offense	Frequency
Assault	11.33% (n = 40)
Disorderly Conduct	8.22% (n = 29)
Domestic Violence	5.95% (n = 21)
Theft	5.10% (n = 18)
Drug Possession	4.25% (n = 15)

A logistic regression was performed to determine whether those who successfully completed the program were less likely to recidivate than those who did not complete the program successfully. Gender, Age, and Ethnicity were also added to the regression model. The overall model was significant: $X^2(4) = 15.54$, $p < .01$. Ethnicity was the only significant predictors of recidivism (see Table 28). The odds of recidivism were 4.38 times as large for African Americans than Caucasians.

Table 28. Regression Table Predicting Recidivism from Gender, Ethnicity, Age, and Treatment Success

	Recidivism			
	B	**SE**	**Exp(B)**	**p**
Ethnicity				
African American	1.48	.50	4.38	.003
(Caucasian)				
Gender				
Female	.59	.49	1.80	.235
(Male)				
Age	.23	3.12	1.25	.259
Completion Status				
Unsuccessful	-.49	.50	.61	.328
(Successful)				

Discussion

A total of 455 youth (229 males and 226 females) from seven counties were enrolled in the BHJJ project. The large sample of females is a great improvement over results from the BHJJ pilot program evaluation (2000-2003), which found that 90% of the youth served were males. The addition of the female-offender only sites significantly increased the proportion of females in the sample. Caucasians comprised 65.5% of the sample while African Americans made up 28.1%. Analysis of family history indicated that many of the youth suffered either physical or sexual abuse, and many were witness to domestic violence. Suicide ideation and actual attempts were quite high among the sample. The youth were primarily referred to the program for conduct/delinquency related issues, substance abuse issues, school performance problems, and depression-related issues.

The 455 youth accounted for 771 Axis I DSM-IV diagnoses, for an average of 1.69 diagnoses per youth. The most prevalent diagnosis for females was Oppositional Defiant Disorder while for males, it was Attention Deficit Hyperactivity Disorder. Over one quarter of the sample (25.9%) had co-occuring mental health and substance abuse diagnoses. Substance use questionnaires revealed the BHJJ youth are starting to use substances around 12 years old, beginning with cigarettes. Alcohol, marijuana, and cocaine use follow soon after. While substance use begins around 12 years old, the average age of youth in BHJJ was approximately 15 years of age. Therefore, it is important to understand that many of these youth enter the program with years of substance use and, as evidenced by an examination of the DSM-IV diagnoses, severe substance use/abuse problems.

The Ohio Scales analyses indicate that the BHJJ youth improved significantly across all areas (Problem Severity, Functioning, Satisfaction, and Hopefulness) and across most measurement intervals. This was measured not only by youth self-report, but also by parent and case worker ratings. All three raters reported significant improvements in all four areas. In addition, trauma symptoms, as reported by the TSCC, and substance use also significantly decreased from Intake to Discharge.

Over one quarter (26.2%) of the sample had been discharged from the program. Of those, 44.5% were labeled as successful completions, meaning they had successfully completed treatment and were discharged from BHJJ. Several youth moved out of county after enrolling in the BHJJ program, and were thus discharged (13.4%). Some clients simply did not attend therapy sessions or were removed from the program by a caregiver (18.5%). Three youth were stepped down *from* an ODYS facility and placed into the BHJJ program. Two of the three were referred back to ODYS. **Therefore, for the 452 youth for whom BHJJ was a true diversion program, none were referred to ODYS.** The overall recidivism rate for the BHJJ youth, as measured by a new charge any time after BHJJ enrollment, was 30.8%. Most of the new charges were misdemeanors (59.8%).

Next Steps and Recommendations

The data collection process will continue for the youth enrolled in BHJJ. In addition, the project sites have been extended so additional youth will be enrolling in the BHJJ program. The data collection packet for the new evaluation was reduced and will take youth, caregivers, and workers much less time to complete while maintaining the integrity of the evaluation. The continued collection of this valuable data will allow for more specific and detailed analyses as well as additional longitudinal analyses not possible with so few Discharge packets. Additional data may also provide an opportunity to examine differential effects of the BHJJ program and ultimately discover for whom this program works best. Additional recidivism data will shed additional light on the impact the BHJJ program has on re-offending.

One major improvement from the pilot evaluation to the current one was the addition of the part-time data manager at each project site. The data manager was responsible for collecting and sending all the data to the evaluation team. The addition of this position is one of the reasons why the data collection process went smoothly and also why there was so much data to analyze. It is the recommendation of the Evaluation Team that this position be maintained at all current and future BHJJ sites.

The next recommendation addresses the potential for disparate enrollment of youth across BHJJ counties. The Evaluation Team suggests the introduction of a common risk assessment tool to the screening and assessment phase of enrollment. This tool would be used in all BHJJ counties and would allow for consistent screening and enrollment across project sites. Children who are enrolled in one county would share a similar risk level with children enrolled in another county. As it stands now, counties determine eligibility based on their own unique screening processes. A uniform risk

screening tool would help to make cross-county comparisons significantly more meaningful.

BHJJ Success Stories

Several counties provided the evaluation team with vignettes from or about youth who have been positively impacted by the BHJJ program.

Cuyahoga County

My Experience with BHJJ

When I first got into the Juvenile Court system in September of 2006 I really didn't think anything of it. After being on probation for about one month I got suspended and Mr. S. put me in the Day Report Program. I thought it was just a waste of my time and I wasn't going to get anything out of being in a boring place all day.

Then I was transferred into the BHJJ program so now I have Day reporting on Monday, Wednesday, and Friday. I get counseling at Applewood on Tuesdays and Bellefaire on Thursdays. My probation officer Mr. L. says that if I do like I'm supposed to, I could be off probation and be able to have more time to do different things that I want to do. I have learned a lot from my programs like to how to respect myself and others.

I've learned different things I could do that won't get me in trouble. I think I have gotten a lot of out being on probation. By being on probation and in Day Reporting I learned to respect myself and others. I know how school has so much effect on my life and how important an education is. I learned coping skills and how to use them. I learned about safety for myself and others.

Overall, the court system has changed me into the person I am today. I have respect for myself and others. I'm going to high school next year. That's what the Juvenile Court system has done for me.

How BHJJ Affected my life…

I was appointed to Juvenile Courts on October 18, 2006 and to many other services. They have helped me tremendously in the past 8 months I've been on their case load. My Probation Officer, Mr. L., has shown me that I still am a young adult, I can not do what I please and I must obey authority figures. He has also shown me that I must take responsibilities for my own actions and any negative consequences or reward that comes along with my choices. Mr. L is a very great Probation Officer and I appreciate everything that he has done for me.

On January 3, 2007 I was recommended to The Day Reporting Program, which has helped me work myself back into the community. It has helped me a great deal because the time schedule gives me no time to get into any trouble. Mr. C. is the director, he

doesn't let us get away with anything. That's a good thing because with him telling me I won't get into any bad habits.

A few months after being in The Day Reporting Program, Bellefaire JCB was added onto my case. With this service I received a counselor named Mrs. W.. She is a very pleasant person, and is someone to whom I can tell anything to without it being spread around. Mrs. W. also helps me employ other coping skills rather that going off and yelling. I enjoy her being my counselor.

Lastly, I was ordered to attend a drug program at Bellefaire JCB. I had to attend 12 groups that I actually participated in.

This program taught me coping skills, and what leads to people's drug use. They helped me a lot because now instead of wanting to use marijuana when I get upset: I do other things like write in a journal or listen to music.

With all of this being said, I think that BHJJ has helped me come a long way from where I used to be. Not only because of disciplinary action, but because of the people who are involved in my case. I used to just think that they were torturing me, but now seeing how much I've changed, I know that they are just here to help. So, I would like to say that I appreciate all of the services that BHJJ and The Juvenile Court has provided for me.

Franklin County

"S" became a part of the BH/JJ project after having been placed in the detention hall for approximately two weeks. *S's* behaviors had included fighting, selling drugs, multiple misdemeanor and one felony charge, gang involvement, drug use, school expulsion, frequent episodes of AWOL, and a complete disrespect for the rules in his home and community. His mother was concerned that she might not be able to help him before he turned 18 and entered the adult system.

From his first day of enrollment into the project, *S* and his mother were part of an interdisciplinary team of individuals committed to his success. *S* was given a comprehensive behavioral health assessment while in DH in order to determine his needs. Indeed, this assessment pointed to the fact that *S* was grappling with more than just the criminal behaviors seen on the surface, but also with some significant mental health issues. Recognizing these multiple and immediate needs, the BH/JJ assessor who consulted on the case quickly linked him with care coordination. Care coordination took the first steps in beginning to bring together the team players that would ultimately provide *S* with the tools he needed to be successful. Quality services were linked in the community that not only focused on *S* and his issues, but also on his family. Probation played a critical role as well, ensuring that *S* knew the rules of the court, and what was expected of him, along with reinforcing positive behaviors. Team meetings were frequent and focused, reassuring the family that although they were the most important members of the team, they were not alone.

S's family journeyed through a long and difficult path during their year in the project. The family endured multiple stressors, including loss of mother's employment, issues of poverty, and chronic medical issues. Despite all of these challenges, however, they persevered. At this time, *S* is once again enrolled in school and working towards his diploma, he has held several jobs where he has learned invaluable skills, has maintained his sobriety, successfully completed both individual and family therapy, and is being given the rare opportunity to successfully terminate a month early from his term of intensive felony probation. His mother reports that she "has her son back" and recognizes the importance of the entire team in making that happen. *S* is a true success story.

Logan County

"A" is a 16 year-old female that was referred to the BHJJ Program in May of 2006. Petty theft was the charge that brought *A* to the Program. During the screening, A presented with substance abuse issues, as well as behavior problems. *A's* grandparents, who had raised her from infancy, had been struggling with *A* for several years and were not aware of what kind of services would be helpful for their grandchild.

A's behaviors at home were antagonistic and destructive. Her grandparents were unsuccessful at controlling her outbursts, her disrespectful attitude, and her negative behaviors. *A* had a history of charges before coming into the BHJJ Program, including drug abuse, alcohol consumption, unruliness, and theft. *A* was out of control and her grandparents were desperate to find a way to keep her in their home because there were no other family members that could take *A* in.

When *A* entered the BHJJ Program she was quickly enrolled into Alcohol and Drug (AOD) counseling, which was an avenue her grandparents had not attempted. A reported first abusing various drugs and alcohol as early as age 13. Some of the substances *A* reported abusing were alcohol, tobacco, inhalants (chemicals), stimulant prescriptions, tranquilizer prescriptions, pain killers, Adderall, over-the-counter medications, marijuana, cocaine, hallucinogens, ecstasy, and acid. *A* had been abusing various substances for three years and was dealing with a serious addiction.

With the support and determination of her grandparents, *A* attended all her AOD counseling appointments and began to make progress for the first time in several years. *A* was active in her AOD counseling for four months and was able to complete the process successfully. *A* and her grandparents participated in family counseling as well, and began to work on their family relationship and A's behavior at home.

A was the first youth to be successfully discharged from the BHJJ Program. *A* had met all her goals and reported at Discharge that she had not used or abused any substances for eight months and had numerous negative drug screens to prove it. *A* is now off probation, drug and alcohol free and finishing her sophomore year in high school. The BHJJ Program was a valuable resource for this family, not only affecting *A*, but helping her family receive the assistance and support needed in order to be successful.

"J" is a 17 year-old male who was referred to the BHJJ Program in May 2006. *J* was the second youth to be screened by the BHJJ Program. Petty theft was the charge that landed *J* in Court, but he presented with several other problems that were identified during the screening. An assessment was completed the next day with the Court Counselor. *J* was diagnosed with cannabis abuse, cocaine abuse, and alcohol abuse. He was referred to outpatient counseling for substance abuse treatment.

During this time, *J* was struggling academically. He was not going to graduate with his class and rarely attended school. *J* continued to test positive for marijuana and cocaine another 4 months while sporadically attending his outpatient Alcohol and Drug (AOD) treatment. In November of 2006, *J* ran away from home and was missing for several days. When *J* was located, he was placed in JDC, put on Probation for six months, and ordered to attend his outpatient AOD treatment consistently. *J* was also ordered to meet with the Treatment Office at the Family Court for BHJJ Compliance Reviews twice a month to monitor his progress and his compliance with his court orders.

As of March of 2007, *J* has maintained a steady job doing construction work with a local company. *J* was able to complete his outpatient AOD treatment and has had clean drug screens. *J* did not return to school based on his inability to graduate, but we are thrilled to report that *J* has passed his GED test. He is currently in the process of being released from Probation and then will be promptly discharged from the BHJJ Program.

J has been in the BHJJ Program for over nine months and an emotional, behavioral, and visible change has happened with *J*. His progress throughout this process was a struggle and slow coming, but *J* will have a GED and has been drug and alcohol free for four months. *J*'s mother has shared her gratitude for the availability of the BHJJ Program. *J* and his mother are very appreciative of the consistency, support and accountability they received through the Program. It took several months, but *J* is a success.

"M" is a 16 year-old male who was referred to the BHJJ Program in June 2006. *M* was put on Probation because of an unruly charge due to negative behaviors at school and home. During the screening, issues of anger management and his relationship with his mother were indicators of needing an assessment. *M* was diagnosed with an Adjustment Disorder with Mixed Disturbance of Emotions and Conduct. *M* was ordered to attend mental health counseling, but his initial attendance was sporadic at best.

During the first period of being in the BHJJ Program, *M* continued to get into trouble at school and home. *M* did not take care of himself or have any independent life skills, such as doing laundry or washing his own dishes. *M* would fight with his mother at home and this behavior seemed to escalate each day. *M* would curse at his mother, physically fought with his mother, and even threaten her and himself with a knife. His behavior was getting out of control. *M* was extremely angry, aggressive, and violent.

The BHJJ Program began having *M* attend counseling more often and also attend BHJJ Compliance Reviews regularly. *M* also attended Community Service at the Court whenever he had negative behaviors at home or school. *M* was working with his counselor on coping skills for anger, independent life skills, and establishing a healthier relationship with his mother. *M* began to show improvement at each Compliance Review he attended. Little things were noticeable at first, such as doing his chores when asked by his mother with little resistance.

As of March 2007, *M* had completed his nine month Ohio Scales and reported doing very well. *M* was doing his chores and extra things around the house without being asked. There had been no violent outburst for several weeks. *M* and his mother reported that he was being respectful at home and school, dealing with his anger appropriately, and building a better relationship with his mother. *M* was extremely proud of himself and his progress during the entire process.

When *M* first entered the BHJJ Program, he was headed down a path that potentially led to more violence, more serious charges, and more serious sanctions. Now, *M* is looking at graduating from high school and being an average teenager in our community.

Montgomery County

"*N*" is a 16-year old female who was referred t the BHJJ program in June 2006. *N* was placed on probation in September 2004 for a runaway offense. While the youth was placed on probation she continued to be truant from school and runaway frequently. *N* was also charged and adjudicated with several counts of domestic violence against her mother.

N lived in a very unstable home. Her father abused alcohol and crack cocaine and was very verbally and physically abusive toward the youth and her mother. As a result of this instability the youth would resort to living on the street, abusing drugs, and engaging in inappropriate relationships with older men. The youth was expelled from several schools due to being physically aggressive toward peers and teachers. *N* became pregnant and gave birth to her son when she was only 15 years old. *N* was very violent toward her mother and would frequently get into verbal and physical altercations that resulted in police intervention. The youth was diagnosed with Post Partum Depression and Oppositional Defiant Disorder in June 2006.

N was referred to the BHJJ program because she continues to be violent toward her mother and would frequently abandon her son. Her probation officer was requesting that the youth be removed from the home because her behavior appeared to be escalating. *N* was struggling with depression and agreed to participate in the program to improve her relationship with her mother and to be a better parent to her son. After six months of weekly family therapy and intensive probation supervision the youth successfully completed the program. *N* struggled with her lack of coping skills, however was able to remain focused and engage in new ways of communicating with her mother. *N* has not

received any new charges and did not runaway. She began testing negative for all illegal substances, participated in parenting classes and is passing her classes at school.

"S" is a 17 year old female who was referred to the BHJJ program in July 2006. *S* was placed on probation in May 2005 for a domestic violence offense. While the youth was on probation she was adjudicated of several domestic violence offenses and a felony assault offense. *S* was very physically violent toward her family and refused to follow any household rules. She had very few friends and would frequently bully peers at school. She was placed on home instruction due to her behaviors in class. She had a history of leaving the house for several days at a time without permission and frequently abused marijuana, cocaine, and Xanax. Her parents were constantly in fear of the youth's assaultive behavior and felt like hostages is their home. *S* was diagnosed with Bipolar Disorder and Manic Depression, however would rarely participate in therapy.

As a result of the youth's out of control behavior, the Court placed *S* at a residential treatment center to address her mental health and substance abuse issues. While in treatment, the youth continued to be resistant and was frequently a disruption. The agency asked that the youth be removed from placement due to consistent non-compliance. *S* was given one last chance to change her behavior and was referred to the BHJJ program instead of being placed at the Ohio Department of Youth Services. *S* participated in family therapy for four months. She developed coping skills and eliminated the physical violence toward her parents. She continues to attend weekly AA/NA groups to maintain sobriety and has completed her G.E.D. *S* successfully completed probation in December 2006.

County Data

The focus of the evaluation now turns to the analysis of individual county-level data. The large sample size in the overall analyses provided for multiple statistical comparisons across time. For counties that had small sample sizes, meaningful statistical comparisons across all time points and raters cannot be made. In addition, while Ohio Scales means are plotted across time, some time points, such as 9 and 12 months post enrollment, may have a very small associated sample sizes. Interpretations of data based on very small sample sizes must be made cautiously, as the results may drastically change with the addition of just a few data points.

Cuyahoga County

There were 36 youth enrolled in the BHJJ program in Cuyahoga County. All of the youth enrolled were female. The average age of the females from Cuyahoga County was 16.26 years (SD = 1.22). Caucasians and African Americans made up the majority of the sample (55.6% and 27.8% respectively). Chart 14 displays ethnicity data for the BHJJ youth in Cuyahoga County. The majority of the youth (52.9%) lived with the biological mother only (see Table 29). While the majority of caregivers had a high school diploma or better, 31.2% did not graduate from high school (see Table 30). The average household income for the BHJJ family in Cuyahoga County was between $20000

and $24999 (see Table 31). Detailed family history information can be found in Table 32, but of note, 45.7% of the females were sexually abused in the past and 88.2% of the females had a substance abuse problem. The most common reasons for treatment for females in the Cuyahoga BHJJ program were substance use/abuse (97.2%) and conduct/delinquency -related problems (97.2%) (see Table 33). Thirty-six females in Cuyahoga County accounted for a total of 104 Axis I diagnoses, for an average of 2.88 diagnoses per youth. Table 34 displays the most common Axis I DSM-IV diagnoses for the females in Cuyahoga County.

Of the 36 females enrolled, only one has been discharged thus far. This was considered an unsuccessful Discharge, as the child rejected services. All other females continue to receive services through the BHJJ project. In Cuyahoga, a child may have been discharged from mental health of substance abuse treatment, but not from the BHJJ project. This explains why there are multiple Ohio Scales Discharge packets from Cuyahoga County, but only one actual Discharge from the project. At the time of final data collection for the evaluation, the average length of stay in treatment was 176.61 days. Before enrollment, there were 111 Juvenile Court charges, for an average of 3.08 charges per female. After enrollment, only one female (2.7%) received a new charge (domestic violence).

Chart 14. Ethnicity of BHJJ Youth in Cuyahoga County

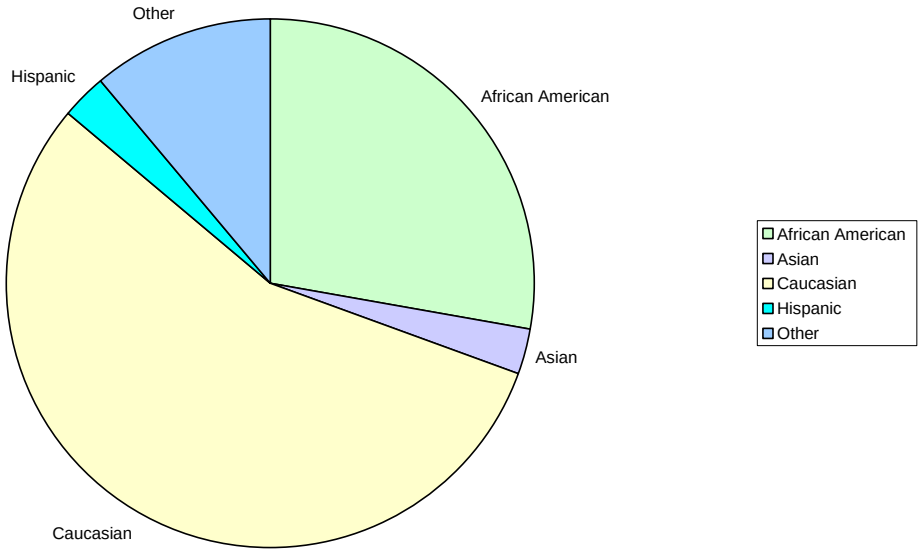


Table 29. Custody Arrangement for BHJJ Youth for Cuyahoga County

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	14.7% (n = 5)
Biological Mother Only	52.9% (n = 18)
Biological Father Only	8.8% (n = 3)
Adoptive Parent(s)	8.8% (n = 3)
Grandparents	8.8% (n = 3)
Ward of the State	2.9% (n = 1)
Other	2.9% (n = 1)

Table 30. Caregiver's Education Level in Cuyahoga County

Number of School Years Completed	Number of Caregivers
6	3.1% (n = 1)
9	3.1% (n = 1)
10	9.4% (n = 3)
11	15.6% (n = 5)
12	28.1% (n = 9)
13	12.5% (n = 4)
14	21.9% (n = 7)
15	3.1% (n = 1)
17	3.1% (n = 1)

Table 31. Household Income for BHJJ Families in Cuyahoga County

Household Income	Frequency
Less than $5000	8.8% (n = 3)
$5000 - $9999	2.9% (n = 1)
$10000 - $14999	8.8% (n = 3)
$15000 - $19999	8.8% (n = 3)
$20000 - $24999	14.7% (n = 5)
$25000 - $34999	17.6% (n = 6)
$35000 - $49999	20.6% (n = 7)
$50000 - $74999	11.8% (n = 4)
$75000 - $99999	5.9% (n = 2)

Table 32. Family and Youth Results from the Caregiver Information Questionnaire for Cuyahoga County

Question	Females (n = 36)
Has the child ever been physically abused?	38.2% (n = 13)
In the last 6 months, has the child been physically abused?	13.3% (n = 2)
Has the child ever been sexually abused?	45.7% (n = 16)
In the last 6 months, has the child been sexually abused?	5.9% (n = 1)
Has the child ever run away?	70.6% (n = 24)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	88.2% (n = 30)
In the last 6 months, has the child had a problem with substance abuse, including alcohol and/or drugs?	92.6% (n = 25)
Has the child ever talked about committing suicide?	64.7% (n = 22)
Has the child ever attempted suicide?	30.3% (n = 10)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	47.1% (n = 16)
In the past six months, has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	8.0% (n = 2)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	78.1% (n = 25)
Has the child ever lived in a household in which someone has shown signs of being depressed?	74.3% (n = 26)
Was the person who showed signs of being depressed involved in providing care and supervision to the child?	86.4% (n = 19)
Has anyone in the child's biological family had a mental illness, other than depression?	61.8% (n = 21)
Other than depression, has the child ever lived in a household in which someone had a mental illness?	38.2% (n = 13)
Has the child ever lived in a household in which someone was convicted of a crime?	44.1% (n = 15)
Has anyone in the child's biological family had a drinking or drug problem?	69.7% (n = 23)
Has the child ever lived in a household in which someone had a drinking or drug problem?	58.8% (n = 20)
Was the person with the drinking or drug problems involved in providing care and supervision to the child?	23.5% (n = 4)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	61.8% (n = 21)

Table 33. Problems Leading to Services in Cuyahoga County

Problems Leading to Services	Females
Suicide-related problems	19.4% (n = 7)
Depression-related problems	52.8% (n = 19)
Anxiety-related problems	11.1% (n = 4)
Hyperactive and attention-related problems	27.8% (n = 10)
Conduct/delinquency-related problems	97.2% (n = 35)
Substance use, abuse, dependence-related problems	97.2% (n = 35)
Adjustment-related problems	11.1% (n = 4)
Psychotic Behaviors	2.8% (n = 1)
Learning disabilities	11.1% (n = 4)
School performance problems not related to learning disabilities	75.0% (n = 27)
Eating disorders	2.8% (n = 1)

Table 34. Top Five DSM-IV Axis I Diagnoses for Females in Cuyahoga County

Axis I Diagnosis	Frequency
Cannabis Abuse/Dependence	80.5% (n = 29)
Alcohol Abuse/Dependence	36.1% (n = 13)
Major Depression/Depressive Disorder	33.3% (n = 12)
Bipolar Disorder	30.5% (n = 11)
Attention Deficit Hyperactivity Disorder	25.0% (n = 9)

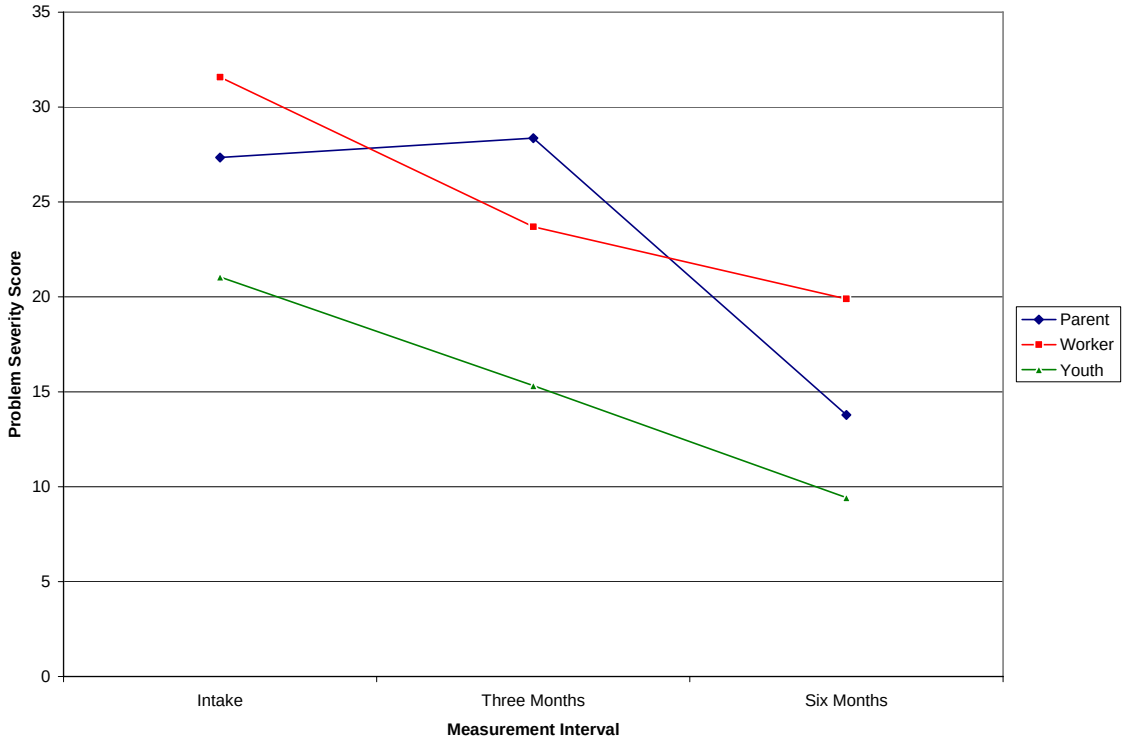
Ohio Scales Analyses

Paired-samples t-tests were conducted on the Ohio Scales data from Cuyahoga County. Because of the low sample size, all comparisons could not be tested. The only comparison that reached significance for the Parent version was between Satisfaction scores at Intake and 3 months: $t(17) = 4.03$, $p = .001$. Parents were significantly more satisfied with mental health services after 3 months of the BHJJ program. For the Worker version, there was a significant increase in Functioning from Intake to 3 months: $t(18) = -2.65$, $p = .01$. For Youth, there was a significant increase in hopefulness from Intake to 3 months: $t(18) = 3.39$, $p = .003$ as well as increases in Satisfaction from Intake to 3 months: $t(15) = 2.49$, $p = .002$. Means and standard deviations for all subscales are found in Tables 35 through 38. Because of the small number of youth discharged, not all data are represented in the charts.

Table 35. Problem Severity Scores for Cuyahoga County

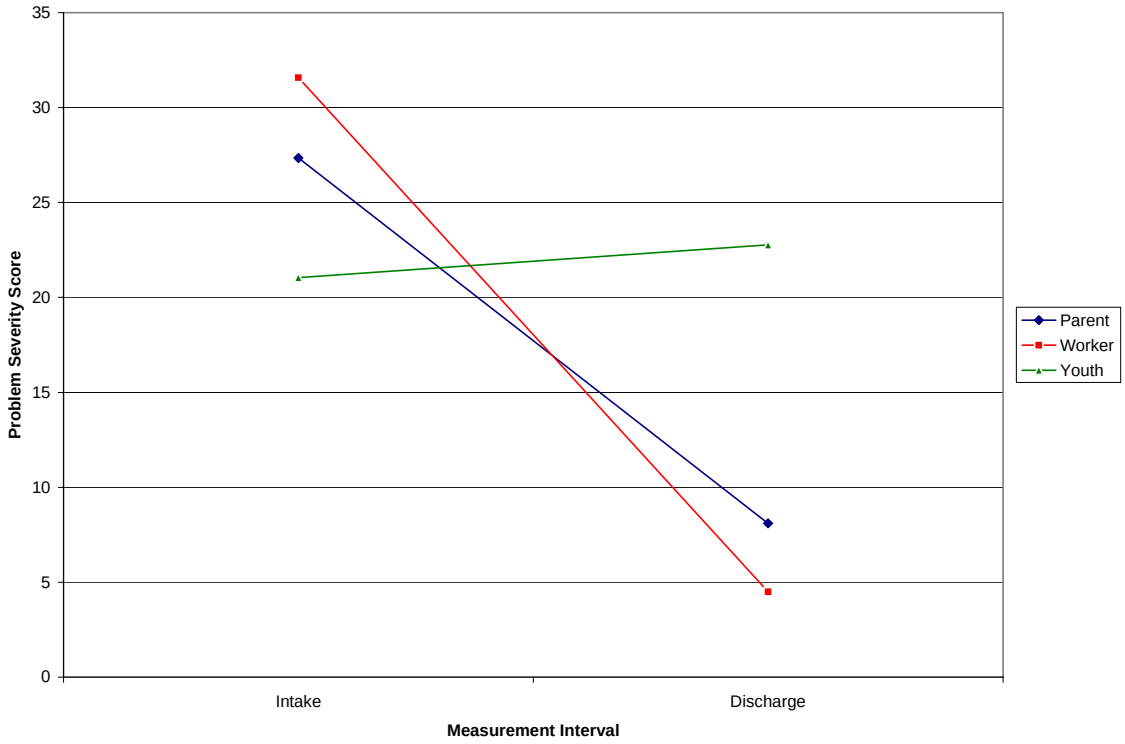
	Parent	Worker	Youth
Intake	27.34 (SD = 17.30) (n = 31)	31.58 (SD = 20.40) (n = 31)	21.05 (SD = 15.83) (n = 30)
Three Months	28.36 (SD = 18.14) (n = 19)	23.70 (SD = 16.17) (n = 20)	15.32 (SD = 13.09) (n = 19)
Six Months	13.78 (SD = 12.98) (n = 9)	19.90 (SD = 12.00) (n = 10)	9.42 (SD = 8.03) (n = 7)
Nine Months	4.00 (SD = NA) (n = 1)	NA	NA
Twelve Months	NA	NA	NA
Discharge	8.10 (SD = 8.14) (n = 3)	4.50 (SD = 4.95) (n = 2)	22.77 (SD = 31.05) (n = 4)

Chart 15. Problem Severity Scores for Cuyahoga County



* Lower scores indicative of less problem severity

Chart 16. Problem Severity Scores from Intake to Discharge for Cuyahoga County

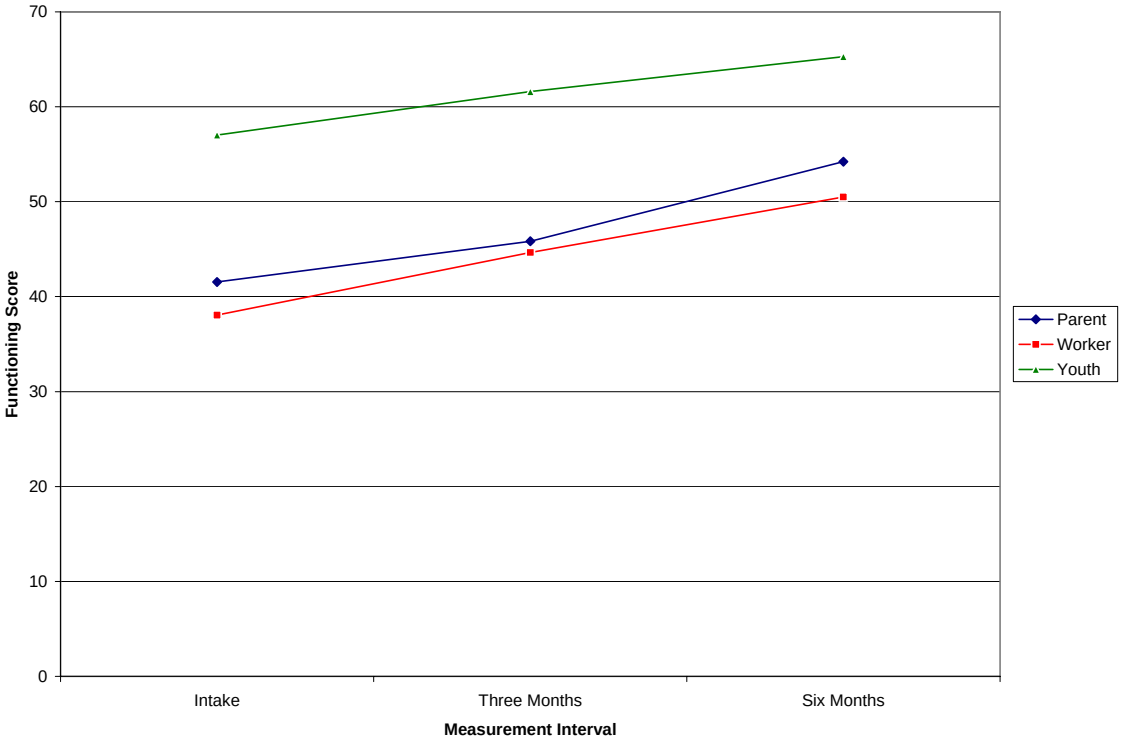


* Lower scores indicative of less problem severity

Table 36. Functioning Scores for Cuyahoga County

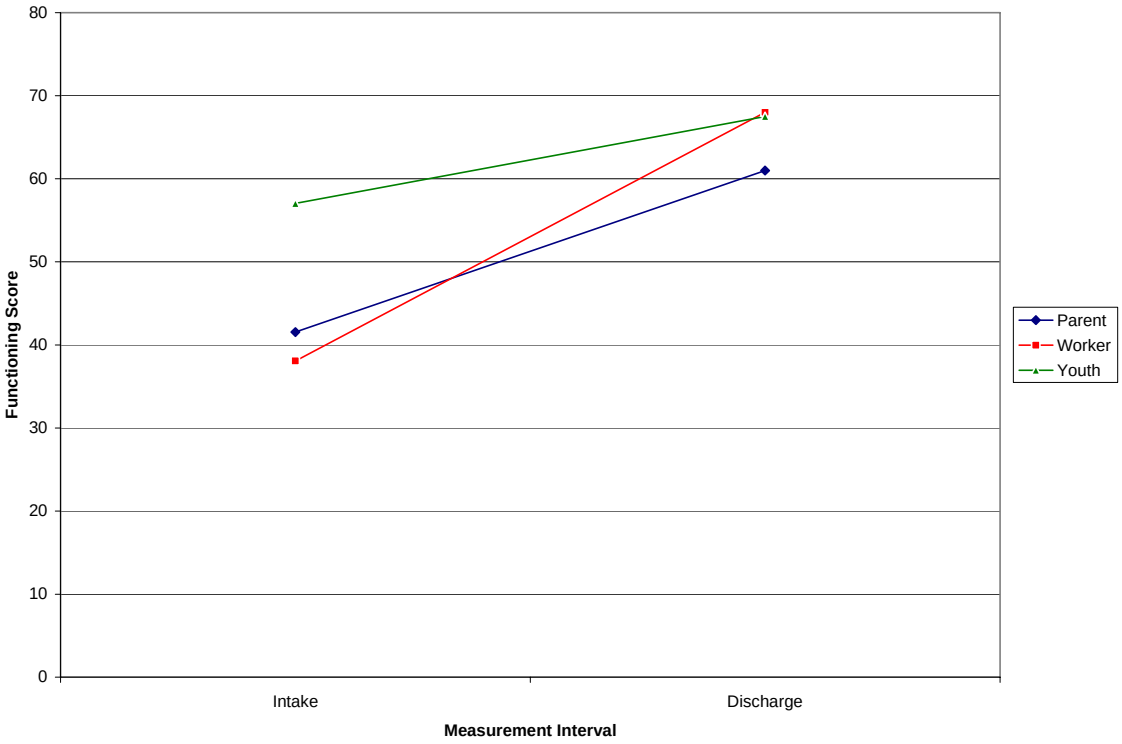
	Parent	Worker	Youth
Intake	41.54 (SD = 19.46) (n = 31)	38.06 (SD = 15.72) (n = 31)	57.03 (SD = 12.55) (n = 30)
Three Months	45.84 (SD = 15.66) (n = 19)	44.65 (SD = 15.72) (n = 20)	61.60 (SD = 14.58) (n = 20)
Six Months	54.22 (SD = 7.91) (n = 9)	50.50 (SD = 7.19) (n = 10)	65.28 (SD = 13.18) (n = 7)
Nine Months	60.00 (SD = NA) (n = 1)	NA	NA
Twelve Months	NA	NA	NA
Discharge	61.00 (SD = 13.74) (n = 3)	68.00 (SD = 19.97) (n = 2)	67.50 (SD = 9.94) (n = 4)

Chart 17. Functioning Scores for Cuyahoga County



* Higher scores indicative of higher functioning

Chart 18. Functioning Scores from Intake to Discharge for Cuyahoga County

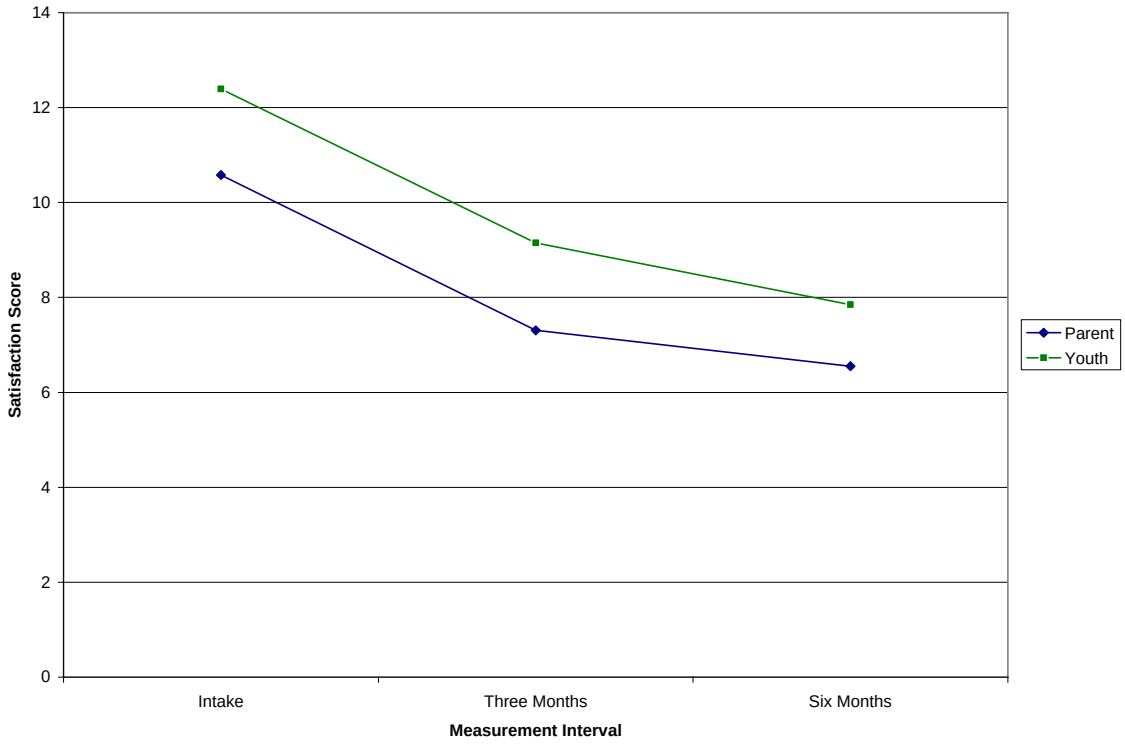


* Higher scores indicative of higher functioning

Table 37. Satisfaction Scores for Cuyahoga County

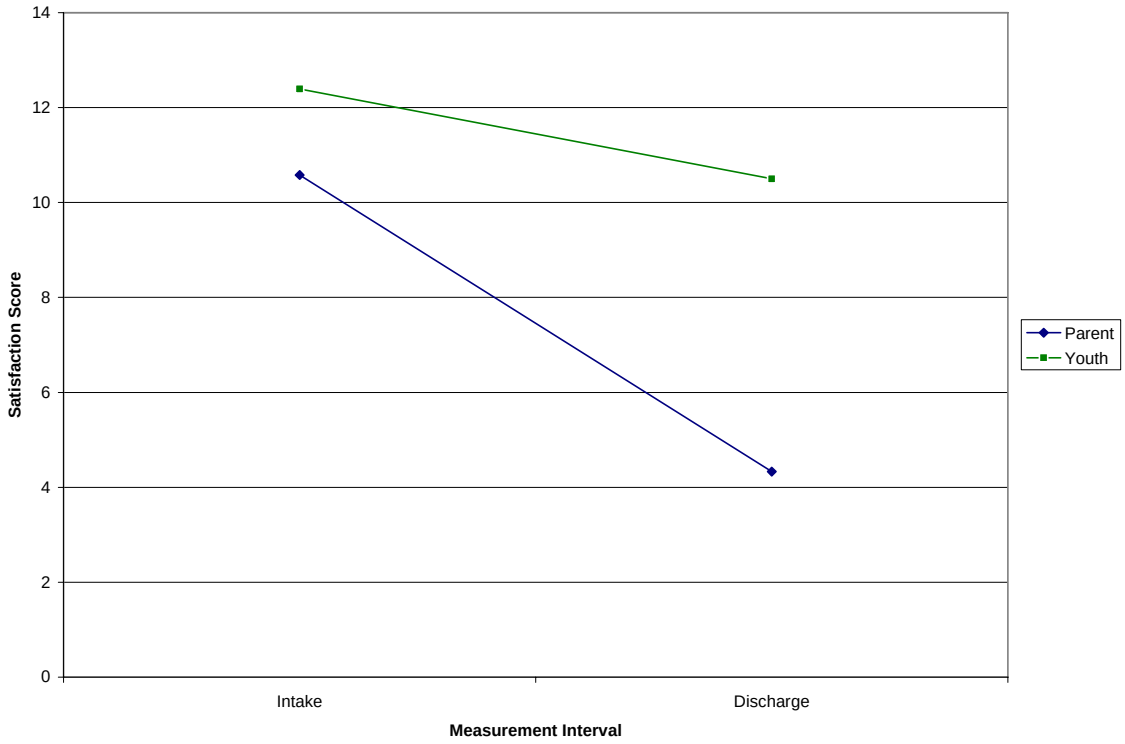
	Parent	Youth
Intake	10.58 (SD = 5.09) (n = 29)	12.39 (SD = 4.88) (n = 28)
Three Months	7.31 (SD = 4.05) (n = 19)	9.15 (SD = 4.54) (n = 19)
Six Months	6.55 (SD = 2.12) (n = 9)	7.85 (SD = 3.89) (n = 7)
Nine Months	5.00 (SD = NA) (n = 1)	NA
Twelve Months	NA	NA
Discharge	4.33 (SD = .57) (n = 3)	10.50 (SD = 7.68) (n = 4)

Chart 19. Satisfaction Scores for Cuyahoga County



* Lower scores indicate greater satisfaction

Chart 20. Satisfaction Scores from Intake to Discharge for Cuyahoga County

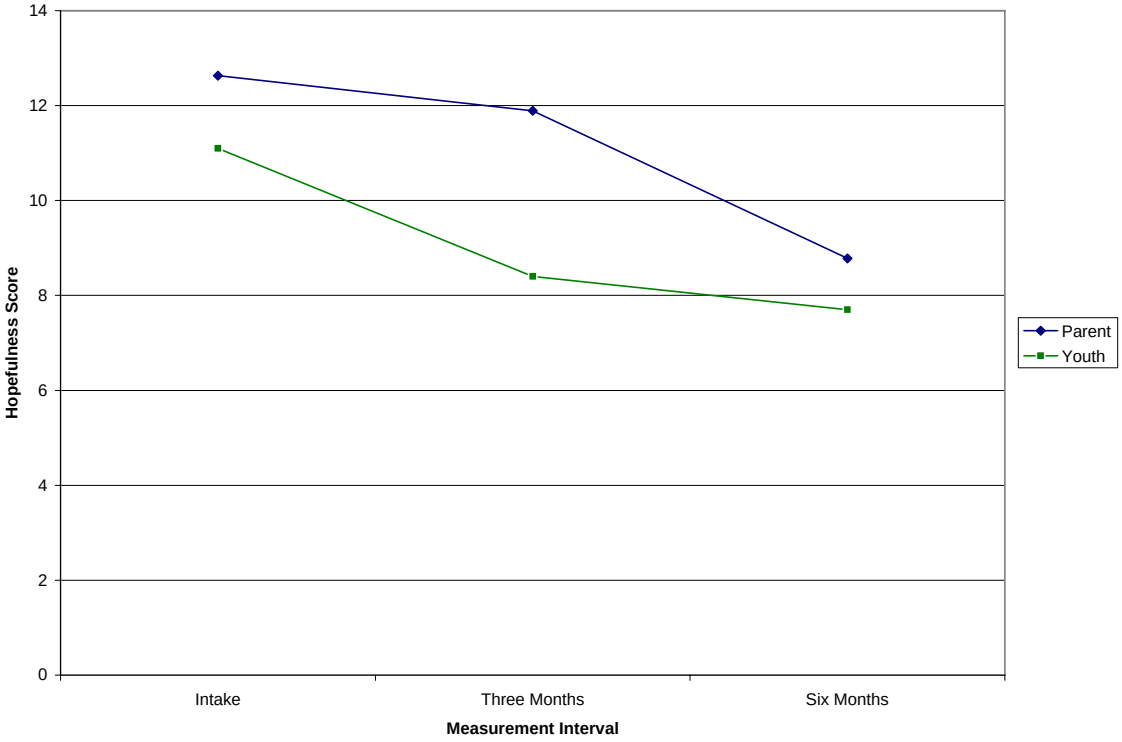


* Lower scores indicate greater satisfaction

Table 38. Hopefulness Scores for Cuyahoga County

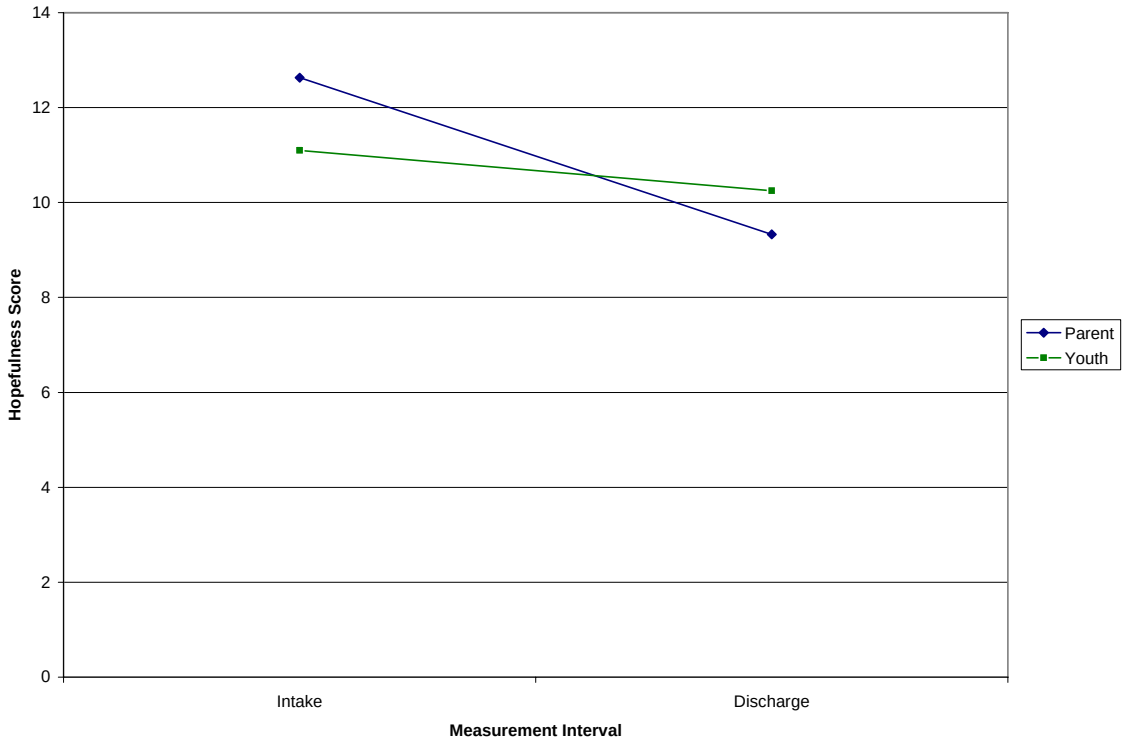
	Parent	Youth
Intake	12.63 (SD = 4.95) (n = 30)	11.10 (SD = 3.99) (n = 30)
Three Months	11.89 (SD = 4.14) (n = 19)	8.40 (SD = 2.85) (n = 20)
Six Months	8.78 (SD = 2.90) (n = 9)	7.71 (SD = 2.13) (n = 7)
Nine Months	4.00 (SD = NA) (n = 1)	NA
Twelve Months	NA	NA
Discharge	9.33 (SD = 3.05) (n = 3)	10.25 (SD = 4.78) (n = 4)

Chart 21. Hopefulness Scores for Cuyahoga County



* Lower scores indicative of greater hopefulness

Chart 22. Hopefulness Scores from Intake to Discharge for Cuyahoga County



* Lower scores indicative of greater hopefulness

Fairfield County

There were 13 youth enrolled in the BHJJ program from Fairfield County. Initially, Fairfield County planned to enroll only female youth, but opened the enrollment to male youth as well. Ten of the youth were females (76.9%) (see Chart 23). The average age of BHJJ youth in Fairfield County was 15.55 years (SD = .82).

Caucasians made up 84.6% of the sample while African Americans comprised 7.7% of the sample. Chart 24 displays ethnicity data for Fairfield County. The majority of the youth (63.6%) lived with the biological mother only (see Table 39). While the majority of caregivers had a high school diploma or better, 37.7% did not graduate from high school (see Table 40). The average household income for the BHJJ family in Fairfield County was between $20000 and $24999 (see Table 41). Detailed family history information can be found in Table 42, but of note, 55.6% of the females (0.0% of males) were sexually abused in the past and 88.9% of the females and 50% of males had family members who had a substance abuse problem. The most common reason for treatment for females and males in the Fairfield BHJJ program was conduct/delinquency-related problems (100%) (see Table 43). The 13 youth in Farifield County accounted for 32 DSM-IV Axis I diagnoses, for an average of 2.46 diagnoses per youth. Tables 44 and 45 displays the most common Axis I DSM-IV diagnoses for the youth in Fairfield County.

Of the 13 youth enrolled, six have been Discharged from the program. Five of the six were Discharged successfully (83.3%). The youth Discharged unsuccessfully failed to return for services. All other youth continue to receive services through the BHJJ project. At the time of final data collection for the evaluation, the average length of stay in treatment was 190.25 days. Before enrollment, there were 45 Juvenile Court charges, for an average of 3.46 charges per youth. After enrollment, only three youth (23.1%) received six additional charges (four charges of disorderly conduct, one assault, and one curfew violation).

Chart 23. Gender of BHJJ Youth in Fairfield County

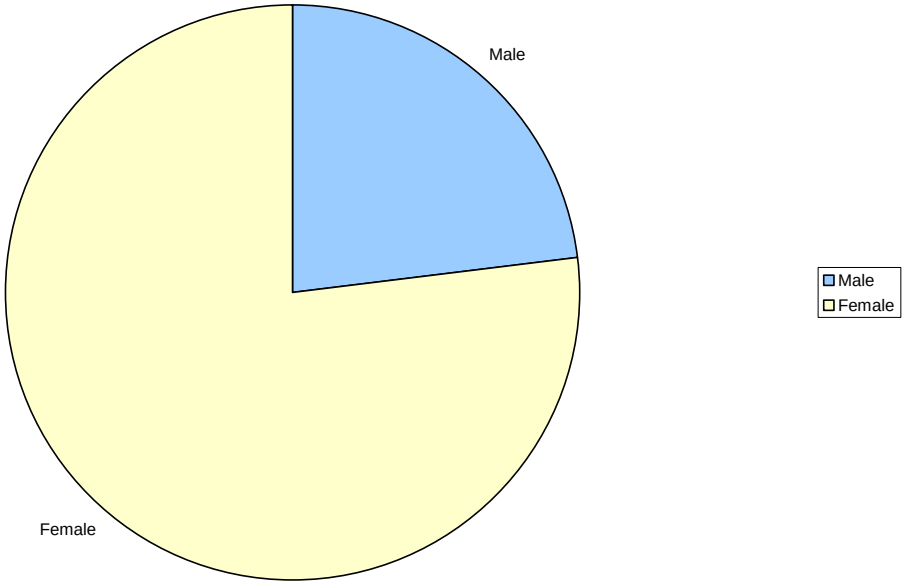


Chart 24. Ethnicity of BHJJ Youth in Fairfield County

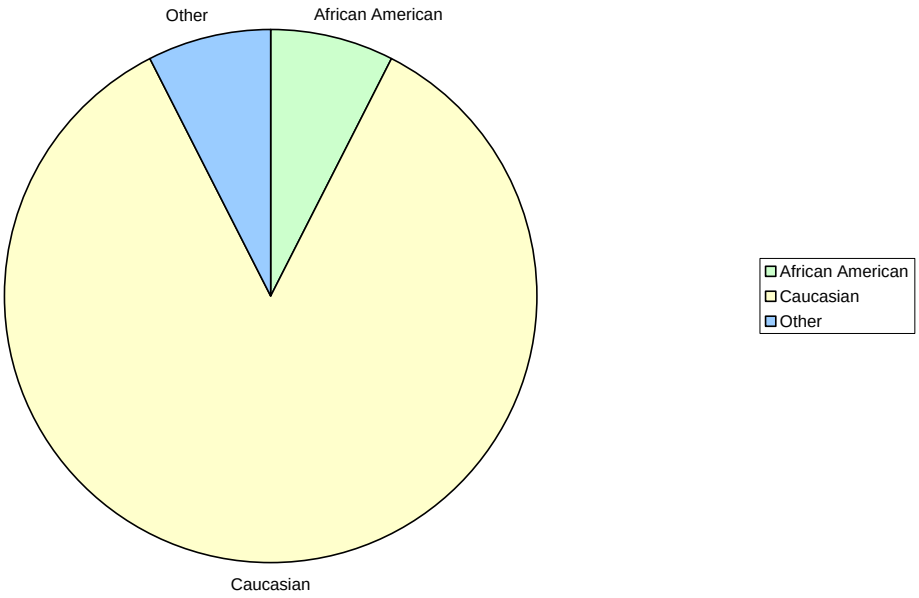


Table 39. Custody Arrangement for BHJJ Youth in Fairfield County

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	18.2% (n = 2)
Biological Mother Only	63.6% (n = 7)
Adoptive Parent(s)	9.1% (n = 1)
Ward of the State	9.1% (n = 1)

Table 40. Caregiver's Education Level in Fairfield County

Number of School Years Completed	Number of Caregivers
6	10.0% (n = 1)
7	20.0% (n = 2)
10	7.7% (n = 1)
12	30.0% (n = 3)
13	10.0 (n = 1)
15	20.0% (n = 2)

Table 41. Household Income for BHJJ Families in Fairfield County

Household Income	BHJJ Families
Less than $5000	18.2% (n = 2)
$10000 - $14999	18.2% (n = 2)
$15000 - $19999	18.2% (n = 2)
$20000 - $24999	9.1% (n = 1)
$35000 - $49999	18.2% (n = 2)
$75000 - $99999	9.1% (n = 1)
$100000 and over	9.1% (n = 1)

Table 42. Family and Youth Results from the Caregiver Information Questionnaire in Fairfield County

Question	Females (n = 10)	Males (n = 3)
Has the child ever been physically abused?	11.1% (n = 1)	50% (n = 1)
In the last 6 months, has the child been physically abused?	0.0% (n = 0)	0.0% (n = 0)
Has the child ever been sexually abused?	55.6% (n = 5)	0.0% (n = 0)
In the last 6 months, has the child been sexually abused?	50.0% (n = 2)	0.0% (n = 0)
Has the child ever run away?	77.8% (n = 7)	50.0% (n = 1)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	66.7% (n = 6)	0.0% (n = 0)
In the last 6 months, has the child had a problem with substance abuse, including alcohol and/or drugs?	71.4% (n = 5)	0.0% (n = 0)
Has the child ever talked about committing suicide?	55.6% (n = 5)	50.0% (n = 1)
Has the child ever attempted suicide?	22.2% (n = 2)	0.0% (n = 0)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	62.5% (n = 5)	0.0% (n = 0)
In the past six months, has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	25.0% (n = 2)	0.0% (n = 0)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	75.0% (n = 6)	50.0% (n = 1)
Has the child ever lived in a household in which someone has shown signs of being depressed?	77.8% (n = 7)	50.0% (n = 1)
Was the person who showed signs of being depressed involved in providing care and supervision to the child?	85.7% (n = 6)	50.0% (n = 1)
Has anyone in the child's biological family had a mental illness, other than depression?	55.6% (n = 5)	50.0% (n = 1)
Other than depression, has the child ever lived in a household in which someone had a mental illness?	44.4% (n = 4)	0.0% (n = 0)
Has the child ever lived in a household in which someone was convicted of a crime?	55.6% (n = 5)	0.0% (n = 0)
Has anyone in the child's biological family had a drinking or drug problem?	88.9% (n = 8)	50.0% (n = 1)
Has the child ever lived in a household in which someone had a drinking or drug problem?	77.8% (n = 7)	50.0% (n = 1)
Was the person with the drinking or drug problems involved in providing care and supervision to the child?	62.5% (n = 5)	100.0% (n = 1)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	33.3% (n = 3)	50.0% (n = 1)

Table 43. Problems Leading to Services in Fairfield County

Problems Leading to Services	Females (n = 10)	Males (n = 3)
Suicide-related problems	20.0% (n = 2)	0.0% (n = 0)
Depression-related problems	40.0% (n = 4)	33.3% (n = 1)
Anxiety-related problems	40.0% (n = 4)	33.3% (n = 1)
Hyperactive and attention-related problems	50.0% (n = 5)	66.7% (n = 2)
Conduct/delinquency-related problems	100.0% (n = 10)	100.0% (n = 3)
Substance use, abuse, dependence-related problems	60.0% (n = 6)	33.3% (n = 1)
Adjustment-related problems	50.0% (n = 5)	0.0% (n = 0)
Psychotic Behaviors	0.0% (n = 0)	33.3% (n = 1)
Pervasive development disabilities	0.0% (n = 0)	0.0% (n = 0)
Specific developmental disabilities	0.0% (n = 0)	0.0% (n = 0)
Learning disabilities	2.0% (n = 2)	33.3% (n = 1)
School performance problems not related to learning disabilities	30.0% (n = 3)	66.7% (n = 2)
Eating disorders	10.0% (n = 1)	0.0% (n = 0)

Table 44. Top Five DSM-IV Axis I Diagnoses for Females in Fairfield County

Axis I Diagnosis	Frequency
Oppositional Defiant Disorder	50.0% (n = 5)
Attention Deficit Hyperactivity Disorder	50.0% (n = 5)
Mood Disorder	30.0% (n = 3)
Alcohol Abuse/Dependence	20.0% (n = 2)
Adjustment Disorder	20.0% (n = 2)

Table 45. Top Five DSM-IV Axis I Diagnoses for Males in Fairfield County

Axis I Diagnosis	Frequency
Attention Deficit Hyperactivity Disorder	66.7% (n = 2)
Conduct Disorder	33.3% (n = 1)
Disruptive Behavior	33.3% (n = 1)
Mood Disorder	33.3% (n = 1)
Oppositional Defiant Disorder	33.3% (n = 1)

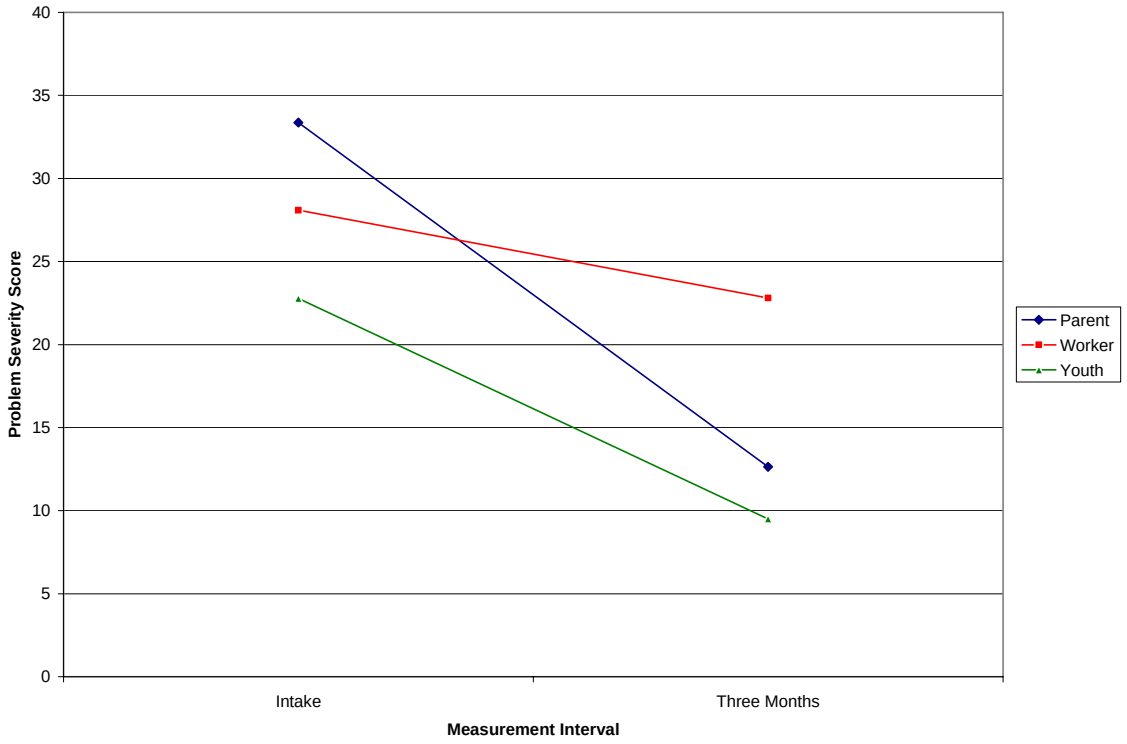
Ohio Scales Analyses

The small sample size in Fairfield County precludes the statistical analysis of the data. Tables 46 through 49 contain the means and standard deviations for the sample and the data is also represented in Charts 25 through 32.

Table 46. Problem Severity Scores for Fairfield County

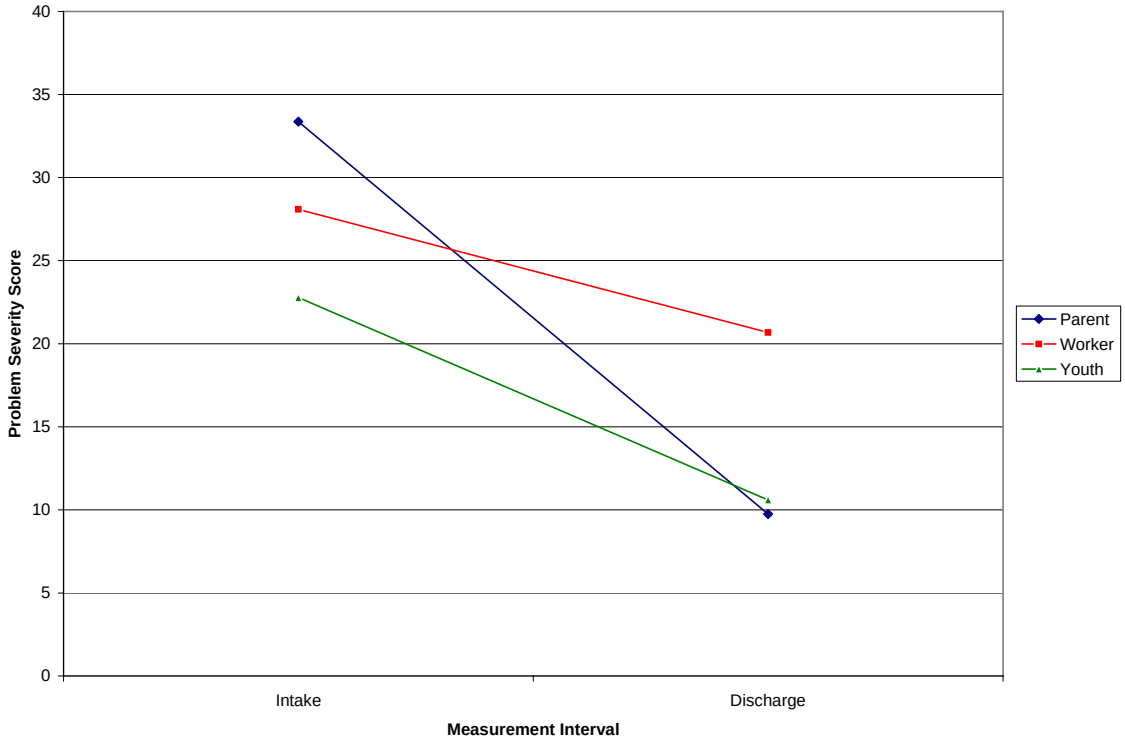
	Parent	Worker	Youth
Intake	33.36 (SD = 22.80) (n = 11)	28.09 (SD = 13.69) (n = 11)	22.78 (SD = 13.14) (n = 9)
Three Months	12.64 (SD = 8.63) (n = 4)	22.80 (SD = 10.47) (n = 5)	9.50 (SD = 4.12) (n = 4)
Six Months	21.28 (SD = 13.73) (n = 2)	19.75 (SD = 6.44) (n = 4)	18.00 (SD = NA) (n = 1)
Nine Months	NA	NA	NA
Twelve Months	NA	NA	NA
Discharge	9.75 (SD = 4.11) (n = 4)	20.67 (SD = 10.96) (n = 6)	10.60 (SD = 4.97) (n = 5)

Chart 25. Problem Severity Scores for Fairfield County



* Lower scores indicative of less problem severity

Chart 26. Problem Severity Scores from Intake to Discharge for Fairfield County

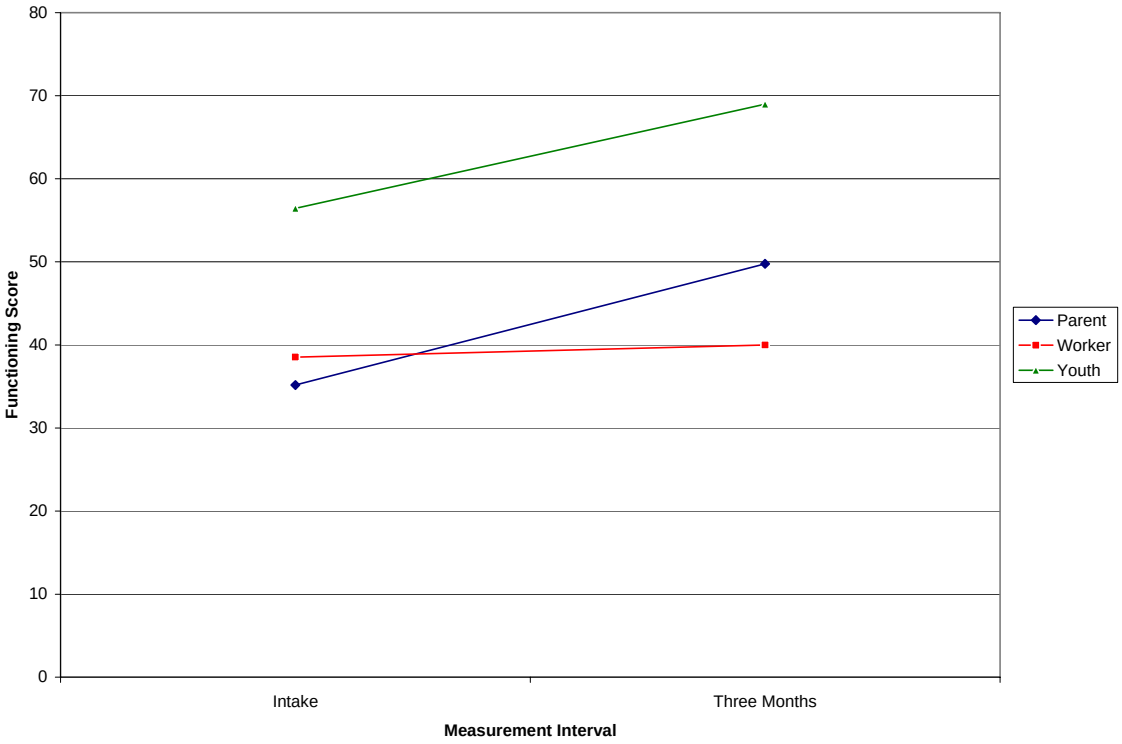


* Lower scores indicative of less problem severity

Table 47. Functioning Scores for Fairfield County

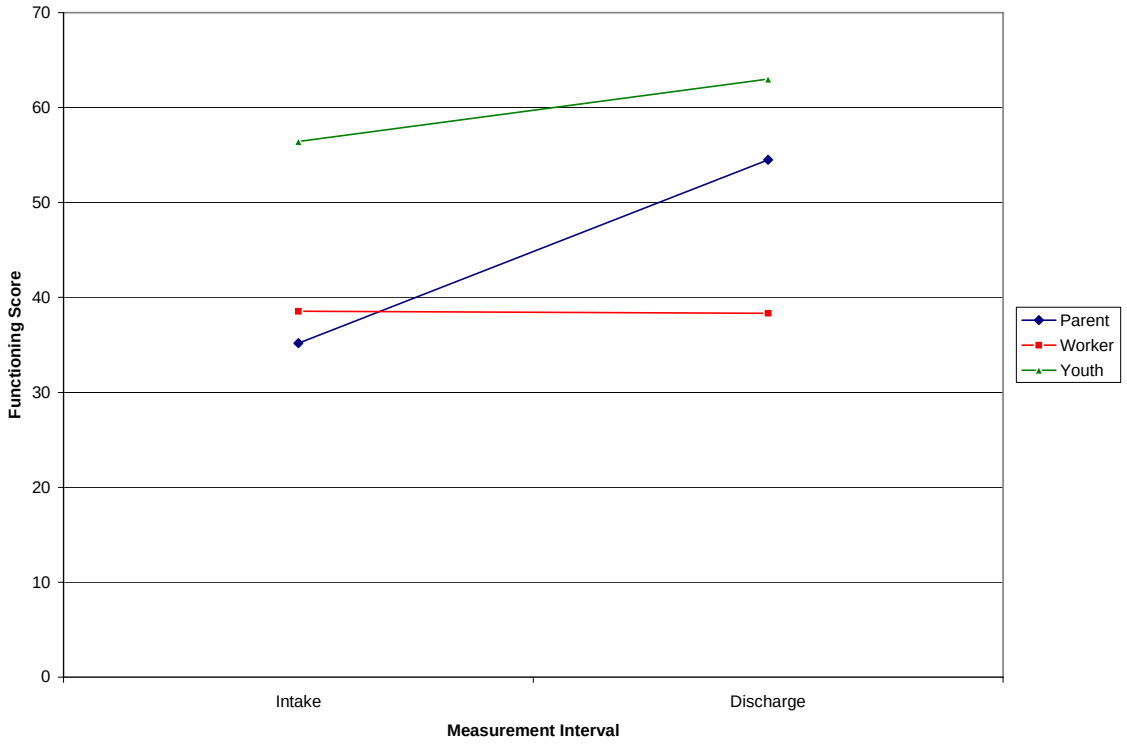
	Parent	Worker	Youth
Intake	35.18 (SD = 24.01) (n = 11)	38.54 (SD = 15.87) (n = 11)	56.44 (SD = 13.33) (n = 9)
Three Months	49.75 (SD = 16.37) (n = 4)	40.00 (SD = 14.81) (n = 5)	69.00 (SD = 6.16) (n = 4)
Six Months	30.00 (SD = 18.38) (n = 2)	45.25 (SD = 13.15) (n = 4)	59.00 (SD = NA) (n = 1)
Nine Months	NA	73.00 (SD = NA) (n = 1)	74.00 (SD = NA) (n = 1)
Twelve Months	NA	NA	NA
Discharge	54.50 (SD = 13.30) (n = 4)	38.83 (SD = 9.47) (n = 6)	63.00 (SD = 7.84) (n = 5)

Chart 27. Functioning Scores for Fairfield County



* Higher scores indicative of higher functioning

Chart 28. Functioning Scores from Intake to Discharge for Fairfield County

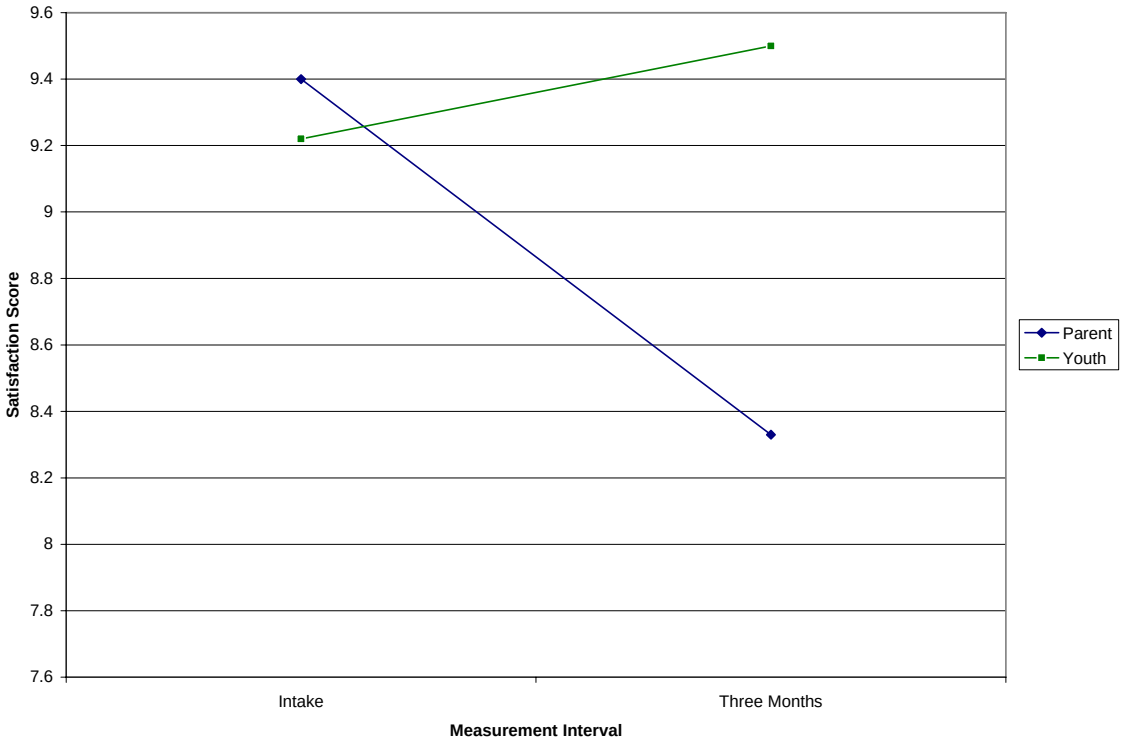


* Higher scores indicative of higher functioning

Table 48. Satisfaction Scores for Fairfield County

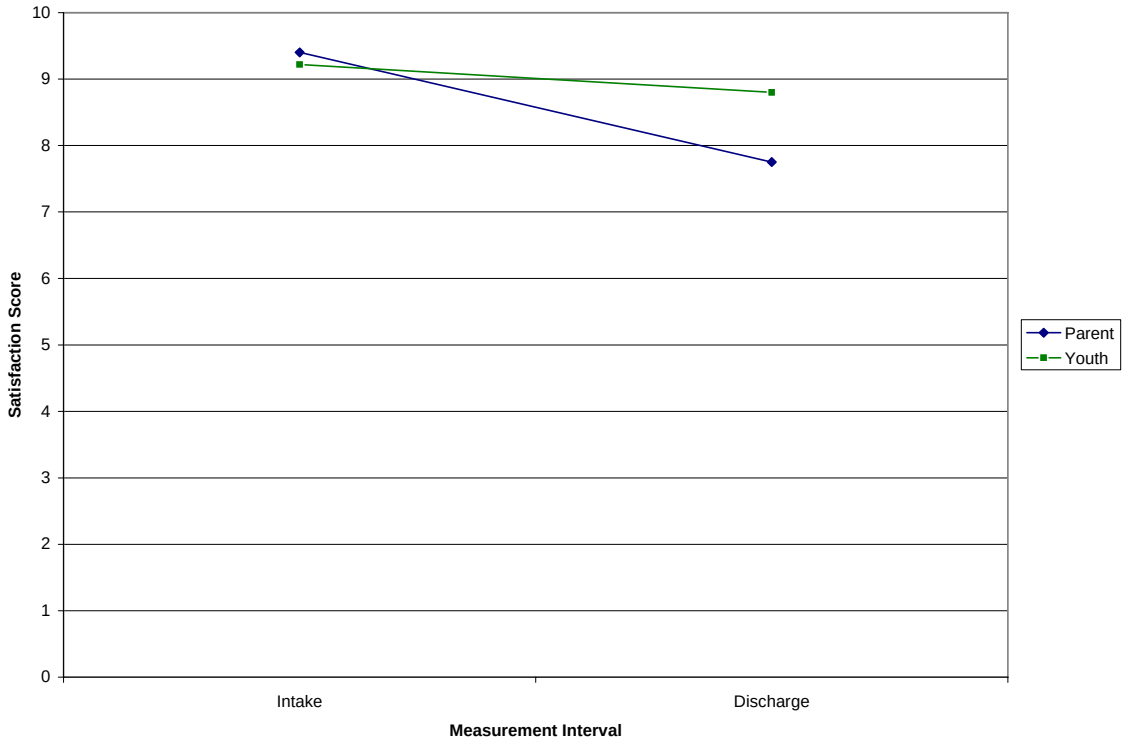
	Parent	Youth
Intake	9.40 (SD = 4.24) (n = 10)	9.22 (SD = 5.11) (n = 9)
Three Months	8.33 (SD = 4.24) (n = 3)	9.50 (SD = 4.35) (n = 4)
Six Months	5.00 (SD = 1.41) (n = 2)	9.00 (SD = NA) (n = 1)
Nine Months	NA	5.00 (SD = NA) (n = 1)
Twelve Months	NA	NA
Discharge	7.75 (SD = 5.56) (n = 4)	8.80 (SD = 3.96) (n = 5)

Chart 29. Satisfaction Scores for Fairfield County



* Lower scores indicate greater satisfaction

Chart 30. Satisfaction Scores from Intake to Discharge for Fairfield County

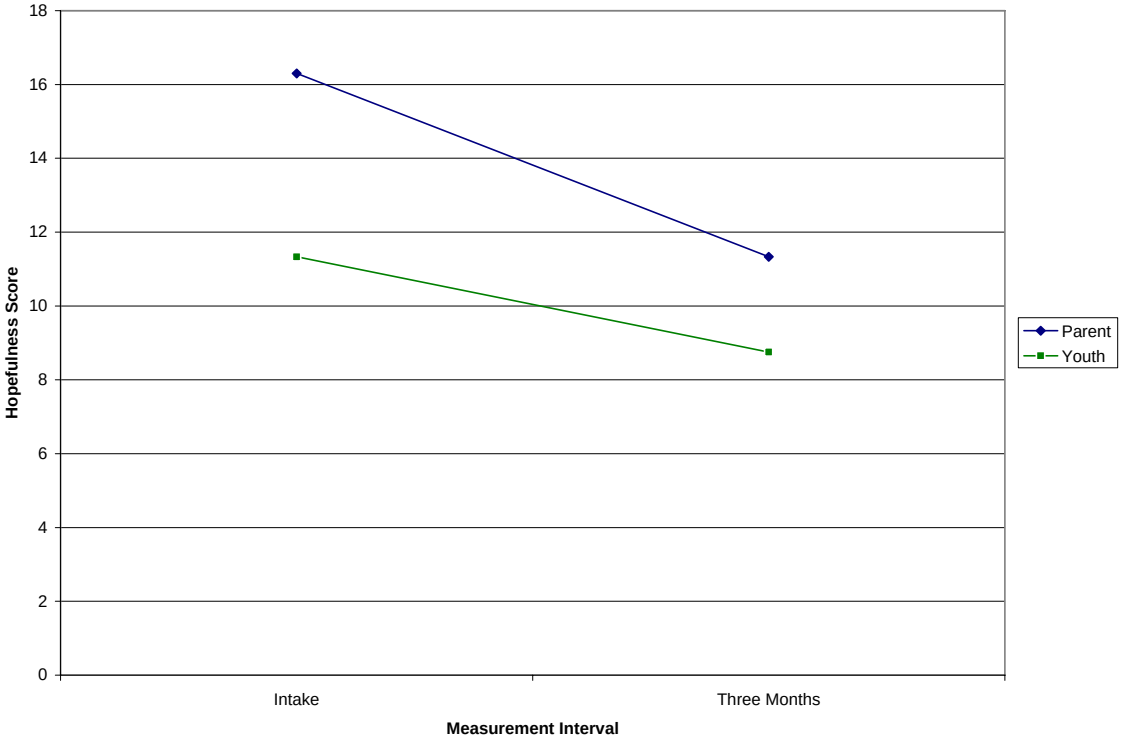


* Lower scores indicate greater satisfaction

Table 49. Hopefulness Scores for Fairfield County

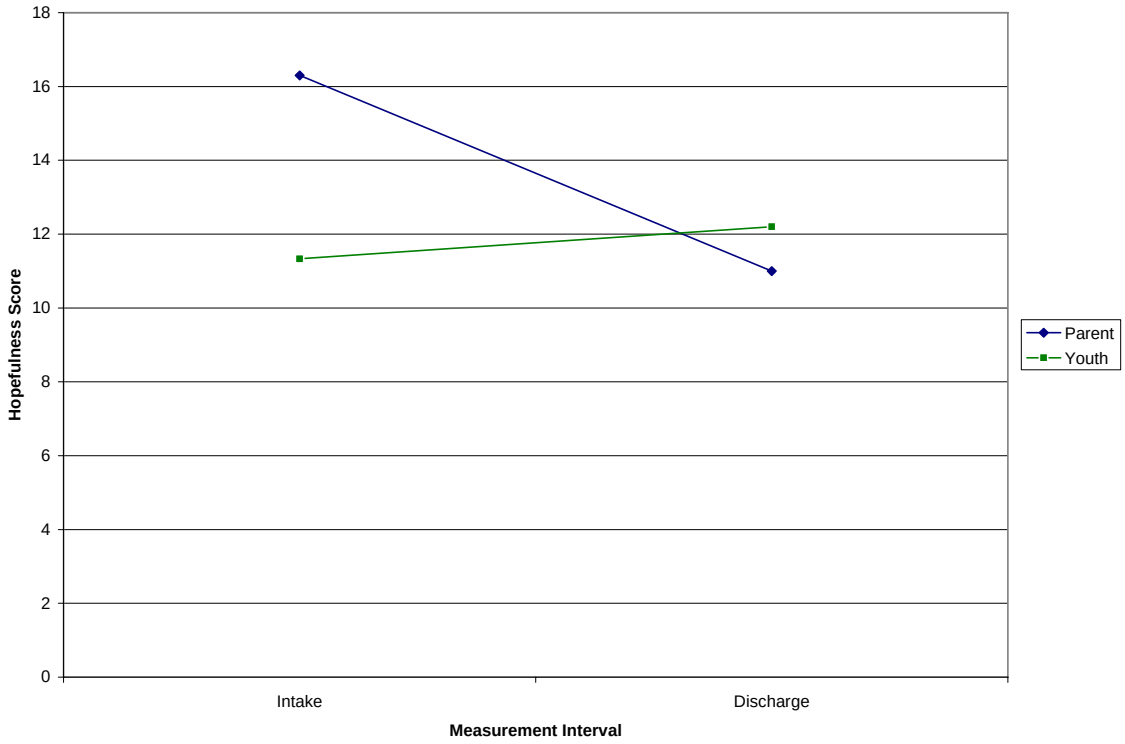
	Parent	Youth
Intake	16.30 (SD = 5.95) (n = 10)	11.33 (SD = 3.16) (n = 9)
Three Months	11.33 (SD = 5.13) (n = 3)	8.75 (SD = 2.36) (n = 4)
Six Months	15.50 (SD = 2.12) (n = 2)	13.00 (SD = NA) (n = 1)
Nine Months	NA	13.00 (SD = NA) (n = 1)
Twelve Months	NA	NA
Discharge	11.00 (SD = 3.26) (n = 4)	12.20 (SD = 2.04) (n = 5)

Chart. 31. Hopefulness Scores for Fairfield County



* Lower scores indicative of greater hopefulness

Chart 32. Hopefulness Scores from Intake to Discharge for Fairfield County



* Lower scores indicative of greater hopefulness

Franklin County

There were 120 youth enrolled in Franklin County (87 males and 33 females) (see Chart 33). The average age of the youth in Franklin County was 15.23 years (SD = 1.37). African Americans and Caucasians made up the majority of the sample (57.5% and 34.2% respectively). Chart 34 displays ethnicity data for Franklin County. The majority of the youth (62.4%) lived with the biological mother only (see Table 50). While the majority of caregivers had a high school diploma or better, 24.2% did not graduate from high school (see Table 51). The average household income for the BHJJ family in Franklin County was between $15000 and $19999 (see Table 52). Detailed family history information can be found in Table 53, but of note, 61.3% of the females were exposed to domestic violence in the past (36.0% of males) and 80.0% of the females and 64.3% of males had a substance abuse problem. The most common reason for treatment for youth in the Franklin County BHJJ program was conduct/delinquency related issues (97.0% for females and 94.2% for males) (see Table 54). One hundred twenty youth in Franklin County accounted for a total of 224 Axis I diagnoses, for an average of 1.86 diagnoses per youth. Tables 55 and 56 display the most common Axis I DSM-IV diagnoses for females and males in Franklin County.

Of the 120 youth enrolled, 14 have been Discharged from the program. Six of the 14 were Discharged successfully (42.6%). Five clients did not return for services, two

withdrew from ongoing services, and one client moved. All other youth continue to receive services through the BHJJ project. At the time of final data collection for the evaluation, the average length of stay in treatment was 245.93 days. Before enrollment, there were 497 Juvenile Court charges, for an average of 4.14 charges per youth. After enrollment, 54 (45.0%) of the youth received new charges (131 new charges).

Chart 33. Gender of BHJJ Youth for Franklin County

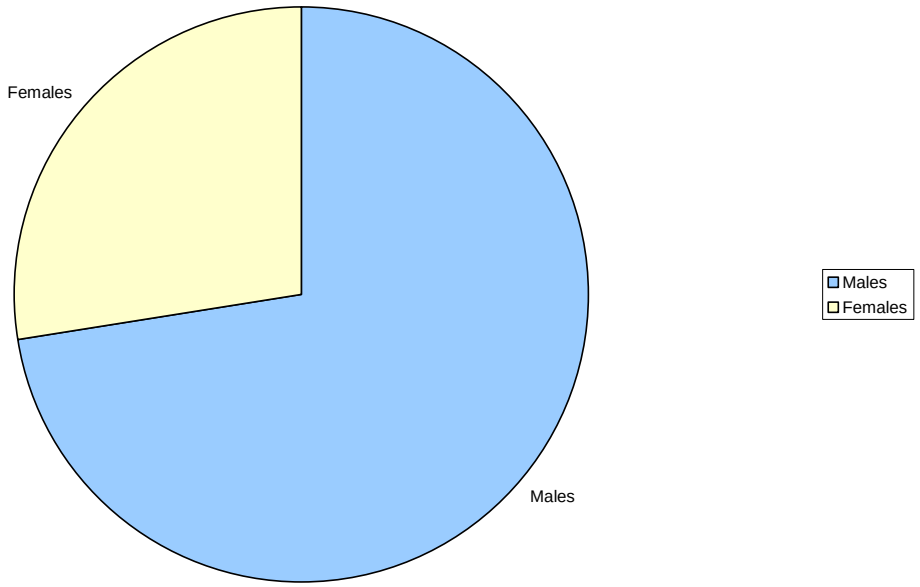


Chart 34. Ethnicity of BHJJ Youth in Franklin County

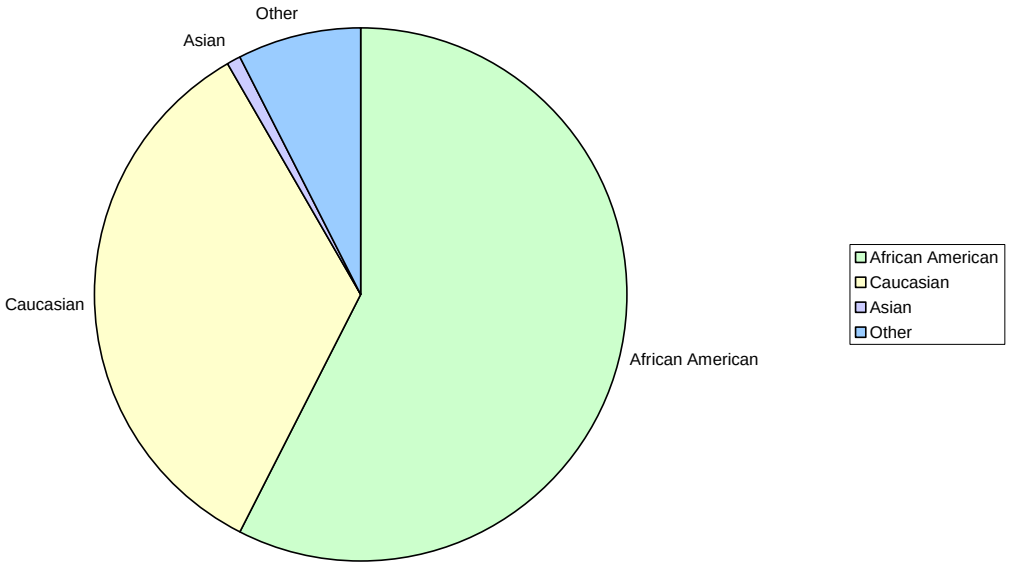


Table 50. Custody Arrangement for BHJJ Youth in Franklin County

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	11.1% (n = 13)
Biological Mother Only	62.4% (n = 73)
Biological Father Only	10.3% (n = 12)
Adoptive Parent(s)	3.4% (n = 4)
Sibling	0.9% (n = 1)
Aunt and/or Uncle	2.6% (n = 3)
Grandparents	5.1% (n = 5)
Ward of the State	9.1% (n = 1)
Other	1.7% (n = 2)

Table 51. Caregiver's Education Level in Franklin County

Number of School Years Completed	Number of Caregivers
7	0.9% (n = 1)
8	3.4% (n = 4)
9	3.4% (n = 4)
10	5.2% (n = 6)
11	12.1% (n = 14)
12	37.9% (n = 44)
13	6.0% (n = 7)
14	25.9% (n = 30)
15	2.6% (n = 3)
16	1.7% (n = 2)
17	0.9% (n = 1)

Table 52. Household Income for BHJJ Families for Franklin County

Household Income	BHJJ Families
Less than $5000	16.5% (n = 19)
$5000 - $9999	11.3% (n = 13)
$10000 - $14999	10.4% (n = 12)
$15000 - $19999	13.0% (n = 15)
$20000 - $24999	18.3% (n = 21)
$25000 - $34999	12.2% (n = 14)
$35000 - $49999	11.3% (n = 13)
$50000 - $74999	4.3% (n = 5)
$75000 - $99999	1.7% (n = 2)
$100000 and over	.09% (n = 1)

Table 53. Family and Youth Results from the Caregiver Information Questionnaire in Franklin County

Question	Females (n = 33)	Males (n = 87)
Has the child ever been physically abused?	25.8% (n = 8)	15.3% (n = 13)
In the last 6 months, has the child been physically abused?	22.2% (n = 2)	3.4% (n = 1)
Has the child ever been sexually abused?	22.6% (n = 7)	2.4% (n = 2)
In the last 6 months, has the child been sexually abused?	0.0% (n = 0)	0.0% (n = 0)
Has the child ever run away?	58.1% (n = 18)	40.0% (n = 34)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	32.2% (n = 10)	50.0% (n = 42)
In the last 6 months, has the child had a problem with substance abuse, including alcohol and/or drugs?	66.7% (n = 8)	64.8% (n = 35)
Has the child ever talked about committing suicide?	48.4% (n = 15)	38.4% (n = 33)
Has the child ever attempted suicide?	19.4% (n = 6)	9.6% (n = 8)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	61.3% (n = 19)	36.0% (n = 31)
In the past six months, has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	19.0% (n = 4)	2.0% (n = 1)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	61.3% (n = 19)	58.3% (n = 49)
Has the child ever lived in a household in which someone has shown signs of being depressed?	58.1% (n = 18)	50.6% (n = 43)
Was the person who showed signs of being depressed involved in providing care and supervision to the child?	83.3% (n = 10)	68.3% (n = 28)
Has anyone in the child's biological family had a mental illness, other than depression?	45.2% (n = 14)	43.5% (n = 37)
Other than depression, has the child ever lived in a household in which someone had a mental illness?	35.5% (n = 11)	22.1% (n = 19)
Has the child ever lived in a household in which someone was convicted of a crime?	58.1% (n = 18)	29.4% (n = 25)
Has anyone in the child's biological family had a drinking or drug problem?	80.0% (n = 24)	64.3% (n = 54)
Has the child ever lived in a household in which someone had a drinking or drug problem?	60.0% (n = 18)	38.8% (n = 33)
Was the person with the drinking or drug problems involved in providing care and supervision to the child?	81.8% (n = 9)	46.7% (n = 14)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	9.7% (n = 3)	21.4% (n = 18)

Table 54. Problems Leading to Services in Franklin County

Problems Leading to Services	Females (n = 33)	Males (n = 87)
Suicide-related problems	12.1% (n = 4)	9.3% (n = 8)
Depression-related problems	42.4% (n = 14)	37.2% (n = 32)
Anxiety-related problems	6.1% (n = 2)	8.1% (n = 7)
Hyperactive and attention-related problems	12.1% (n = 4)	23.3% (n = 20)
Conduct/delinquency-related problems	97.0% (n = 32)	94.2% (n = 81)
Substance use, abuse, dependence-related problems	9.1% (n = 3)	46.5% (n = 40)
Adjustment-related problems	9.1% (n = 3)	3.5% (n = 3)
Psychotic Behaviors	3.0% (n = 1)	2.3% (n = 2)
Pervasive development disabilities	0.0% (n = 0)	0.0% (n = 0)
Specific developmental disabilities	0.0% (n = 0)	1.2% (n = 1)
Learning disabilities	9.1% (n = 3)	18.6% (n = 16)
School performance problems not related to learning disabilities	66.7% (n = 22)	54.7% (n = 47)
Eating disorders	0.0% (n = 0)	0.0% (n = 0)

Table 55. Top Five DSM-IV Axis I Diagnoses for Females for Franklin County

Axis I Diagnosis	Frequency
Oppositional Defiant Disorder	33.3% (n = 11)
Major Depression/Depressive Disorder	21.2% (n = 7)
Disruptive Behavior Disorder	18.2% (n = 6)
Attention Deficit Hyperactivity Disorder	15.2% (n = 5)
Conduct Disorder	15.2% (n = 5)

Table 56. Top Five DSM-IV Axis I Diagnoses for Males for Franklin County

Axis I Diagnosis	Frequency
Conduct Disorder	47.7% (n = 42)
Cannabis Abuse/Dependence	30.7% (n = 27)
Major Depression/Depressive Disorder	22.7% (n = 20)
Attention Deficit Hyperactivity Disorder	23.9% (n = 21)
Oppositional Defiant Disorder	14.8% (n = 13)

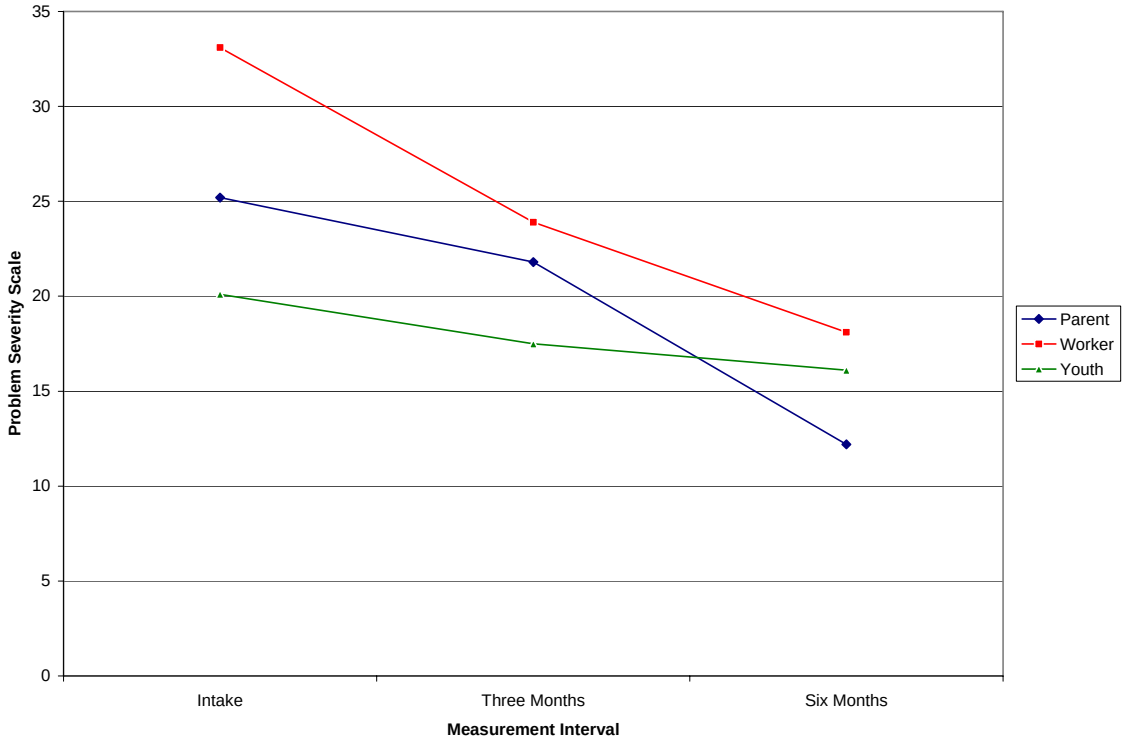
Ohio Scales Analyses

Paired-samples t-tests were conducted on the Ohio Scales data from Franklin County. Because of the low sample size, all comparisons could not be tested. For Youth, no test reached significance. For Workers, significant decreases in Problem Severity were observed from Intake to 3 months: $t(31) = 3.98$, $p < .001$ and Intake to 6 months: $t(8) = 4.13$, $p < .01$. While Workers did report improved functioning at all other times, the tests failed to reach statistical significance, likely due to the low sample size. For Parents, a significant improvement in Functioning was observed from Intake to Discharge: $t(6) = -4.17$, $p < .01$. No other tests reached statistical significance. Means can be found in Tables 57 through 60 and are represented in Charts 35 through 42.

Table 57. Problem Severity Scores for Franklin County

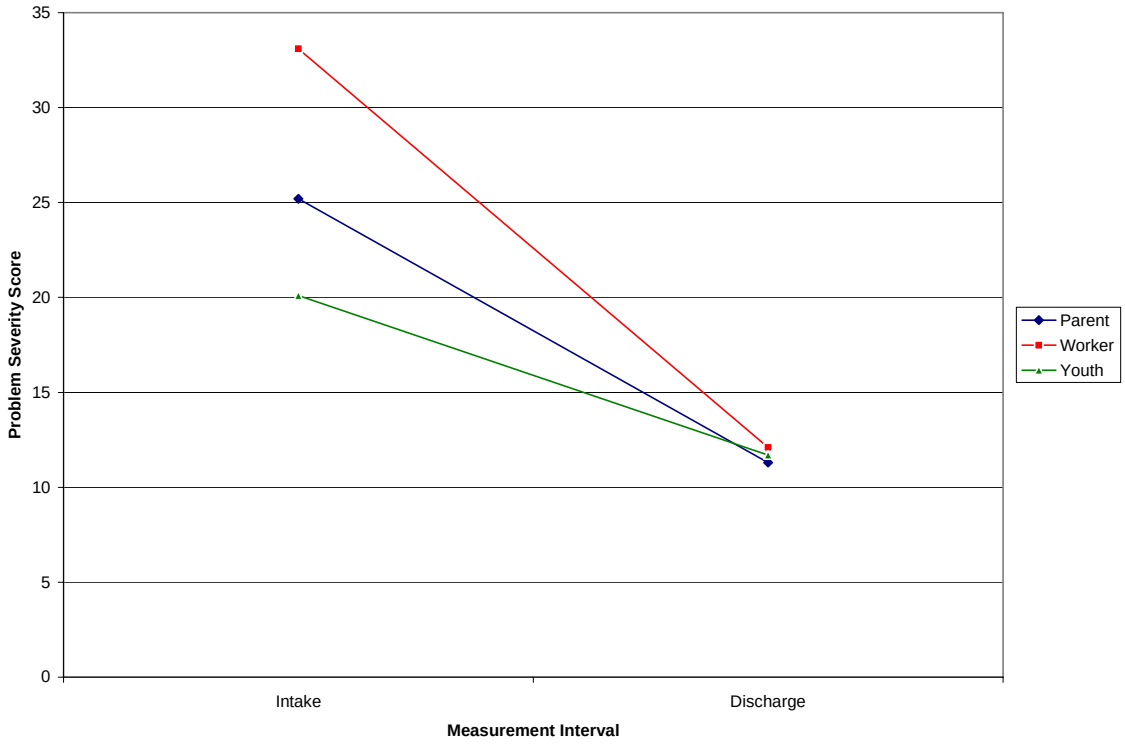
	Parent	**Worker**	**Youth**
Intake	25.19 (SD = 16.44) (n = 116)	33.08 (SD = 13.21) (n = 119)	20.17 (SD = 15.12) (n = 117)
Three Months	21.86 (SD = 14.37) (n = 36)	23.96 (SD = 11.74) (n = 33)	17.53 (SD = 12.64) (n = 39)
Six Months	12.25 (SD = 6.60) (n = 8)	18.11 (SD = 9.99) (n = 9)	16.16 (SD = 11.68) (n = 9)
Nine Months	8.00 (SD = NA) (n = 1)	10.00 (SD = NA) (n = 1)	15.00 (SD = NA) (n = 1)
Twelve Months	NA	NA	NA
Discharge	11.29 (SD = 13/73 (n = 7)	12.16 (SD = 11.89) (n = 6)	11.71 (SD = 5.28) (n = 7)

Chart 35. Problem Severity Scores for Franklin County



* Lower scores indicative of less problem severity

Chart 36. Problem Severity Scores from Intake to Discharge for Franklin County

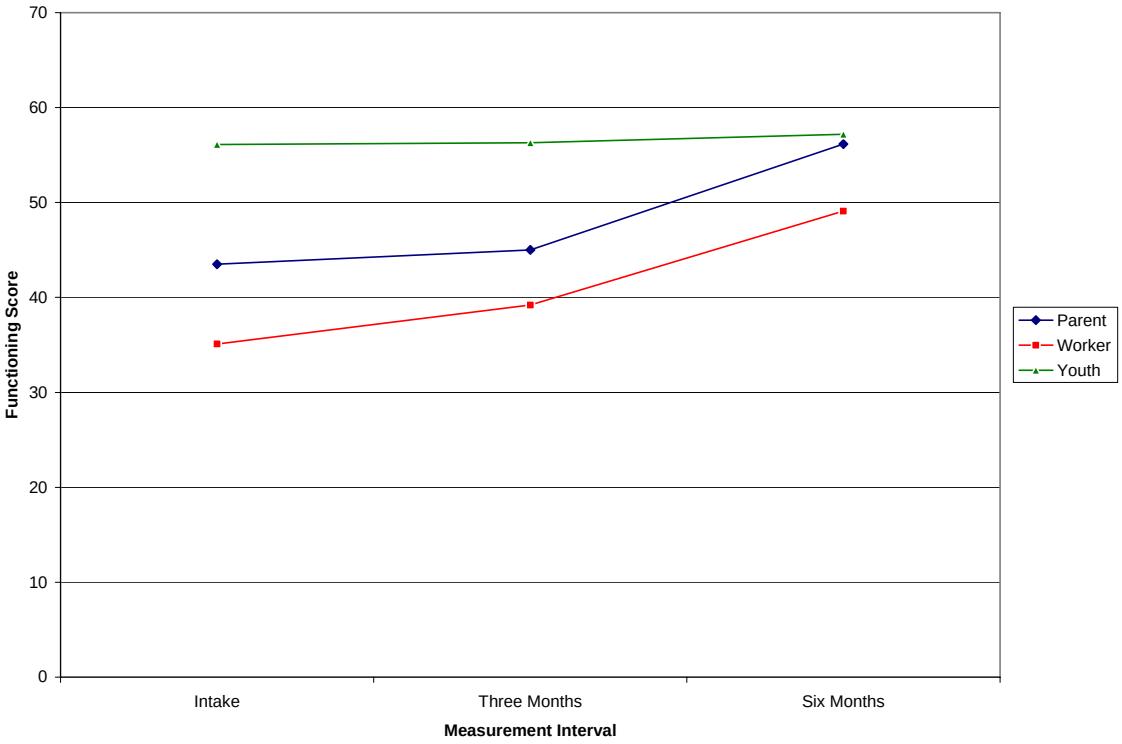


* Lower scores indicative of less problem severity

Table 58. Functioning Scores for Franklin County

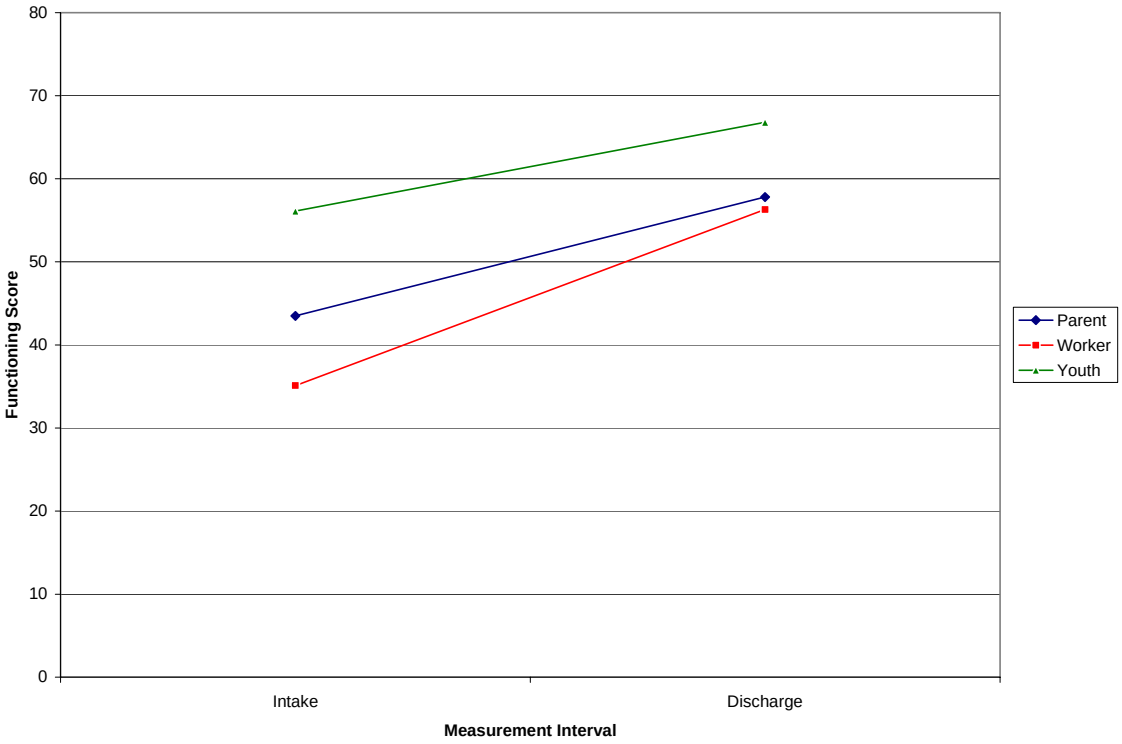
	Parent	Worker	Youth
Intake	43.52 (SD = 16.68) (n = 116)	35.15 (SD = 12.75) (n = 119)	56.16 (SD = 14.07) (n = 118)
Three Months	45.52 (SD = 13.60) (n = 36)	39.24 (SD = 10.82) (n = 33)	56.28 (SD = 12.65) (n = 38)
Six Months	56.14 (SD = 9.41) (n = 7)	49.11 (SD = 9.92) (n = 9)	57.22 (SD = 12.99) (n = 9)
Nine Months	NA	48.00 (SD = NA) (n = 1)	54.00 (SD = NA) (n = 1)
Twelve Months	NA	NA	NA
Discharge	57.85 (SD = 17.39) (n = 7)	56.33 (SD = 16.93) (n = 6)	66.86 (SD = 5.75) (n = 7)

Chart 37. Functioning Scores for Franklin County



* Higher scores indicative of higher functioning

Chart 38. Functioning Scores from Intake to Discharge for Franklin County

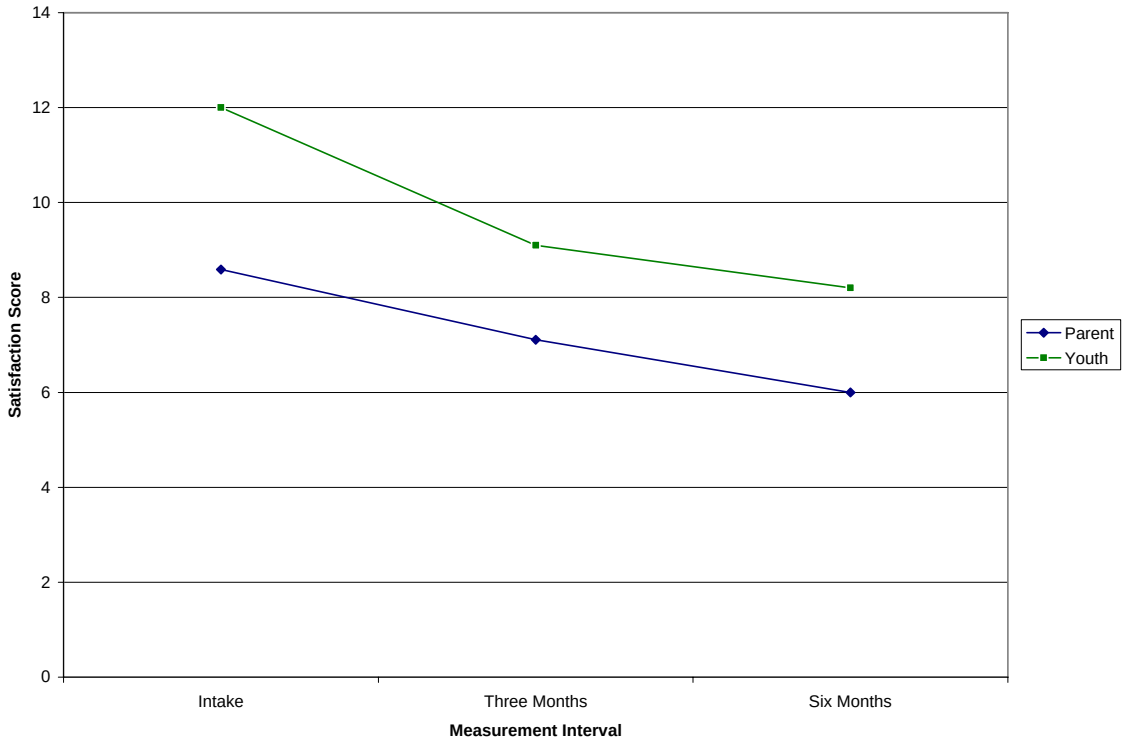


* Higher scores indicative of higher functioning

Table 59. Satisfaction Scores for Franklin County

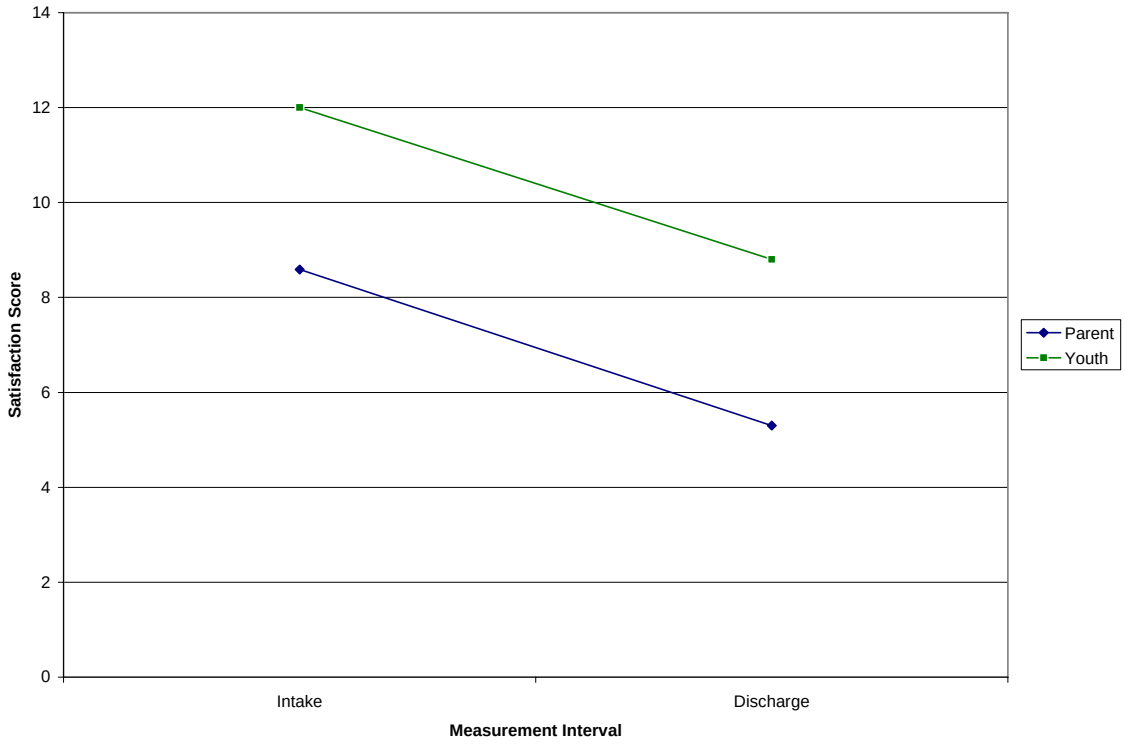
	Parent	Youth
Intake	8.59 (SD = 4.82) (n = 91)	12.01 (SD = 5.37) (n = 84)
Three Months	7.11 (SD = 4.22) (n = 34)	9.09 (SD = 5.08) (n = 31)
Six Months	6.00 (SD = 4.12) (n = 7)	8.22 (SD = 3.56) (n = 9)
Nine Months	NA	11.00 (SD = NA) (n = 1)
Twelve Months	NA	NA
Discharge	5.33 (SD = 3.26) (n = 6)	8.83 (SD = 5.34) (n = 6)

Chart 39. Satisfaction Scores for Franklin County



* Lower scores indicate greater satisfaction

Chart 40. Satisfaction Scores from Intake to Discharge for Franklin County

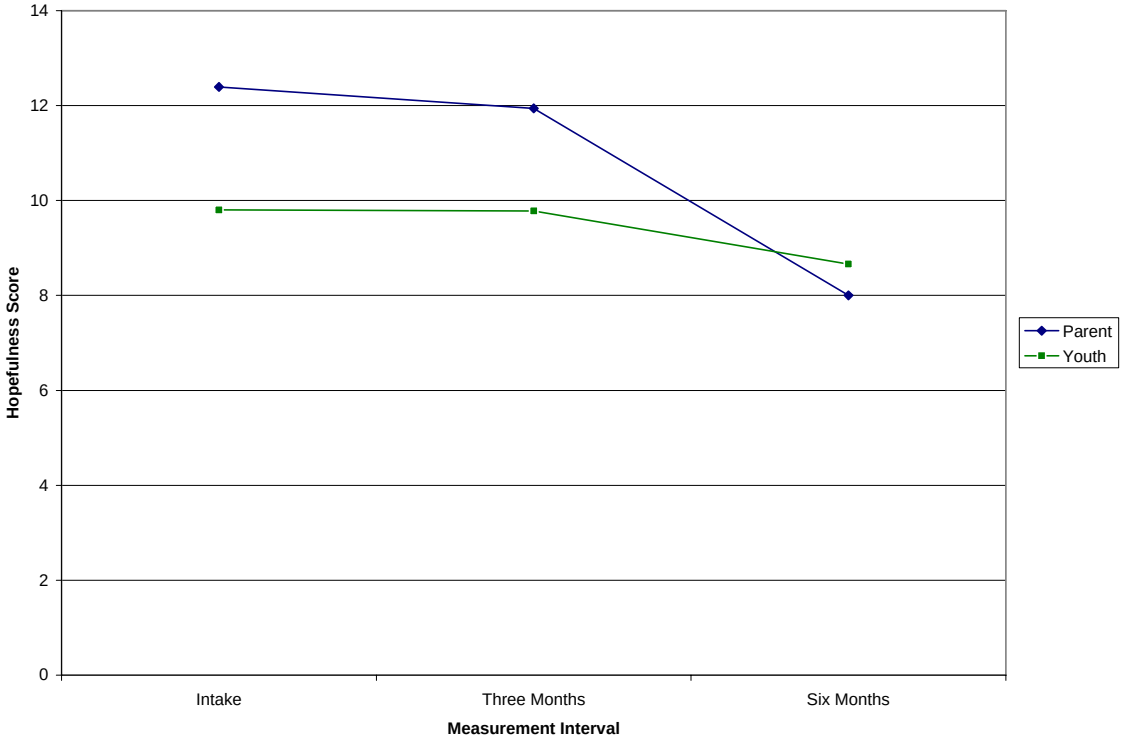


* Lower scores indicate greater satisfaction

Table 60. Hopefulness Scores for Franklin County

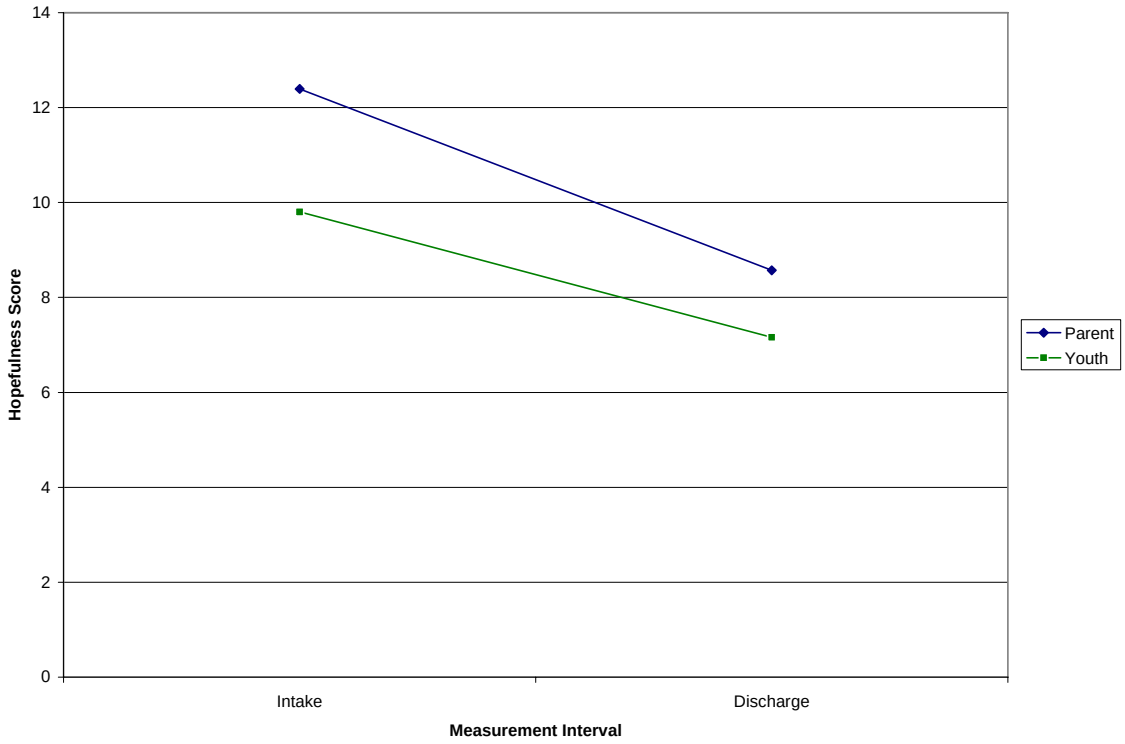
	Parent	Youth
Intake	12.39 (SD = 4.81) (n = 110)	9.82 (SD = 3.92) (n = 106)
Three Months	11.94 (SD = 4.30) (n = 36)	9.78 (SD = 3.69) (n = 37)
Six Months	8.00 (SD = 3.46) (n = 7)	8.66 (SD = 3.27) (n = 9)
Nine Months	11.00 (SD = NA) (n = 1)	13.00 (SD = NA) (n = 1)
Twelve Months	NA	NA
Discharge	8.57 (SD = 6.16) (n = 7)	7.16 (SD = 2.40) (n = 6)

Chart 41. Hopefulness Scores for Franklin County



* Lower scores indicative of greater hopefulness

Chart 42. Hopefulness Scores from Intake to Discharge for Franklin County



* Lower scores indicative of greater hopefulness

Logan County

Logan County enrolled 143 youth into the BHJJ program. Eighty-three (58.0%) were males and 60 (41.9%) were females (see Chart 43). The average age in Logan County was 15.36 years (SD = 1.49). Caucasians made up 93.7% of the sample (93.7%) while African Americans comprised 2.1% of the sample. Chart 44 displays ethnicity data for Logan County. The majority of the youth (47.1%) lived with the biological mother only (see Table 61). While most of the caregivers had a high school diploma or better, 20.8% did not graduate from high school (see Table 62). The average household income for the BHJJ family in Logan County was between $20000 to $24999 (see Table 63). Detailed family history information can be found in Table 64, but of note, 32.1% of females and 6.0% of males were sexually abused in the past and 80.0% of the females and 50.0% of males had a biological family member diagnosed with or show signs of depression. The most common reason for treatment for youth in the Logan County BHJJ program was conduct/delinquency related issues (94.9% for females and 91.6% for males) (see Table 65). One hundred forty-three youth in Logan County accounted for a total of 137 Axis I diagnoses, for an average of .96 diagnoses per youth. Tables 66 and 67 display the most common Axis I DSM-IV diagnoses for females and males in Logan County.

Of the 143 youth enrolled, 36 have been Discharged from the program. Eighteen of the 36 were Discharged successfully (50.0%). Nine youth moved out of county, three rejected services, two were re-evaluated and found to be inappropriate for BHJJ, one youth aged out of the program, one was placed in JDC without receiving services, and two others were unsuccessful without explanation. All other youth continue to receive services through the BHJJ project. At the time of final data collection for the evaluation, the average length of stay in treatment was 206.02 days. Before enrollment, there were 317 Juvenile Court charges, for an average of 2.21 charges per youth. After enrollment, 23 (16.1%) of the youth received 35 new charges.

Chart 43. Gender of BHJJ Youth for Logan County

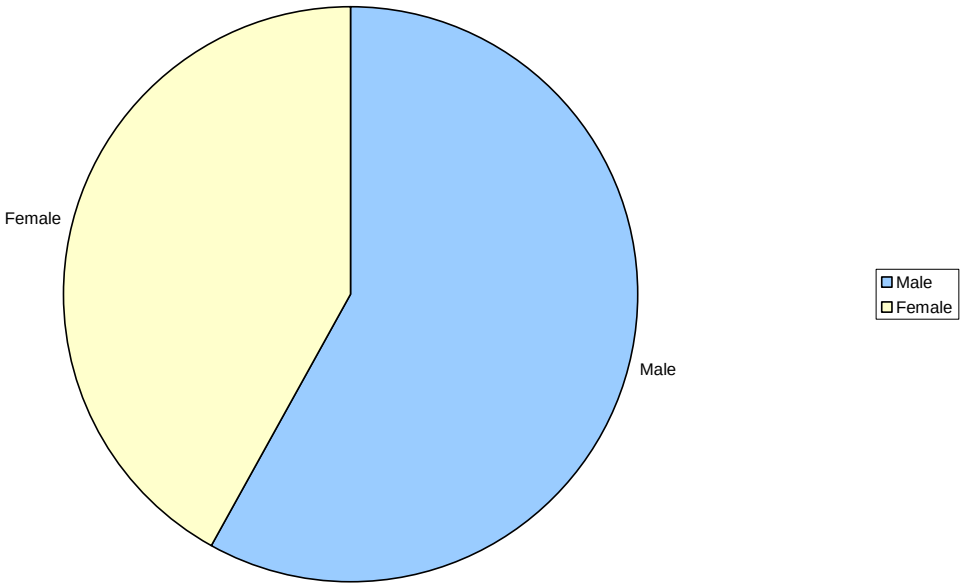


Chart 44. Ethnicity of BHJJ Youth for Logan County

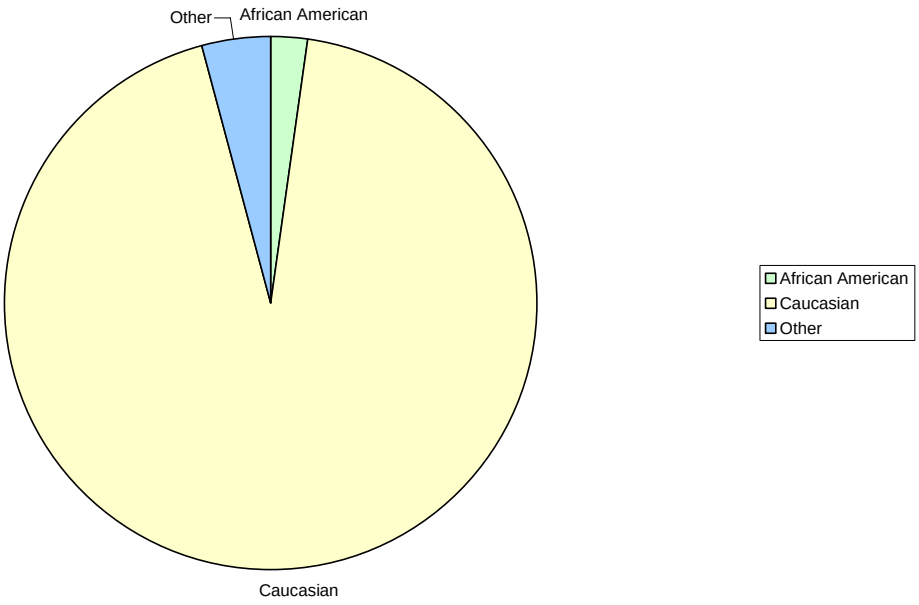


Table 61. Custody Arrangement for BHJJ Youth in Logan County

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	23.6% (n = 33)
Biological Mother Only	47.1% (n = 66)
Biological Father Only	12.9% (n = 18)
Adoptive Parent(s)	2.9% (n = 4)
Aunt and/or Uncle	2.9% (n = 4)
Grandparents	8.6% (n = 12)
Friend	2.1% (n = 3)

Table 62. Caregiver's Education Level in Logan County

Number of School Years Completed	Number of Caregivers
8	2.9% (n = 4)
9	5.0% (n = 7)
10	8.6% (n = 12)
11	4.3% (n = 6)
12	50.4% (n = 70)
13	7.9% (n = 11)
14	17.3% (n = 24)
15	1.4% (n = 2)
16	0.7% (n = 1)
18	0.7% (n = 1)

Table 63. Household Income for BHJJ Families in Logan County

Household Income	BHJJ Families
Less than $5000	9.8% (n = 12)
$5000 - $9999	13.9% (n = 17)
$10000 - $14999	9.8% (n = 12)
$15000 - $19999	10.7% (n = 13)
$20000 - $24999	9.8% (n = 12)
$25000 - $34999	10.7% (n = 13)
$35000 - $49999	18.9% (n = 23)
$50000 - $74999	8.2% (n = 10)
$75000 - $99999	3.3% (n = 4)
$100000 and over	4.9% (n = 6)

Table 64. Family and Youth Results from the Caregiver Information Questionnaire in Logan County

Question	Females (n = 60)	Males (n = 83)
Has the child ever been physically abused?	22.8% (n = 13)	15.7% (n = 13)
In the last 6 months, has the child been physically abused?	11.8% (n = 2)	5.9% (n = 1)
Has the child ever been sexually abused?	32.1% (n = 18)	6.0% (n = 5)
In the last 6 months, has the child been sexually abused?	18.2% (n = 4)	12.5% (n = 1)
Has the child ever run away?	28.1% (n = 16)	20.7% (n = 17)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	21.4% (n = 12)	34.2% (n = 27)
In the last 6 months, has the child had a problem with substance abuse, including alcohol and/or drugs?	62.5% (n = 10)	56.7% (n = 17)
Has the child ever talked about committing suicide?	50.9% (n = 29)	33.7% (n = 28)
Has the child ever attempted suicide?	21.1% (n = 12)	7.2% (n = 6)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	49.1% (n = 28)	44.6% (n = 37)
In the past six months, has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	18.8% (n = 6)	4.3% (n = 2)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	80.0% (n = 44)	50.0% (n = 40)
Has the child ever lived in a household in which someone has shown signs of being depressed?	73.7% (n = 42)	49.4% (n = 40)
Was the person who showed signs of being depressed involved in providing care and supervision to the child?	88.2% (n = 30)	73.0% (n = 27)
Has anyone in the child's biological family had a mental illness, other than depression?	44.6% (n = 25)	22.2% (n = 18)
Other than depression, has the child ever lived in a household in which someone had a mental illness?	39.3% (n = 22)	25.0% (n = 20)
Has the child ever lived in a household in which someone was convicted of a crime?	51.8% (n = 29)	44.6% (n = 37)
Has anyone in the child's biological family had a drinking or drug problem?	63.2% (n = 36)	54.9% (n = 45)
Has the child ever lived in a household in which someone had a drinking or drug problem?	65.5% (n = 36)	51.9% (n = 41)
Was the person with the drinking or drug problems involved in providing care and supervision to the child?	65.4% (n = 17)	67.7% (n = 21)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	29.8% (n = 17)	22.9% (n = 19)

Table 65. Problems Leading to Services in Logan County

Problems Leading to Services	Females (n = 60)	Males (n = 83)
Suicide-related problems	0.0% (n = 0)	3.6% (n = 3)
Depression-related problems	5.1% (n = 3)	2.4% (n = 2)
Anxiety-related problems	0.0% (n = 0)	0.0% (n = 0)
Hyperactive and attention-related problems	0.0% (n = 0)	0.0% (n = 0)
Conduct/delinquency-related problems	94.9% (n = 56)	91.6% (n = 76)
Substance use, abuse, dependence-related problems	18.6% (n = 11)	24.1% (n = 20)
Adjustment-related problems	0.0% (n = 0)	1.2% (n = 1)
Psychotic Behaviors	0.0% (n = 0)	0.0% (n = 0)
Pervasive development disabilities	0.0% (n = 0)	0.0% (n = 0)
Specific developmental disabilities	0.0% (n = 0)	0.0% (n = 0)
Learning disabilities	0.0% (n = 0)	0.0% (n = 0)
School performance problems not related to learning disabilities	5.1% (n = 3)	2.4% (n = 2)
Eating disorders	0.0% (n = 0)	0.0% (n = 0)

Table 66. Top Five DSM-IV Axis I Diagnoses for Females for Logan County

Axis I Diagnosis	Frequency
Adjustment Disorder	36.7% (n = 22)
Oppositional Defiant Disorder	11.7% (n = 7)
Attention Deficit Hyperactivity Disorder	10.0% (n = 6)
Major Depression/Depressive Disorder	10.0% (n = 6)
Alcohol Abuse/Dependence	8.3% (n = 5)

Table 67. Top Five DSM-IV Axis I Diagnoses for Males for Logan County

Axis I Diagnosis	Frequency
Cannabis Abuse/Dependence	19.3% (n = 16)
Attention Deficit Hyperactivity Disorder	16.9% (n = 14)
Adjustment Disorder	15.7% (n = 13)
Alcohol Abuse/Dependence	12.0% (n = 10)
Oppositional Defiant Disorder	10.8% (n = 9)

Ohio Scales Analyses

Paired-samples t-tests were conducted on the Ohio Scales data from Logan County. Means can be found in Tables 68 through 71 and are represented in Charts 45 through 52. Parents reported significant decreases in Problem Severity for Intake to 3 months: $t(101) = 5.41$, $p < .001$, Intake to 6 months: $t(55) = 4.13$, $p < .001$, Intake to 9

months: $t(26) = 3.88$, $p = .001$, and Intake to Discharge: $t(16) = 3.20$, $p = .006$. Similar improvements in Functioning were observed from Intake to 3 months: $t(104) = -4.62$, $p < .001$, Intake to 6 months: $t(58) = -2.86$, $p = .006$, Intake to 9 months: $t(27) = -4.16$, $p < .001$, and Intake to 45 through Discharge: $t(17) = -3.56$, $p = .002$. Parental increases in Satisfaction were seen from Intake to 3 months: $t(104) = 3.43$, $p = .001$, Intake to 6 months: $t(58) = 2.21$, $p = .031$, Intake to 9 months: $t(28) = 3.82$, $p = .001$, and Intake to Discharge: $t(18) = 4.41$, $p < .001$. No significant improvements in Hopefulness were reported by Parents.

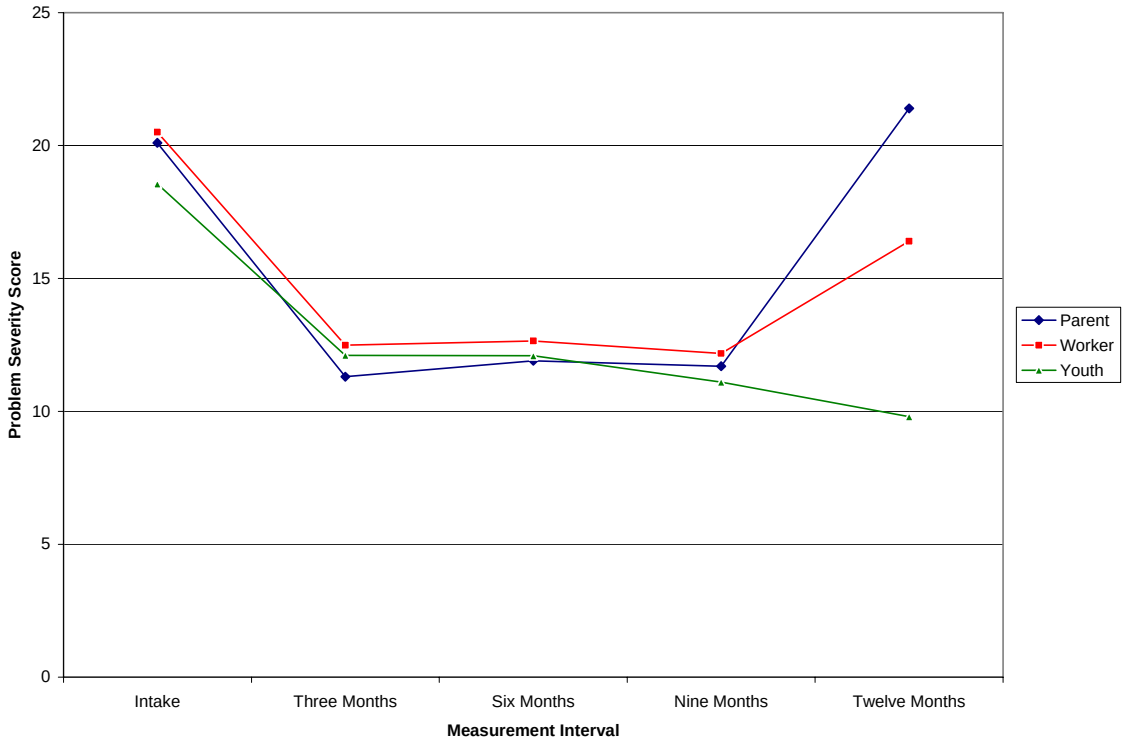
For Workers, statistically significant improvements on Problem Severity were reported for all measurement intervals: Intake to 3 months: $t(98) = 7.99$, $p < .001$, Intake to 6 months: $t(55) = 5.63$, $p < .001$, Intake to 9 months: $t(26) = 6.02$, $p < .001$, and Intake to Discharge: $t(15) = 5.08$, $p < .001$. Similar improvements were reported by Workers for Functioning across all measurement intervals: Intake to 3 months: $t(98) = -6.79$, $p < .001$, Intake to 6 months: $t(55) = -6.69$, $p < .001$, Intake to 9 months: $t(27) = -6.90$, $p < .001$, and Intake to Discharge: $t(16) = -2.77$, $p = .014$.

Youth reported significantly less Problem Severity from Intake to 3 months: $t(106) = 5.72$, $p < .001$, Intake to 6 months: $t(62) = 4.06$, $p < .001$, Intake to 9 months: $t(30) = 5.53$, $p < .001$, and Intake to Discharge: $t(20) = 3.95$, $p = .001$. Youth also reported significantly better Functioning from Intake to 3 months: $t(106) = -4.60$, $p < .001$, Intake to 6 months: $t(62) = -4.12$, $p < .001$, Intake to 9 months: $t(31) = -4.21$, $p < .001$, and Intake to Discharge: $t(20) = -2.68$, $p = .015$. Youth reported significantly more Satisfaction from Intake to 6 months: $t(39) = 2.83$, $p = .007$, Intake to 9 months: $t(18) = 2.63$, $p = .017$, and Intake to Discharge: $t(12) = 4.14$, $p = .001$. Finally, Youth reported significantly more Hopefulness from Intake to 3 months: $t(105) = 2.92$, $p = .004$ and Intake to 9 months; $t(31) = 2.51$, $p = .017$.

Table 68. Problem Severity Scores for Logan County

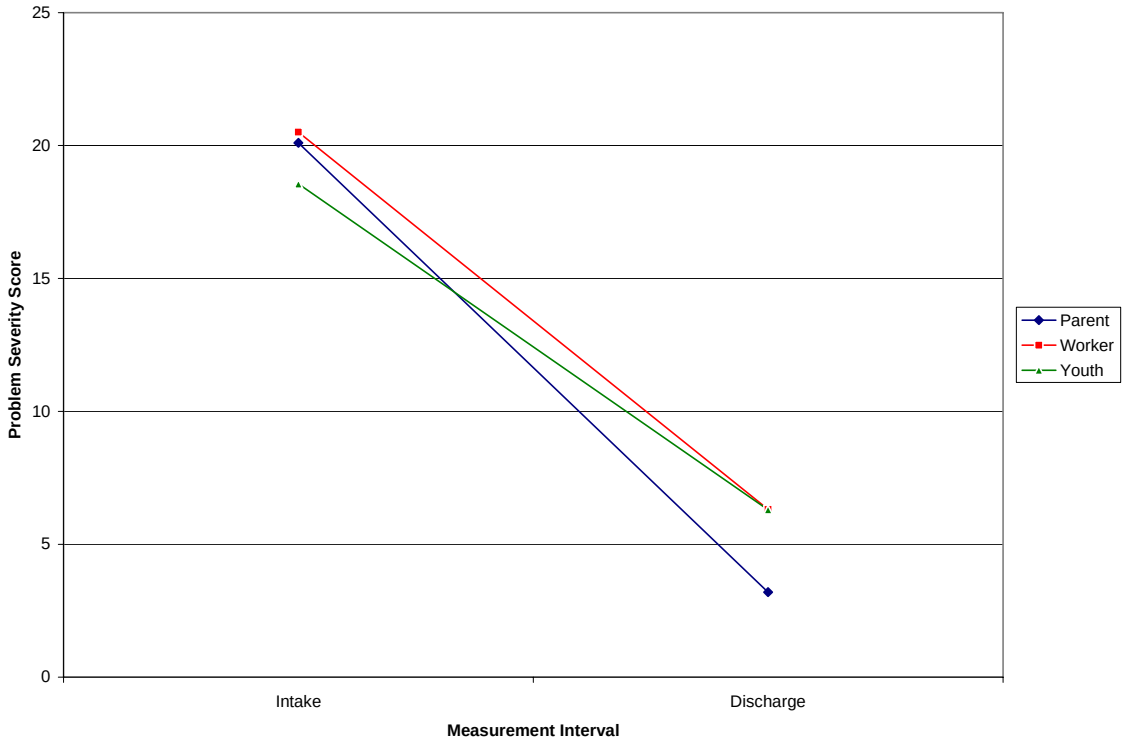
	Parent	**Worker**	**Youth**
Intake	20.14 (SD = 15.69) (n = 135)	20.54 (SD = 11.67) (n = 133)	18.56 (SD = 13.47) (n = 142)
Three Months	11.35 (SD = 9.97) (n = 105)	12.49 (SD = 7.99) (n = 107)	12.11 (SD = 10.74) (n = 107)
Six Months	11.90 (SD = 11.16) (n = 59)	12.65 (SD = 8.48) (n = 63)	12.09 (SD = 10.74) (n = 63)
Nine Months	11.79 (SD = 9.31) (n = 29)	12.18 (SD = 7.51) (n = 32)	11.10 (SD = 7.76)
Twelve Months	21.40 (SD = 20.91) (n = 5)	16.40 (SD = 14.05) (n = 5)	9.80 (SD = 9.28) (n = 5)
Discharge	3.32 (SD = 3.00) (n = 17)	6.31 (SD = 6.18) (n = 19)	6.33 (SD = 7.39) (n = 21)

Chart 45. Problem Severity Scores for Logan County



* Lower scores indicative of less problem severity

Chart 46. Problem Severity Scores from Intake to Discharge for Logan County

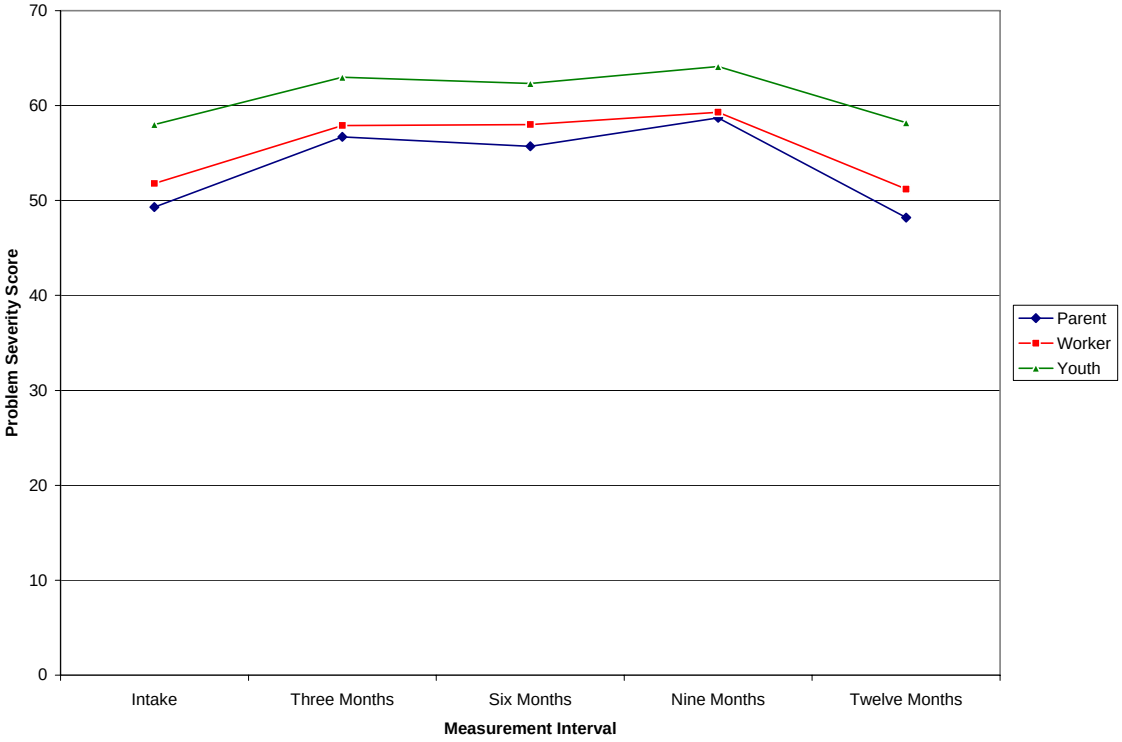


* Lower scores indicative of less problem severity

Table 69. Functioning Scores for Logan County

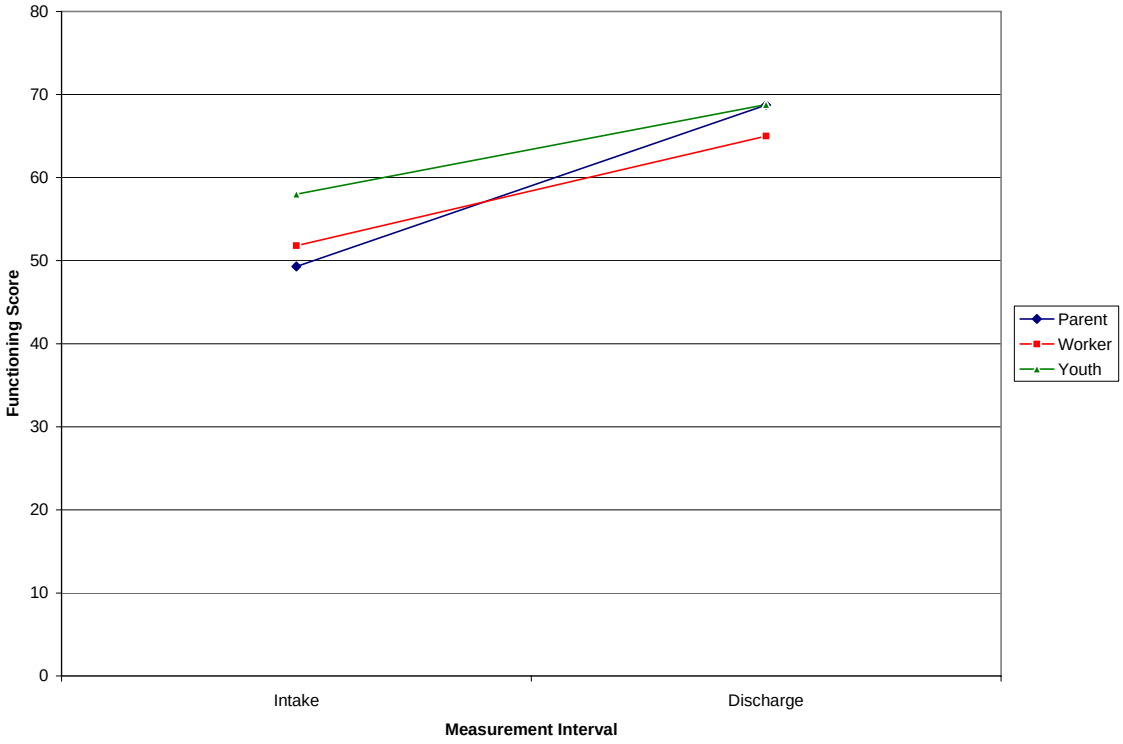
	Parent	Worker	Youth
Intake	49.36 (SD = 16.54) (n = 139)	51.84 (SD = 11.21) (n = 133)	58.05 (SD = 12.16) (n = 142)
Three Months	56.74 (SD = 15.04) (n = 106)	57.94 (SD = 10.14) (n = 107)	62.99 (SD = 12.16) (n = 107)
Six Months	55.75 (SD = 16.20) (n = 60)	58.03 (SD = 9.62) (n = 9.62)	62.33 (SD = 10.33) (n = 63)
Nine Months	58.72 (SD = 13.02) (n = 29)	59.53 (SD = 9.69) (n = 32)	64.10 (SD = 12.06) (n = 32)
Twelve Months	48.20 (SD = 26.90) (n = 5)	51.20 (SD = 17.86) (n = 5)	58.20 (SD = 15.89) (n = 5)
Discharge	68.72 (SD = 8.34) (n = 18)	65.00 (SD = 8.87) (n = 20)	68.80 (SD = 11.02) (n = 21)

Chart 47. Functioning Scores for Logan County



* Higher scores indicative of higher functioning

Chart 48. Functioning Scores from Intake to Discharge for Logan County

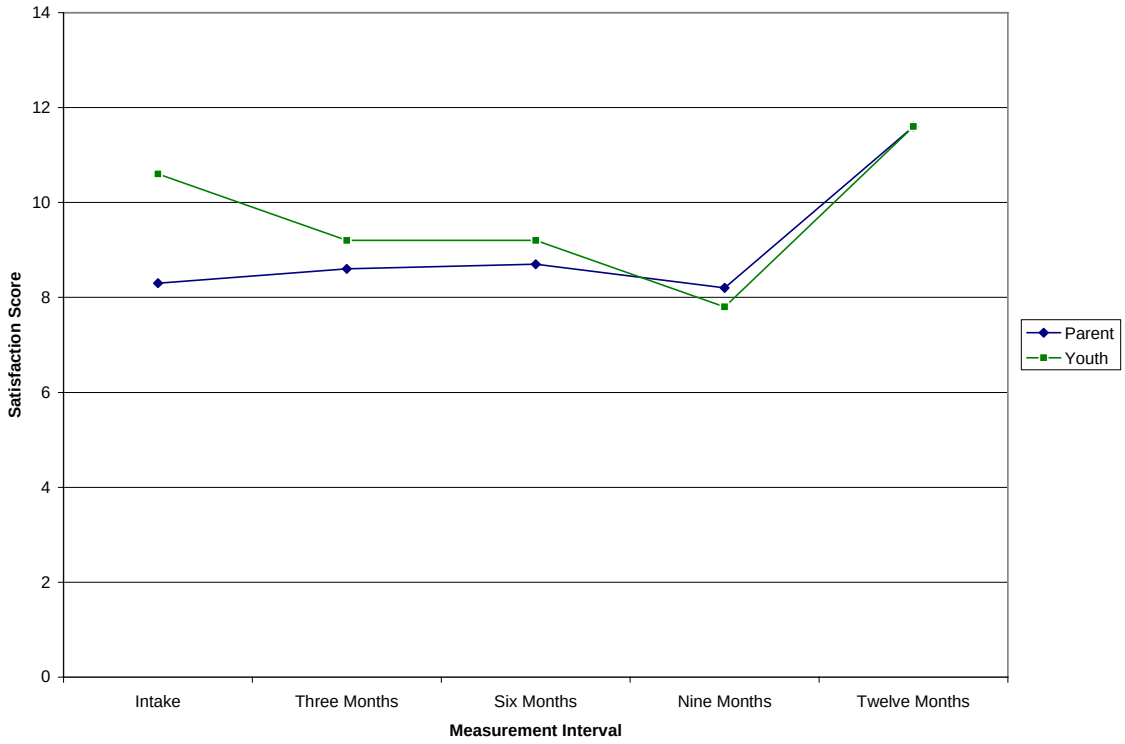


* Higher scores indicative of higher functioning

Table 70. Satisfaction Scores for Logan County

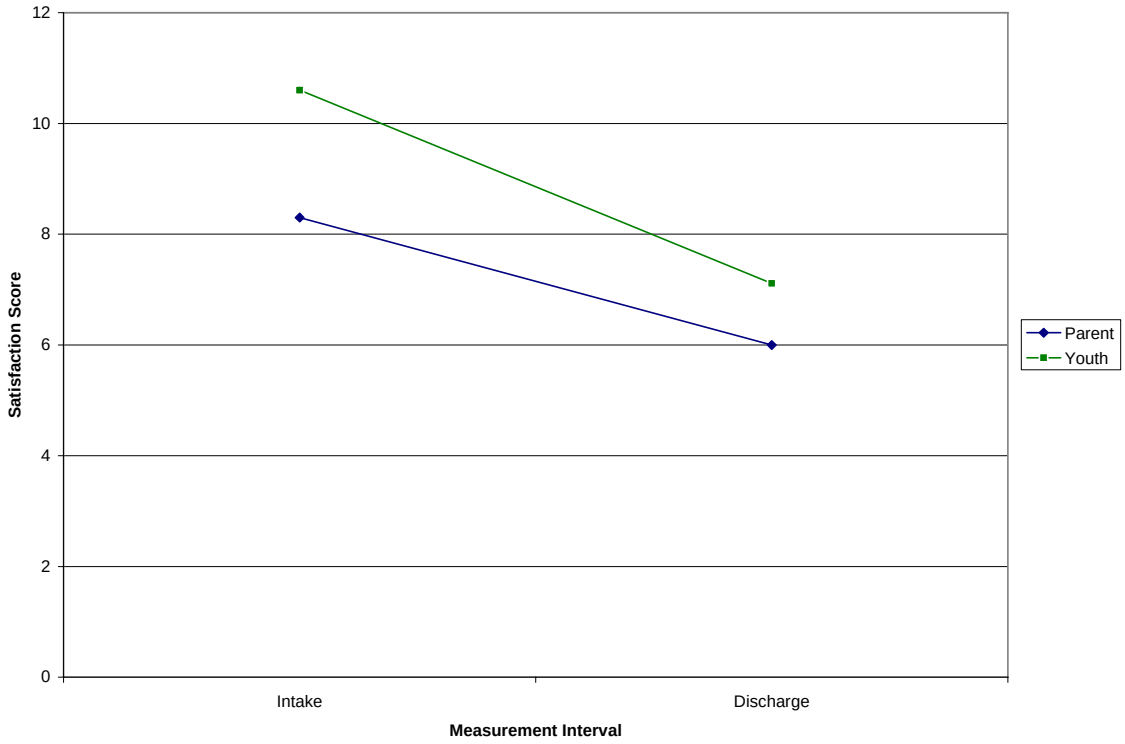
	Parent	Youth
Intake	8.33 (SD = 4.76) (n = 98)	10.65 (SD = 4.73) (n = 90)
Three Months	8.63 (SD = 4.92) (n = 99)	9.24 (SD = 5.13) (n = 97)
Six Months	8.68 (SD = 5.20) (n = 57)	9.25 (SD = 4.76) (n = 59)
Nine Months	8.23 (SD = 4.27) (n = 26)	7.86 (SD = 3.91) (n = 23)
Twelve Months	11.60 (SD = 8.20) (n = 5)	11.60 (SD = 5.89) (n = 5)
Discharge	6.00 (SD = 3.76) (n = 13)	7.11 (SD = 3.42) (n = 18)

Chart 49. Satisfaction Scores for Logan County Across All Measurement Intervals



* Lower scores indicate greater satisfaction

Table 50. Satisfaction Scores from Intake to Discharge for Logan County

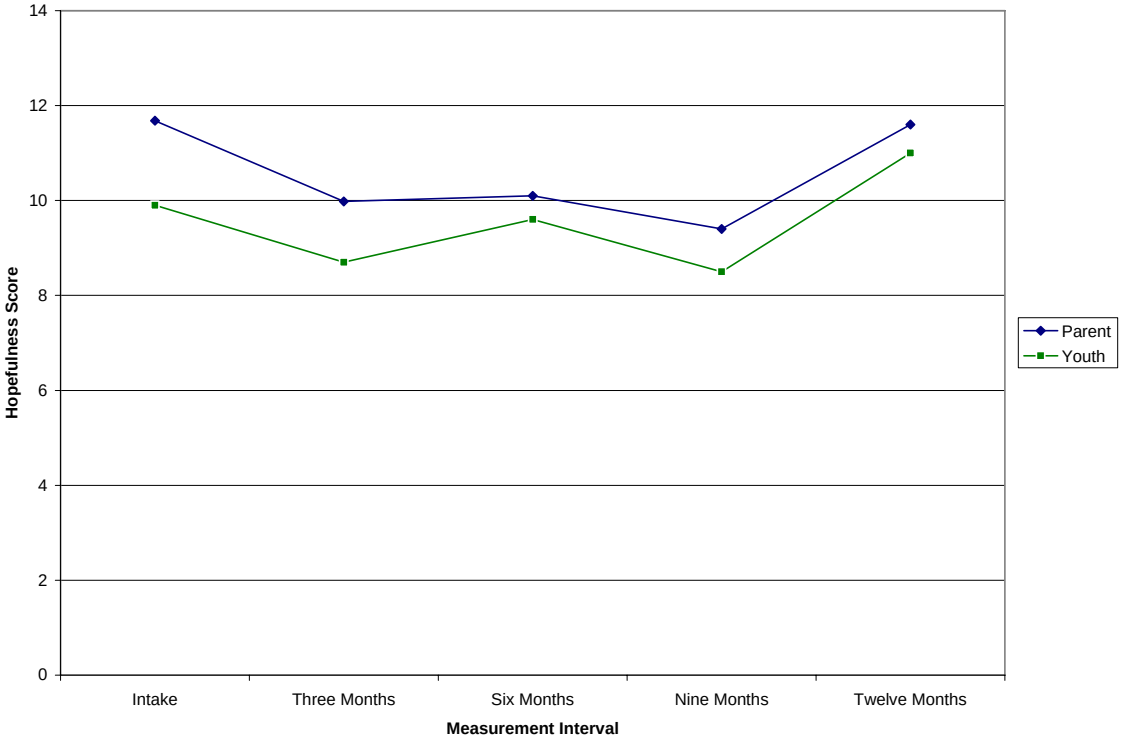


* Lower scores indicate greater satisfaction

Table 71. Hopefulness Scores for Logan County

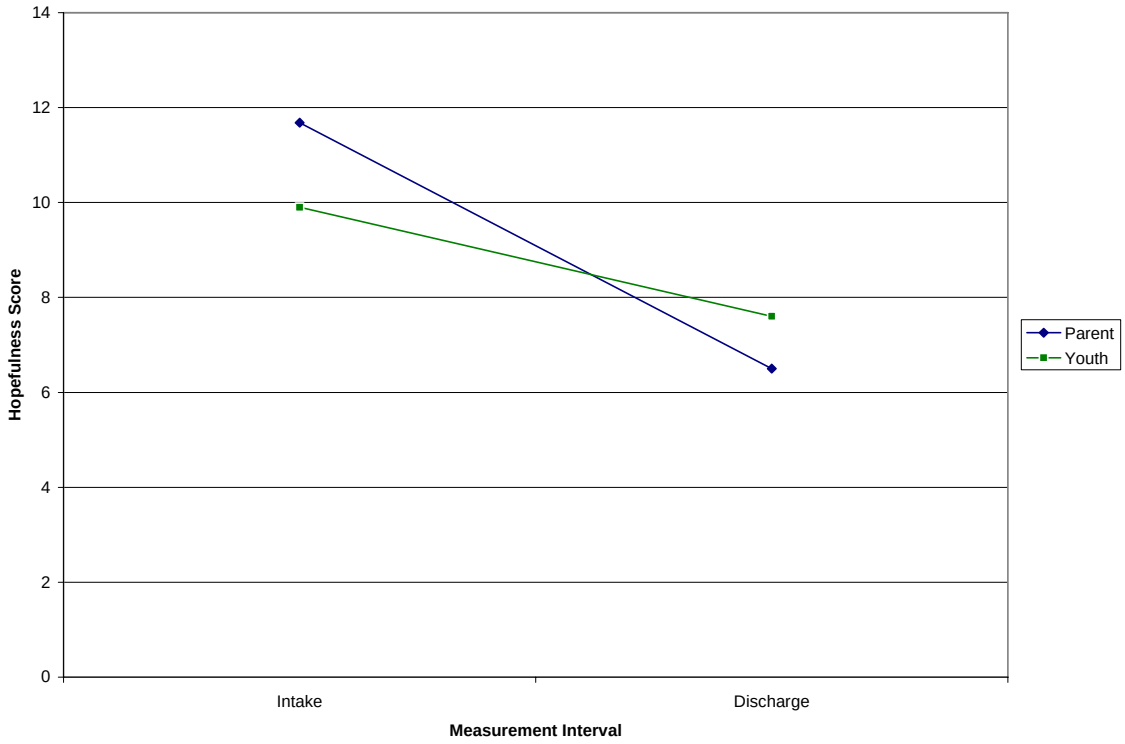
	Parent	Youth
Intake	11.68 (SD = 4.58) (n = 138)	9.96 (SD = 3.91) (n = 141)
Three Months	9.98 (SD = 3.69) (n = 107)	8.73 (SD = 3.44) (n = 107)
Six Months	10.11 (SD = 4.34) (n = 60)	9.69 (SD = 3.79) (n = 63)
Nine Months	9.44 (SD = 3.54) (n = 29)	8.59 (SD = 32) (n = 32)
Twelve Months	11.60 (SD = 4.82) (n = 5)	11.00 (SD = 4.06) (n = 5)
Discharge	6.52 (SD = 1.71) (n = 19)	7.76 (SD = 3.63) (n = 21)

Chart 51. Hopefulness Scores for Logan County



* Lower scores indicative of greater hopefulness

Chart 52. Hopefulness Scores from Intake to Discharge for Logan County



* Lower scores indicative of greater hopefulness

Champaign County

Champaign County enrolled 55 youth into the BHJJ program. Thirty-eight of the youth were males (69.1%) and 17 youth were female (30.9%) (see Chart 53). The average age of the Champaign County BHJJ sample was 15.13 years (SD = 1.39). Caucasians and African Americans made up the majority of the sample (78.2% and 9.1% respectively). Chart 54 displays ethnicity data for Champaign County. The majority of the youth (49.0%) lived with the biological mother only (see Table 72). While the majority of caregivers had a high school diploma or better, 19.5% did not graduate from high school (see Table 73). The average household income for the BHJJ family in Champaign County was between $20000 to $24999 (see Table 74). Detailed family history information can be found in Table 75, but of note, 40.0% of females and 11.1% of males were sexually abused in the past and 66.7% of the females and 51.4% of males had been exposed to domestic violence. The most common reason for treatment for youth in the Champaign County BHJJ program was conduct/delinquency related issues (66.7% for females and 64.9% for males) (see Table 76). Fifty-five youth in Champaign County accounted for a total of 102 Axis I diagnoses, for an average of 1.85 diagnoses per youth. Tables 77 and 78 display the most common Axis I DSM-IV diagnoses for females and males in Champaign County.

Of the 55 youth enrolled, 33 have been Discharged from the program. Eleven of the 33 were Discharged successfully (33.3%). Six clients rejected services, four moved,

three were placed out of home, two were withdrawn from the program, one youth aged out of the program, one could not get in to see a counselor, and one youth was placed in the custody of a relative. Seven youth were discharged with no specific reason. All other youth continue to receive services through the BHJJ project. At the time of final data collection for the evaluation, the average length of stay in treatment was 215.98 days. Before enrollment, there were 206 Juvenile Court charges, for an average of 3.74 charges per youth. After enrollment, 10 (18.1%) of the youth received 15 new charges.

Chart 53. Gender for BHJJ Youth in Champaign County

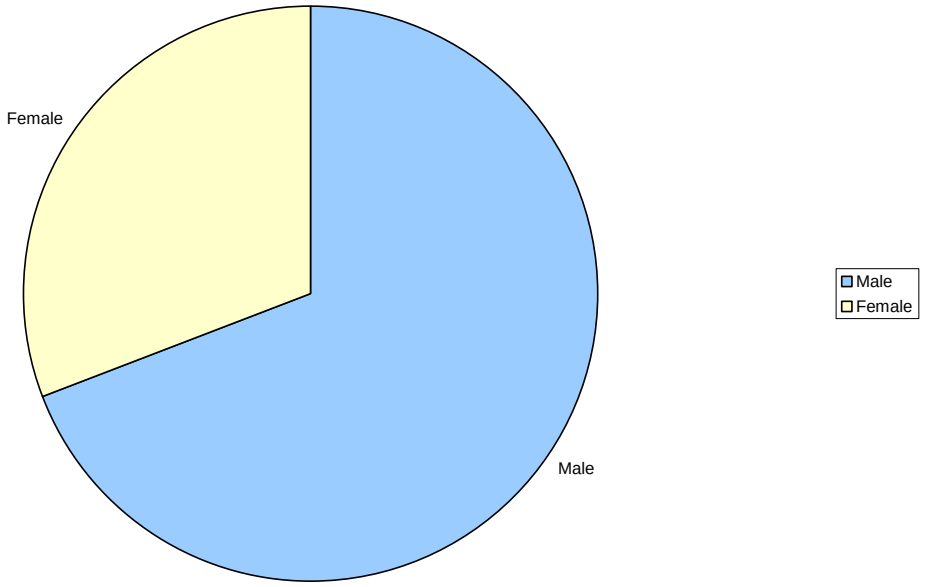


Chart 54. Ethnicity of BHJJ Youth in Champaign County

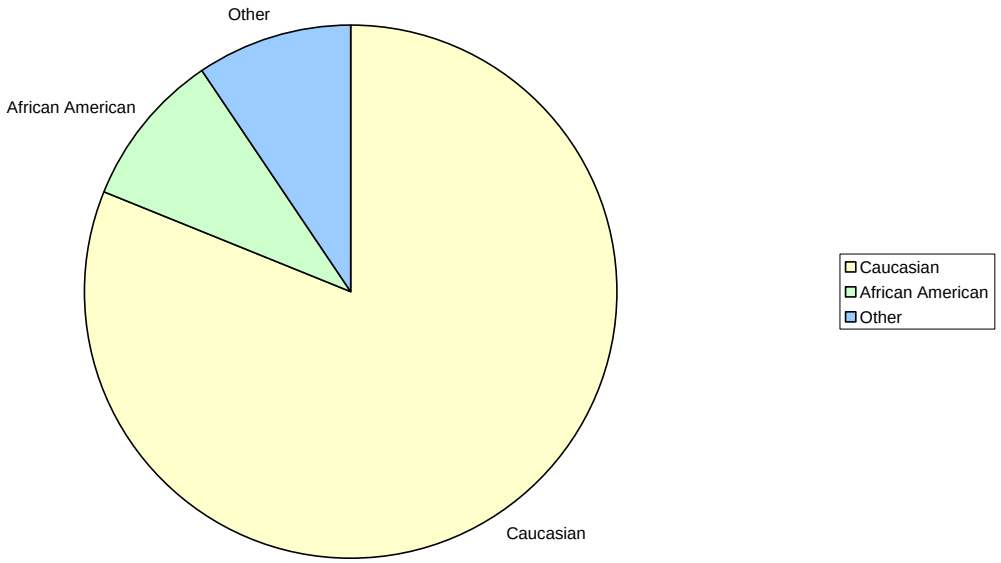


Table 72. Custody Arrangement for BHJJ Youth in Champaign County

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	11.8% (n = 6)
Biological Mother Only	49.0% (n = 25)
Biological Father Only	21.6% (n = 11)
Adoptive Parent(s)	3.9% (n = 2)
Grandparents	11.8% (n = 6)
Other	2.0% (n = 1)

Table 73. Caregiver's Education Level in Champaign County

Number of School Years Completed	Number of Caregivers
9	4.3% (n = 2)
10	4.3% (n = 2)
11	10.9% (n = 5)
12	50.0% (n = 23)
13	6.5% (n = 3)
14	21.7% (n = 10)
16	2.2% (n = 1)

Table 74. Household Income for BHJJ Families in Montgomery County

Household Income	BHJJ Families
Less than $5000	10.0% (n = 5)
$5000 - $9999	8.0% (n = 4)
$10000 - $14999	6.0% (n = 3)
$15000 - $19999	12.0% (n = 6)
$20000 - $24999	10.0% (n = 5)
$25000 - $34999	20.0% (n = 10)
$35000 - $49999	18.0% (n = 9)
$50000 - $74999	10.0% (n = 5)
$75000 - $99999	4.0% (n = 2)
$100000 and over	2.0% (n = 1)

Table 75. Family and Youth Results from the Caregiver Information Questionnaire in Champaign County

Question	Females (n = 15)	Males (n = 38)
Has the child ever been physically abused?	35.7% (n = 5)	28.6% (n = 10)
In the last 6 months, has the child been physically abused?	25.0% (n = 2)	0.0% (n = 0)
Has the child ever been sexually abused?	40.0% (n = 6)	11.1% (n = 4)
In the last 6 months, has the child been sexually abused?	0.0% (n = 0)	0.0% (n = 0)
Has the child ever run away?	26.7% (n = 4)	35.1% (n = 13)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	50.0% (n = 7)	36.1% (n = 13)
In the last 6 months, has the child had a problem with substance abuse, including alcohol and/or drugs?	54.5% (n = 6)	61.9% (n = 13)
Has the child ever talked about committing suicide?	40.0% (n = 6)	34.3% (n = 12)
Has the child ever attempted suicide?	13.3% (n = 2)	11.4% (n = 4)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	66.7% (n = 10)	51.4% (n = 19)
In the past six months, has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	9.1% (n = 1)	10.7% (n = 3)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	53.3% (n = 8)	52.8% (n = 19)
Has the child ever lived in a household in which someone has shown signs of being depressed?	53.3% (n = 8)	54.1% (n = 20)
Was the person who showed signs of being depressed involved in providing care and supervision to the child?	40.0% (n = 4)	57.4% (n = 9)
Has anyone in the child's biological family had a mental illness, other than depression?	40.0% (n = 6)	30.6% (n = 11)
Other than depression, has the child ever lived in a household in which someone had a mental illness?	21.4% (n = 3)	11.1% (n = 4)
Has the child ever lived in a household in which someone was convicted of a crime?	46.7% (n = 7)	41.7% (n = 15)
Has anyone in the child's biological family had a drinking or drug problem?	80.0% (n = 12)	59.5% (n = 22)
Has the child ever lived in a household in which someone had a drinking or drug problem?	60.0% (n = 9)	52.9% (n = 18)
Was the person with the drinking or drug problems involved in providing care and supervision to the child?	30.0% (n = 3)	52.9% (n = 9)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	23.1% (n = 3)	30.6% (n = 11)

Table 76. Problems Leading to Services in Champaign County

Problems Leading to Services	Females (n = 15)	Males (n = 38)
Suicide-related problems	6.7% (n = 1)	10.8% (n = 4)
Depression-related problems	20.0% (n = 3)	16.2% (n = 6)
Anxiety-related problems	26.7% (n = 4)	13.5% (n = 5)
Hyperactive and attention-related problems	20.0% (n = 3)	37.8% (n = 14)
Conduct/delinquency-related problems	66.7% (n = 10)	64.9% (n = 24)
Substance use, abuse, dependence-related problems	33.3% (n = 5)	32.4% (n = 12)
Adjustment-related problems	6.7% (n = 1)	16.2% (n = 6)
Psychotic Behaviors	0.0% (n = 0)	2.7% (n = 1)
Pervasive development disabilities	0.0% (n = 0)	0.0% (n = 0)
Specific developmental disabilities	0.0% (n = 0)	0.0% (n = 0)
Learning disabilities	6.7% (n = 1)	8.1% (n = 3)
School performance problems not related to learning disabilities	26.7% (n = 4)	16.2% (n = 6)
Eating disorders	6.7% (n = 1)	0.0% (n = 0)

Table 77. Top Five DSM-IV Axis I Diagnoses for Females for Champaign County

Axis I Diagnosis	Frequency
Attention Deficit Hyperactivity Disorder	33.3% (n = 5)
Cannabis Abuse/Dependence	33.3% (n = 5)
Post-Traumatic Stress Disorder	33.3% (n = 5)
Adjustment Disorder	26.7% (n = 4)
Oppositional Defiant Disorder	26.7% (n = 4)

Table 78. Top Five DSM-IV Axis I Diagnoses for Males for Champaign County

Axis I Diagnosis	Frequency
Attention Deficit Hyperactivity Disorder	44.7% (n = 17)
Oppositional Defiant Disorder	42.1% (n = 16)
Cannabis Abuse/Dependence	26.3% (n = 10)
Adjustment Disorder	23.7% (n = 9)
Alcohol Abuse/Dependence	10.5% (n = 4)

Ohio Scales Analysis

Paired-samples t-tests were performed on the Ohio Scales data from Champaign County. Problem Severity scores for the Parent version significantly decreased across all measurement intervals: Intake to 3 months: $t(36) = 4.92$, $p < .001$, Intake to 6 months: $t(19) = 5.11$, $p < .001$, Intake to 9 months: $t(5) = 6.95$, $p = .001$, and Intake to Discharge: $t(14) = 5.49$, $p < .001$. Similar significant increases were observed for the parent version

of the Functioning Scale, Intake to 3 months: $t(36) = -4.40$, $p < .001$, Intake to 6 months: $t(19) = -3.69$, $p = .002$, Intake to 9 months: $t(5) = -5.48$, $p = .003$, and Intake to Discharge: $t(14) = -4.75$, $p < .001$. Parents reported significant increases in Hopefulness from Intake to 3 months: $t(34) = 4.02$, $p < .001$, Intake to 6 months: $t(18) = 4.07$, $p = .001$, and Intake to Discharge: $t(14) = 5.28$, $p < .001$. No significant increases in Satisfaction were found.

For Workers, significant decreases in Problem Severity were observed from Intake to 3 months: $t(36) = 4.84$, $p < .001$, Intake to 6 months: $t(19) = 6.57$, $p < .001$, Intake to 9 months: $t(5) = 4.58$, $p = .006$, and Intake to Discharge: $t(15) = 11.12$, $p < .001$. Workers also reported significant increases in Functioning from Intake to 6 months: $t(19) = -3.25$, $p = .004$, Intake to 9 months: $t(5) = -6.32$, $p = .001$, and Intake to Discharge: $t(14) = -6.50$, $p < .001$.

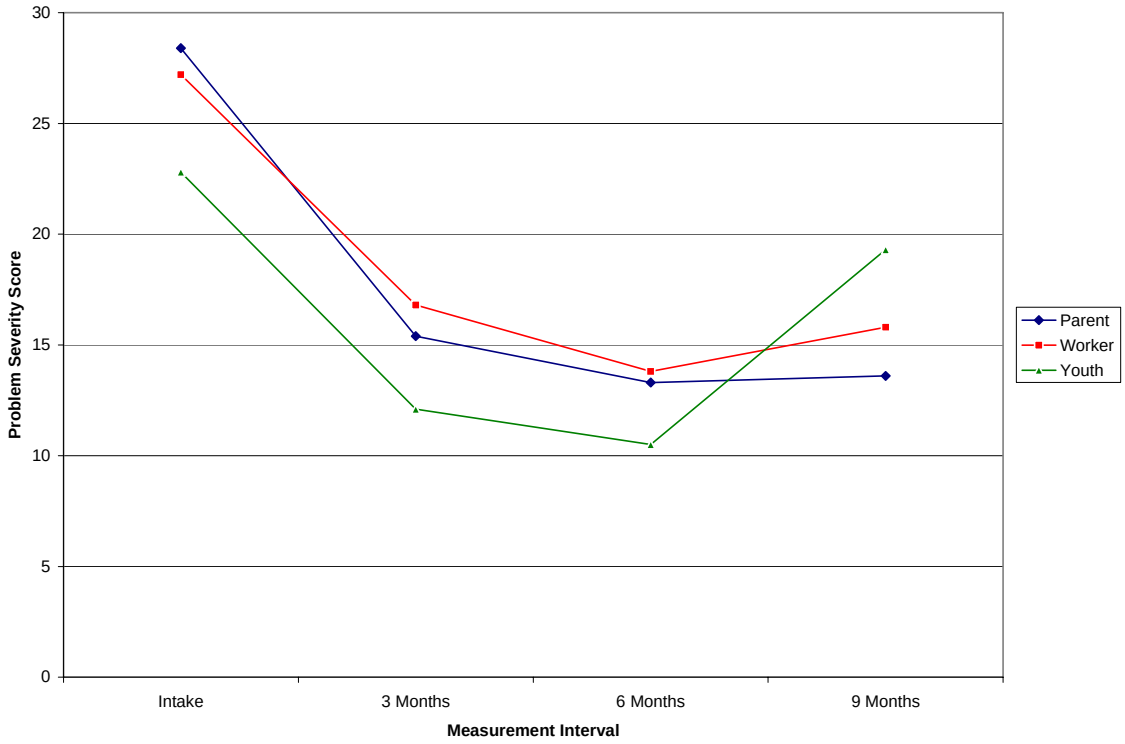
For Youth, significant decreases in Problem Severity were observed from Intake to 3 months: $t(34) = 5.10$, $p < .001$, Intake to 6 months: $t(18) = 5.14$), $p < .001$, and Intake to Discharge: $t(12) = 6.95$, $p < .001$. Youth reported significant increases in Functioning from Intake to 3 months: $t(36) = -3.18$, $p = .003$, and Intake to Discharge: $t(12) = -4.57$, $p = .001$. Satisfaction scores increases from Intake to 3 months: $t(5.93$, $p < .001$, Intake to 6 months: $t(9) = 4.78$, $p = .001$, and Intake to Discharge: $t(5) = 3.96$, $p = .01$. Hopefulness scores improved from Intake to 3 months: $t(35) = 3.17$, $p = .003$, Intake to 6 months: $t(18) = 4.38$, $p < .001$, and Intake to Discharge: $t(12) = 3.41$, $p = .005$.

Ohio Scales means are presented in Table 79 through 82 and Charts 55 through 62.

Table 79. Problem Severity Scores for Champaign County

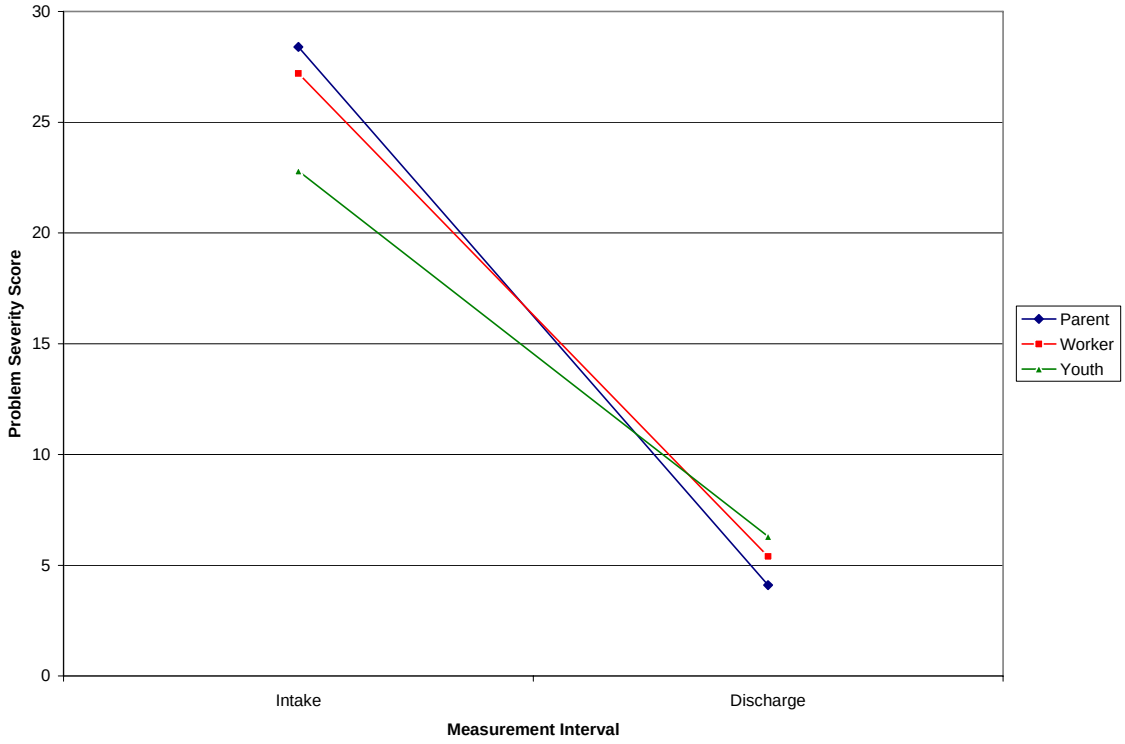
	Parent	**Worker**	**Youth**
Intake	28.42 (SD = 17.06) (n = 51)	27.27 (SD = 9.24) (n = 52)	22.87 (SD = 12.79) (n = 51)
Three Months	15.48 (SD = 13.57) (n = 38)	16.79 (SD = 11.70) (n = 37)	12.19 (SD = 12.13) (n = 36)
Six Months	13.33 (SD = 10.96) (n = 21)	13.86 (SD = 7.98) (n = 20)	10.57 (SD = 10.64) (n = 19)
Nine Months	13.66 (SD = 4.32) (n = 6)	15.83 (SD = 10.24) (n = 6)	19.33 (SD = 19.47) (n = 6)
Twelve Months	NA	NA	5.00 (SD = NA) (n = 1)
Discharge	4.06 (SD = 1.66) (n = 15)	5.40 (SD = 2.48) (n = 16)	6.38 (SD = 11.75) (n = 13)

Chart 55. Problem Severity Scores for Champaign County



* Lower scores indicative of less problem severity

Chart 56. Problem Severity Scores from Intake to Discharge for Champaign County

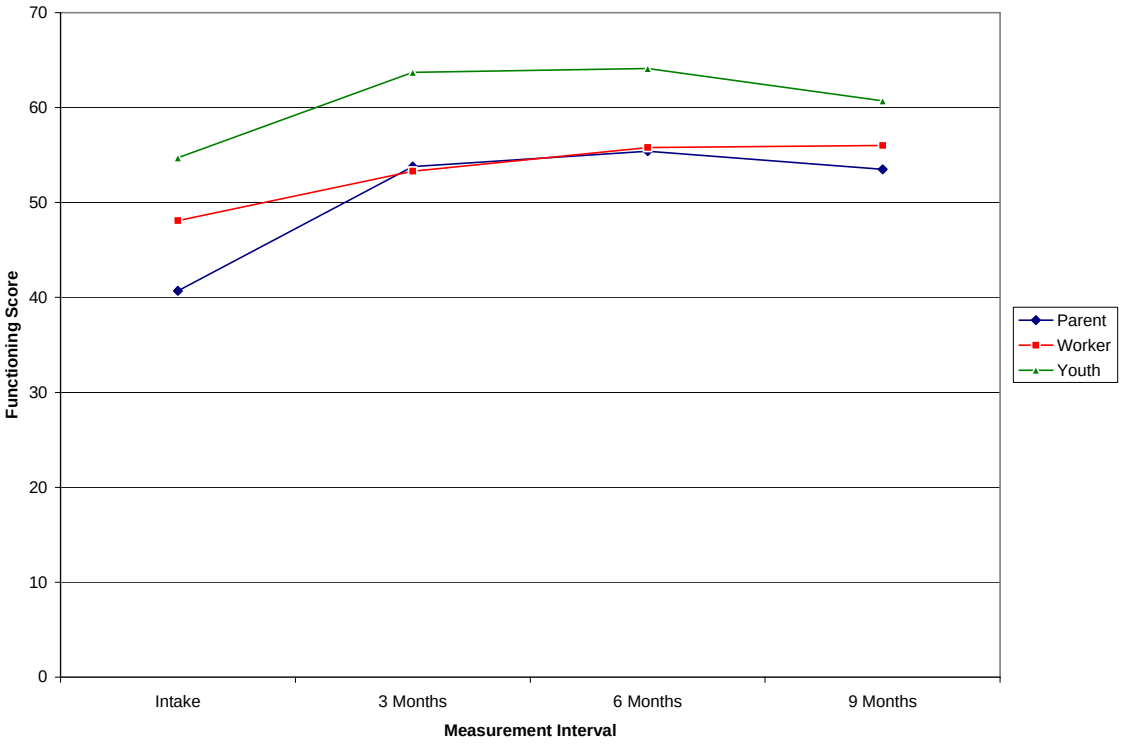


* Lower scores indicative of less problem severity

Table 80. Functioning Scores for Champaign County

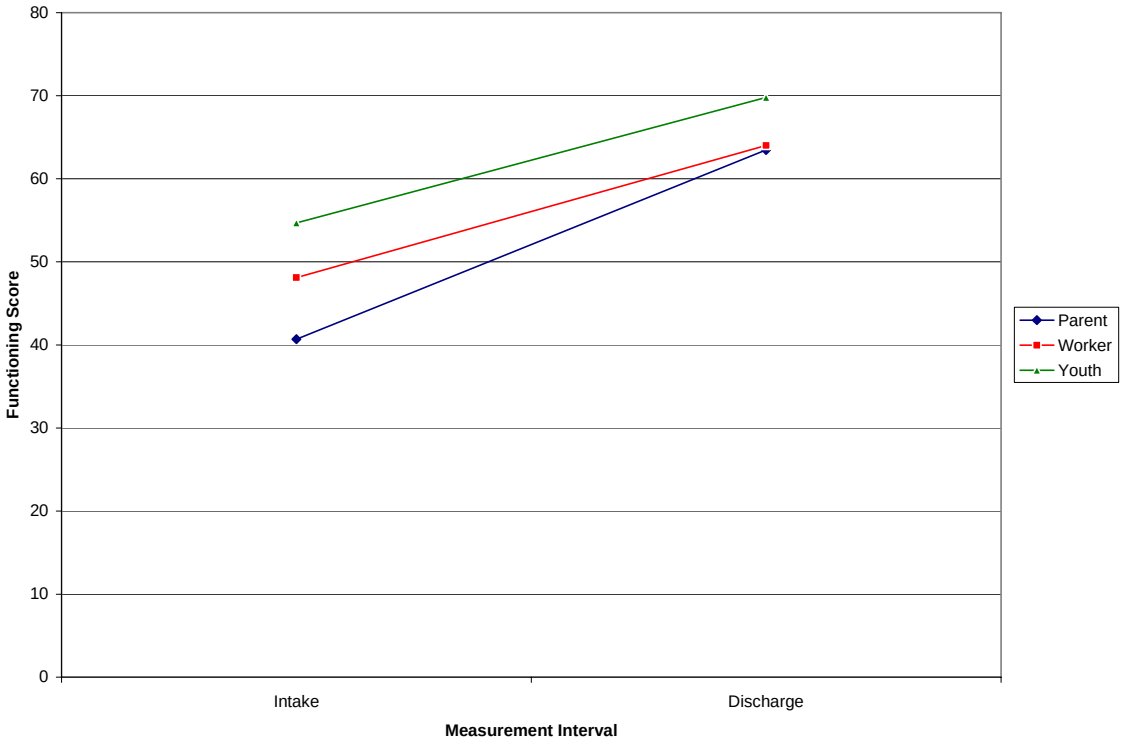
	Parent	Worker	Youth
Intake	40.76 (SD = 15.37) (n = 51)	48.06 (SD = 7.89) (n = 50)	54.76 (SD = 10.34) (n = 51)
Three Months	53.79 (SD = 16.85) (n = 38)	53.29 (SD = 12.14) (n = 38)	63.68 (SD = 9.26) (n = 38)
Six Months	55.38 (SD = 15.18) (n = 21)	55.85 (SD = 10.26) (n = 20)	64.11(SD = 9.86) (n = 18)
Nine Months	53.50 (SD = 3.98) (n = 6)	56.00 (SD = 6.06) (n = 6)	60.67 (SD = 11.70) (n = 6)
Twelve Months	NA	NA	69.00 (SD = NA) (n = 1)
Discharge	63.46 (SD = 8.06) (n = 15)	64.00 (SD = 5.77) (n = 16)	69.84 (SD = 11.01) (n = 13)

Chart 57. Functioning Scores for Champaign County



* Higher scores indicative of higher functioning

Chart 58. Functioning Scores from Intake to Discharge for Champaign County

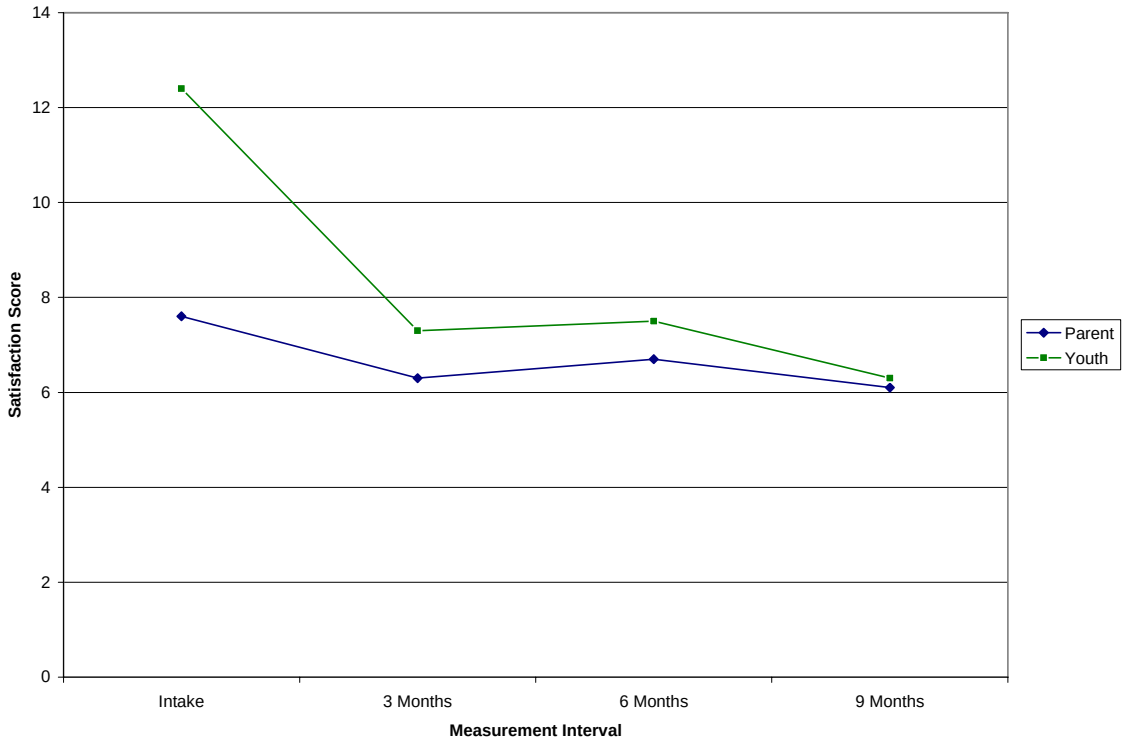


* Higher scores indicative of higher functioning

Table 81. Satisfaction Scores for Champaign County

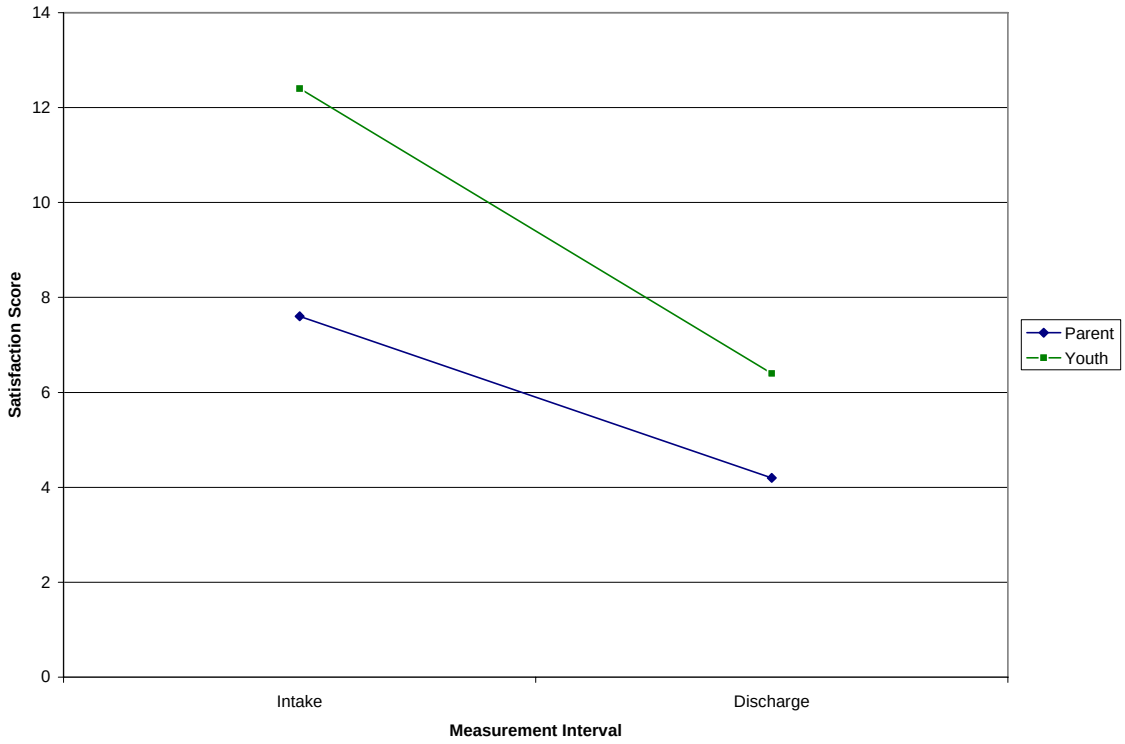
	Parent	Youth
Intake	7.67 (SD = 3.62) (n = 31)	12.42 (SD = 4.57) (n = 28)
Three Months	6.36 (SD = 2.53) (n = 33)	7.34 (SD = 3.72) (n = 35)
Six Months	6.67 (SD = 4.08) (n = 15)	7.53 (SD = 4.22) (n = 15)
Nine Months	6.16 (SD = 2.40) (n = 6)	6.33 (SD = 3.38) (n = 6)
Twelve Months	NA	5.00 (SD = NA) (n = 1)
Discharge	4.16 (SD = .39) (n = 12)	6.44 (SD = 3.53) (n = 9)

Chart 59. Satisfaction Scores for Champaign County



* Lower scores indicate greater satisfaction

Chart 60. Satisfaction Scores from Intake to Discharge for Champaign County

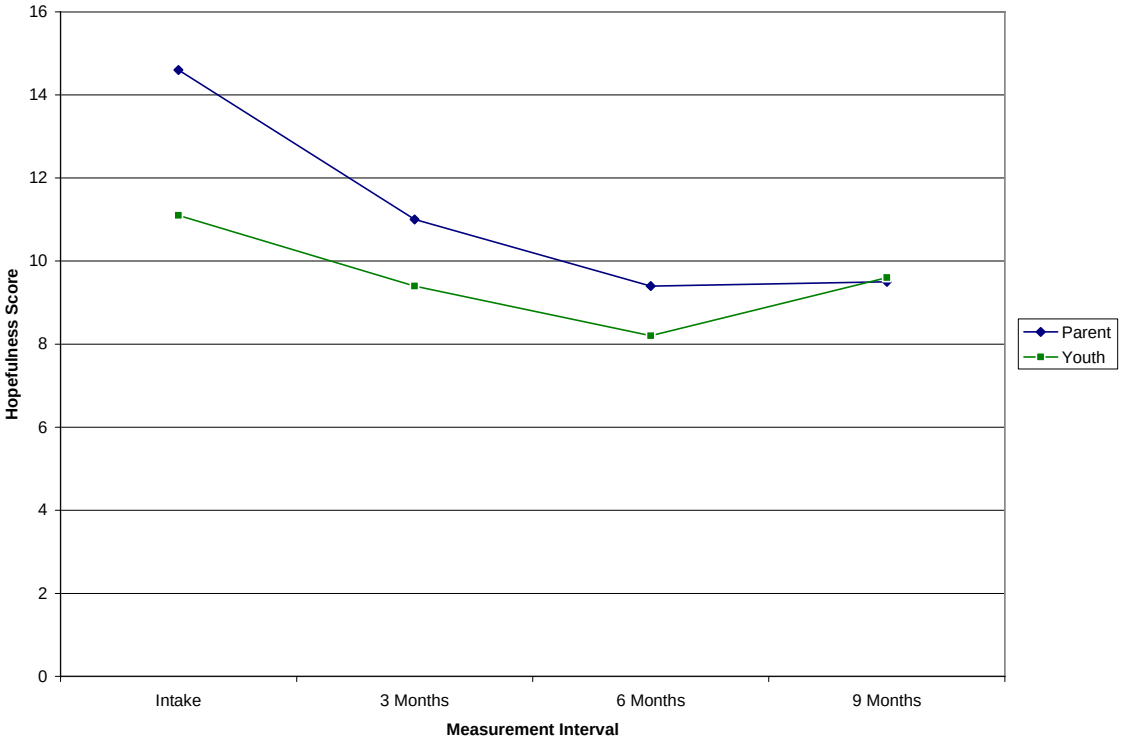


* Lower scores indicate greater satisfaction

Table 82. Hopefulness Scores for Champaign County

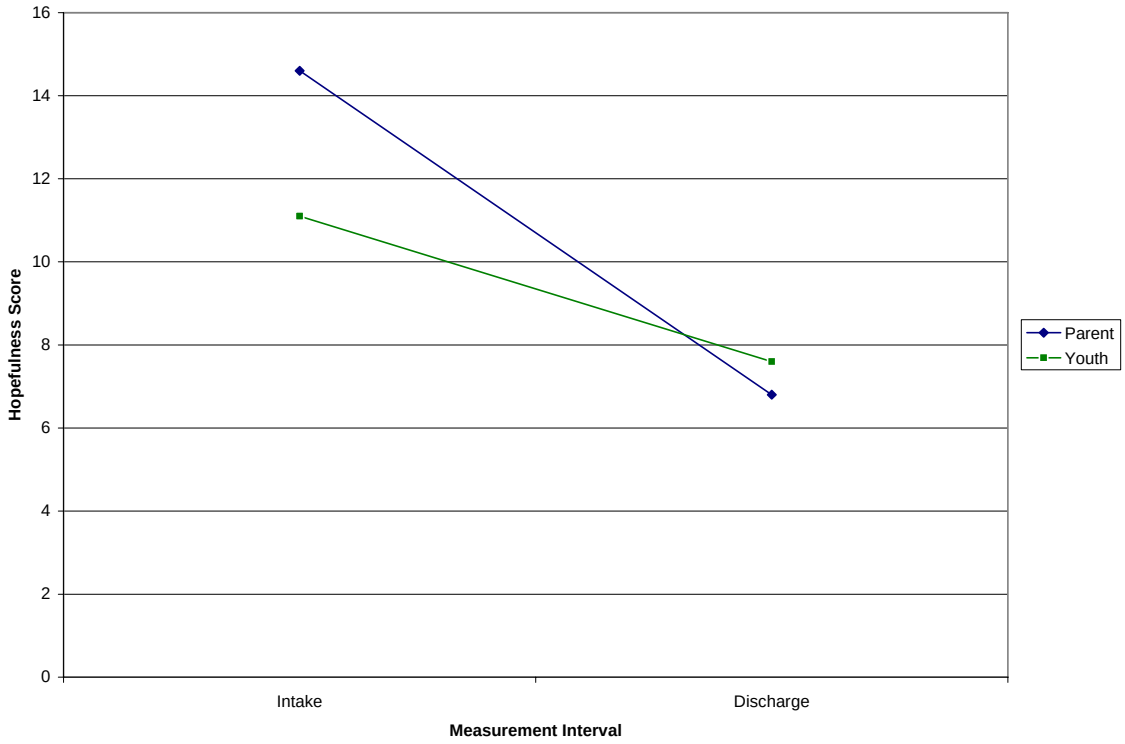
	Parent	Youth
Intake	14.65 (SD = 4.85) (n = 51)	11.14 (SD = 3.19) (n = 50)
Three Months	11.05 (SD = 4.79) (n = 36)	9.44 (SD = 3.35) (n = 38)
Six Months	9.40 (SD = 3.63) (n = 20)	8.26 (SD = 2.32) (n = 19)
Nine Months	9.50 (SD = 2.88) (n = 6)	9.67 (SD = 3.55) (n = 6)
Twelve Months	NA	8.00 (SD = NA) (n = 1)
Discharge	6.80 (SD = 1.65) (n = 15)	7.61 (SD = 3.20) (n = 13)

Chart 61. Hopefulness Scores for Champaign County



* Lower scores indicative of greater hopefulness

Chart 62. Hopefulness Scores from Intake to Discharge for Champaign County



* Lower scores indicative of greater hopefulness

Montgomery County

Montgomery County enrolled 67 females into the BHJJ program. The average age of the youth was 15.00 years (SD = 1.72). For those who had ethnicity data, African Americans and Caucasians made up the entire sample (68.9% and 31.1% respectively). Chart 63 displays ethnicity data for Montgomery County. The majority of the youth (65.5%) lived with the biological mother only (see Table 83). While the majority of caregivers had a high school diploma or better, 24.1% did not graduate from high school (see Table 84). The average household income for the BHJJ family in Montgomery County was between $15000 to $19000 (see Table 85). Detailed family history information can be found in Table 86, but of note, 36.8% of the females were sexually abused in the past and 32.0% of the females have attempted suicide. The most common reason for treatment for youth in the Montgomery County BHJJ program was conduct/delinquency related issues (96.5%) (see Table 87). Sixty-seven youth in Montgomery County accounted for a total of 142 Axis I diagnoses, for an average of 2.12 diagnoses per youth. Table 88 displays the most common Axis I DSM-IV diagnoses for females in Montgomery County.

Of the 67 youth enrolled, 22 have been Discharged from the program. Ten of the 22 were Discharged successfully (45.5%). Three clients were AWOL, three were removed from the BHJJ program, one female was transferred to individual counseling, one lacked a proper family structure for FFT to work properly, and 4 were simply labeled

as unsuccessfully Discharged. All other youth continue to receive services through the BHJJ project. At the time of final data collection for the evaluation, the average length of stay in treatment was 166.78 days. Before enrollment, there were 808 Juvenile Court charges, for an average of 12.06 charges per youth. After enrollment, 33 (49.3%) of the youth received 117 new charges.

Chart 63. Gender of BHJJ Youth for Montgomery County

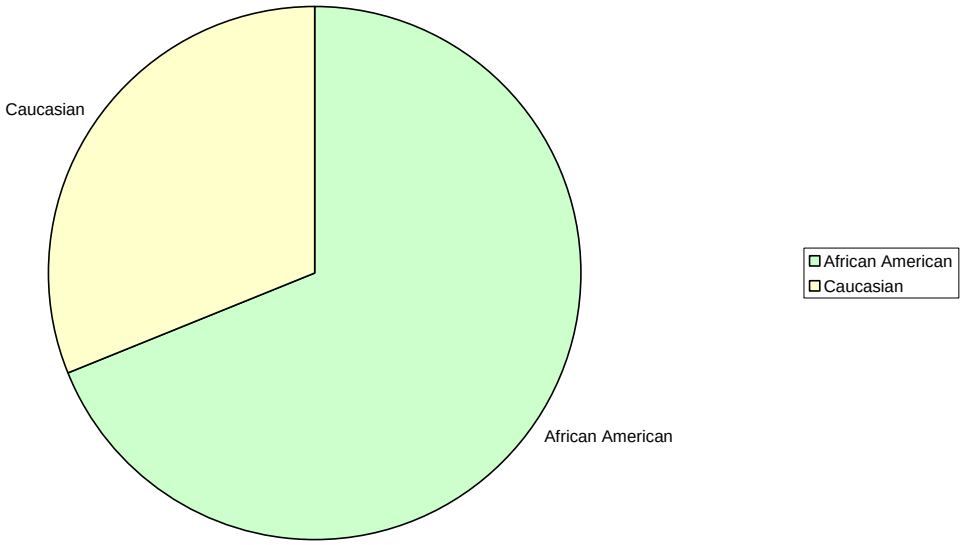


Table 83. Custody Arrangement for BHJJ Youth in Montgomery County

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	15.5% (n = 9)
Biological Mother Only	65.5% (n = 38)
Adoptive Parent(s)	1.7% (n = 1)
Aunt and/or Uncle	3.4% (n = 2)
Grandparents	10.3% (n = 6)
Other	3.4% (n = 2)

Table 84. Caregiver's Education Level in Montgomery County

Number of School Years Completed	Number of Caregivers
6	1.7% (n = 1)
9	6.9% (n = 4)
10	5.2% (n = 3)
11	10.3% (n = 6)
12	44.8% (n = 26)
13	10.3% (n = 6)
14	15.5% (n = 9)
15	1.7% (n = 1)
17	3.4% (n = 2)

Table 85. Household Income for BHJJ Families in Montgomery County

Household Income	BHJJ Families
Less than $5000	10.3% (n = 6)
$5000 - $9999	12.1% (n = 7)
$10000 - $14999	13.8% (n = 8)
$15000 - $19999	22.4% (n = 13)
$20000 - $24999	10.3% (n = 6)
$25000 - $34999	6.9% (n = 4)
$35000 - $49999	13.8% (n = 8)
$50000 - $74999	5.2% (n = 3)
$75000 - $99999	3.4% (n = 2)
$100000 and over	1.7% (n = 1)

Table 86. Family and Youth Results from the Caregiver Information Questionnaire in Montgomery County

Question	Females (n = 67)
Has the child ever been physically abused?	22.8% (n = 13)
In the last 6 months, has the child been physically abused?	6.7% (n = 1)
Has the child ever been sexually abused?	36.8% (n = 21)
In the last 6 months, has the child been sexually abused?	17.4% (n = 4)
Has the child ever run away?	72.4% (n = 42)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	44.8% (n = 26)
In the last 6 months, has the child had a problem with substance abuse, including alcohol and/or drugs?	53.6% (n = 15)
Has the child ever talked about committing suicide?	48.3% (n = 28)
Has the child ever attempted suicide?	32.0% (n = 16)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	41.4% (n = 24)
In the past six months, has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	20.0% (n = 5)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	64.9% (n = 37)
Has the child ever lived in a household in which someone has shown signs of being depressed?	64.3% (n = 36)
Was the person who showed signs of being depressed involved in providing care and supervision to the child?	82.1% (n = 23)
Has anyone in the child's biological family had a mental illness, other than depression?	42.1% (n = 24)
Other than depression, has the child ever lived in a household in which someone had a mental illness?	17.2% (n = 10)
Has the child ever lived in a household in which someone was convicted of a crime?	34.5% (n = 20)
Has anyone in the child's biological family had a drinking or drug problem?	61.4% (n = 35)
Has the child ever lived in a household in which someone had a drinking or drug problem?	45.6% (n = 26)
Was the person with the drinking or drug problems involved in providing care and supervision to the child?	50.0% (n = 5)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	32.8% (n = 19)

Table 87. Problems Leading to Services in Montgomery County

Problems Leading to Services	Females (n = 67)
Suicide-related problems	40.4% (n = 23)
Depression-related problems	73.7% (n = 42)
Anxiety-related problems	59.6% (n = 34)
Hyperactive and attention-related problems	50.9% (n = 29)
Conduct/delinquency-related problems	96.5% (n = 55)
Substance use, abuse, dependence-related problems	54.4% (n = 31)
Adjustment-related problems	63.2% (n = 36)
Psychotic Behaviors	12.3% (n = 7)
Pervasive development disabilities	7.0% (n = 4)
Specific developmental disabilities	3.5% (n = 2)
Learning disabilities	12.3% (n = 7)
School performance problems not related to learning disabilities	73.7% (n = 42)
Eating disorders	10.5% (n = 6)

Table 88. Top Five DSM-IV Axis I Diagnoses for Females for Montgomery County

Axis I Diagnosis	Frequency
Oppositional Defiant Disorder	47.8% (n = 32)
Major Depression/Depressive Disorder	25.4% (n = 17)
Alcohol Abuse/Dependence	19.4% (n = 13)
Bipolar Disorder	19.4% (n = 13)
Cannabis Abuse/Dependence	17.9% (n = 12)

Ohio Scales Analyses

Paired-samples t-tests were conducted on the Ohio Scales data from Montgomery County. Because of the small cell sizes associated with some of the measurement intervals, no statistical comparisons could be made for 9 and 12 month data. Means can be found in Tables 89 through 92 and are represented in Charts 64 through 71. Parents reported significant decreases in Problem Severity for Intake to 3 months: $t(32) = 3.03$, $p < .01$ and Intake to 6 months: $t(10) = 3.52$ $p < .01$. Parents failed to report statistical improvements in Functioning, Satisfaction, or Hopefulness at any measurement interval, although improvements in the predicted direction were observed.

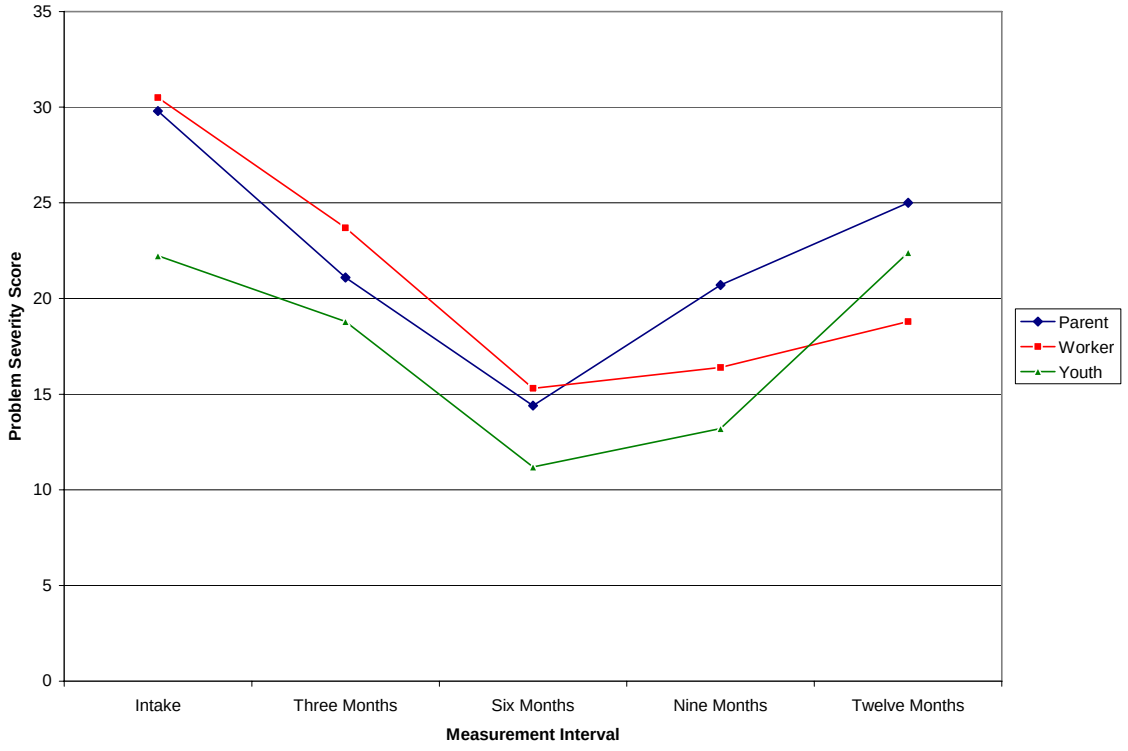
For Workers, statistically significant improvements on Problem Severity were reported for: Intake to 3 months: $t(33) = 3.58$, $p = .001$, Intake to 6 months: $t(10) = 3.60$, $p < .01$, and Intake to Discharge: $t(25) = 5.20$, $p < .001$. No statistically significant improvements in Functioning were reported, although improvements in the predicted direction were observed.

Youth reported significantly less Problem Severity from Intake to Discharge: $t(19) = 3.68$, $p = .002$. No other comparison reached statistical significance.

Table 89. Problem Severity Scores for Montgomery County

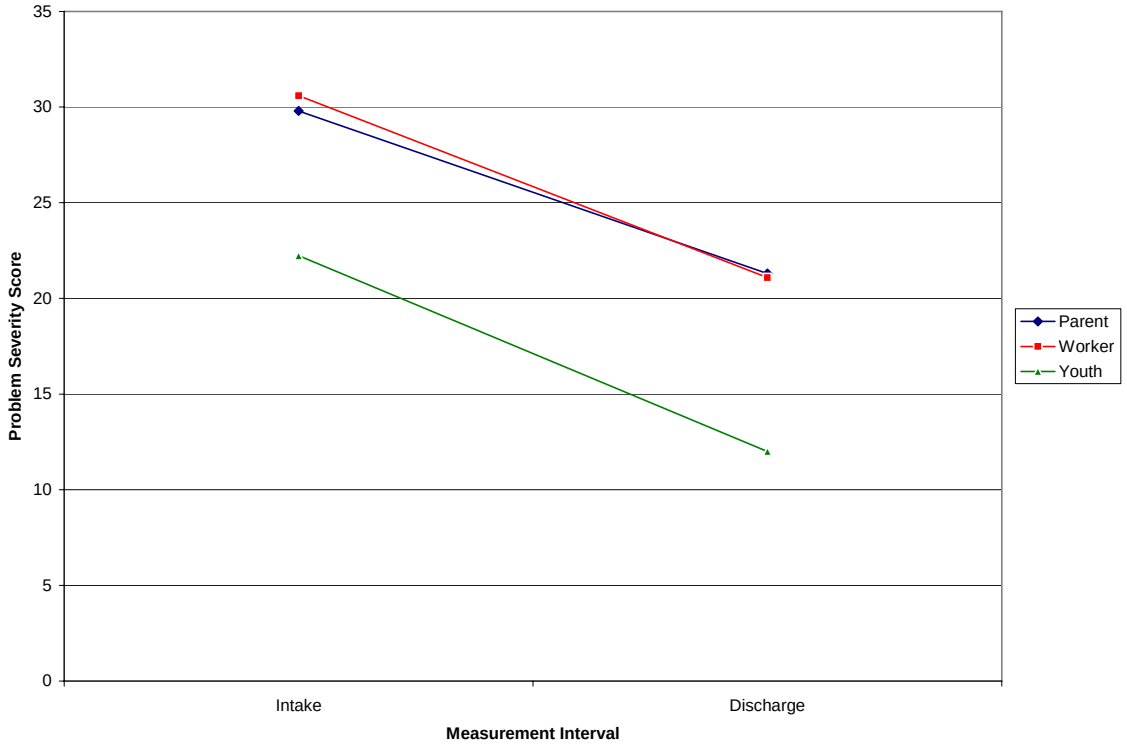
	Parent	Worker	Youth
Intake	29.84 (SD = 19.36) (n = 58)	30.58 (SD = 15.09) (n = 58)	22.23 (SD = 14.57) (n = 56)
Three Months	21.12 (SD = 16.99) (n = 35)	23.74 (SD = 12.64) (n = 36)	18.79 (SD = 16.71) (n = 33)
Six Months	14.41 (SD = 13.49) (n = 13)	15.31 (11.36) (n = 13)	11.23 (SD = 9.07) (n = 13)
Nine Months	20.71 (SD = 19.03) (n = 7)	16.43 (SD = 9.64) (n = 7)	13.29 (SD = 6.89) (n = 7)
Twelve Months	25.00 (SD = 17.93) (n = 5)	18.80 (SD = 15.83) (n = 5)	22.40 (SD = 16.65) (n = 5)
Discharge	21.34 (SD = 16.70) (n = 24)	21.09 (SD = 14.57) (n = 26)	12.00 (SD = 11.20) (n = 20)

Chart 64. Problem Severity Scores for Montgomery County



* Lower scores indicative of less problem severity

Chart 65. Problem Severity Scores from Intake to Discharge for Montgomery County

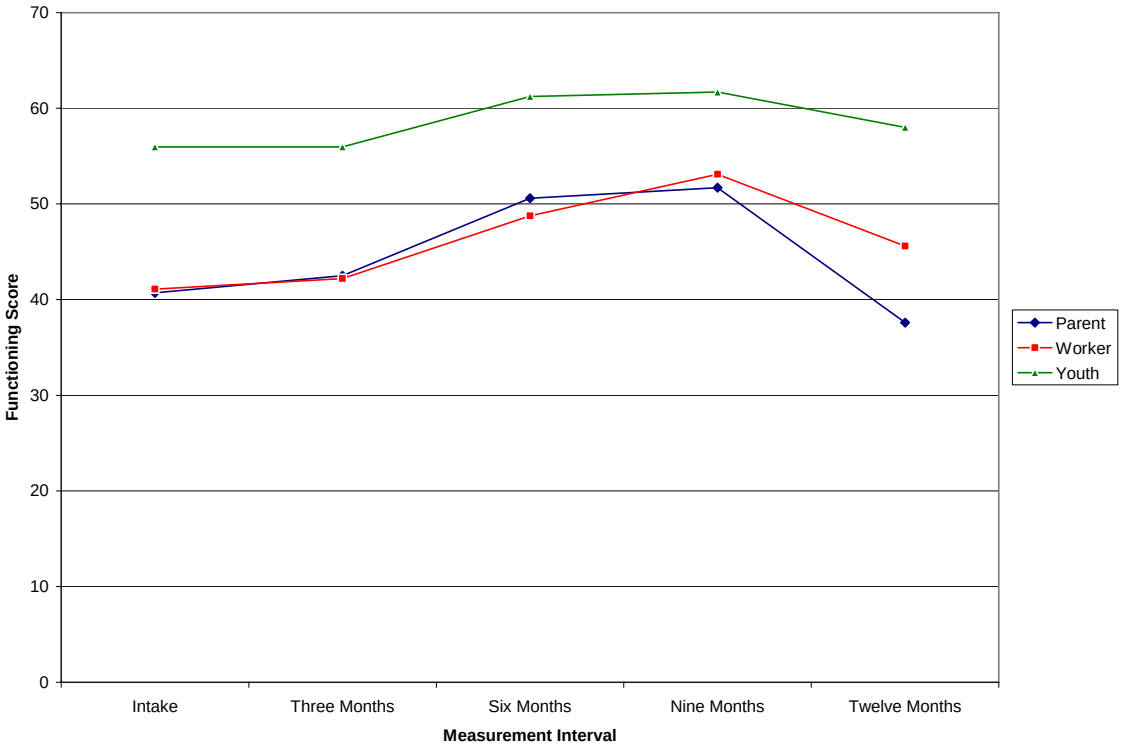


* Lower scores indicative of less problem severity

Table 90. Functioning Scores for Montgomery County

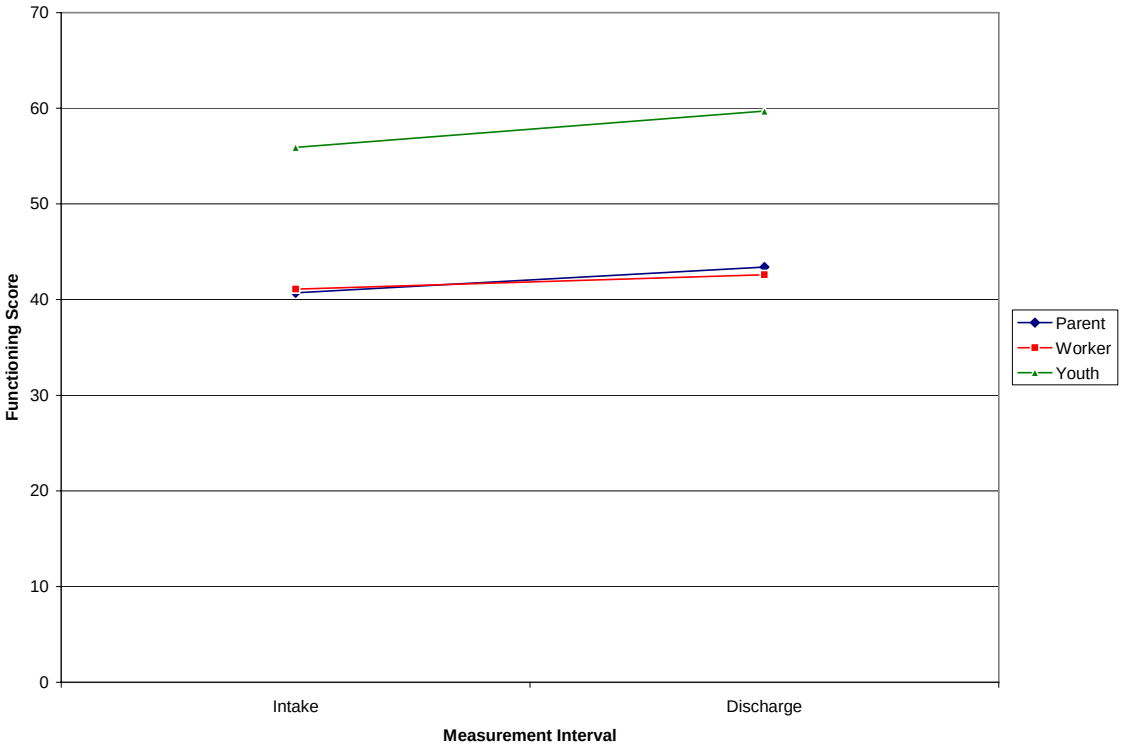
	Parent	Worker	Youth
Intake	40.76 (SD = 17.77) (n = 58)	41.15 (SD = 12.20) (n = 58)	55.96 (SD = 12.84) (n = 56)
Three Months	42.53 (SD 18.95) (n = 34)	42.22 (SD = 12.73) (n = 36)	55.96 (SD = 14.57) (n = 33)
Six Months	50.61 (SD = 18.98) (n = 13)	48.77 (SD = 11.70) (n = 13)	61.23 (SD = 10.84) (n = 13)
Nine Months	51.71 (SD = 21.77) (n = 7)	53.14 (SD = 9.97) (n = 7)	61.71 (SD = 5.08) (n = 7)
Twelve Months	37.60 (SD = 26.82) (n = 5)	45.60 (SD = 11.23) (n = 5)	58.00 (SD = 5.14) (n = 5)
Discharge	43.41 (SD = 19.04) (n = 24)	42.62 (SD = 14.59) (n = 25)	59.65 (SD = 17.11) (n = 20)

Chart 66. Functioning Scores for Montgomery County



* Higher scores indicative of higher functioning

Chart 67. Functioning Scores from Intake to Discharge for Montgomery County

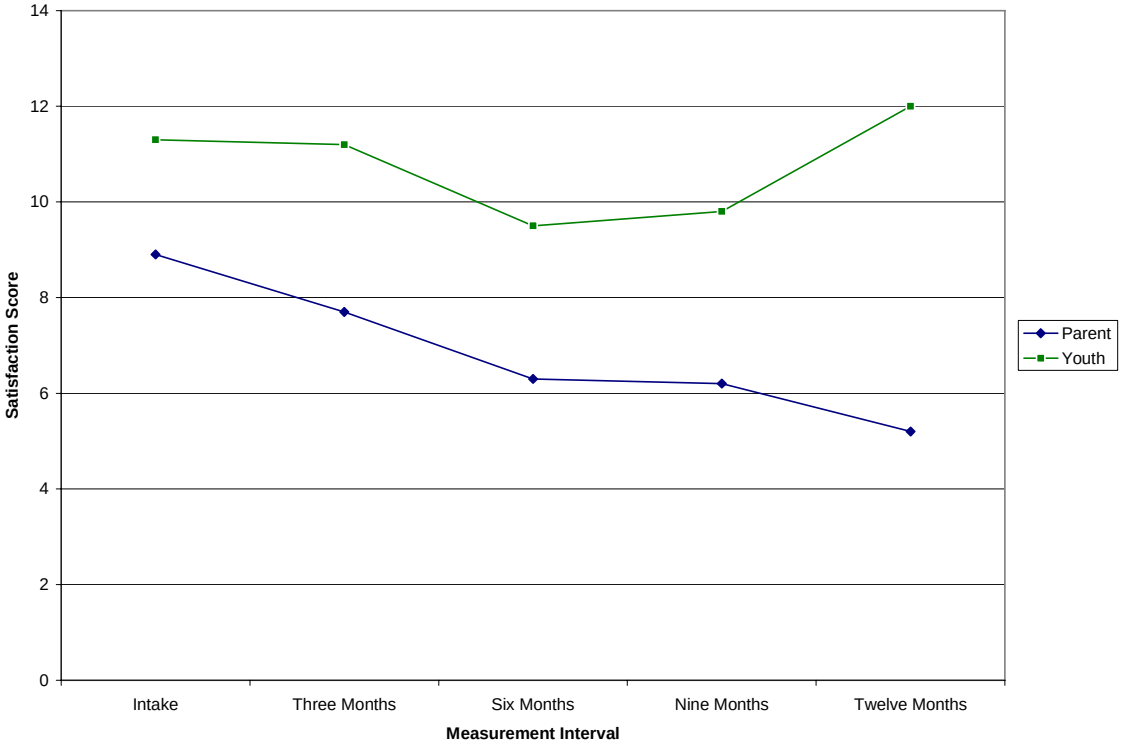


* Higher scores indicative of higher functioning

Table 91. Satisfaction Scores for Montgomery County

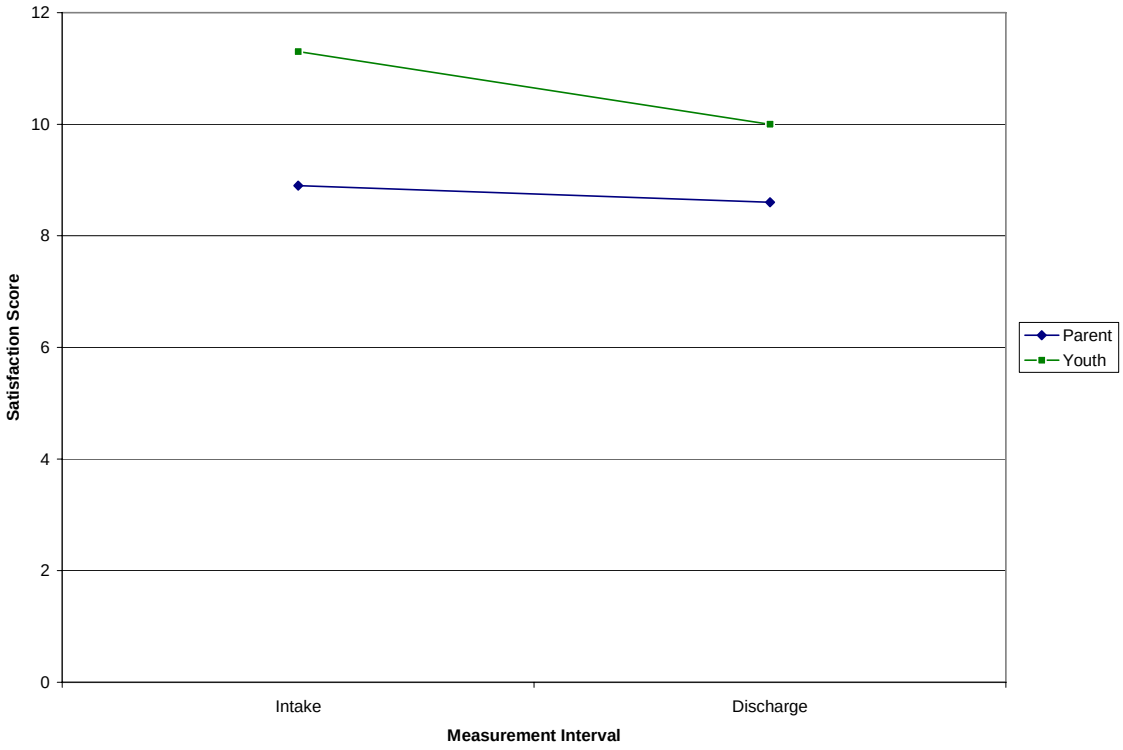
	Parent	Youth
Intake	8.90 (SD = 4.23) (n = 51)	11.30 (SD = 4.84) (n = 52)
Three Months	7.76 (SD = 3.66) (n = 34)	11.21 (SD = 5.75) (n = 33)
Six Months	6.30 (SD = 3.17) (n = 13)	9.53 (SD = 5.44) (n = 13)
Nine Months	6.29 (SD = 2.69) (n = 7)	9.85 (SD = 4.77) (n = 7)
Twelve Months	5.20 (SD = 2.16) (n = 5)	12.00 (SD = 4.69) (n = 5)
Discharge	8.60 (SD = 4.15) (n = 23)	10.05 (SD = 5.23) (n = 20)

Chart 68. Satisfaction Scores for Montgomery County



* Lower scores indicate greater satisfaction

Chart 69. Satisfaction Scores from Intake to Discharge for Montgomery County

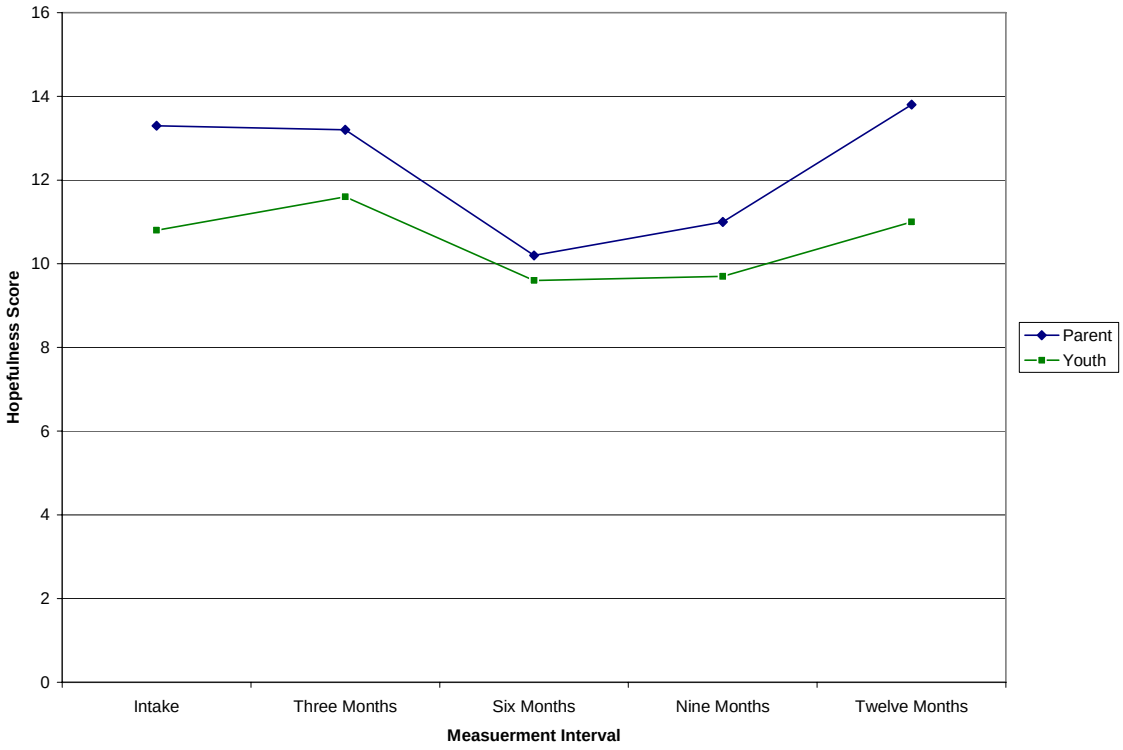


* Lower scores indicate greater satisfaction

Table 92. Hopefulness Scores for Montgomery County

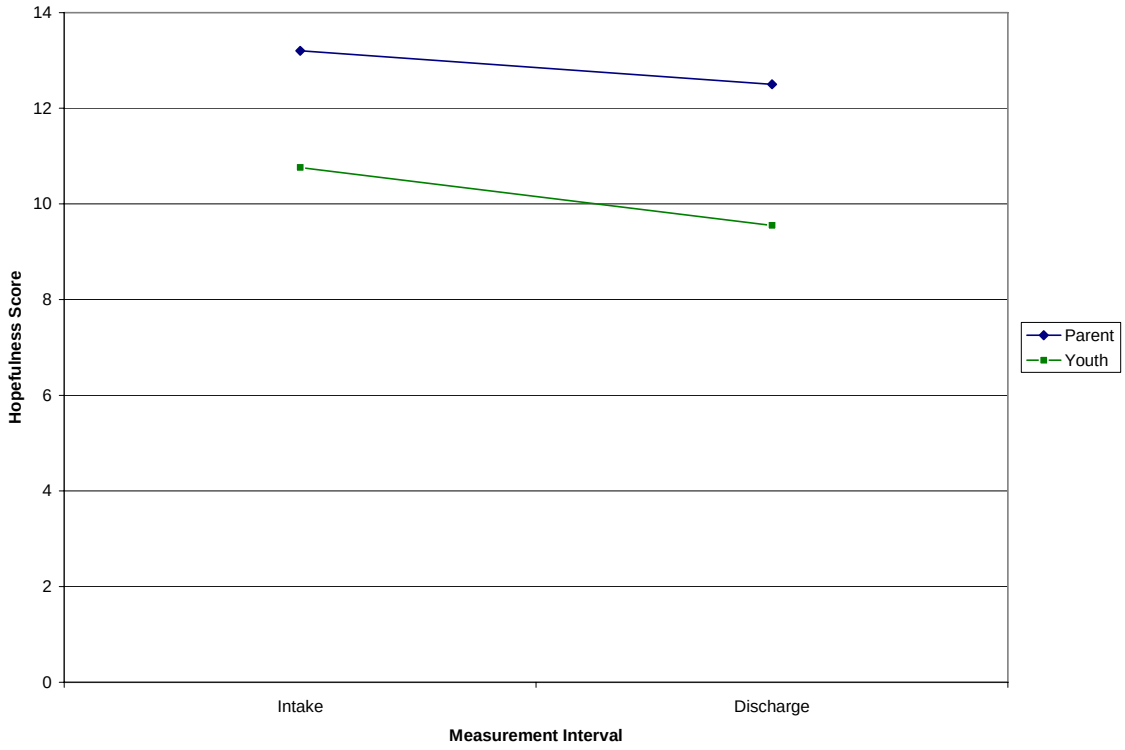
	Parent	Youth
Intake	13.27 (SD = 4.02) (n = 58)	10.76 (SD = 3.92) (n = 56)
Three Months	13.20 (SD = 4.19) (n = 35)	11.61 (SD = 4.54) (n = 33)
Six Months	10.23 (SD = 4.96) (n = 13)	9.69 (SD = 5.29) (n = 13)
Nine Months	11.00 (SD = 5.22) (n = 7)	9.71 (SD = 3.03) (n = 7)
Twelve Months	13.80 (SD = 5.35) (n = 5)	11.00 (SD = 4.30) (n = 5)
Discharge	12.50 (SD = 4.90) (n = 24)	9.55 (SD = 3.95) (n = 20)

Chart 70. Hopefulness Scores for Montgomery County



* Lower scores indicative of greater hopefulness

Chart 71. Hopefulness Scores from Intake to Discharge for Montgomery County



* Lower scores indicative of greater hopefulness

Union County

Union County enrolled 21 youth into the BHJJ Program, 18 males and three females (see Chart 72). The average age of the BHJJ youth in Union County was 13.83 years (SD = 2.80). All of the youth from Union County were Caucasian. Table 93 displays ethnicity data for Union County. The majority of the youth lived with the either both parents (35.0%) or the biological mother only (35.0%) (see Table 94). While the majority of caregivers had a high school diploma or better, 11.2% did not graduate from high school (see Table 95). The average household income for the BHJJ family in Union County was between $20000 to $24999 (see Table 96). Detailed family history information can be found in Table 97, but of note, 19.0% of the youth enrolled had attempted suicide at least once and 75% of males and 33.3% of females have had a biological family member diagnosed with depression or who showed signed of depression. The most common reason for treatment for youth in the Union County BHJJ program was conduct/delinquency related issues (100% for females and 82.4% for males) (see Table 98). Twenty-one youth in Union County accounted for a total of 30 Axis I diagnoses, for an average of 1.42 diagnoses per youth. Tables 99 and 100 display the most common Axis I DSM-IV diagnoses for females and males in Union County.

Of the 21 youth enrolled, 7 have been Discharged from the program. Three of the seven (42.9%) were Discharged successfully. One youth was withdrawn from the

program, one was incarcerated (not in a DYS facility), and one was placed out of home. All other youth continue to receive services through the BHJJ project. At the time of final data collection for the evaluation, the average length of stay in treatment was 201.50 days. Before enrollment, there were 66 Juvenile Court charges, for an average of 3.14 charges per youth. After enrollment, 10 (47.6%) of the youth received 30 new charges.

Chart 72. Gender of BHJJ Youth in Union County

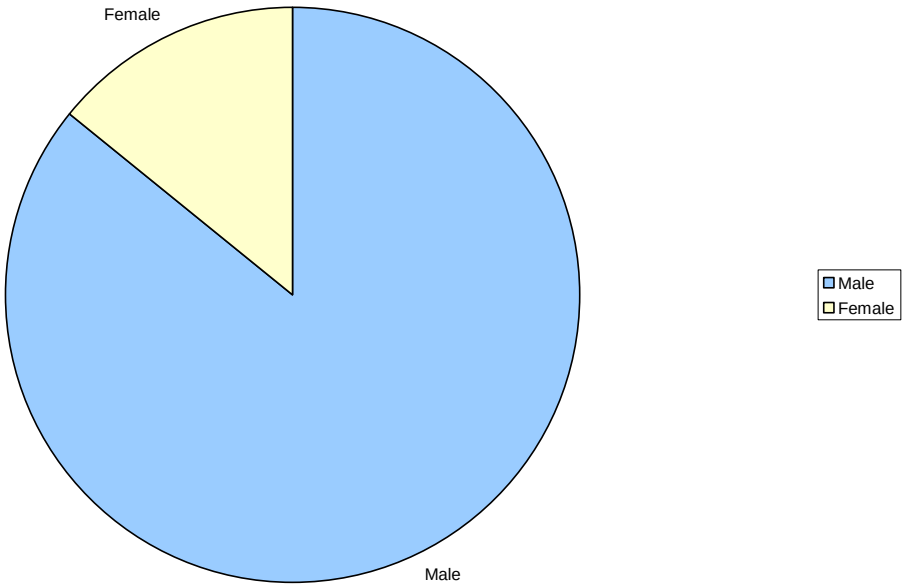


Table 93. Ethnicity of BHJJ Youth in Union County

Ethnicity	BHJJ Youth
Caucasian	100.0% (n = 21)

Table 94. Custody Arrangement for BHJJ Youth in Union County

Custody	BHJJ Youth
Two Biological Parents or One Biological and One Step or Adoptive Parent	35.0% (n = 7)
Biological Mother Only	35.0% (n = 7)
Biological Father Only	10.0% (n = 2)
Grandparents	5.0% (n = 1)
Ward of the State	5.0% (n = 1)
Other	10.0% (n = 2)

Table 95. Caregiver's Education Level in Union County

Number of School Years Completed	Number of Caregivers
8	5.6% (n = 1)
10	5.6% (n = 1)
12	38.9% (n = 7)
13	16.7% (n = 3)
14	16.7% (n = 3)
15	11.1% (n = 2)
17	5.6% (n = 1)

Table 96. Household Income for BHJJ Families in Union County

Household Income	BHJJ Families
Less than $5000	5.0% (n = 1)
$5000 - $9999	5.0% (n = 1)
$10000 - $14999	10.0% (n = 2)
$15000 - $19999	10.0% (n = 2)
$20000 - $24999	20.0% (n = 4)
$25000 - $34999	15.0% (n = 3)
$35000 - $49999	10.0% (n = 2)
$50000 - $74999	10.0% (n = 2)
$100000 and over	15.0% (n = 3)

Table 97. Family and Youth Results from the Caregiver Information Questionnaire in Union County

Question	Females (n = 3)	Males (n = 18)
Has the child ever been physically abused?	33.3% (n = 1)	5.9% (n = 1)
In the last 6 months, has the child been physically abused?	33.3% (n = 1)	0.0% (n = 0)
Has the child ever been sexually abused?	66.7% (n = 2)	6.7% (n = 1)
In the last 6 months, has the child been sexually abused?	0.0% (n = 0)	0.0% (n = 0)
Has the child ever run away?	100.0% (n = 3)	12.5% (n = 2)
Has the child ever had a problem with substance abuse, including alcohol and/or drugs?	0.0% (n = 0)	25.0% (n = 4)
In the last 6 months, has the child had a problem with substance abuse, including alcohol and/or drugs?	0.0% (n = 0)	27.3% (n = 3)
Has the child ever talked about committing suicide?	33.3% (n = 1)	52.9% (n = 9)
Has the child ever attempted suicide?	33.3% (n = 1)	17.6% (n = 3)
Has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	66.7% (n = 2)	25.0% (n = 4)
In the past six months, has the child ever been exposed to domestic violence or spousal abuse, of which the child was not the direct target?	0.0% (n = 0)	10.0% (n = 1)
Has anyone in the child's biological family ever been diagnosed with depression or shown signs of depression?	33.3% (n = 1)	75.0% (n = 12)
Has the child ever lived in a household in which someone has shown signs of being depressed?	33.3% (n = 1)	52.9% (n = 9)
Was the person who showed signs of being depressed involved in providing care and supervision to the child?	100% (n = 1)	64.3% (n = 9)
Has anyone in the child's biological family had a mental illness, other than depression?	33.3% (n = 1)	43.8% (n = 7)
Other than depression, has the child ever lived in a household in which someone had a mental illness?	33.3% (n = 1)	35.3% (n = 6)
Has the child ever lived in a household in which someone was convicted of a crime?	66.7% (n = 2)	29.4% (n = 5)
Has anyone in the child's biological family had a drinking or drug problem?	66.7% (n = 2)	41.2% (n = 7)
Has the child ever lived in a household in which someone had a drinking or drug problem?	66.7% (n = 2)	50.0% (n = 8)
Was the person with the drinking or drug problems involved in providing care and supervision to the child?	0.0% (n = 0)	36.4% (n = 4)
Is the child currently taking any medication related to his/her emotional or behavioral symptoms?	66.7% (n = 2)	76.5% (n = 13)

Table 98. Problems Leading to Services in Union County

Problems Leading to Services	Females (n = 3)	Males (n = 18)
Suicide-related problems	0.0% (n = 0)	0.0% (n = 0)
Depression-related problems	0.0% (n = 0)	5.9% (n = 1)
Anxiety-related problems	0.0% (n = 0)	0.0% (n = 0)
Hyperactive and attention-related problems	50.0% (n = 1)	52.9% (n = 9)
Conduct/delinquency-related problems	100% (n = 2)	82.4% (n = 14)
Substance use, abuse, dependence-related problems	0.0% (n = 0)	23.5% (n = 4)
Adjustment-related problems	0.0% (n = 0)	0,0% (n = 0)
Psychotic Behaviors	0.0% (n = 0)	0.0% (n = 0)
Pervasive development disabilities	0.0% (n = 0)	17.6% (n = 3)
Specific developmental disabilities	0.0% (n = 0)	5.9% (n = 1)
Learning disabilities	50.0% (n = 1)	47.1% (n = 8)
School performance problems not related to learning disabilities	50.0% (n = 1)	41.2% (n = 7)
Eating disorders	0.0% (n = 0)	0.0% (n = 0)

Table 99. Top Two DSM-IV Axis I Diagnoses for Females for Union County

Axis I Diagnosis	Frequency
Oppositional Defiant Disorder	66.7% (n = 2)
Attention Deficit Hyperactivity Disorder	33.3% (n = 1)

Table 100. Top Five DSM-IV Axis I Diagnoses for Males for Union County

Axis I Diagnosis	Frequency
Oppositional Defiant Disorder	38.9% (n = 7)
Attention Deficit Hyperactivity Disorder	33.3% (n = 6)
Bipolar Disorder	27.7% (n = 5)
Conduct Disorder	27.7% (n = 5)
Major Depression/Depressive Disorder	11.1% (n = 2)

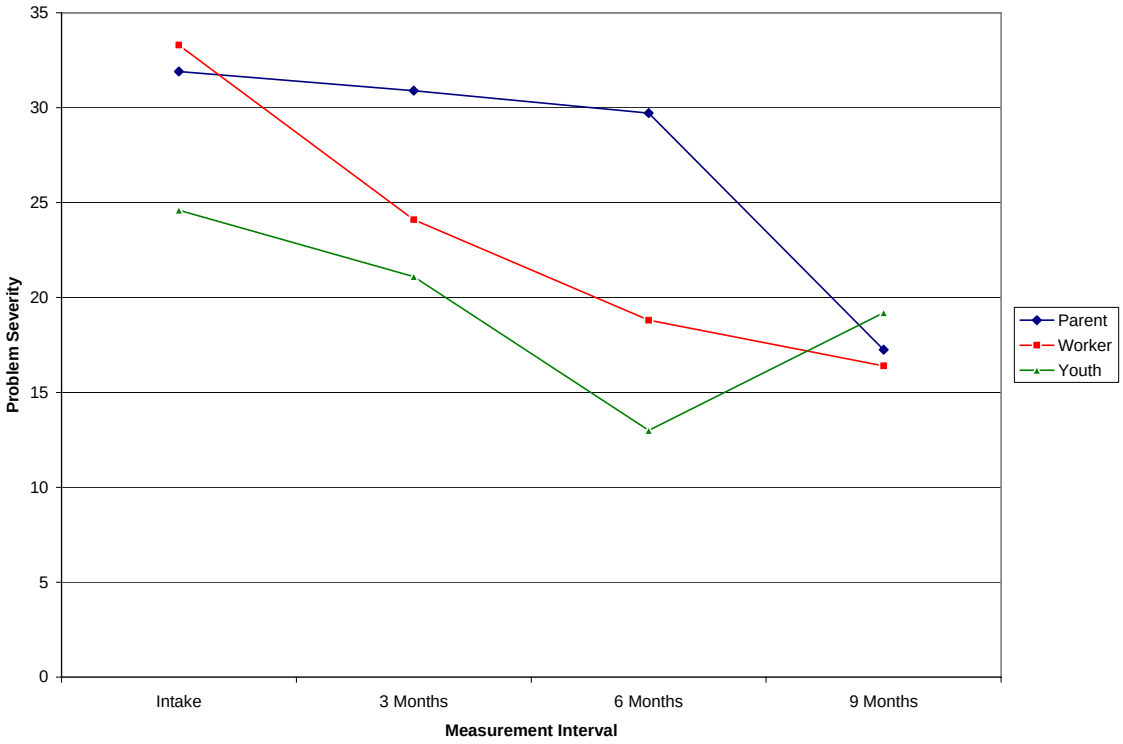
Ohio Scales Analyses

Because of the low sample size in Union County, few statistical tests were performed on the Ohio Scales data. No paired-samples t-test reached statistical significance. Scale means are presented in Table 101 through 104 and in Chart 73 through 80.

Table 101. Problem Severity Scores for Union County

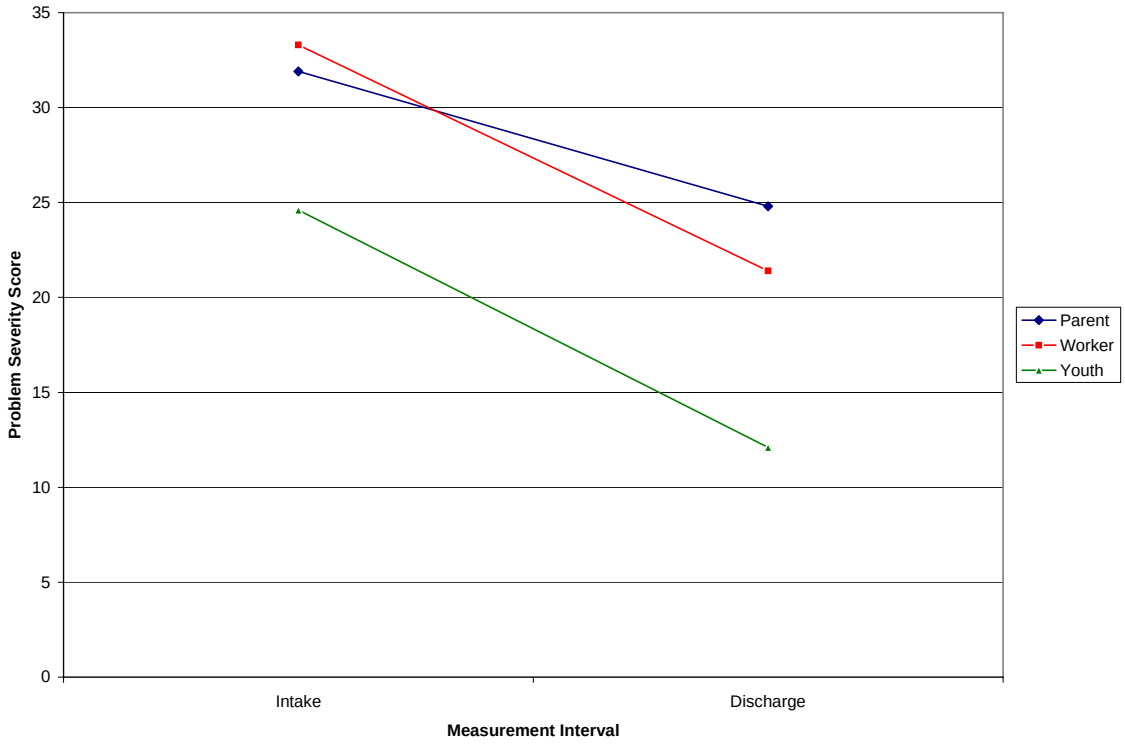
	Parent	Worker	Youth
Intake	31.96 (SD = 14.84) (n = 21)	33.38 (SD = 12.85) (n = 21)	24.63 (SD = 17.92) (n = 19)
Three Months	30.91 (SD = 13.40) (n = 11)	24.16 (SD = 10.65) (n = 12)	21.14 (SD = 11.31) (n = 12)
Six Months	29.71 (SD = 11.82) (n = 7)	18.83 (SD = 8.04) (n = 6)	13.00 (SD = 8.36) (n = 6)
Nine Months	17.25 (SD = 10.87) (n = 2)	16.40 (SD = 10.59) (n = 5)	19.20 (SD = 18.91) (n = 5)
Twelve Months	12.00 (SD = 1.41) (n = 2)	8.00 (SD = .00) (n = 2)	2.00 (SD = .00) (n = 2)
Discharge	24.88 (SD = 11.47) (n = 7)	21.38 (SD = 9.07) (n = 7)	12.14 (SD = 10.31) (n = 7)

Chart 73. Problem Severity Scores for Union County



* Lower scores indicative of less problem severity

Chart 74. Problem Severity Scores from Intake to Discharge for Union County

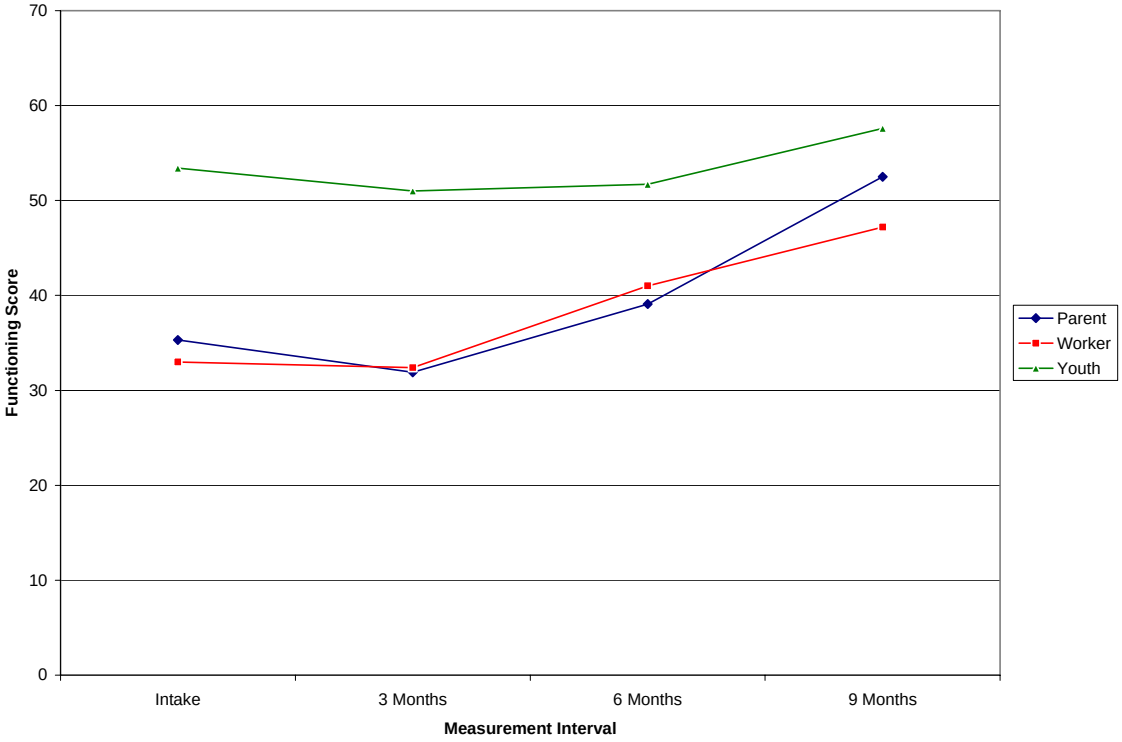


* Lower scores indicative of less problem severity

Table 102. Functioning Scores for Union County

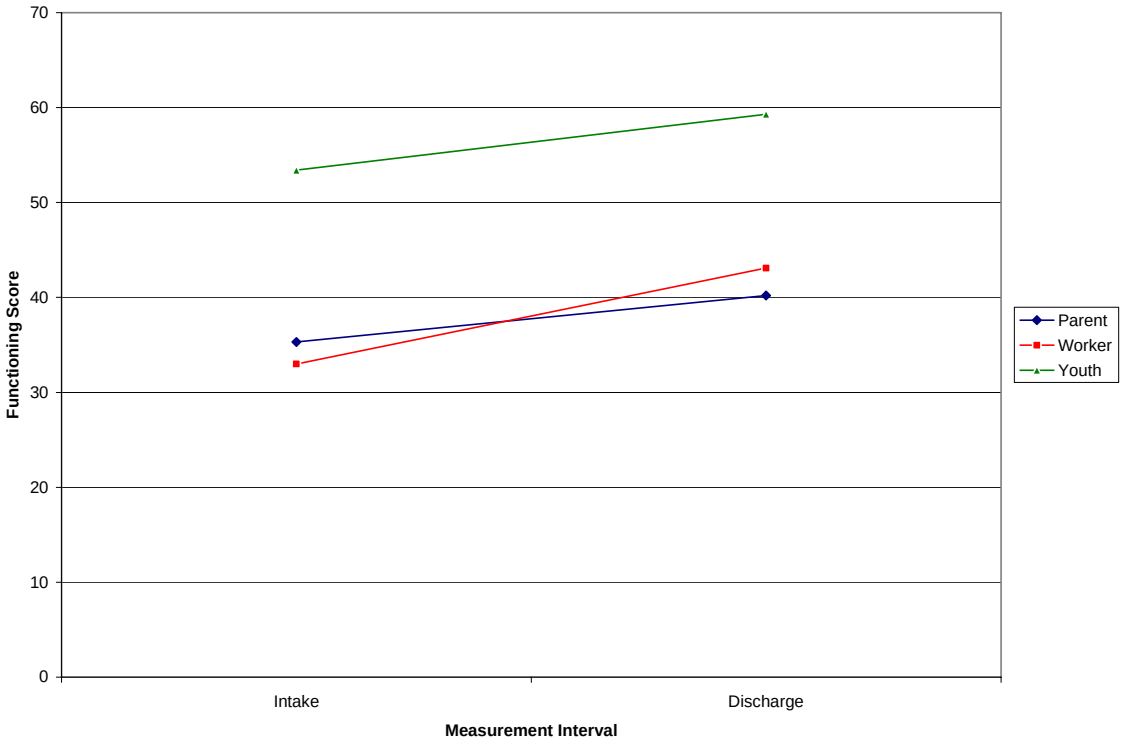
	Parent	Worker	Youth
Intake	35.30 (SD = 10.75) (n = 20)	33.04 (SD = 11.00) (n = 21)	53.47 (SD = 15.15) (n = 19)
Three Months	31.90 (SD = 16.81) (n = 11)	32.41 (SD = 16.33) (n = 12)	51.00 (SD = 15.63) (n = 11)
Six Months	39.14 (SD = 10.96) (n = 7)	41.00 (SD = 16.04) (n = 6)	51.7 (SD = 14.52) (n = 6)
Nine Months	52.50 (SD = 13.37) (n = 4)	47.20 (SD = 10.94) (n = 5)	57.60 (SD = 20.03) (n = 5)
Twelve Months	67.00 (SD = NA) (n = 1)	67.00 (SD = 1.41) (n = 2)	77.50 (SD = 3.53) (n = 2)
Discharge	40.24 (SD = 17.38) (n = 7)	43.16 (SD = 11.23) (n = 6)	59.28 (SD = 17.66) (n = 7)

Chart 75. Functioning Scores for Union County



* Higher scores indicative of higher functioning

Chart 76. Functioning Scores from Intake to Discharge for Union County

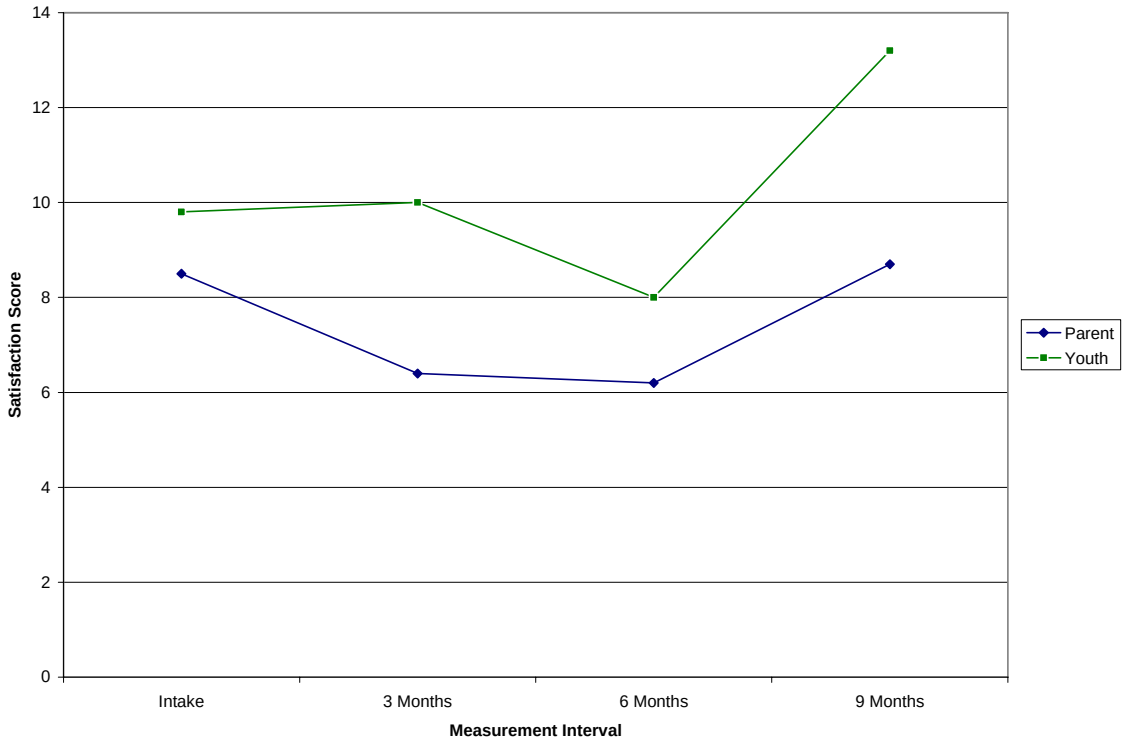


* Higher scores indicative of higher functioning

Table 103. Satisfaction Scores for Union County

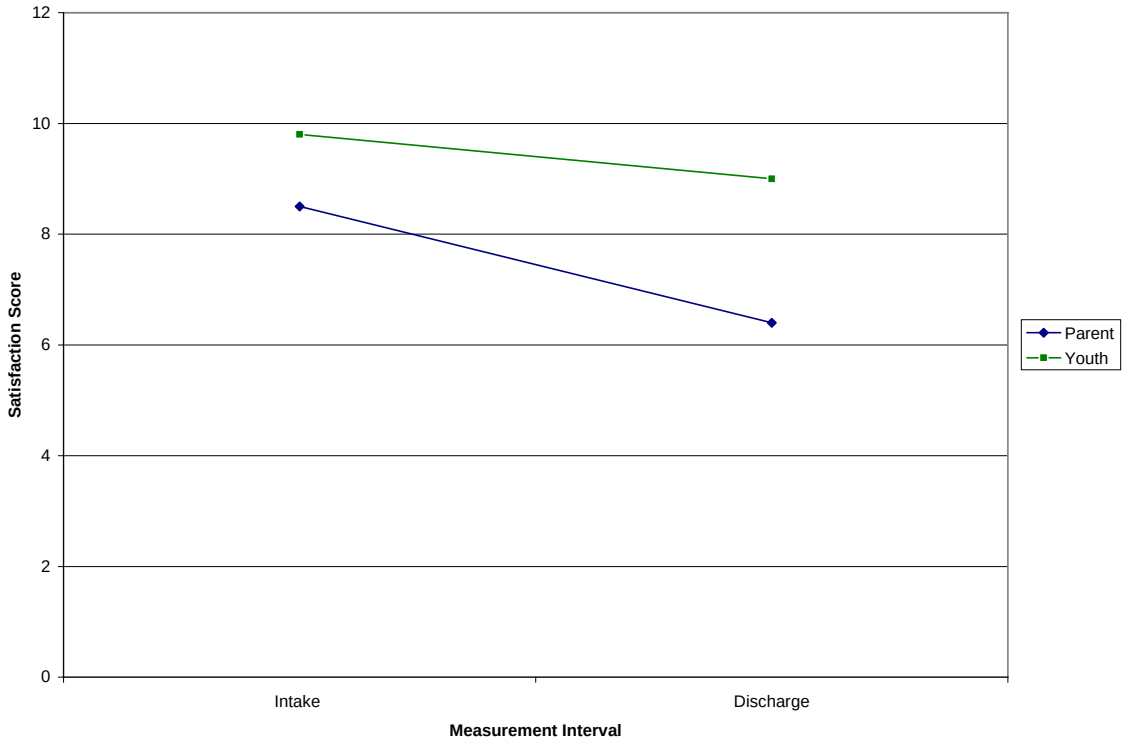
	Parent	Youth
Intake	8.55 (SD = 4.37) (n = 20)	9.88 (SD = 5.37) (n = 17)
Three Months	6.45 (SD = 2.33) (n = 11)	10.00 (SD = 5.58) (n = 11)
Six Months	6.28 (SD = 1.12) (n = 7)	8.00 (SD = 3.16) (n = 5)
Nine Months	8.75 (SD = 4.34) (n = 4)	13.20 (SD = 6.41) (n = 5)
Twelve Months	5.00 (SD = 1.41) (n = 2)	8.00 (SD = .00) (n = 2)
Discharge	6.42 (SD = 2.37) (n = 7)	9.00 (SD = 3.63) (n = 6)

Chart 77. Satisfaction Scores for Union County



* Lower scores indicate greater satisfaction

Chart 78. Satisfaction Scores from Intake to Discharge for Union County

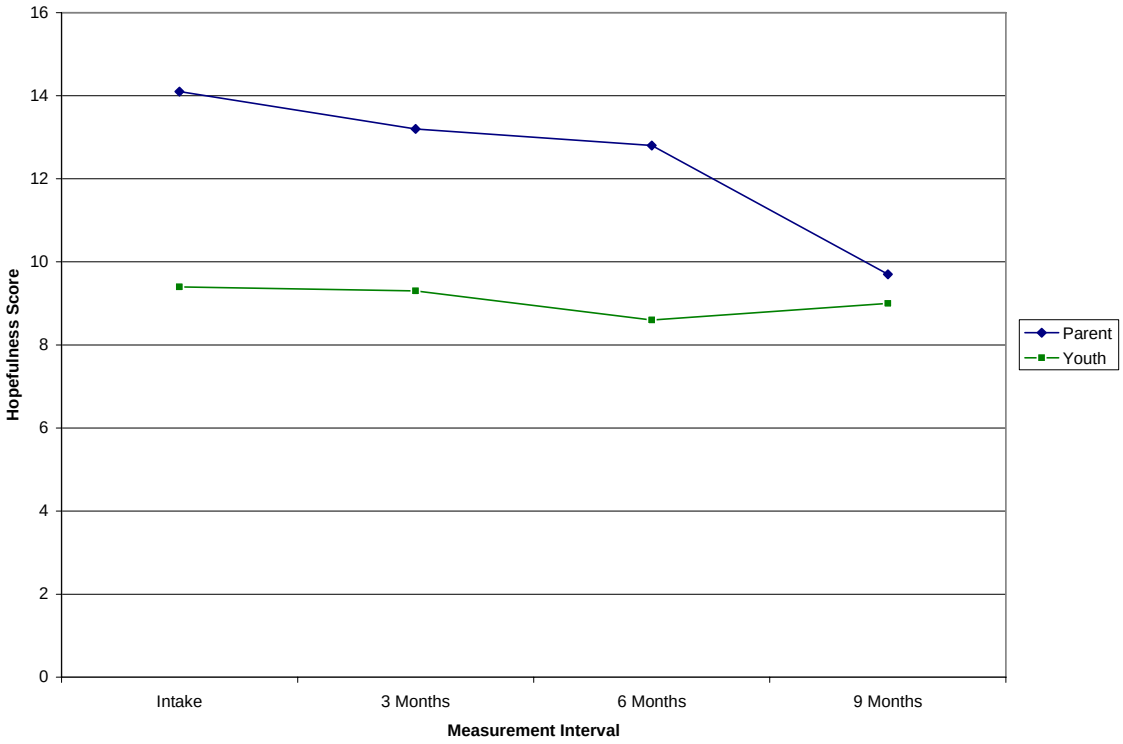


* Lower scores indicate greater satisfaction

Table 104. Hopefulness Scores for Union County

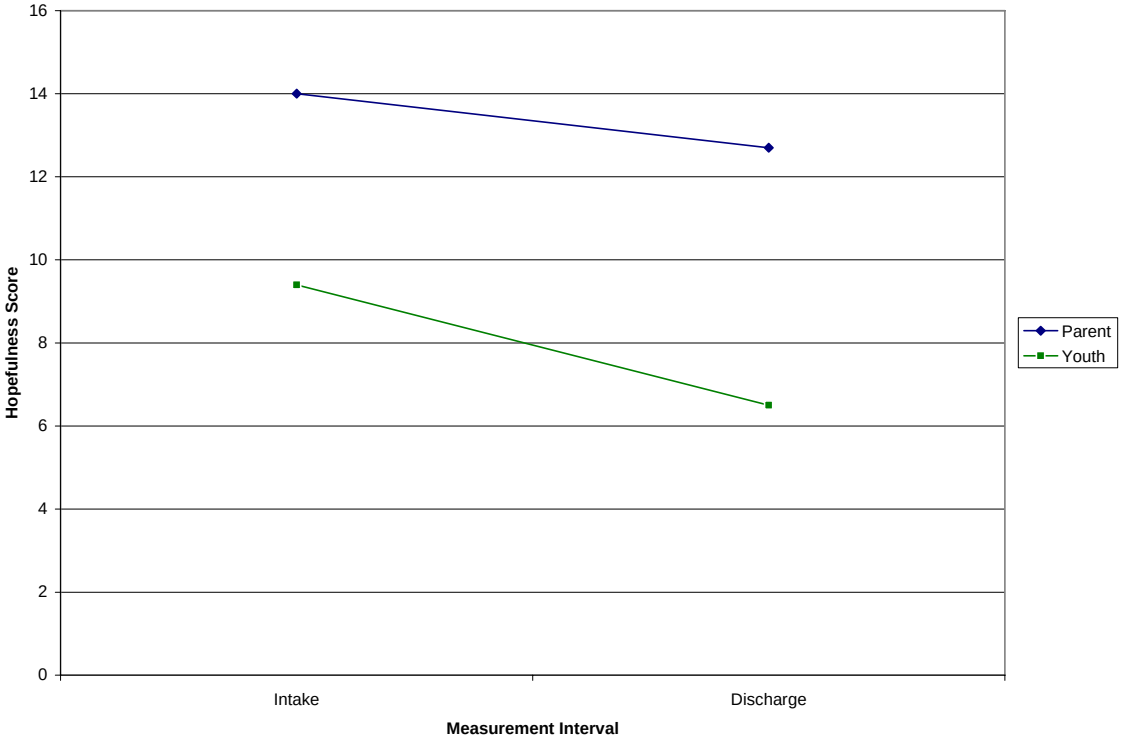
	Parent	Youth
Intake	14.09 (SD = 3.57) (n = 21)	9.42 (SD = 4.11) (n = 19)
Three Months	13.27 (SD = 5.08) (n = 11)	9.36 (SD = 3.61) (n = 11)
Six Months	12.85 (SD = 4.87) (n = 7)	8.67 (SD = 2.58) (n = 6)
Nine Months	9.75 (SD = 3.30) (n = 4)	9.00 (SD = 5.70) (n = 5)
Twelve Months	7.50 (SD = .70) (n = 2)	5.50 (SD = 2.12) (n = 2)
Discharge	12.72 (SD = 4.23) (n = 7)	6.57 (SD = 3.10) (n = 7)

Chart 79. Hopefulness Scores for Union County



* Lower scores indicative of greater hopefulness

Chart 80. Hopefulness Scores from Intake to Discharge for Union County



* Lower scores indicative of greater hopefulness

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