

**JUVENILE DRUG USE IN THE STATE OF OHIO:  
TRENDS, TREATMENT AND AGENCY CONCERNS**

**AKRON AND CANTON, OHIO**

**AN OSAM RAPID RESPONSE REPORT  
PREPARED FOR  
THE OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION  
SERVICES**

June 2000

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### **Abstract**

*Alcohol and marijuana are the most frequently abused drugs by juveniles in Summit and Stark Counties. Juveniles are also using crack, LSD and abusing over-the counter drugs such as Corcidin, Robitussin and Nyquil. In the past 6 months, use of Methamphetamine has increased moderately and Ecstasy has increased significantly. Many of the juveniles have serious academic, behavioral, emotional and family problems that present barriers to treatment. In addition, families, professionals, and the service delivery system lack the skill and resources that are needed to adequately address these barriers.*

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**Table 1: Qualitative Data Sources.****Focus Groups**

Date of Focus Group	Number of Participants	Active Drug Users or Front-Line Professionals (Type: counselor, police officer, social worker, etc.)
5-2-00	3	Stark County probation officers, school prevention coordinator
5-8-00	3	Summit County juvenile diversion project staff
6-8-00	8	DYS staff, probation officers, counselors

**Individual Interviews**

Date of Individual Interview	Active Drug Users or Front-Line Professionals (Type: counselor, police officer, social worker, etc.)
5-30-00	Chief Probation Officer – Summit County Juvenile Court
5-30-00	Magistrate – Summit County Juvenile Court
6-8-00	Magistrate – Summit County Juvenile Drug Court

**Totals**

Total Number of Focus Groups	Total Number of Focus Group Participants	Total Number of Individual Interviews	TOTAL Number of Participants
3	14	3	17

**Table 2: Detailed Focus Group/Interview Information**

May 2, 2000: Stark County Probation Officers, School Prevention Professionals

<b>"Name"</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
"Laura"	47	White	Female	Teacher for 20 years; PANDA Coordinator for 7 years
"Mindy"	44	White	Female	Juvenile services coordinator for 1 year; previously worked in social service
"Barb"	50	White	Female	Probation officer for 13 years; currently is coordinator of a youth diversion project

Recruitment Procedure: *The three participants listed above were recruited by contacting them directly based on the recommendation of a director at a drug treatment program in Stark County.*

May 8, 2000: Juvenile Diversion Project personnel

<b>"Name"</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
"Renee"		White	Female	Youth diversion staff for 18 years; B.A. in sociology in 1982, A.A. in criminal justice in 1982; LSW, CCDCCI
"Shelly"	25	White	Female	Youth division staff member for 1 year; BSW in 1997; LSW
"Alyssia"	30	White	Female	Youth division staff member for 3 years; MSW in 1999, BA in psychology; LSW

Recruitment Procedure: *The three participants listed above were recruited by contacting them directly. Directors of all youth divisions in Summit County were invited; these were the only 3 who participated.*

June 8, 2000: DYS Staff, Probation Officers, Counselors

<b>"Name"</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
"Cathy"	24	White	Female	Probation officer for 1 year; B.A. in sociology/corrections in 1999
"Shane"	37	White	Male	Casework supervisor at DYS for 5 years; probation officer at DYS for 14 years; B.A. in criminal justice in 1986
"Karen"	48	White	Female	Regional Administrator at DYS, previously a supervisor and probation officer for a total of 22 years at DYS; B.A. in psychology in 1973
"Renee"	32	White	Female	Parole officer at DYS for 1 year; worked in residential facility for youth for 5 years; B.A. in criminal justice in 1992
"Margaret"	31	White	Female	Adolescent drug counselor for 6 years; M.S. in community counseling
"Myron"	36	Black	Male	Adolescent counselor for 9 years; B.A. in actuarial science
"Mike"	24	White	Male	Probation officer at drug court for 1 year; B.A. in criminology
"Curtis"	43	Black	Male	Probation officer for 10 years; B.A. in communications

Recruitment Procedure: *The DYS participants were recruited by calling the Regional Administrator who attended and selected 2 others to also participate. The juvenile court probation officers and counselors were contacted directly.*

May 30 and June 8, 2000: Individual Interviews with Juvenile Court Personnel

<b>"Name"</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
"Mark"		White	Male	Chief probation officer for 3 years with 10 years prior experience as a probation officer; B.A. in criminal justice in 1984; CCDCIII-E
"Maria"		White	Female	Chief magistrate for 1.5 years, 3 years with juvenile court; J.D. in 1988, B.A. in political science and sociology
"John"		White	Male	Drug Court magistrate for 1 year; juvenile court magistrate for 2 years; J.D. MSW

Recruitment Procedure: *The three individual participants were identified by the key informant and contacted directly.*

## INTRODUCTION

Fourteen participants attended three focus groups held between May 2, 2000 and June 8, 2000. Focus group participants included counselors, probation officers at juvenile court, probation officers with county youth diversion programs and Department of Youth Services personnel. Three individual interviews with juvenile justice magistrates and the chief probation officer were held between May 30 and June 8, 2000. A total of 17 professionals participated.

All participants agreed that alcohol and marijuana are the most widely used drugs by juveniles with disagreement about which was “number one”. Most agreed that marijuana is “big with inner-city males.” However, all ethnic groups, ages, socioeconomic classes and both males and females use it. All agreed “pot isn’t even viewed as a drug anymore.” Blunts have increased in use and “crossed over to white kids” although some participants contend blunts are a “lower class” form of use. One focus group talked about “high tech” marijuana pipes being used by upper middle class juveniles who tend to favor pipes over blunts. Many believed the THC level was increasing. Following alcohol and marijuana in popularity are Ecstasy, LSD or crack. The later tends to be more popular with inner-city males. Several participants who work with African-American juveniles believe juveniles deal crack in order to earn money to buy marijuana, their drug of choice. Stark County participants believe “suburban kids are afraid of crack; it is viewed as a minority drug.” LSD is currently used in vials “like a Binaca bottle with food coloring because you can control the amount taken in.” LSD is more popular with males than females. Participants agree that LSD use has been stable. One probation officer said use of Ecstasy has “exploded” in the last 3-6 months and all agreed it is definitely on the rise. It tends to be used more by suburban juveniles although inner-city African-American males have also begun to start using it. Participants said “many juveniles think they can get away with it on a drug screen, but it’s often laced with coke so they get caught anyway.” Many juveniles are going to Raves. There has been some increase in methamphetamine, with “motorcycle gangs moving in with methamphetamine.” Another participant said it is moving into Summit County from southern Ohio. Stark County participants said methamphetamine is not yet a problem in Stark County. Juveniles are also using cough syrups and Coricidin, particularly younger suburban juveniles who often steal it. “They will take 8 – 10 Coricidin at a time with a shot of Robitussin or Nyquil and it gives a high like LSD.” There seems to be a decrease in inhalants according to Summit County participants although Stark County said they are “still popular especially with the younger juvenile.” Stark County participants also talked about the use of prescription drugs, particularly Zanax, Darvoset, Percodan and Ritalin, which kids are now beginning to snort. Prescription drugs are popular with the white, female high school student. They have seen an increase in Ritalin abuse and report that juveniles are stealing it from younger siblings or even selling their own Ritalin. However, all agreed that the two drugs that definitely seem to be on the increase with juveniles are Ecstasy and methamphetamine.

## GENERAL PERCEPTIONS

## 1. Familiarity and Adequacy of Services

The majority of participants were very familiar with drug and alcohol treatment services for juveniles. Although they believed there are a broad array of services and one even stated, "there is no excuse for not being able to get kids into treatment in this county," most agreed that there is a shortage of residential facilities and there are gaps for specific populations: (1) Youth with behavior management problems who have been involved with the juvenile justice system frequently have difficulty following the rules in residential treatment and are terminated from the program. "After they are kicked out, no one wants them. They are the hardest group to get treatment for." Many agreed that some facilities "kicked them out at the drop of a hat." "Kids with severe problems and on probation aren't wanted by treatment facilities." (2) "More and more kids are dual diagnosis and get conflicting advice from the mental health and substance abuse treatment people." The parents and court are then in a quandary about which professional advice to follow. These youth present major challenges due to the "layers" of problems and the difficulty in "knowing where to start." (3) Families with limited incomes and limited insurance also have difficulty getting the treatment they need, particularly residential. (4) Residential treatment for females is especially difficult to find.

## 2. Priority Populations

Participants agreed that elementary school children should be a priority for prevention; "past 11 or 12 years old, patterns become entrenched; by high school, forget it!" One teacher believed DARE worked well for elementary students. In terms of treatment, most agreed the dual diagnosed youth, whose numbers are increasing, definitely need to be a priority. Several participants think programs for parents need to be a priority, particularly since many parents use drugs themselves and "we are seeing sicker families with many issues; it's a real problem." Many felt youth with "severe" drug usage in need of residential treatment should be prioritized. "Youth from these drug-using families need to rank high on the priority list." Several participants felt inner-city African-American youth between the ages of 14-18 should be a priority.

## 3. Ancillary Services Needed

Participants mentioned the need for the following ancillary services:

- Tutoring - Many youth have serious reading problems and concomitant school failure. This contributes to the cycle of drug abuse and legal trouble. There need to be "wrap-around services with education." "There are no literacy programs for adolescents in Summit County." "Nine out of ten of the kids we see can't read," according to a magistrate at juvenile court. "Educational services are really needed." One P.O. said, "Kids can only read on a 3<sup>rd</sup> grade level and can't even do the work required by treatment programs." Participants seemed to feel very strongly about the need for ancillary educational services due to the serious reading deficits of many of the drug-abusing youth and the implication these deficits had for changing maladaptive behavior.

- Recreational activities – Community outreach centers need to be open 24 hours a day and staffed by professionals who can work with youth; “basically anything that involves the youths in a healthy activity.”
- Parent programs – Mentoring and diversion programs that require parental involvement are needed. In addition, “parents should be made accountable if the kid doesn’t follow through.”
- Multi-team approach – This was popular in the 80s and worked well. Now, there is no communication among professionals and parents get conflicting messages from various professionals involved with their child.
- Locked units – “These are needed for the behavior management kid who typically gets kicked out of treatment. These units should use a tiered system that gradually gives more privileges.”
- Home contact after the youth is released from treatment. Parents need to be involved with their child’s treatment.
- Aftercare is lacking; youth may be referred to AA or NA, but “more formalized” aftercare programs need to be developed. Participants agreed that many youth make progress in treatment, but due to lack of follow-up after discharge, they get back into trouble.
- Boot camps, especially for felons. “I used to work at one and it had a 50% success rate; it was working for the deep end kids.”
- More programs for the youth with dual diagnosis

#### 4. Training Needs

Training is needed in the following areas:

- The newest “fad drugs” “We often find out from the kids what’s going on before there is any information or stats” given to professionals. “Harold Crosley was the most knowledgeable person I’ve heard in 13 years; we need more trainers like him. He was very aware of the change in drugs on the street.”
- The value of the multi-disciplinary approach, particularly with mental health and substance abuse professionals.
- Behavior management training on how to deal with violent, manipulative youth. “Kids are tougher cookies now; they are hard as nails. We need to learn how to deal with them; they’re a new population of kid who know how to play the system.”
- Dealing with burnout
- Dual diagnosis
- Diversity, particularly with Asian youth and hearing impaired. Information is needed on how to access translators
- Probation officers need more training on alcoholism as a “disease” and how to determine “that line between social drinking and alcoholism.”
- Mediation or conflict resolution skills. This is important to teach youth and their families.
- Integration of the counseling and criminal justice approach; recognizing the value of counseling along with accountability

## 5. Prevalence of Use

Stark County participants believe use has increased in Jackson Township where middle to upper class youth have more money to spend. “They have more access to prescription drugs, do more experimenting and more club drugs.” One participant talked about a doctor’s son who is selling crack. Summit County participants believed use was stable, perhaps with a slight increase. One believed that those who are using are using more, and use is beginning at a younger age, i.e. 8 or 9. Treatment providers determine this when the juvenile comes to treatment at age 14-15 and gives a history of starting at this young age. Most participants agreed that those who begin at a young age are from using families. Another juvenile justice professional believed there is an “increase in the numbers of kids chronically using marijuana; they smoke blunt after blunt after blunt. Their whole life revolves around smoking marijuana.”

## 6. Recommendations to ODADAS

- “Talk directly to the kids.”
  - Teach the public and teachers how to recognize use in kids; what are the first signs of problem use?
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- Parent education – “parents need education; more and more are working out of the home; they give kids mixed messages; parents need to provide structure.”
  - Start prevention early – “In Germany, social workers are involved with the family from birth – age 5. We need to identify kids at birth who are at-risk and provide intensive services.” “DARE has been a failure even though it has the best of intentions.”
  - Increase community-based services, specifically recreational programs with education about AOD; provide job training and job opportunities for youth. “Teach kids how to move in a winner direction.”
  - Develop effective programs for minorities
  - Establish more programs that are geared to females. They have special issues and many of them don’t do well in traditional settings, i.e. “they tend to run from residential.” Many of them are dual diagnosed and need very specialized treatment.

## 7. Juvenile Drug Use and Schools

There was consensus that **all** schools have drug problems. The suburban schools may “hide” it better, but there are no schools that are drug-free. “Basically, drugs in school are easy to get.” The problem is somewhat reduced in the private Christian schools because of the “no tolerance” policy that is strictly enforced and their refusal to “bend the rules” for athletes and other high-profile students. Marijuana and alcohol are the most frequently used drugs. “Third place” varies among crack, LSD, methamphetamine and over-the-counter drugs with crack being more popular in the inner city schools. Ecstasy is on the rise. Juveniles use prescription drugs (Vicoden, Zanex, Percocet), over-the-counter cough medicine and cold pills (Corcidin). Summit County youth diversion staff believes there is an increase in the use of Corcidin and Robitussin. Over-the-counter drugs are “particularly popular with the younger kids because they are easy to get.” Focus groups participants said they are not

aware of any use of heroin.

Some schools have programs such as PANDA, DARE, SAD. The Akron schools have a teacher who is a “drug liaison” and keeps “informed about prevention and education issues.”

One Stark County middle school has students grouped in clusters with a teacher assigned to each cluster; the teacher tries to stay alert to potential problems with students in that cluster and intervenes when problems surface. It reportedly is “extremely effective.” However, there don’t tend to be certified drug professionals in schools. Some schools use a drug dog; it reportedly has helped reduce drugs in schools. Participants enthusiastically supported the idea of using a drug dog.

Many felt professionals in the schools weren’t effective, although opinions varied. Most agreed that the major focus of counselors is academic; “they have too many things to do” to be able to be available to help students with AOD problems.” Many said “schools ignore the problem; security officers even turn the other way.”

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Most schools give 10-day suspension for students who are using and expel students who deal. However, “often the high-profile kids are treated differently.”

There need to be more prevention programs and activities, perhaps dances and activities that send a drug-free message. Most agreed that some of the programs like PANDA aren’t “cool” so kids won’t attend. There should be more in-school suspension instead of out-of-school suspension since “kids try to get kicked out and then go use.” There need to be law enforcement officers in schools, “not the hard-line types, but the type who work to get to know the kids.” One juvenile justice professional said in schools where there have been drug sweeps, drug dogs and officers in the schools, there has been a decrease in drugs in the schools. In addition, “schools need to be better at connecting poor school performance to substance abuse.”

## **BARRIERS/ISSUES AND RECOMMENDATIONS**

### **1. Parents**

“Parents don’t want to admit the problem” was a statement around which there was group consensus. “In many cases they allow the kid to go to court rather than being assessed.” Also, parents have AOD problems themselves and minimize the youth’s problem, i.e. parents say, “I smoke pot and it’s not a problem.” The fact that parents abuse “gives the kid the message there is nothing wrong with it.” In many cases, parents don’t want to spend money on assessment and treatment. Participants agreed that at times financial reasons were valid, although frequently it was an “excuse.” Parents are also afraid family

secrets will be revealed. “Parents aren’t going to do what needs to be done. They have their own problems.”

**Recommendation(s)**

- Juveniles from drug-abusing families should be a priority for treatment.
- Parents should be held accountable if their children don’t comply.
- Home-based services that involve parents should be established
- The family-as-a unit needs to be treated

**2. Waiting lists**

The waiting period for an assessment is a deterrent.

**Recommendation(s)**

- Improve response.

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**3. Denial**

The youth don’t think there is a problem. Even if they go to treatment, “they adhere to the program just so they can get out and go home,” but they don’t really believe they have a problem. “There is a whole culture of kids who don’t think there is anything wrong with it.” In addition, youth don’t make a connection between all the problems they are having and their substance abuse.

**Recommendations:**

- Intervene early with at-risk youths and families.
- Develop more “formalized” aftercare.
- Establish boot camps for the more severe user.
- Increase community-based services that provide recreation, job training, etc.

**4. Professional’s Enabling and Attitudes**

Teacher’s, counselors, mental health workers, and school administrators often minimize the extent of the problem. Too, many of them use and/or abuse AOD themselves and their use leads to enabling.

**Recommendations:**

- Training about AOD for professionals
- Officers and drug dogs in schools

**5. Challenging Populations**

Treatment professionals often do not want to accept youths on probation. “They are apprehensive about putting the DYS kids in treatment with other kids because of their

attitudes.” “One particular program thinks kids have to come with insight and ready to cooperate and they can’t move them from resistance to motivation.” There is an increase in juveniles with dual diagnosis and an absence of services that integrate the two areas.

**Recommendation(s):**

- Boot camps for the severe user
- Programs for dual diagnosed
- Training on dual diagnosis
- Residential care should be more accessible for juveniles with behavior management problems.

**6. Transportation**

Finding transportation to treatment, especially for youth living in the suburbs, is a problem. Parents work and aren’t available to drive them to treatment.

**Recommendation(s):**

- Resources for transportation
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**7. Absence of Culturally Specific Treatment**

The majority of staff at some of the treatment centers are white and aren’t sensitive to minority issues. “It is especially hard for African-American males to fit in.”

**Recommendation(s):**

- Training about cultural-specific issues
- Establish effective minority treatment programs.

**8. Insurance/Financial**

The limits imposed by insurance interfere with youth getting the help they need, particularly with residential treatment.

**SUMMARY**

Barriers rest with the juveniles, their parents, the professionals and the service delivery system.

- Juveniles are in denial and consequently lack motivation for change or help. Many are

behavior management problems and/or seriously emotionally disturbed. Juveniles involved with the justice system tend to have serious reading deficits that contribute to academic failure and concomitant maladaptive behavior. Special-need juveniles, such as hearing impaired or “new” minority groups such as Asians, present special communication challenges.

- Parents frequently abuse drugs themselves and/or have multiple problems of their own. There are many single parents whose work and family demands prevent them from being available to help their teenage children. Many parents deny their child has a problem and resist the involvement of professionals.
  - School officials lack the training or the time to deal effectively with drug problems. In many cases, school administrators and security personnel ignore the problem. Probation officers lack an understanding of the disease concept. Mental health, substance abuse professionals and juvenile justice professionals often work at cross-purposes.
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- There is a lack of treatment facilities for juveniles who are behavior management problems and/or dual diagnosed. In addition, females and minorities have special needs and there is a lack of gender-specific programs or effective minority programs.

Recommendations are:

- Develop juvenile education (literacy) and community-based programs to address deficits, provide recreation, teach job skills, and provide activities that are an alternative to drug use.
- Involve parents in treatment programs, develop home-based programs, and make parents accountable if their child doesn't comply with treatment.
- Provide training for school officials, treatment (mental health and substance abuse) professionals and juvenile justice professionals. Reinstigate the multi-disciplinary approach.
- Place drug enforcement officers and drug dogs in the schools.
- Develop programs for the seriously troubled (behavior management problem or dual diagnosed) juvenile.
- Establish specialized programs and/or resources for females, minorities, and the disabled.



**JUVENILE DRUG USE IN THE STATE OF OHIO:  
TRENDS, TREATMENT AND AGENCY CONCERNS**

**COLUMBUS, OHIO AND FRANKLIN COUNTY**

**AN OSAM RAPID RESPONSE REPORT  
PREPARED FOR  
THE OHIO DEPARTMENT OF ALCOHOL AND DRUG  
ADDICTION SERVICES**

June, 2000

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## Abstract

*Focus group participants identified numerous barriers to the proper identification, treatment and referral of young people with alcohol and other drug problems. Those barriers include teachers, parents and social workers who are unprepared to deal with alcohol and other drug issues; inadequate services for differing levels of care; programs, services, and insurance coverage subject to rapid changes; and inadequate services for certain populations.*

*Recommendations included cross training, so that professionals could better understand the developmental issues of juveniles as well as AOD signs and symptoms. This approach could be effective in reducing the fragmentation that exists when providing services for juveniles. In-home care with wrap-around services such as mentoring, family counseling, and employment counseling was deemed desirable. Aftercare is necessary to avoid relapse. Those young people who are dually diagnosed, exhibit severe behavior, are sex offenders or homeless need specialized services.*

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Table 1: Qualitative Data Sources

**Focus Groups**

Date of Focus Group	Number of Participants	Front-Line Professionals
5-16-00	7	Safe and Drug Free Schools Advisory Group
5-18-00	11	SDFS Consortium
6-20-00	6	Netcare staff at Juvenile Detention Center
6-28-00	13	Department Youth Services

**Totals**

Total Number of Focus Groups	Total Number of Focus Group Participants	Total Number of Individual Interviews	TOTAL Number of Participants
4	37	0	37

Table 2: Detailed Focus Group/Interview Information

May 16, 2000: Safe and Drug Free Schools Advisory Committee

Name	Ethnicity	Gender	Experience/Background
Tom	W	M	2yrs. at Prevention Institute
Joan	W	F	4yrs. SDFS coordinator
Rick	W	M	19yrs. prevention specialist at Columbus Health Dept.
Patrick	B	M	5yrs. Grandview Chief of Police
Debbie	W	F	4yrs. United Way
Kitty	W	F	11 yrs. Diocese of Franklin County
Wendell	W	M	12yrs. Franklin County Juvenile Court

**Recruitment Procedure:** *Key Informant is the chair of this Advisory Group. Focus group took the place of the regularly scheduled meeting.*

May 18, 2000: Safe and Drug Free Schools Consortium

Name	Ethnicity	Gender	Experience/Background
Jeff	W	M	1 yr. Student asst. coord. for Scioto Darby
Vince	W	M	15yrs. Alcohol coordinator for Bexley
Rich	W	M	5yrs. Prevention coordinator for Worthington
Joan	W	F	4yrs. Coordinator for SDFS
Ed	W	M	5yrs. SDFS Coordinator for Gahanna
Joan	W	F	2yrs. SDFS
Suzanne	W	F	13yrs. SDFS
Kevin	W	M	9yrs. Worthington
Kathy	W	F	12yrs. CPS
Destree	W	F	8yrs. SDFS
Andy	W	M	1yr. SDFS Coordinator for Upper Arlington

**Recruitment Procedure:** *Joan Klemek, Safe and Drug Free Schools Coordinator for Franklin County, gave permission to have focus group during regularly scheduled meeting*

June 20, 2000: Netcare staff at Juvenile Detention Center

Name	Ethnicity	Gender	Experience/Background
Tammy	W	F	3yrs. crisis social worker
Ray	W	M	3 months, juvenile court assessment
Trisha	W	F	6yrs. juvenile court assessment
Pete	W	M	6yrs. juvenile court assessment
George	B	M	8yrs. crisis social worker
Cheri	W	F	12yrs. court services manager

**Recruitment Procedure:** *Contacted Netcare who furnished me with Cheri's number. Arranged focus group as part of staff meeting*

June 28, 2000

<b>Name</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
Beth	W	F	3yrs. case work supervisor
Jeff	W	M	7yrs. regional administrator
Chuck	W	M	14yrs. parole officer
Loretta	B	F	20yrs. parole officer
Larry	B	M	11yrs. case work supervisor
Roger	W	M	28yrs. program developer
Siprah	A	F	10yrs. psychologist
Ned	B	M	11yrs. substance abuse specialist
Lynne	B	F	20yrs. employment specialist
Shirley	B	F	15yrs. corrections officer
Denise	B	F	15yrs. parole officer
Joyce	B	F	Came in during course of focus group
Billy	B	F	Came in during course of focus group

**Recruitment Procedure:** Contact supplied by Wright State

## INTRODUCTION

Barriers to care among this population are numerous. Many juveniles and their parents are in denial regarding the identification of abuse/addiction as a problem. Some juveniles are coming from addicted households. There is a lack of understanding about the dynamics of juvenile abuse/addiction, necessitating cross-training across disciplines. Providers frequently change their services to keep stride with managed care, so consistency is often a problem. The current focus in the schools is proficiency testing and teachers are not well trained in ATOD issues.

Juveniles are perceived to be using more. Alcohol, marijuana, and cocaine are the most frequently used substances. The using population is becoming younger, typically 13-14, with reports of marijuana and ecstasy use as early as 11. There are some reports of inhalant abuse, primarily among very young suburban youth. Use is becoming normative.

## BARRIERS/ISSUES AND RECOMMENDATIONS

### 1. Teachers and social workers are unprepared to deal with drug and alcohol issues.

Safe and Drug Free School personnel identified that there is a lack of training in drug and alcohol issues for teachers. This did not use to be the case. Preservice teachers were getting this training as a part of their undergraduate work and training opportunities were offered through the schools. Now the focus is on proficiency testing.

*Teachers are overwhelmed. We're put in a situation. You're damned if you do and damned if you don't. We're afraid the situation will show up on transcripts. Teachers don't want to take this on.*

Coordinators report an attitudinal shift in teachers coming into the ranks. There is a different attitude about looking at drug use and signs and symptoms. There aren't as many teachers coming forward if drug use is suspected. There is a perception that the more experienced teachers are retiring with the necessary knowledge.

Many social workers do not have the basic developmental knowledge or the desire to deal with this population, especially those youth in juvenile detention or youth services. Others are ill-equipped to confront drug and alcohol issues.

*Some say, "Well, he should have been thinking of that." Well, he's not thinking of that. He's 14. He's thinking about something else or his hormones are thinking about something else. He's not going to act like an adult.*

*Social workers and other therapists say "Drug and alcohol is not my thing." I don't know. The cross training isn't there. They don't want it. They're not comfortable with it. Even if they're O.K. with drug and alcohol issues, they don't want to deal with kids.*

### **Recommendations**

Suggestions included returning drug and alcohol education to the preservice curriculum, offering training opportunities for staff development purposes, and making AOD knowledge a part of license renewal. There needs to be more of a focus on prevention that should be for everyone that recognizes biological and sociological variables. The field of prevention is seen as fragmented by specializing in populations. This reinforces the myth that abuse and addiction only happens to certain people. More research-based prevention and prevention standards are needed.

Training is needed on basic human growth and development. Professionals are not often prepared to deal with the juvenile offender. They are used to clients who have some motivation to change, which many of these youth do not.

**2. Parents are unprepared to deal with drug and alcohol issues.**

Parents have a tend to ignore these types of problems or to actually be a part of it because of their own use. In some cases, parents are not in agreement regarding the diagnosis or treatment of the child. In addition, many other life issues can overshadow the drug and alcohol abuse.

**Recommendations**

Focus group participants felt that there needs to be additional effort made to get information out to parents regarding basic human development and signs and symptoms of abuse/addiction. Prevention, child development, and parenting should be part of the high school curriculum.

More services should be home based. Too many parents and children see treatment as an inconvenience or a punishment instead of a therapeutic service. If services, including family therapy, transportation, employment counseling, and mentoring could be offered in child's environment, this barrier could be better addressed.

**3. There are inadequate services for different levels of care and special needs youth.**

Participants identified the need for detox and day treatment for juveniles. Currently in Franklin County, publicly funded programs provide outpatient and some inpatient, with nothing in-between. A juvenile is often referred to a higher level of care than is necessary. There is a paucity of care for juveniles who are dually diagnosed and those within the youth services system. Providers are scared by the diagnosis and are disinclined to admit these youth due to the historically high failure rate. Drug Free Schools personnel felt that that once a youth entered treatment, there was no attempt on the part of the provider to communicate with the school.

**Recommendations**

Although services are generally seen as adequate, certain populations suffer from inadequate care. More in-county services need to be provided for the dually diagnosed juvenile and those with severe behavior problems. Day treatment and detox were specifically identified as necessary.

Providers and schools need to communicate better. School personnel feel that they have a great deal of insight on the child's behavior as a result of day-to-day interaction. They also want to know if treatment was successful, if the child can enter back into the old atmosphere with "strategies," and what specific support the school can provide. Comprehensive aftercare was universally identified as a priority.

**4. Programs, services, and insurance coverage are subject to rapid change.**

School and court personnel do not feel they have a good understanding of services available because of rapid changes.

*We see people in a time of crisis. You send them somewhere and when they get to the door they're told that service is no longer provided. You don't want to recommend anything anymore. Now it's, "Have you checked your insurance" as opposed to "Here's a place to go."*

*They have it. It's cut two months later. They have it. It's cut a year later, or it never gets off the ground after its advertised.*

*The people you're trying to call aren't available. I've made an entire referral by way of voicemail.*

*Right now it's a merry-go round. We don't know what's going to happen. Quite frankly, I have to tell parents that. The stakes are higher for our kids. We have to provide services in a healthy environment and I'm not sure that's happening.*

## Recommendations

A centralized, current listing of services would be ideal. Providers need to develop efficient and responsive systems in order to become more accessible to those referring clients.

### 5. Approach to dealing with juveniles is often fragmented.

Providers working in the juvenile court setting identified that those involved with the child are often at odds with one another.

*There are conflicting parents. The court system is a barrier. You have ad litums, you have prosecutors, you've got CAP, you've got juvenile court, you've got the parents, you've got the kids themselves. You've got everybody tug-of-warring. The guardian ad litum may go completely against the recommendation. They have the magic wand. Kids that might already be in mental health counseling, it seems that even among our colleagues there is a lack of education or knowledge about addiction. The issue gets sidestepped.*

## Recommendations

Cross training across disciplines and systems was seen as desirable. Participants say mental health as consistently lagging behind medical services. Drug and alcohol abuse/addiction are highly stigmatized. Perhaps if cross training occurred, professionals would gain an understanding of some systemic issues and feel more empowered to work toward barrier reduction.

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### 6. Certain populations are not adequately served.

Some populations were extremely difficult to place, while others require some tailored approaches to care. Homeless young people tend to fall through the cracks. Those young people who are dually diagnosed and those with severe behavior problems had difficulty in accessing services.

*Heaven help you if they're dually diagnosed, cuz there's nothin' in this county. Must refer out of county and even then, they may not take them.*

*There's only one place in the county that has secure beds. They can be picky on who they take. They take kids who are likely to demonstrate the best outcomes.*

Sex offenders and females were identified as two populations in need of specialized approaches.

*Sex offenders represent a fourth of total commitments. An awful lot of our money, time energy is spent meeting community safety requirements and at the same time provide treatment services for those youth once they get out of institutions. A lot of times you have to provide placement as a safeguard. The amount of treatment service money spent for them is at least a third of the treatment center budget. If you don't have a whole lot of money, you know, to begin with... Yeah, that's a population that gets an awful lot of attention and probably rightly so.*

Participants saw an increase in this population and noted that the juvenile offender was most likely under the influence at the time of the incident.

Females are tending to exhibit more aggressive, male-like behaviors such as participating in violent acts and joining gangs. However, they may require a different approach as they are often victims of sexual abuse, sometimes have children, and tend to be more concerned with relationships. Providers perceived females as needing more one-on-one interaction, requiring more verbal processing, and needing different life skills than males.

**Recommendations**

Specialized services should be provided for those youth who are dually diagnosed, sex offenders, homeless, and have severe behavioral problems. Gender specific services should also be available.

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## SUMMARY

Juveniles are in need of treatment and ancillary services. Certain populations such as those youth who are dually diagnosed, homeless, sex offenders, and those with severe behavior problems are in need of specialized care. There is a growing need for gender specific programming. Participants identified the lack of understanding of juvenile behavior and drug and alcohol issues as major barriers to appropriate treatment and referral. These issues are exacerbated by the rapid changes that are occurring in managed care.

Cross training across disciplines and systems would help to reduce these barriers. Also, services provided in the home would increase acceptability among the target population and their families. Adequate aftercare is necessary prevent the youth from slipping back into destructive behavior patterns.

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**JUVENILE DRUG USE IN THE STATE OF OHIO:  
TRENDS, TREATMENT AND AGENCY CONCERNS**

**DAYTON, OHIO (MONTGOMERY COUNTY)**

**AN OSAM RAPID RESPONSE REPORT  
PREPARED FOR  
THE OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION  
SERVICES**

**June 2000**

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(State Demand and Needs Assessment: Alcohol and Other Drugs).*

## Abstract

*Two focus groups and one individual interview were conducted with twelve individuals representing various agencies in Montgomery County. The information was collected between January 2000 and June 2000. Marijuana was considered the most used drug among juveniles in Montgomery County. Club drugs, especially ecstasy was perceived as increasing significantly among juveniles in the past six months. Other illicit drugs were reportedly used by juveniles, but at a much lesser degree. Several issues/barriers to the successful treatment of juveniles were expressed and recommendations for those issues/barriers were noted. Participants were especially concerned with the lack of residential treatment facilities for female juveniles within Montgomery County. Participants also expressed concerns regarding an increasing DD/MR population, a convoluted system of care, inadequate supervision in some residential treatment programs, insufficient knowledge of current drugs and drug trends, and a paucity of healthy alternatives and after care services for juveniles.*

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Table 1: Qualitative Data Sources.

**Focus Groups**

Date of Focus Group	Number of Participants	Active Drug Users or Front-Line Professionals (Type: counselor, police officer, social worker, etc.)
5/3/00	4	Treatment providers/counselors
5/4/00	7	Probation officers & DYS parole officers

**Individual Interviews**

Date of Individual Interview	Active Drug Users or Front-Line Professionals (Type: counselor, police officer, social worker, etc.)
5/25/00	Safe & Drug Free Schools counselor

**Totals**

Total Number of Focus Groups	Total Number of Focus Group Participants	Total Number of Individual Interviews	TOTAL Number of Participants
2	11	1	12

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**Table 2: Detailed Focus Group/Interview Information**

## May 3, 2000: Treatment Providers (Juvenile Clients)

<b>"Name"</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
"L"	White	Female	CCDC-III and licensed social worker working in the Dayton area since 1974 with drug-involved adults and adolescents.
"S"	White	Male	Working in field of addiction counseling for 16 years with adults and juveniles. Last four and half years working with juveniles and their families.
"J"	White	Female	CCDC-I working nine years in field of addictions with adolescents.
"N"	White	Female	CCDC-I, case manager working with adolescents for approximately 5 years.

Recruitment Procedure: *The four participants listed above were recruited by contacting various drug treatment agencies located within Montgomery County. Agency supervisors were contacted and asked to send representatives to the focus group.*

## May 4, 2000: Probation Officers &amp; DYS Parole Officers

<b>"Name"</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
"D"	White	Female	Probation officer working in juvenile court for approximately 3 years.
"CA"	White	Male	Probation officer working in juvenile court for more than 25 years.
"J"	Black	Male	Probation officer working in juvenile court 10 years.
"NK"	White	Female	Department of Youth Services seven years and parole officer for just over 1 year.
"T"	White	Male	Probation officer working in juvenile court for about 8 years.
"B"	White	Female	Probation officer working in juvenile court for 4 years.
"K"	White	Male	Parole officer Department of Youth Services.

Recruitment Procedure: *The participants listed above were recruited by contacting the supervisors of the Montgomery County Juvenile Probation Department and the Department of Youth Services. The supervisors of each department sent participants based on their availability on the date of the focus group.*

## May 25, 2000: Safe &amp; Drug free Schools Representative

<b>"Name"</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
"MC"	White	Female	Intervention counselor with several years experience in the field.

Recruitment Procedure: *The participant listed above was recruited by contacting all the representatives of the Safe & Drug Free Schools program. Because of the closing school year, only one of the six originally contacted participants was able to attend the interview. However, all representatives contacted expressed the desire to participate on future focus groups.*

## INTRODUCTION

This report summarizes the findings of the second OSAM Network Rapid Response initiative conducted in Dayton, Ohio, concerning juvenile drug use and treatment. The report focuses on barriers and issues to successfully treating juveniles involved with alcohol or other drugs and recommendations to those barriers/issues. Two focus groups and one individual interview were conducted with a total of twelve participants representing various agencies serving the juvenile population in Montgomery County.

According to treatment providers, probation officers, parole officers, and Safe and Drug Free Schools representatives, the use of ecstasy has increased significantly over the past six months to a year in the Dayton area. In fact, the perception is that this drug has shown the greatest increase in use among all other drugs during that time period. Marijuana continues to be the most widely used illicit drug and it continues to increase in prevalence, although at a much lower rate than ecstasy. All participants noted a decrease in the age of first use of marijuana. Powder cocaine appears to be increasing slightly in its prevalence in the area. This increase is especially evident among white, female juveniles. Probation officers working with juveniles report that positives for cocaine have increased both in frequency and intensity.

Drugs such as heroin, GHB, Ketamine, crack cocaine, and LSD were considered to be used infrequently by juveniles. One participant commented that because so many juveniles have parents strung out on crack, the juveniles learn the detrimental consequences of the drug and therefore avoid it. However, the prevalence of juveniles selling crack cocaine remains to be high.

## GENERAL PERCEPTIONS

Participants were familiar with the various agencies that provided services for juveniles, but most were unable to be specific about the actual treatment that occurred within those agencies. Participants did not perceive the current treatment services for juveniles as being adequate. Treatment providers expressed the need for additional inpatient services for females. Currently, there are no such programs in Montgomery County. Females have to be referred to Dettmer for inpatient treatment. Because Dettmer is hospital-based, it tends to be too expensive for most clients to afford.

Participants also noted the need for more services for developmentally disabled and mentally retarded clients. Not only is there a lack of appropriate services for these individuals, many do not get identified because the current assessment process does not staff professionals knowledgeable about MR/DD individuals.

Probation officers expressed their concern over the apparent lack of adequate supervision in some agencies. For example, one probation officer stated that of the last ten males he sent to residential treatment, eight had runaway from the program. Because of poor locations of some agencies, recovering juveniles have to travel through bad parts of town to access these services. Consequently, relapse is common.

Probation and Parole Officers believed that in general the system that exists in Montgomery County is too convoluted. They complained that currently much paperwork must be completed and numerous approvals have to be obtained before they can get a client referred and into treatment. In addition, the current system enrolls juveniles into outpatient services first and then intensifies those services (e.g., intensive outpatient, residential) sequentially if it is deemed necessary. In order to move a juvenile upward into more intense services, a "level of care change" must be obtained. This includes several signatures and justification for the change. Participants stated that too often juveniles were "lost in the cracks" because this process took too long, especially because it is often difficult to track down the juveniles (substance abusing) parents for required signatures.

Treatment providers perceived the lack of transportation as a barrier to accessing treatment for many juveniles. Because most clients will be admitted to outpatient services, they must rely on transportation to access these services.

A representative of the Safe and Drug Free Schools initiative expressed her concern over the lack of prevention specialists such as herself in the area schools. Currently, only the larger schools can afford to employ a full time prevention specialist. Consequently, some specialists have to divide their time among several schools and some schools are not given the attention needed to employ effective prevention efforts.

## BARRIERS/ISSUES AND RECOMMENDATIONS

### **1. Residential Services for Female Juveniles Do Not Exist in Montgomery County.**

Participants expressed a need for inpatient services for females in Montgomery County. As it currently stands, professionals have to send their female clients in need of inpatient treatment to Dettmer. Dettmer is a hospital-based treatment program; therefore, it is much more costly than a non-hospital-based program. In addition, the lack of inpatient services for female juveniles in Montgomery County is inconvenient for families who have to travel to Miami County to obtain these services at Dettmer.

Participants explained how most female clients are prone to running away. Consequently, without the intense, 24-hour supervision provided by residential programs, outpatient services are of little help to these clients.

### **Recommendation(s)**

- A residential program for female juveniles is needed in Montgomery County. This program should be non-hospital-based (to keep costs low) and provide a secure environment, including intense supervision, given the runaway nature of many of the clients.

### **2. Services/Training Needed to Effectively Treat Developmentally Disabled and Mentally Retarded Juveniles.**

Participants perceived an increased population of developmentally disabled and mentally retarded juveniles. It was also believed that services provided in Montgomery County could not appropriately treat these individuals. ~~Treatment providers explained that often DD/MR juveniles are not appropriately identified during assessments and therefore many receive treatment they are unable to benefit from, given their cognitive limitations.~~

Treatment providers admitted that even if a juvenile is identified as DD/MR they are not trained to properly serve them. Also, there were concerns that many of these clients would be *misunderstood* by the professionals (e.g., probation officers, juvenile court professionals) that interact with them. For example, a DD/MR client may be expected to complete certain tasks (e.g., reading, making an appointment) without regard for the juvenile's cognitive disability.

### **Recommendation(s)**

- Services specifically tailored to and/or professionals trained to meet the needs of DD/MR juvenile clients are needed. This should include professionals trained and experienced in identifying DD/MR clients at assessment.
- Treatment providers as well as other professionals who may work with DD/MR juveniles need to receive training concerning DD/MR juveniles so that effective treatment can be provided to these individuals.

### **3. Poor Locations and Inadequate Supervision of Juvenile Treatment Programs.**

Participants agreed that the location of many treatment programs increases the chance of relapse for juveniles because the juvenile is required to travel many *bad* parts of town to get to the treatment program. While traversing to counseling, many see and are tempted by drugs—many are even offered drugs on their way to or from counseling. This situation creates a significant barrier to juveniles involved in outpatient treatment services (the majority of clients), and reduces their involvement in vital aftercare services.

Probation officers were especially concerned about the apparent lack of supervision provided to their clients in residential treatment. One officer stated that eight of the last ten male juveniles he enrolled into residential treatment ran away from treatment within a few days. Given the amount of effort required to get a juvenile into residential treatment, this is a significant issue.

## Recommendation(s)

- Transportation to and from treatment programs seems necessary to reduce the chance of relapse and to increase the participation of clients in outpatient counseling and aftercare services.
- Protocols at residential treatment facilities should be implemented that will reduce the chance of a juvenile leaving the program prior to the completion of treatment.

### 4. System Complexity and Resulting Poor Communication Between Involved Agencies.

Because of confidentiality laws, required approvals and signatures, it is very difficult to communicate information about a client to other agencies and professionals involved in that client's treatment. Consequently, some procedures (e.g., assessment, testing) may be repeated at each agency and may increase the costs incurred by the client. In addition, the time it takes to get a juvenile client the treatment he/she needs is increased.

Probation officers were concerned about the difficulty in making a *level of care change* for their juvenile clients. Currently in Montgomery County, juvenile clients are enrolled in the least intense treatment option and then move upward to more intense treatment sequentially, if necessary. However, probation officers state that in order to make this change in level of care, a *level of care change* must be filed and justified by the officer. Because of the difficulty in acquiring parental signatures and the lack of information about the client's progress in treatment to the officer, this change in care request is too difficult to obtain. Consequently, many juveniles do not get the care they need.

## Recommendation(s)

- A *release form* should be created that will allow all involved agencies to communicate and release information about the client to one another. This release would allow agencies (e.g., treatment, juvenile court) to freely communicate the progress of the client and would allow the sharing of assessment information and other testing results (e.g., urine screens).
- This release form would also allow treatment providers and other involved agencies to cooperatively adjust the level of care for a juvenile client as needed.

### 5. Unknown Progress of Juvenile in Treatment.

Probation officers expressed a concern regarding the progress of their clients in treatment. These participants stated that it was very difficult to get information from treatment providers about the progress of their clients in treatment. This information is vital if the probation officer needs to justify a level of care change.

Probation officers agreed that information on the progress of their client in treatment would not only be beneficial to the officer, but the officer could then present consequences to the juvenile if he/she were not cooperating in treatment. Consequently, a partnership could be created between the probation department and the treatment agency that could ultimately benefit the client. Also, because family involvement is important (and rare) in the treatment process of the juvenile, probation officers may be able to increase family involvement through legal sanctions.

## Recommendation(s)

- Probation officers believed that brief, monthly status reports on each of their clients in treatment would be extremely beneficial to them and their client. These reports should include a description of the juvenile's behavior in treatment, level of family involvement, and specifics about the juvenile's treatment program (e.g., what is the treatment?).

### 6. Ignorance About Substance Abuse Treatment.

Probation officers expressed the need for training about drug treatment. They report that currently they must learn from their clients about drug use and trends in the area. Probation officers believe that brief training about the signs and symptoms of drug use and intervention techniques would prove useful to them when interacting with their clients. This training could also improve communication between probation officers and treatment providers because the officers would have a better understanding of substance abuse treatment and related terms.

### **Recommendation(s)**

- Basic drug and alcohol training should be provided to non-treatment agencies. This training should include signs and symptoms of specific drugs of abuse and basic intervention skills that non-treatment professionals can utilize when interacting with their clients.
- OSAM-O-Grams, statewide and area-specific, should be communicated to non-treatment agencies as well as treatment agencies. Such information can keep professionals up-to-date with current and emergent drug use trends (some participants were unfamiliar with Raves and knew very little about Ecstasy and other *club drugs*).

### **7. Lack of *Healthy Alternatives* in Montgomery County.**

Participants believe that juveniles are less likely to become involved with drugs if they have activities to become involved in that promote a drug-free lifestyle. Currently in Montgomery County, these *healthy alternatives* to drug use are lacking.

### **Recommendation(s)**

- Participants felt that recreational activities promoting a drug-free lifestyle for juveniles would provide an environment where juveniles can associate with one another and learn healthy ways of coping with stress and other hardships in their lives.

### **8. Increased After Care Services Needed in Montgomery County.**

Because relapse is so prevalent among the juveniles they serve, treatment providers and probation officers expressed a need for more aftercare services for their juvenile clients in Montgomery County. Along with these aftercare services, participants believed that case management for their juveniles would also be beneficial.

### **Recommendation(s)**

- Increase after care services for juveniles in Montgomery County. After care services could reduce the likelihood of relapse and could help juveniles in their transition from treatment back to their home environment.
- Case management is needed for juveniles. This service would not only help the juvenile in their transition from treatment, but would help the juvenile access needed services (e.g., job training, GED). Case management would also allow qualified professionals to keep in contact with the juvenile and curtail potential instances of relapse.
- Probation officers were especially enthusiastic about the “Lighthouse” program in Montgomery County. This program brings juveniles to one location where they receive all their needed services (e.g., counseling, probation, meals, and education) throughout the day. Probation officers boasted significant positive changes in their clients attending this program. Consequently, more *full service* programs like Lighthouse were highly recommended.

### **Summary**

Several barriers/issues were identified concerning drug treatment for juveniles in Montgomery County. A fundamental concern among all participants was the lack of residential treatment facilities for female juveniles in Montgomery County. Treatment providers recognized an increasing population of developmentally disabled and/or mentally retarded juveniles in the system, and these individuals were not being properly served by the agencies involved with their care. A complex system, poor supervision in existing residential treatment programs, poor location of treatment programs, and the lack of adequate aftercare services and healthy alternatives also contribute to the difficulty in successfully treating the juvenile in Montgomery County.

Specific to non-treatment professionals, there was a concern over the lack of training needed to identify signs and symptoms of current and new drugs of abuse. Also, non-treatment professionals believed that basic training about drug treatment would help them to effectively communicate concerns about their clients to treatment professionals caring for those clients.

All participants expressed a need to receive up-to-date information about drug use and emergent drug trends statewide and area-specific. Consequently, participants thought it important to receive OSAM-O-Grams at their agencies on a regular basis.

All participants acknowledged ODADAS and the OSAM Network for a concerted effort to improve the current system of drug and alcohol treatment for juveniles. Participants voiced their gratitude for having their concerns heard. The authors greatly appreciate the time each participant devoted to this initiative.

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**RAPID RESPONSE: JUVENILE DRUG USE**  
**IN CLEVELAND, OHIO**  
**A REPORT PREPARED FOR THE**  
**OHIO SUBSTANCE ABUSE MONITORING (OSAM) NETWORK**

June, 2000

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## Abstract

*There is a paucity of existing drug/alcohol treatment services specifically aimed towards the juvenile/adolescent population throughout Cuyahoga County and the Cleveland area. Of the programs/services that are presently in operation, many barriers to treatment currently exist in accessing such services. There is a tremendous need for education of all school-age children and adolescents and their families. Many of the educational programs currently offered (i.e. DARE Program) need to be evaluated and possibly revised to more effectively capture the attention of the target population. The use of drugs among juveniles has increased overall; however, certain drugs have experienced a decrease in utilization (i.e. heroin, other opiates, powder cocaine). Drug availability in the school systems is rampant. Select school systems have adopted a "zero tolerance policy" towards both drug use and drug dealing. Many school systems continue to deny that a "drug problem" exist within their system and/or are unwilling to aggressively pursue juvenile drug use interventions due to financial burdens, alternative priorities and the culture of the school system. "Club drugs" such as 'Special K' (Ketamine), 'Ecstasy' (MDMA), GBA and LSD/acid are increasing in utilization among the adolescent population at all-night Raves and concerts. These "Club drugs" are readily available for purchase and are becoming cheaper in price. Inhalant abuse ("Huffing") remains very popular with the younger adolescent population (10 - 14 years of age) and is usually associated with a juvenile's first experimentation into drug use.*

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# INTRODUCTION

## 1. Area Description

More than 1.4 million people live in Cuyahoga County, the most populous and urbanized of Ohio's 88 counties. About half a million individuals reside in Cleveland. Although the poverty rate in the county suburbs has gradually increased (14%), the rate in Cleveland remains more than eight times higher - approximately 45% of Cleveland residents live in poverty. Poverty rates have increased while unemployment rates have declined to a record low in most areas.

## 2. Data Sources and Time Periods

- **Qualitative Data** were collected in one focus group and 2 individual interviews conducted in April, May and June, 2000. The number and type of participants are described in Table 1 and 2.
- **Alcohol and Drug Abuse Treatment percentages** for adolescents in treatment facilities are provided by the Ohio Department of Alcohol and Drug Addiction Services for the state of Ohio and each specific county.
- **National statistics** are available from the Treatment Episode Data Set (TEDS) 1992 -1997 provided by SAMSHA.
- **Availability, price and purity data** are available through the Cuyahoga County Sheriff's Department and local suburban police/sheriff departments for January, 1999 through June, 2000.

**Table 1: Qualitative Data Sources**

**Focus Groups**

Date of Focus Group	Number of Participants	Type: school counselors, treatment providers, drug free school representatives, juvenile probation/court professionals, DYS personnel, etc.
06/22/00	4	Treatment Providers, Juvenile Prosecutor, police officer

**Individual Interviews**

Date of Individual Interview	Type: school counselor, treatment provider, school representative, juvenile probation/court professional, DYS personnel, etc.
06/20/00	Treatment Provider, past DYS personnel (Executive Director of DYS-funded program)
06/24/00	Treatment Provider

**Totals**

Total number of Focus Groups	Total Number of Focus Group Participants	Total Number of Individual Interviews	TOTAL Number of Participants
1	4	2	6

**Table 2: Detailed Focus Group/interview Information**

June 20, 2000

<b>"Name"</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
Debra	35	White	Female	Thirteen years experience in adolescent treatment. Seven years experience as Executive Director of DYS-funded youth shelter. Currently, Clinical Director of WSEM, a large, multi-cultural service agency specializing in children, adolescent and family treatment programs that services Cuyahoga County. LISW and Master's degree in counseling/psychology.

Recruitment procedure: *The participant above was recruited through a previously established contact with the Executive Director of WSEM and Center for Families and Children. This individual was recommended for participation in this Rapid Response Initiative because of her expertise in juvenile/adolescent chemical dependency treatment issues and background in DYS programs and services.*

June 22, 2000

<b>"Name"</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
Anne	44	White	Female	Fifteen years experience in justice system, the past three years has served in juvenile justice system. Juris Doctorate degree.
Thomas	52	White	Male	Twenty five years experience in Behavioral Health - both chemical dependency, mental health and forensics. Registered Nurse.
Karen	37	White	Female	Fourteen years experience in adolescent forensics - registered nurse at juvenile detention center.
Anna	29	White	Female	Six years experience in adolescent chemical dependency. LISW, Master's degree in counseling, psychology.

Recruitment Procedure: *The four participants listed above were recruited through a contact with the Cuyahoga County Forensic/Correction Program and the Juvenile Detention system. The nurse liaison asked the nurse at the detention facility to identify appropriate candidates for participation.*

June 24, 2000

<b>"Name"</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
Betty	57	White	Female	33 years experience in Behavioral Health field - specializing in chemical dependency and adolescent mental health. Master's degree in nursing and counseling. Director of chemical dependency unit at St. Vincent Charity Hospital/Rosary Hall.

Recruitment Procedure: *The individual above was recruited through a previously established contact with St. Vincent Charity Hospital and the Cuyahoga County Drug Board.*

## METHODOLOGY

- One focus group and two individual interviews related to Juvenile Drug Use were conducted between April, 2000 and June, 2000 with a total of 5 participants.
- A focus group consisting of four treatment professionals and representatives from the juvenile justice system was conducted on June 24, 2000. All focus group participants are professionals providing chemical dependency services to adolescents and their families requiring intervention and support.
- Qualitative data contained in this report was gathered through successful completion of one focus group and two individual interviews that were audio-taped, transcribed, analyzed and summarized.

## OVERVIEW

The focus group and individual interviews were well-received by the participants with most appreciating the opportunity to be involved in this research project and express their concerns, issues and opinions related to adolescent drug use. The general tone of the participants in regard to drug use among juveniles was of concern and frustration with existing services and treatment options. Many concerns were expressed regarding treatment barriers, lack of effective educational programs for adolescents and their families, and the relatively lenient marijuana (the predominant drug of choice for adolescents throughout Cuyahoga County) laws that exist throughout the state.

There is a paucity of existing drug/alcohol treatment services specifically designed to treat the juvenile/adolescent population throughout Cuyahoga County and the Cleveland area. There is a tremendous need for education of all school-age children and adolescents and their families. Furthermore, many of the educational programs currently in existence (i.e. the DARE program) need to be evaluated to ascertain effectiveness in reaching the target population. The participants shared that there is limited training available for treatment professionals that address the unique treatment issues that relate to the adolescent abusing drugs. Drug availability in the school systems is rampant. The majority of school systems have not had the capacity to aggressively implement many of the drug policies that have been developed due to financial restraints and limited personnel. "Club drugs" are readily available for purchase and have become increasingly popular. LSD/acid and other hallucinogens also remain popular.

## JUVENILE DRUG USE TRENDS

### **Familiarity with Existing Services for Adolescents**

- ▶ In Cuyahoga County, four treatment programs are predominantly utilized for adolescent treatment - 1) Edwin Shaw; 2) Oakview, a division of Southwest General Hospital; 3) *New Directions* in Pepper Pike; 4) and Oriana house.
- ▶ Because of the scarcity of adolescent chemical dependency treatment programs available, all participants were **very** familiar with services currently in existence.
- ▶ Many of these programs have limitations:
  - long waiting lists
  - a limited amount of indigent beds
  - Oriana house is limited to only adolescent males
  - a lack of residential options for females.
  - accessibility to outpatient programming - ie. dependency on parents to transport adolescent to outpatient treatment programs - this is often not successfully maintained.
  - a lack of intensive outpatient services

### **Barriers to Identifying Substance Abuse Problems Among Adolescents**

- ▶ Access to the adolescent for a complete evaluation - again, parents are predominantly depended upon to follow through with either court-mandated or recommended treatment programs for an adolescent with chemical dependency issues. Many times, the parents are not compliant with the treatment plans and protocols that have been developed.
- ▶ A complete lack of intensive outpatient therapy modalities - often, this is defined as regular attendance at Alcoholics Anonymous meetings that are rarely enforced.
- ▶ The county lacks sufficient residential services, particularly for the female population (there is none currently in existence).
- ▶ Once the juvenile has been identified as requiring treatment, there is a limited amount of services to refer these individuals. Often, many adolescents "*fall through the cracks*" while awaiting placement in treatment programs. Furthermore, there is a very limited availability of non-insured beds available.

### **Priority Populations Among Juveniles**

- ▶ Juveniles between the ages of 13 and 16, predominantly male, whom are unsupervised and "*not bright enough to stay out of trouble*".
- ▶ Females, between the ages of 15 and 18, that may have presenting medical problems such as pregnancy, sexually transmitted diseases, vitamin deficiencies.

### **Increasing Effectiveness of Existing Services**

- ▶ Prevention education at a much younger age than is currently being offered - kindergarten or first grade.
- ▶ Identifying truancy as a potential precursor to impending chemical dependency problems - either with the juvenile or with the family unit - "*odds are that if mom cannot get the kids to school, something is going on in that house and that behavior that is truant is going to turn delinquent. Is mom sleeping because she has a hangover and cannot get up?*"

### **Training Needs**

- ▶ Training that would assist treatment providers in dealing with the unique aspects of adolescent chemical dependency - for example, a lack of belief that "*something bad will happen to me if I do drugs*", adolescent hopelessness - "*Why shouldn't I use? My life sucks anyway*", peer pressure, lack of parental support.
- ▶ Parental education - specifically, educating parents regarding identifying a potential/existing drug problem with their children -behaviors, physical presentation, drug paraphanelia.
- ▶ Training of treatment providers that outlines different levels of treatment that addresses diverse adolescent groups.

## **Prevalence of Drug Use Among Juveniles**

▶ Drug use among juveniles has decreased for cocaine and heroin, has remained stable for marijuana and has seen an increase in the use of “Club Drugs” such as ‘Special K’, ‘Ecstasy’, LSD/acid and other hallucinogens such as ‘Mushrooms’. Inhalant abuse (“Huffing”) remains very popular with younger juveniles (10-14 years of age) and is most often associated with a juvenile’s first experimentation into drug utilization.

## **Juvenile Drug Use and Schools**

- ▶ Select school systems have adopted a ‘zero tolerance policy’ towards both drug use and drug dealing - if an individual is caught with any type of drugs or involved with dealing of drugs, that adolescent is immediately expelled.
- ▶ Many school systems continue to deny that a ‘drug problem’ may exist within their system and/or are unwilling to aggressively pursue intervention due to financial restraints, alternative priorities or the culture of the school environment.
- ▶ Many school systems are unwilling to work with law enforcement personnel to intervene with drug prevention protocols - do not want to have law enforcement personnel on school grounds.
- ▶ Drug availability is rampant in all schools. If an adolescent wants to purchase drugs, he/she usually knows whom to contact to obtain a drug of choice.
- ▶ Drug education programs such as DARE have not proven to be effective in inhibiting drug use amongst juveniles/adolescents. Many of these programs may need to be re-evaluated and redesigned in order to have a greater impact on the present day adolescent population.

## **General Drug Trend Questions Concerning Juveniles**

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▶ The most common drug abused by juveniles under the age of 18 is marijuana and alcohol. “Club Drugs” such as ‘Ecstasy’ and GBA are increasingly popular and have become readily available and very cheap in price. Both powder and crack cocaine are decreasing in utilization, as well as heroin. ‘Primos’ and ‘Blunts’ are a very popular method of smoking marijuana amongst the adolescent population.

## **Recommendations For ODADAS Concerning the Prevention and Treatment of Drug Use Among Juveniles**

- ▶ Changing the laws that make possession and utilization of marijuana a much more serious offense. The legislation currently states that marijuana possession and utilization is a minor misdemeanor (\$50 fine) which is in comparison to disorderly conduct or a curfew violation. Research has indicated repeatedly that marijuana usage among young juveniles leads to a higher propensity for increased drug usage among different classes of drugs. The consequences for marijuana usage and possession need to be more serious - possibly in alignment with a DWI conviction.
  - ▶ School systems need to have parental education of drug use mandatory curriculum. Parents need to be trained regarding addictions and identification of addictive behavioral traits.
  - ▶ Re-evaluation of current educational programs being offered to the juvenile population. Today's juveniles are much more sophisticated and street-savvy than juveniles of fifteen-twenty years ago when many of these programs were first designed. Utilization of incarcerated individuals that have a history of drug involvement to speak with the adolescent population may be more effective.
  - ▶ School systems need to have uniform, mandatory drug protocols that address juveniles dealing/using drugs. Financial reimbursement to utilize city/suburban law enforcement personnel to assist with drug usage should be made available.
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**JUVENILE DRUG USE IN THE STATE OF OHIO:  
TRENDS, TREATMENT AND AGENCY CONCERNS**

**MAHONING COUNTY, OHIO**

**AN OSAM RAPID RESPONSE REPORT  
PREPARED FOR  
THE OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION  
SERVICES**

**June 29, 2000**

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### **Abstract**

*Four focus groups (20 participants) were convened over a 4 month period to gather information concerning alcohol and other drug (hereafter also referred to as AOD) abuse trends and problems in Mahoning County, OH. The widespread use and growing cultural acceptance of alcohol and marijuana in particular was noted along with other community specific drug use trends. Perceived obstacles to effective prevention, intervention and treatment of AOD involved adolescents were solicited. These obstacles and similarly solicited recommendations regarding potential solutions are summarized in the report.*

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Table 1: Qualitative Data Sources.

**Focus Groups**

Date of Focus Group	Number of Participants	Active Drug Users or Front-Line Professionals (Type: counselor, police officer, social worker, etc.)
<i>3-29-00</i>	<i>6</i>	<i>Probation officers, Delinquency Prevention Specialists, Intake Hearing Officer, Assessment Counselor</i>
<i>5-30-00</i>	<i>4</i>	<i>DYS Casework Supervisor, Adolescent Counselors, Adolescent Treatment Program Director</i>
<i>6-7-00</i>	<i>4</i>	<i>Prevention Specialists, Peer Youth Prevention Program Participant, Juvenile Diversion Programs Staff, Police Officer</i>
<i>6-9-00</i>	<i>6</i>	<i>Juvenile Diversion Officers</i>

**Totals**

Total Number of Focus Groups	Total Number of Focus Group Participants	Total Number of Individual Interviews	TOTAL Number of Participants
<i>4</i>	<i>20</i>	<i>0</i>	<i>20</i>

**Table 2: Detailed Focus Group/Interview Information**

March 29, 2000: Juvenile Court Officers and Diversion Program Staff

<b>"Name"</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
<b>"Duane"</b>	30	<i>African-Amer.</i>	<i>Male</i>	<i>Probation Officer</i>
<b>"Norma"</b>	29	<i>Caucasian</i>	<i>Female</i>	<i>Delinquency Prevention Specialist</i>
<b>"Jen"</b>	31	<i>Caucasian</i>	<i>Female</i>	<i>Delinquency Prevention Specialist</i>
<b>"Sallie"</b>	41	<i>African-Amer.</i>	<i>Female</i>	<i>Intake Hearing Officer</i>
<b>"Butch"</b>	44	<i>African-Amer.</i>	<i>Male</i>	<i>Probation Officer</i>
<b>"Debra"</b>	31	<i>Caucasian</i>	<i>Female</i>	<i>Assessment Counselor</i>

Recruitment Procedure: *Recruited by contacting Mahoning County Juvenile Court Diversion Program Coordinator*

May 30, 2000: Adolescent Treatment Programs and DYS Staff

<b>"Name"</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
<b>"Deidre"</b>	40	<i>African-Amer.</i>	<i>Female</i>	<i>DYS Casework Supervisor</i>
<b>"Ann"</b>	32	<i>Caucasian</i>	<i>Female</i>	<i>Adolescent Counselor</i>
<b>"Joe"</b>	42	<i>Caucasian</i>	<i>Male</i>	<i>Adol. Tx. Program Director</i>
<b>"Marla"</b>	27	<i>Caucasian</i>	<i>Female</i>	<i>Adolescent Counselor</i>

Recruitment Procedure: *Recruited by contacting local programs that treat and serve alcohol and other drug dependent adolescents.*

June 7, 2000: AOD Prevention Program Staff and Prevention Program Participant

<b>"Name"</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
<b>"Cathy"</b>	39	<i>Caucasian</i>	<i>Female</i>	<i>Prevention Specialist</i>
<b>"Joe"</b>	18	<i>Caucasian</i>	<i>Male</i>	<i>PANDA participant</i>
<b>"Booker"</b>	27	<i>African-Amer.</i>	<i>Male</i>	<i>Prevention Specialist</i>
<b>"Heidi"</b>	32	<i>Caucasian</i>	<i>Female</i>	<i>Prevention Specialist</i>

Recruitment Procedure: *Contact with "Prevention Partners Plus"*

June 9, 2000: Juvenile Diversion Programs (local police jurisdictions)

<b>"Name"</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>Experience/Background</b>
<b>"Lucinda"</b>	25	<i>Caucasian</i>	<i>Female</i>	<i>Poland / Lowellville Diversion Program</i>
<b>"Danielle"</b>	25	<i>Caucasian</i>	<i>Female</i>	<i>Struthers Diversion Program</i>
<b>"Dan"</b>	33	<i>Caucasian</i>	<i>Male</i>	<i>Police Officer (Beaver Local)</i>
<b>"Jennifer"</b>	28	<i>Caucasian</i>	<i>Female</i>	<i>Boardman Diversion Program</i>
<b>"Heidi"</b>	27	<i>Caucasian</i>	<i>Female</i>	<i>Boardman Diversion Program</i>
<b>"Jeff"</b>	35	<i>Caucasian</i>	<i>Male</i>	<i>Austintown Diversion Program</i>

Recruitment Procedure: *Contact with local police jurisdictions and their diversion programs*

## **INTRODUCTION**

In general, juvenile use of alcohol, tobacco and marijuana was reported to be extremely prevalent and readily available both in the city (Youngstown) and the suburbs. It was reported that these drugs are seen as very common and accepted and that their use seems to cut across socio-economic and ethnic groups and geographic boundaries. (Alcohol remains the #1 drug of juvenile use while marijuana is a rising 2<sup>nd</sup>).

According to reports, marijuana is very widely used among urban young people. Focus group participants described the use of “blunts” (cigars unwrapped to insert marijuana that may sometimes, in turn, be laced with cocaine or other substances...of particular note is the use of a cigar brand called “Black and Milds” for this purpose). Cocaine when used in urban areas is reportedly more often crack cocaine.

Reports from one area of the county that is predominately Caucasian and working class were that while alcohol, tobacco (especially smokeless / chew) and marijuana were very available and widely used, the use of other drugs was the exception rather than the rule.

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In contrast, the more affluent middle to upper middle class suburbs reported growing use of “club drugs” like Ecstasy (especially in connection with “Raves”), opiates such as Vicodan and Oxycotin (especially the later) as well as some use of LSD and powder cocaine among adolescents.

Several sources reported the accepted and prevalent use of alcohol and other drugs by athletes. There were several reports of coaches actually borrowing “Chew” from athletes and of coaches “looking the other way” regarding athletes use of alcohol and steroids. There was one report of a very high profile athlete on a state level recognized team dealing drugs.

## **GENERAL PERCEPTIONS**

As an aggregate, the focus group participants saw alcohol and other drug use as widespread among adolescents in Mahoning County. As stated above, alcohol and marijuana reportedly seem to be staples among this population with a trend toward increased use of “Ecstasy” and opiates in some venues. All participants referred to apathy and tacit “acceptance” of juvenile alcohol and marijuana use on the part of communities (schools, parents, etc.) and naiveté on the part of these same groups regarding the growing use of other drugs.

There was a fairly high level of expressed awareness of and satisfaction with existing adolescent alcohol and other drug treatment services. The need for improved access to residential services for area adolescents was commonly expressed. Barriers to treatment and to community wide solutions to adolescent alcohol and other drug use were cited and are listed below.

## **BARRIERS/ISSUES AND RECOMMENDATIONS**

### **Barrier / Issues:**

1. Lack of consistently applied protocols for handling school related AOD (alcohol and other drug) abuse problems.  
*Recommendation: Mandated application of uniform Student Assistance Protocols statewide.*
2. Denial, apathy and actual acceptance of alcohol and marijuana use on the part of community systems and parents. (Contributing factors were cited including: Parental AOD use; Desire by suburban school systems to “look good” etc., Reluctance of schools to identify kids of high profile or affluent parents, etc.).  
*Recommendation: Mandated programs/protocols (see above). Education and training for schools, communities, parents.*
3. Lack of judicial consistency in handling AOD related cases.  
*Recommendation: Training for judges and their staffs, resources for additional probation officers for the courts, mandated sentencing and use of treatment alternatives.*
4. Lack of in-home case management services in support of adolescent treatment.  
*Recommendation: Resources in support of the development of in-home case management services.*

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5. Lack of transportation to treatment in some areas.  
*Recommendation: Provision of resources necessary to develop transportation systems for teens that need treatment and other services in support of prevention and recovery.*
6. Lack of in-school counseling services. (School counselors have become involved with scheduling and proficiency testing to the exclusion of actual student counseling).  
*Recommendation: Addition of school counselors in every school whose primary and sole responsibility is counseling.*
7. Obstacles to appropriate care levels set by managed care organizations as part of their relationship with health care insurance companies.  
*Recommendation: Mandated use of ODADAS Levels of Care protocols by Managed Care entities doing business in the state.*
8. Lack of access to longer-term residential treatment services.  
*Recommendation: Development of community resources and programs necessary to provide access to adolescent residential treatment that is in excess of 30 days duration.*
9. **Additional Recommendation:** Align local efforts with Healthy Valley 2000, Comprehensive Strategy and UAW, GM, IUE Community Health Initiative recommendations. (see exhibits III & IV)

### **Summary**

The above barriers and issues deal primarily with community perceived obstacles to identification, referral and appropriate treatment of adolescents with alcohol and other drug abuse related problems. The recommendations provide some suggestions for creative solutions to these obstacles. The suggestions call for increased resources, an active governmental role in mandating solution-focused processes and stimulation of community efforts to address these problems.

**Exhibits**

- Exhibit 1: Table 2: National, State of Ohio and Mahoning County's total number of adolescent treatment admissions by specific drug
- Exhibit 2: National, State of Ohio and Mahoning County adolescent treatment patient primary drug of choice (figures 5-7)
- Exhibit 3: a Community Health Plan for Mahoning County developed by Healthy Valley 2000 (May 1998, pages 14-17)
- Exhibit 4: Mahoning County Strategic Plan for Youth and Families – Executive Summary (January 2000)
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