

JUVENILE JUSTICE / MENTAL HEALTH INITIATIVE
(JJMHI)

FINAL EVALUATION REPORT

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Submitted to:
Youth Network Council / Illinois Collaboration On Youth

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DISCLAIMER

Points of view or opinions contained within this document are those of the author. They do not represent the official position of Youth Network Council, Illinois Collaboration On Youth, or the USDHHS / Substance Abuse Mental Health Services Administration unless specifically acknowledged as such.

This evaluation is based on data submitted by the agencies and, then in turn, by Youth Network Council /Illinois Collaboration On Youth to the Lead Evaluator.

PREFACE

This report represents the final evaluation of the Juvenile Justice / Mental Health Initiative (JJMHI). The evaluation was performed by ABBATE GROUP, LTD., under the direction and supervision of Gary B. Beringer, Dr. P.H., Lead Evaluator. It charts the progress of this grant from the inception of the Initiative through the sixteen months of the grant period (initial award made and approved for July 1, 2005; time period for no-cost extension then moved to September 1, 2005 through December 30, 2006, inclusive).

Opinions expressed and interpretations of the data are those of the Lead Evaluator. In part, both the accuracy and precision of the data are based upon the information supplied by the staff of Youth Network Council. The importance of the on-going data collection in the eventual evaluation was stressed and reinforced throughout the duration of the grant period.

This report is based on the data submitted to the Lead Evaluator by the staff of Youth Network Council, which in turn was based on self-reported data and other information submitted by the agencies. Every effort has been made to clarify the data.

An opening comment about the format and style of this Evaluation Report seems warranted. This is an assessment of the Juvenile Justice Mental Health Initiative from both an administrative viewpoint and the measurement of an outcome evaluation. However, there is an element of scientific rigor firmly underlying the undertaking. There are sections at the beginning

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of this Evaluation Report that present aspects of the organization, events, and paperwork of this program. The methodology which was followed is described in thorough terms.

The outcomes are presented in the “Results” section which is a comprehensive retelling of the fifteen months that the program was operating. The “Results” section is unfiltered according to common survey design strategies. Some categories are shown even if the cells are equal to only one or two cases. Results are presented in individual categories instead of being grouped or collected in “catch-all” classes such as “Other”. This step is at the specific request of the administration of Youth Network Council / Illinois Council on Youth. Thus, some tables show all conceivable responses rather than being truncated. At the early stage of a program, this approach may be justified for future planning efforts.

Additional chapters of this Evaluation Report contain what is usually limited to the “Discussion”. There also is a separate “Discussion” section. References to the literature are contained in both sections. This may be considered unusual, but the format of this Evaluation Report is not strictly a traditional scientific report. A rigid format is appropriate for a research piece, but not for this Evaluation Report. Each has its own purpose and there is room for both types. This Evaluation Report is designed to try to tell the developing story of a creative and innovative juxtaposition of community-based youth-and-family serving human service organizations, mental health providers, and the juvenile justice system. The Evaluation Report then attempts to make a professional judgment about the effectiveness of that program to date.

Some authors speak of the high unmet need for appropriate treatment for many different disorders (Wells, Miranda, Bruce et al, 2004). No where can the high unmet need be seen than in this special population — the interface between the juvenile justice system and the child or adolescent with mental health issues. These youngsters are considered by some to be outside the area of professional and paraprofessional concern. They deserve a chance and JJMHI may be giving some clients that chance.

This effort has been an extended pilot study designed to see if the combination of youth agencies and mental health strategies could effectively be combined to bring mental health services to juvenile justice system youth on a community-based level. The Juvenile Justice Mental Health Initiative was a true start-up effort on the part of the participants. Studying the organizational process is a potential bridge for the introduction of new types of intervention models into mental health practice (Rosenheck, 2001).

It is vital that every attempt be made to analyze the descriptive variables of a program in as complete a fashion as possible. One of the important factors in any start-up program, particularly in those that pertain to mental health, is the complexity and labor-intensive nature involved in getting the program started successfully from the time of implementation. Many lessons were learned by the individual organizations and by Youth Network Council along the way. This is the sum of their efforts.

PURPOSE

JJMHI was a multi-faceted, responsive, community-based recovery management system for 10-17 year old juvenile justice-involved youth, utilizing Illinois' youth services system's unique "safety net" of supports. It ran between September 1, 2005 and December 31, 2006

JJMHI grew out of several years of discussion by Illinois community-based youth service providers identifying mental health needs in their juvenile justice involved clients. Unfortunately, due to lack of resources, the providers felt inadequate to address these concerns in a creative and effective fashion.

The purpose of the present review is to provide a complete overview of the 22 participating agencies that made up the JJMHI during the entire duration of the grant period. This involved varying time frames for the agencies because of client acquisition. Some agencies met their projected targets successfully in twelve months while the remainder needed sixteen months (i.e., the grant period plus the no-cost extension) to reach their projected targets.

An interim report issued by the Lead Evaluator was intended as a "snapshot" of the first seven months of the entire program. Essentially, this was a report just past the mid-point in the original grant period. The extension was added later. The data were descriptive and any conclusions drawn necessarily had to be considered preliminary. Data changed over time simply due to the collection of additional cases. Greater experience with clients and longer contact with them may have led to additional information on clients. The strengths and weaknesses of the

data set become apparent. To the Lead Evaluator, tendencies and trends to consider were suggested.

This data set takes into account the program start-up efforts at the participating agencies. All programs were not at the same level when JJMHI began. It took several months for all of the programs to come to essentially the same level. Start-up efforts took longer for certain programs than for others. Selection of the 22 agency participants was through a competitive process. This really meant that their original submissions were quite different. Each had strengths and weaknesses which yielded different concepts. All programs originally did not have the same idea of how to address the approach. Youth Network Council / Illinois Collaboration On Youth had to mold the unified program as the leader. But, the organizations developed into a uniform entity by the seventh month, i.e., March 31, 2006. This was a “shakedown cruise” in the truest sense. Staff had to be trained, new approaches learned, and data requirements satisfied. The program was a challenge to the various youth workers in the field as well as to the internal staff of YNC. But, the project did become stronger as time went on.

Therefore, this evaluation attempts to assess what is essentially a pilot effort specifically aimed towards bringing additional targeted mental health services to a group of juveniles at moderate-to-high risk for re-offending. It attempts to demonstrate the value of community-based youth agencies at a statewide level in serving these youth. It looks at the ability of community-based youth agencies to collaborate with mental health partners to provide services to youth with juvenile justice histories or tendencies. Finally, it measures the frequency of next offenses during the program.

RATIONALE FOR EVALUATION

One of the strengths of the proposed program when the application was submitted rested upon the on-going involvement of an external evaluator.

The evaluation focuses on the development of an evidence-based assessment of the intervention model of JJMHI. Even though these 22 programs are disparate programs that have independent identities, there was a single logic model advanced. The project required an initial quantitative evaluation which was a hybrid of accepted methods. The Lead Evaluator usually attempted to verify the appropriate implementation of the model through the use of formal assessment tools that quantified fidelity to the model (Teague, Bond, and Drake, 1998). Some of the major instruments that were employed are available in the Appendices.

What are the effects of the identification and diagnostic process in the broadest terms? Are the clients — and society — served in terms of access to mental health care that is of high quality and the outcomes therein? Mental health organizations by their very nature are large and complex organizations. These organizations have established goals and value systems that often are not understood by human services organizations.

The goal involved both prevention of the next arrest and reduction of future contacts with the police and the juvenile justice system as well as reduction of the recidivism rate. One wants to look at the outcome measures on many levels.

GOALS

Based on the discussions among providers, the stated goals of the Juvenile Justice /Mental Health Initiative program were stated succinctly by the Executive Director of Youth Network Council at the beginning of the program. The goals were:

- Increased local capacity to serve juvenile justice-involved 10-17 year olds with mental health problems.
- Higher utilization rates for existing community-based mental health services for the target population.
- Increased multi-system collaboration among youth services providers, mental health providers, law enforcement, and the courts.
- Client ownership of the recovery process through family, youth, and significant community stakeholders collaborating on the plan.
- Increased use of evidence-based methodologies, as well as gender- and cultural-specific and cultural approaches.
- Recognition within the State of Illinois of the youth services system as a competent delivery mechanism of mental health services, leading to sustained funding.
- Increased service integration for targeted youth.

METHODOLOGY

This report reviews in a comprehensive fashion the JJMHI experience during the course of the program. These data cover the original twelve month period of the SAMHSA grant, awarded for September 1, 2005 through August 31, 2006, plus the addition no-cost extension for the period September 1, 2006 through December 30, 2006.

The agency participants originally were selected by a competitive process. This led to a difference in the readiness of programs to begin on the very first day of the grant. Some agencies were fully operational when the program began, and others had to catch up. It took approximately three months for the level of readiness essentially to equalize and have all programs be fully operational. Staff had to become familiar with the data reporting requirements for the grant. In addition, there were several weeks of specialized training in the use of the V-DISC that had to be integrated into staff readiness. These activities all contributed to usual start-up issues in the program.

Program data were regularly submitted by the staffs of each participating agency. Data were submitted every two-to-three months throughout the program. For the convenience of the agencies, there were six major submission deadlines rather than a rolling continuous submission. Given the volume of data, however, this proved to be more manageable. Simultaneously, data were being analyzed in a continuous fashion. Each report was reviewed and checked for accuracy by YNC. Data were cleaned and corrected, where necessary. This has been a very time-consuming step, but a necessary one. The processing of the data collection continued until

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approximately 30 days before the end date of the program to allow adequate time for reporting of the information.

Then, a 100% case audit of data submitted by the program staff was conducted by the administrative staff of YNC. Only after the YNC staff completed the audit, were the data then made available subsequently to the Lead Evaluator. All data, including the audit, were made available to the Lead Evaluator to guarantee an independent review of the results and make unrestricted judgments about program.

Much additional data subsequently have been submitted for each additional period. However, each report had to be reviewed and checked for accuracy by YNC and only then was it made available subsequently to the evaluator. The processing of the data for the entire program was turned over to the Lead Evaluator on February 1, 2007.

For the most part, all clients were considered in the analysis. Certain exclusions became necessary due to improper enrollment, insufficient small pieces of data that were unavailable to program staff or auditors, or insufficient data to make an assessment. These deviations are noted for the record where they occurred.

A voluntary data collection effort began on December 1, 2006 amongst the programs. Twenty-one of the programs agreed to continue participation with only one not choosing to continue. This voluntary data collection is on a level of intensity that will be less burdensome than the data collection of the JJMHI. What was learned, as of the twelfth month of the grant,

was used to plan for minimal continuation of the program without specific funding of the entire program. A copy of the revised protocol for this effort is contained in Appendix E.

Demographic data are consistent with the methodology and definitions employed by the United States Department of Commerce, Bureau of the Census and the Illinois Criminal Justice Information Authority and are referenced herein.

The Lead Evaluator personally reviewed every case in depth to develop a qualitative and quantitative assessment of the particular individual and to determine their current situation. Comparative analyses exploring ideas and concepts that appear in this early data will be explored through later work.

PARTICIPANTS

The following twenty-two youth agencies, led by their respective Executive Directors, along with the Line Staff, participated in the Juvenile Justice / Mental Health Initiative (with additional sites listed):

ORGANIZATION	LOCATION	EXECUTIVE DIRECTOR
Aunt Martha's Youth Service Center	<ul style="list-style-type: none"> • Chicago Heights • Kane • Kankakee • Kendall 	C. Gary Leofanti
The Bridge Youth & Family Services	<ul style="list-style-type: none"> • Paletine 	Peter Cunneen
The Center for Children's Services	<ul style="list-style-type: none"> • Granite City 	Ed Michaels
Chicago Youth Centers	<ul style="list-style-type: none"> • Chicago 	J. Harry Wells
Children's Home Association of Illinois	<ul style="list-style-type: none"> • Peoria 	Arlene Happach
Children's Home & Aid Society of Illinois	<ul style="list-style-type: none"> • Granite City 	Nancy Ronquillo
Delta Center	<ul style="list-style-type: none"> • Cairo 	Fredrica Garnett
DuPage Youth Service Coalition: <ul style="list-style-type: none"> - Quad Community Social Services - Center for Community Services - NCO Youth & Family Services - Outreach Community Ministries 	<ul style="list-style-type: none"> • Addison • Aurora • Naperville • Wheaton 	Chris Ellerman
Hanover/Schaumburg Township Youth Services Planning Board, Inc.	<ul style="list-style-type: none"> • Hoffman Estates 	Jerry Lipsch
Illinois Coalition for Community Services	<ul style="list-style-type: none"> • Charleston 	Joe Dunn
Kids Hope United	<ul style="list-style-type: none"> • Effingham 	Pat Griffith
OMNI Youth & Family Services	<ul style="list-style-type: none"> • Buffalo Grove • Arlington Heights • Wheeling 	Jay Meyer
Project Oz	<ul style="list-style-type: none"> • Bloomington 	Peter Rankaitis
Southern Illinois Regional Social Services	<ul style="list-style-type: none"> • Carbondale 	Karen Freitag

	<ul style="list-style-type: none"> • Pinkneyville 	
The Success Center	<ul style="list-style-type: none"> • Lansing 	Kelly Anoe
Transitions of Western Illinois	<ul style="list-style-type: none"> • Quincy 	Michael Rein
Universal Family Connection, Inc.	<ul style="list-style-type: none"> • Chicago 	Lorraine Broyls
Uhlich Children's Advantage Network / Westside Association for Community Action	<ul style="list-style-type: none"> • Chicago 	Uhlich: Tom Vanden Berk Westside: Ernest Jenkins
Youth Outreach Services	<ul style="list-style-type: none"> • Chicago • Albany Park • Austin • Irving • Melrose Park • New City • Cicero 	Rick Velasquez
Youth Organization Umbrella, Inc.	<ul style="list-style-type: none"> • Evanston 	Don Baker
Youth Service Bureau	<ul style="list-style-type: none"> • Springfield 	Kathleen Wright
Youth Service Bureau of Illinois Valley	<ul style="list-style-type: none"> • Ottawa • LaSalle • Princeton 	Dave McClure

Note that the specific participants are identified here for purposes of identification and to acknowledge their participation only. This is the only place in this report where agencies are identified by name and location. Every effort has been made not to indicate any performance data among and between the agencies. Data are presented at the aggregate level rather than the organization-specific level.

COMMENT ON THE TOOLS: YASI AND V-DISC

YASI:

The Youth Assessment and Screening Inventory (YASI) was used as the major inclusion criterion of the project. Youth who were rated at moderate-to-high risk of re-offending were included in the population. It was supplemented, where necessary, when youth exhibited signs that were considered indicative of mental health problems in the trained and experienced judgment of a Qualified Mental Health Professional (QMHP),

The YASI has been adapted for use in a number of additional jurisdictions by Orbis Partners, Inc. of Ottawa, Canada. A complete descriptive package about the YASI may be accessed at their website, www.orbispartners.com. The YASI has good item definitions with multiple response categories as opposed to a “checklist” format. Previously, Orbis has customized the YASI for use in additional new settings including Illinois Juvenile Probation through the Administrative Office of the Illinois Courts and Illinois Status Offenders and Delinquency Prevention Services through the Illinois Department of Human Services.

The YASI is based on multiple sources of information about the youth including interviews with the youth and parent(s), as well as supplementation with official records, social histories, school reports, mental health service providers, and any other additional source that can be identified.

Since the YASI is in the public domain, it was feasible to make the document for data collection in the original report period consistent with the YASI. This was expressed by the various agency staffs as the preferred strategy in order to minimize their workloads. The amount of data still was extensive, but the evaluator complied with their collective wishes. The primary reporting tool upon intake is contained in Appendix A.

There were no formal exclusion criteria. However, the practical exclusion criteria were refusal to become involved in JJMHI.

V-DISC:

At the initial collective meeting of the Executive Directors in August 2005, the participating agencies were given the choice of either using a psychiatrist, a Qualified Mental Health Professional (QMHP), or the V-DISC to reach a diagnosis. The line staff were scheduled for training about the V-DISC before it could be used.

The DISC-IV is the most extensively tested child and adolescent diagnostic interview (Shaffer et al, 2000). It has been evaluated in both clinical and community samples. The Voice format of the DISC was administered to the youth using a computer and headphones.

The DISC has been used in various mental health studies. It is well documented with an extensive bibliography of validation and topic-specific studies. On account of that, no attempt will be made to cover the background material for this instrument.

RESULTS

(a) Explanation Of The Data Set:

YNC submitted data on 702 cases gathered during the sixteen months to the evaluator. YNC administrative staff previously had removed three cases from the data set either by a memo or other notation. These cases were dropped for improper enrollment by the programs and inclusion by the staff in the data set. The evaluator removed one additional case for reasons of questionable enrollment. This left 698 cases finally available for evaluation.

In certain places, relative percentages are given. These percentages are given as part of the results FOR INFORMATION ONLY. These final calculations are based on more extensive data drawn from the latter portion of the entire one year program, coupled with the no-cost extension period. These numbers are not identical to the interim data set for several reasons: (1) additional cases were reported in all programs; (2) programs had additional time to work with individual youths; (3) in many cases, agencies had more extensive periods to work with the youths. However, some cases were acquired toward the final thirty-to-sixty days of the JJMHI Program and still were in the process of intake, assessment, or preliminary counseling the end of the program. These cases proved to be less complete overall.

Relative percentages frequently do not add exactly to 100.00% due to rounding error. The base used for specific distributions may be the entire population, a segment of the

population, or multiple events from the same individual. This was done in order to utilize the data in its most complete fashion. This adjustment is indicated whenever necessary.

(b) Population:

There were a total of 698 youth enrolled in the JJMHI program by the participating twenty-two agencies. There were 437 males and 261 females. This is a gender ratio of 1.67 boys to each 1.00 girl. These figures include a diverse youth group that was composed of 275 African-Americans/Blacks (39.40% of the entire population of 698), 322 Caucasians (46.13%), 85 Hispanics/Latinos (12.18%), only 2 Asians (0.29%), and 9 self-described Others (1.29%). There were no missing data for race/ethnicity.

(c) Referring Program:

Individuals were referred to the JJMHI Program on the basis of risk of re-occurrence of contact with the juvenile justice system substantiated by the Youth Assessment and Screening Instrument (YASI) scores. Youth at moderate-to-high risk of re-offending were included, as described under “Inclusion Factors”.

The roster of various referring agencies and programs is shown in Table 1. It is unusually long because the Administration of YNC indicated a preference to learn this information in extended format. This was not part of the original format, but the information was reconfirmed during the auditing process.

Comprehensive Community-Based Youth Services (CCBYS) contributed more than half of the total referrals to the Juvenile Justice / Mental Health Initiative. These sources actually are greater than the anticipated contributors originally thought to be likely referral sources. Programs had to stay vigilant to follow the inclusion criteria for JJMHI. The process of identification of appropriate youth could have become stilted and therefore biased since so many individuals were referred from one type of source. However, this was not the situation.

At times, referrals to some in some agencies were sporadic and infrequent. At other times, it was steadier. The inclusion criteria were reinforced, particularly when the initial audit was carried out by YNC staff. Some data were missing and could not be verified. This accounts for the “Other” category.

TABLE 1: REFERRING PROGRAMS

PROGRAM	NUMBER	RELATIVE PERCENTAGE
CCBYS	324	46.42%
COMMUNITIES FOR YOUTH	59	8.45%
INTERVENTION	45	6.45%
JUVENILE JUSTICE INTERVENTION (TITLE II)	39	5.59%
UDIS	25	35.82%
YOUTH DRIVE	25	
RELEASE UPON REQUEST	23	3.29%
MENTAL HEALTH JUVENILE JUSTICE PROGRAM	24	
JDAI	13	1.86%
DONATED FUNDS INITIATIVE	9	
PREVENTION	8	1.00%
CROSSROADS	2	0.29%
SCHOOL-BASED PREVENTION SERVICES	2	
TEEN REACH	2	
JAIBG	1	0.14%
IDHS INTERVENTION PROGRAM	1	
NO ORGANIZED PROGRAM	16	2.29%
NOT INDICATED	14	2.00%
OTHER	66	9.46%
TOTAL	698	

(d) Age:

The age distribution of the clients enrolled in JJMHI is indicated in Table 2

TABLE 2: CHRONOLOGICAL AGE

AGE	NUMBER	RELATIVE PERCENTAGE
10	22	3.13%
11	23	3.29%
12	50	7.16%
13	85	12.18%
14	123	17.62%
15	143	20.49%
16	139	19.91%
17	66	9.46%
NOT INDICATED	47	6.63%
TOTAL	698	

The largest portion of this group is 14, 15, or sixteen years old (58.02%). There are much fewer younger children in the group. Those individuals less than 13 only amount to 13.61%.

(e) Education:

The grade level of the youth at the time of entry into the JJMHI was determined for each youth. The distribution of education in the population is indicated in Table 3 that follows:

TABLE 3: EDUCATION

GRADE	NUMBER	RELATIVE PERCENTAGE
3	2	0.29%
4	16	2.29%
5	36	5.17%
6	54	7.74%
7	91	13.04%
8	111	15.90%
9	148	21.20%
10	122	17.48%
11	52	7.45%
12	10	1.43%
COLLEGE	1	0.14%
TOTAL	698	

Analysis of this distribution may suggest appropriate targets for mental health interventions by JJMHI and/or other programs. For example, should effective strategies be aimed at younger youth? Eighth, ninth and tenth graders made up a major portion of clients (n=381, or 54.58% of the group). It might be appropriate to initiate intervention strategies towards adolescents in these age groups, or even prior to reaching these grades. By that time, behavior patterns may be firmly established.

(f) Geographic Location:

The distribution of the county of home residence was determined. These data are shown in Table 4. The city of residence also was determined using ZIP codes, but looking at the data at

this level potentially was considered too intrusive for this population. The distribution of the county of primary home residence was compared to the catchment areas for the 22 youth agencies. Exhibit 1 gives an alphabetical listing of the counties represented by the clients.

There were 34 counties throughout the state represented by the youths' primary residence. The location of the primary residence was identified from the registration data at intake. A map of the counties of the State of Illinois with the counties of clients' primary residence is included for reference in Map 1.

Table 5 shows the demographic characteristics of these counties. The 2003 population data, area in square miles, and a designation of the urban/rural breakdown is reflected in this table. There are 8 urban counties, 22 rural counties, 3 collar counties and 1 county that generally acknowledged locally and throughout Illinois to have unique characteristics, i.e., Cook County, the location of Chicago. This compared to a total of 102 counties in Illinois, namely 36 urban counties and 66 rural counties taken as a whole.

TABLE 4: COUNTIES OF PRIMARY RESIDENCE FOR YOUTH

ADAMS COUNTY
ALEXANDER COUNTY
BUREAU COUNTY
CLARK COUNTY
CLAY COUNTY
COLES COUNTY
COOK COUNTY
CUMBERLAND COUNTY
DOUGLAS COUNTY
DUPAGE COUNTY
EDGAR COUNTY
EFFINGHAM COUNTY
FAYETTE COUNTY
HAMILTON COUNTY
HANCOCK COUNTY
JACKSON COUNTY
JASPER COUNTY
KANE COUNTY
KANKAKEE COUNTY
KENDALL COUNTY
LASALLE COUNTY
LAKE COUNTY
MADISON COUNTY
MARION COUNTY
MCLEAN COUNTY
MOULTRIE COUNTY
PEORIA COUNTY
PERRY COUNTY
PIKE COUNTY
PULASKI COUNTY
PUTNAM COUNTY
SANGAMON COUNTY
ST. CLAIR COUNTY
VERMILION COUNTY

MAP 1: COUNTIES OF CLIENTS' PRIMARY RESIDENCE

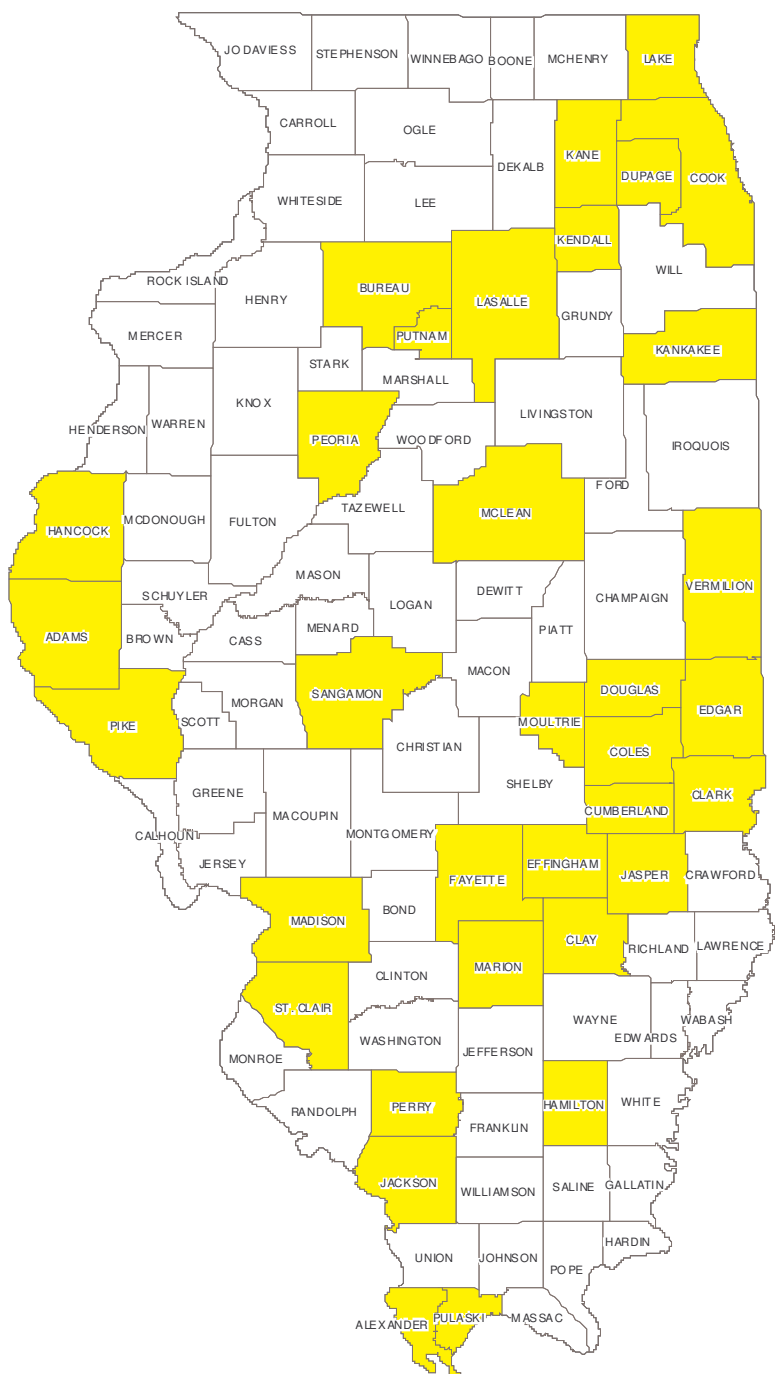


TABLE 5: CHARACTERISTICS OF COUNTIES

COUNTY	2003 CENSUS POPULATION ESTIMATE	AREA (SQUARE MILES)	CATEGORY BASED ON CHARACTERISTICS *
ADAMS	67,582	857	RURAL
ALEXANDER	9,327	236	RURAL
BUREAU	35,221	868	RURAL
CLARK	16,998	501	RURAL
CLAY	14,316	469	RURAL
COLES	51,880	508	RURAL
COOK	5,351,552	946	UNIQUE
CUMBERLAND	11,063	346	RURAL
DOUGLAS	19,923	417	RURAL
DUPAGE	925,188	334	COLLAR
EDGAR	19,396	623	RURAL
EFFINGHAM	34,529	479	RURAL
FAYETTE	21,539	717	RURAL
HAMILTON	8,334	435	RURAL
HANCOCK	19,393	795	RURAL
JACKSON	58,976	588	RURAL
JASPER	9,955	494	RURAL
KANE	457,122	520	COLLAR
KANKAKEE	105,625	677	URBAN
KENDALL	66,565	321	URBAN
LAKE	685,019	448	COLLAR
LASALLE	112,037	1,135	RURAL
MADISON	261,689	725	URBAN
MARION	40,751	572	RURAL
MCLEAN	156,879	1,183	URBAN
MOULTRIE	14,469	335	RURAL
PEORIA	181,609 **	619	URBAN
PERRY	22,684	441	RURAL
PIKE	16,927	830	RURAL
PULASKI	7,077	201	RURAL
PUTNAM	6,119	160	RURAL
SANGAMON	191,875	868	URBAN
ST. CLAIR	261,941 **	664	URBAN
VERMILLION	82,803	899	URBAN

* Table adapted from Illinois Criminal Justice Information Authority (ICJIA), 2004 and U.S. Department of Commerce, 2003

** 1998 data

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(g) Relationship To Primary Residence:

In what kind of circumstances do these youngsters live? The primary living arrangement was identified for each youth and is shown in Table 6. The population overwhelmingly lives with the biological or adoptive mother (63.47%). Less than 10% live with the fathers and another five percent live with grandparents. The number of remaining relatives as primary home is quite minimal.

TABLE 6: PRIMARY RESIDENCE OF YOUTH

RELATIONSHIP	NUMBER	RELATIVE PERCENTAGE
MOTHER (BIOLOGICAL OR ADOPTIVE)	443	63.47%
FATHER (BIOLOGICAL OR ADOPTIVE)	64	9.17%
STEPPARENT	6	0.86%
SIBLINGS	12	1.72%
OTHER RELATIVES	16	2.29%
OTHER ADULT	12	1.72%
GRANDPARENTS	39	5.59%
FOSTER / GROUP HOME	10	0.14%
INDEPENDENT	0	0.00%
NO PERMANENT ADDRESS / SHELTER	2	0.003%
OTHER	2	0.003%
NOT INDICATED	92	13.18%
TOTAL	698	

(h) Diagnoses:

Diagnoses established for each case were enumerated for the entire population. Multiple diagnoses were included, usually primary and secondary. As a result, there are more diagnoses than the total population base. The entire roster of psychiatric diagnoses is shown in Table 7. It is reflective of the kinds of wide variety of mental health problems faced by the group.

Participating agencies had to use the language of the current version of the *Diagnostic and Statistical Manual of the American Psychiatric Association, Text Revision* (APA, 2000). It was difficult for the staffs of some organizations to become used to keeping their records with emphasis on the DSM-IV-TR criteria. One of the reasons that the auditing process was initiated on a more intensive level rather than just as a quality measure was to be sure that this approach was being followed.

These diagnoses are “final” diagnoses. It took several months to work through the diagnostic process until the programs, YNC staff, and the Lead Evaluator were comfortable with how the diagnoses were being reached. There was a tendency initially to report “preliminary” diagnoses, but this got worked out over time. This may have been a reflection of staff members at the agencies wanting to provide information on one side, and simultaneously needing time to get complete clinical picture prior to reporting to the JJMHI Project Staff. Differences caused by the tendency of some practitioners to include more expansive, non-standard definitions were controlled by the auditing process and did not continue after the first seven months of the fifteen month grant period. The Lead Evaluator did not include “preliminary diagnoses” that essentially were in the nature of “problem lists” or “differential diagnoses”.

TABLE 7: PSYCHIATRIC DIAGNOSES

DIAGNOSIS	NUMBER
CONDUCT DISORDER	147
OPPOSITIONAL DEFIANT DISORDER	127
ADD/ADHD	107
SUBSTANCE ABUSE	95
DEPRESSION	56
BIPOLAR DISORDER	53
DYSTHYMIC DISORDER	21
GENERALIZED ANXIETY DISORDER	28
ALCOHOL ABUSE	22
MOOD DISORDER	25
SEPARATION ANXIETY	29
OBSESSIVE-COMPULSIVE DISORDER	19
POST-TRAUMATIC STRESS DISORDER	13
ADOLESCENT ANTISOCIAL DISORDER	9
ADJUSTMENT DISORDER	7
DISRUPTIVE BEHAVIOR	6
SCHIZOPHRENIA	6
ASPERGER'S SYNDROME	4
EATING DISORDER	4
LEARNING DISORDER, NOS	4
PARENT-CHILD RELATIONSHIP PROBLEM	4
SOCIAL PHOBIA	4
SPECIFIC PHOBIAS	4
EXPLOSIVE DISORDER	3
IMPULSE CONTROL	2
PSYCHOSIS	2
REACTIVE ATTACHMENT DISORDER	2
TRAUMATIC BRAIN INJURY	2
AGGRESSION	1
AUTISM	1
FETAL ALCOHOL SYNDROME	1

TABLE 7: PSYCHIATRIC DIAGNOSES (CONTINUED)

MANIC EPISODE	1
MENTAL RETARDATION	1
PERSONALITY DISORDER	1
POST-PARTUM DEPRESSION	1
PSYCHOSIS	1
SEXUAL ABUSE	1

Final diagnoses were reached in 632 cases out of 698 (90.54%)

Thus, looked another way, these diagnostic categories may be regrouped.

- Attention-Deficit and Disruptive Disorders

390 cases 61.71% of the diagnosed subgroup
(Attention Deficit/Hyperactivity Disorder) and (Oppositional Defiant Disorder, Conduct Disorder, Adolescent Antisocial Disorder)

- Mood Disorders

186 cases 36.64% of the diagnosed subgroup
(Depression Disorders, Bipolar Disorders)

- Substance Related Disorders

117 cases 16.76% of the diagnosed subgroup

- Anxiety Disorders

84 cases 12.03% of the diagnosed subgroup
(General Anxiety Disorder, Social Phobia, Obsessive Compulsive Disorder, Separation Anxiety)

(i) Service Unit Contacts:

JJMHI provided the youth with 18,791 service units during the grant period. This includes direct services such as individual and family counseling, individual therapy, mental health assessment, psychiatric services, peer group counseling, case management, and treatment planning. A service unit does not take into account the actual time involved. Each service unit represents various amounts of time. Thus, the services provided by the 22 youth agencies were both intensive to the youth and labor-intensive to the staff members of the agency. Note that these services would not have been provided to these youth except for this program.

(j) School :

How did the youngsters interact with their school situations? What were the characteristics of their school enrollment and the type of school attended? How were the youth performing in their academic endeavors? This experience is described in Table 8, Table 9, and Table 10.

TABLE 8: SCHOOL ENROLLMENT

CURRENT ENROLLMENT	NUMBER	RELATIVE PERCENTAGE
ENROLLED, FULL-TIME	599	85.82%
ENROLLED, PART-TIME	8	1.15%
GRADUATED, GED	11	1.57%
DROPPED OUT	23	3.29%
SUSPENDED	26	3.72%
NOT INDICATED	31	4.44%
TOTAL	698	

Despite their contact with the juvenile justice system, school enrollment was high (Table 8). Most of the youth were enrolled full time in the school setting. Registration does not, however, guarantee attendance.

What types of schools do these youngsters attend? Is there a sense of the local community? What role do the parent(s) or guardians play in the schools? The types are shown in Table 9.

TABLE 9: TYPES OF SCHOOLS

TYPES	NUMBER	RELATIVE PERCENTAGE
PUBLIC ACADEMIC	471	67.48%
VOCATIONAL INSTITUTION	4	0.57%
ALTERNATIVE	134	19.20%
GED PROGRAM	6	0.86%
PRIVATE ACADEMIC	6	0.86%
HOME SCHOOL	2	0.29%
COLLEGE	2	0.29%
OTHER	11	1.58%
NOT INDICATED	62	8.88%
TOTAL	698	

The majority of the children were enrolled in public settings (67.48%). How were the youth doing in the schools, regardless of the type? The level of their current performance is shown in Table 10. More than 40% indicated that they are failing some or all their classes.

TABLE 10: LEVEL OF CURRENT ACADEMIC PERFORMANCE

LEVEL OF CURRENT ACADEMIC PERFORMANCE	NUMBER	RELATIVE PERCENTAGE
B+ OR ABOVE	61	8.74%
C OR BETTER	174	24.93%
C- OR LOWER	121	17.33%
FAILING SOME CLASSES	176	25.21%
FAILING ALL CLASSES	111	15.90%
NOT INDICATED	55	7.88%
TOTAL	698	

Although there are some students who perform remarkably well, academic life is a major stumbling block. At least 41.17% are experiencing academic failure in some or all their classes,

(k) Family Income:

The income level distribution of the parents of the clients is presented in Table 11.

TABLE 11: INCOME LEVEL

GROSS INCOME	NUMBER	RELATIVE PERCENTAGE
UNDER \$5,000	48	6.66%
\$ 5,000 TO \$ 9,999	46	6.59%
\$10,000 TO \$14,999	87	12.46%
\$15,000 TO \$19,999	67	9.60%
\$20,000 TO \$24,999	78	11.17%
\$25,000 TO \$29,999	72	10.31%
\$30,000 TO \$34,999	47	6.73%
\$35,000 TO \$39,999	24	3.43%
\$40,000 TO \$44,999	19	2.72%
\$45,000 TO \$49,999	15	2.15%
\$50,000 TO \$54,999	20	2.86%
\$55,000 TO \$59,999	8	1.15%
\$60,000 TO \$64,999	8	1.15%
\$65,000 TO \$69,999	8	1.15%
\$70,000 AND OVER	0	0.00%
REFUSED, NOT INDICATED	151	21.63%
TOTAL	698	

Family size was not considered here. This was meant to give a rough estimate of income level and not supply adequate data for calculation of a more accurate estimate of the income.

There also is a particularly large percentage of non-responses (21.63%). This primarily may be

due to several agencies not providing data for this item *en mass*. Whether this was agency choice or client embarrassment, a better baseline measure of this factor is necessary. The figures remain bottom-heavy. However, there are some income levels at the other end that are potentially billable clients.

(1) Insurance:

The insurance distribution of the population is given in Table 12.

TABLE 12: MEDICAL INSURANCE

TYPE OF INSURANCE	NUMBER	RELATIVE PERCENTAGE
PRIVATE HEALTH INSURANCE	204	29.22%
CURRENTLY ON MEDICAID	354	50.72%
ELIGIBLE FOR MEDICAID	68	9.74%
NOT QUALIFIED FOR MEDICAID	44	6.30%
NOT INDICATED	34	4.87%
TOTAL	698	

Third party payers are a critical element in providing services to adolescents for a variety of services, including mental health services. More than three-quarters (79.94%) of these youth are covered by some form of health insurance, either privately supplied or through the State of Illinois. However, mental health benefits may differ among specific plans. Effort by each site to guarantee enrollment in insurance programs probably has swelled this number successfully.

This is particularly true after the production of the Interim Evaluation Report. Almost one-third (29.22%) are privately insured while more than one-half (50.72%) are covered by Medicaid with nearly another one-tenth (9.74%) eligible. Additional efforts to make responsible individuals aware of coverage may even increase this factor further. However, there is a greater difference in specific coverage for mental health care services. This inequity tends to vary even further based on ethnicity and the degree to which the needs are unmet varies by insurance status (Kataoka, Zhang and Wells, 2002).

(m) Mental Health:

1. Practitioner:

Various mental health practitioners evaluated the youth. The basis for enrollment was standardized for all youth. The YASI was used to determine appropriateness for entry into the program on the basis of a moderate-to-high determination for being at-risk of re-offending.. However, the manner of the assessment differed among agencies. The predilection for certain categories of practitioners to be used varied in specific agencies. This was based upon factors such as staffing availability, staffing patterns at any given time, financial considerations (i.e., mostly how much the individual agency received from YNC under this grant), preference at the agency, and suitability of the assignment.

“Qualified Mental Health Professionals” were used extensively by the youth organizations. Essentially, a “Qualified mental health professional” (QMHP) means one of the

professions defined in 59 Ill. Adm. Code 132.25 (Medicaid Community Mental Health Services Program): licensed physician, psychiatrist, psychologist, social worker possessing a master’s or doctoral degree in social work, a nurse with a master’s level degree in psychiatric nursing, a related field with a 1,000 hour internship, or a master’s degree social worker with two years of supervised experience. However, for purposes of this Evaluation Report, medically-qualified psychiatrists and psychologists with Ph.D. degrees in Clinical Psychology were looked at separately in the original data. As a rule, M.D.-qualified physicians such as those in family practice, were classified under “ Other” by the agencies in the original data, but reclassified based upon additional information gained in the auditing process.

The practitioners are shown in Table 13.

TABLE 13: MENTAL HEALTH SERVICES PROVIDERS

TYPE OF PROVIDER	NUMBER	RELATIVE PERCENTAGE
“FINAL” DIAGNOSES:		
PSYCHIATRIST (M.D.)	197	31.17%
NON-PSYCHIATRIST PHYSICIAN (M.D.)	14	2.21%
CLINICAL PSYCHOLOGIST (Ph. D.)	8	1.26%
QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP)	295	46.68%
V-DISC	118	18.67
TOTAL	632	
DIAGNOSTIC SERVICES PROVIDED IN THE POPULATION	632 OF 698	90.54%

The need for additional psychiatrists was underscored. There were also agencies which in specific instances based their assessment upon direct staff observation of the client together with some supervision or concurrence by QMHPs rather than on more traditional clinical encounters with the client. Better training in the scope of the protocol will lead to better procedures. Agencies basically were not “interfered with”. But the model demands fidelity without any deviation, except for good clinical reasons.

2. Referral Pattern:

After initial evaluation, where are these youth referred for follow-up care? Ultimately, there were 195 referrals made by the psychiatrists or QMHPs (Table 14). They referred to other psychiatrists 92 times and mental health facilities accounted for another 103 referrals. The assumption must be that these clients may be seen by an inter-disciplinary team, including psychiatrist, via a mental health facility. Unfortunately, the specific primary practitioner at these community facilities often was not identified. The relationship with the local mental health facility may have seemed easier given prior contacts, low income of the family, or lack of knowledge on the practitioner.

TABLE 14: REFERRALS BY JJMHI

TYPE OF REFERRAL	NUMBER	RELATIVE PERCENTAGE
REFERRAL TO ANOTHER PSYCHIATRIST	92	47.18% OF REFERRALS
REFERRAL TO MENTAL HEALTH FACILITY	103	52.18% OF REFERRALS
TOTAL	195	

3. Selected Mental Health Problems:

These families often were familiar with the mental health care system. Their needs were real. But, these concerns probably were met with limited access, lack of comprehensive services, and little, if any, follow-up care. The services may or may not have been culturally competent and incorporated respect for and understanding of ethnic and racial groups, as well as their histories, traditions, beliefs, and value systems (CMHS, 1998). Resistance to mental health care had to be overcome.

These families and individuals previously had some degree of contact with mental health services providers. Some of these clients entered JJMHI with past or existing relationships for medication, but little else. The nature of selected aspects of their mental health problems is contained in Table 15.

TABLE 15: SELECTED MENTAL HEALTH PROBLEMS

PROBLEM	NUMBER	RELATIVE PERCENTAGE
PAST MENTAL HEALTH PROBLEM KNOWN	377	54.01%
MEDICATION PRESCRIBED PREVIOUSLY	264	37.82%
PAST MENTAL HEALTH TREATMENT	293	41.98%
HOMICIDAL IDEATION	78	11.17%
INDICATIONS OF VIOLENCE	421	60.31%
SUICIDAL THOUGHTS	130	18.62%
SUICIDE ATTEMPT (1 OR MORE)	55	7.88%
NON-SPECIFIC INDICATIONS OF SUICIDE	15	2.15%
SELF-INJURY / SELF-MUTILATION	64	9.17%
EATING DISORDERS	37	5.30%
GENERAL HEALTH:		
EXCELLENT	235	33.67%
GOOD	333	47.70%
FAIR	29	4.15%
POOR	0	0.00%
NOT INDICATED	101	14.47%

The frequency for indications of violence in this group may have made dealing with these youngsters and their families even more difficult for agency personnel. Osofsky and Osofsky (2001) pointed out that aggressive behavior and violence lead to disciplinary and legal difficulties in record numbers.

Most of the clients saw their health as “Excellent” or “Good” and did not relate their mental health issues to their overall health.

4. Use Of Psychotropic Medications:

Many youth already were receiving psychotropic medication when they were enrolled in JJMHI. Many others previously had been given such medications and were in limbo in terms of the cost factors and side effects. Psychotropic medications are a part of current psychopharmacology and have been advancing at a rapid pace. They have become part of the role of psychiatrist, primary care practitioners, family practitioners, and non-psychiatrist physicians (Dubovsky, 2005). In many communities served by the agency partners, prescribing is expected of them and the routine practice of medicine. This aspect of clinical care is part of the organizational culture in some agencies and communities.

In order to learn more about the use of psychotropic medications in this group, YNC staff made a special effort to obtain information about these drugs use. The results are presented in Table 16.

**TABLE 16: AUDIT ON PSYCHOTROPIC AND OTHER
PRESCRIPTION MEDICATIONS**

BRAND NAME	GENERIC NAME	PRESCRIPTIONS BEFORE JJMHI	PRESCRIPTIONS DURING JJMHI
ABILIFY	Aripiprazole	7	0
ADDERAL	Amphetamine	10	3
ATIVAN	Lorazepam	1	0
CELEXA	Citalopram	1	1
COGENTIN	Benzotropin	2	0
CONCERTA	methylphenidate, controlled release	8	4
DEPAKOTE	Divalproex	7	0
EFFEXOR	Venlafaxine	2	0
FOCALIN	methylphenidate	3	2
GEODON	Ziprasidone	2	1
ESKALITH	lithium carbonate	2	0
PAXIL	Paroxetine	2	2
PROZAC	fluoxetine	4	5
RISPERDAL	Risperidone	9	6
RITALIN	methylphenidate	4	2
SEROQUEL	Quetiapine	7	0
STRATERRA	Atomoxetine	3	2
TEGRETOL	carbamazepine	0	1
TOPAMAX	Topiramate	1	1
DESYREL	Trazadone	2	0
TRILEPTAL	Oxcarbazepine	3	3
VALIUM	Diazepam	2	0
WELLBUTRIN	Bupropin	2	0
XANEX	Alprazolam	0	1
ZOLOFT	Sertraline	7	5
FOR MEDICAL CONDITIONS	Various	12	4

5. Use Of Psychotropic Medications:

Before JJMHI:

Although many youth had taken various psychotropic medications at some point before embarking on the JJMHI, this simply reflected common psychiatric and pediatric practice in many communities (Barnes, Stein, and Rosenberg, 1999; Dubovsky, 2005). During the past medical histories for these individuals, many self-reported such medication.

During JJMHI:

Since prescriptions must be written either to start new medications, or to modify existing prescriptions, there are comparatively few in this category. Few agencies were seen as “health” agencies. In some communities, such prescriptions clearly are left to family physicians . However, these individuals may be less qualified as a result of specific training in psychopharmacology than child, adolescent, or even general adult psychiatrists.

Medication Monitoring:

Comparatively few clients chose and/or had recommended that the staff of participating agencies maintain a check on client medications during JJMHI. It is possible that the

practitioners did not view this as an appropriate function for staff, doubted the knowledge base of staff about these medications, or other unexplained reasons.

6. Substance Abuse and Co-Occurring Conditions:

The population experienced particular problems which were indicative of drug and alcohol usage. These are shown in Table 17.

TABLE 17: INDICATIONS OF DRUGS AND ALCOHOL

INDICATION	NUMBER	RELATIVE PERCENTAGE
DRUG USE	286	40.97%
ALCOHOL USE	259	37.10%

Of the 632 diagnoses made, 250 (39.55%) were co-existing conditions. Substance abuse was a partial component of the co-occurring diagnoses in 67 of the 250 ((26.80% of the subset). However, these indications were not reflective of co-morbidity. It may be possible that “true” co-existing conditions may arise in another manner than anticipated, e.g., nosological considerations (Caron and Rutter, 1991). These are presented in Table 18.

TABLE 18: CO-EXISTING DISORDERS

DISORDER	NUMBER	RELATIVE PERCENTAGE
NUMBER OF CASES DIAGNOSED	632	100.00% OF SUBSET
CO-EXISTING DISORDERS OF ALL TYPES	250	39.56% OF SUBSET
SUBSTANCE ABUSE CO-MORBIDITY	67	10.60% OF SUBSET

(n) Juvenile Justice Data:**1. Juvenile Justice History:**

All of these youth were identified as being at-risk for contact with the juvenile justice system. But, the issue is not as simple as “recidivism rate”. Actually, there are at least four issues which can be identified in relation to juvenile justice history. These are: (a) How many youth commit further offenses? (b) How many youth come into contact with the juvenile justice system (notably the police and/or the courts) to deal with their earlier offense? (c) Are there data that suggest whether these youth will continue to become involved with the juvenile justice system (i.e., give a reasonable “at-risk” profile rather being a predictor)? (d) What effect does this have on understanding juvenile justice involvement?

How early in life did the youth first become involved with someone in an authority position? This does not necessarily mean the juvenile justice system. This simply may mean the

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age when the earliest episode of the behavior that led to more formal involvement with the juvenile justice system. This is indicated in Table 19.

TABLE 19: AGE AT FIRST EPISODE

AGE	NUMBER	RELATIVE PERCENTAGE
6	1	0.14%
7	2	0.29%
6	6	0.86%
9	9	1.29%
10	18	2.58%
11	40	5.73%
12	73	10.46%
13	84	12.02%
14	88	12.61%
15	84	12.02%
16	46	10.895
17	3	0.43%
NUMBER OF YOUTH INDICATING AGE OF FIRST EPISODE	454	65.04%
NUMBER OF YOUTH WITH JUVENILE JUSTICE SYSTEM CONTACT, NOT INDICATING AGE OF FIRST EPISODE, BUT AT-RISK	95	13.61%
TOTAL WITH NO JUVENILE JUSTICE SYSTEM CONTACT YET, BUT AT-RISK	149	21.35%

There are still segments of the population who are at-risk for subsequent contact with the juvenile justice system. Even though the contact has not happened yet, it may be threatening to happen. Other youngsters or their families conceivably may be denying the existence of the episode.

The occurrence of prior status episodes may also be an area of concern. This is shown in Table 20.

TABLE 20: PRIOR STATUS EPISODES

NUMBER OF STATUS OFFENSES FOR YOUTH	NUMBER	NUMBER OF EPISODES
1	137	137
2	73	148
3	59	177
4	30	120
5	36	180
6	14	84
7	4	28
8	3	24
NUMBER OF YOUTH	356	
TOTAL EPISODES ACCOUNTED FOR		898

Although only 356 youngsters had status offenses, 61.51% had more than one episode thus far.

What about episodes of running away and lockouts? These are shown in Table 21.

TABLE 21: RUNAWAYS AND LOCKOUTS

EPISODE	NUMBER
RUNAWAY	
1	78
2	64
3	34
4	19
5	55
6 OR MORE	2
TOTAL	252
LOCKOUTS	
1	49
2	23
3	14
4	3
5	14
6 OR MORE	0
TOTAL	103

On the other hand, how important are prior contacts with the police? These are shown in Table 22.

TABLE 22: PRIOR CONTACTS WITH POLICE

NUMBER OF CONTACTS FOR EACH YOUTH	NUMBER	NUMBER OF EPISODES
1	145	145
2	82	164
3	39	117
4	23	92
5	19	95
6	13	78
7	6	42
8	3	24
9	4	36
10	16	160
NUMBER OF YOUTH	350	
TOTAL EPISODES ACCOUNTED FOR		953

The multiple occurrences indicate that only 41.14% have had a single exposure to police. The remaining 205 (58.57%) had multiple contacts that accounted for 808 involvements with the police.

2. Past Offenses:

What kinds of offenses were these youth involved with prior to JJMHI? These are shown in Table 23 that follows. Note that some youth have an extensive history and may be involved in multiple offenses, accounting for the overall number of youths.

TABLE 23: OFFENSES AND OTHER JUVENILE JUSTICE EVENTS

OFFENSE	NUMBER
RUNAWAY	109
BATTERY	93
THEFT / ROBBERY	84
SUBSTANCE POSSESSION	69
STATUS OFFENSES	67
CURFEW	52
DOMESTIC VIOLENCE	49
ASSAULT	42
FIGHTING	28
TRUANCY	28
VIOLATION OF PROBATION	23
DRINKING / DUI	22
CRIMINAL TRESPASS	21
LOCKOUT	21
BEHAVIOR	19
SUBSTANCE ABUSE	19
SHOPLIFTING	17
DAMAGE TO PROPERTY	16
WEAPON	13
RESISTING	7
BEHAVIOR	6
SEXUAL ASSAULT	6
THREAT	6
VANDALISM	5
DISORDERLY CONDUCT	4
BREAKING & ENTERING	3
GRAND THEFT AUTO	3
POSSESSION OF A STOLEN VEHICLE	3
SCHOOL ALTERCATION	3
CARRYING A KNIFE	2
DISTURBING THE PEACE	2
DRIVING WITHOUT A LICENSE	2

TABLE 23: OFFENSES AND OTHER JUVENILE JUSTICE EVENTS (CONTINUED)

OFFENSE	NUMBER
INTENT TO SELL A CONTROLLED SUBSTANCE	2
MOB ACTION	2
OFFENSE AGAINST ANOTHER PERSON	2
POINTING A GUN AT ANOTHER PERSON	2
SOLICITING	2
TOBACCO VIOLATION	2
UNLAWFUL USE OF A CREDIT CARD	2
WEAPON	2
ASSAULT	1
ATTENDED PARTY WITHOUT CONSENT	1
BB GUN	1
CARJACKING	1
CLASS 3 FELONY	1
DOMESTIC	1
FAILURE TO APPEAR IN COURT	1
FALSE BOMB REPORT	1
FELONY AGAINST OTHER PERSON	1
FRAUD	1
GAMBLING	1
GRAFFITI	1
HOME INVASION	1
JAYWALKING	1
MAKING A FALSE POLICE REPORT	1
OBSTRUCTION OF JUSTICE	1
POSSESSING HYPODERMIC NEEDLES	1
PULLING FIRE ALARM	1
SCHOOL VIOLENCE	1
SETTING A FIRE	1

TABLE 23: OFFENSES AND OTHER JUVENILE JUSTICE EVENTS (CONTINUED)

OFFENSE	NUMBER
SEXUAL HARASSMENT	1
TAKING CAR WITHOUT PERMISSION	1
THEFT	1
TRUANCY	1
VERBAL ABUSE	1
VIOLATING A COURT ORDER	1

3. “Improvement”:

In order to determine which youth had committed further offenses, all case records were reviewed based upon uniform criteria. The criteria were based on positive youth development approaches. Each case was rated by the Lead Evaluator. The outcome of the ratings is summarized in Table 24.

TABLE 24: SUMMARY MEASURE OF JJMHI EXPERIENCE

RATING	NUMBER	RELATIVE PERCENTAGE
“IMPROVED”	365	64.49%
NO CHANGE	173	30.56%
“WORSE”	28	4.97%
ABLE TO JUDGE	566	81.09%
UNABLE TO JUDGE FOR VARIOUS REASONS	132	18.91%
TOTAL POPULATION	698	
BASE FOR RATING	566	

Of the 566 case records that could be reviewed, 365 youth “improved” (64.49% of the restricted subgroup). This does not mean that youth may not continue to have contact with authorities in relation to events which transpired during the period before JJMHI.

“Improvement” conveys the idea that youth did not offend further and that the circumstances could be documented. It may mean that authorities will continue to be involved in their lives in some fashion.

(o) Abuse:

What is the frequency of physical and sexual abuse in this population? “Inside the family” refers to mother, father, sibling, and other relatives. “Outside the family” refers to individuals other than family members. “Both” suggests that the abuse existed with both sources. This is described in the matrix of Table 25. The categories are mutually exclusive.

TABLE 25: PHYSICAL AND SEXUAL ABUSE

AGE	NUMBER
PHYSICAL ABUSE:	
INSIDE OF FAMILY	105
OUTSIDE OF FAMILY	9
BOTH INSIDE AND OUTSIDE OF FAMILY	12
SUBTOTAL	126
SEXUAL ABUSE:	
INSIDE OF FAMILY	20
OUTSIDE OF FAMILY	22
BOTH INSIDE AND OUTSIDE OF FAMILY	9
SUBTOTAL	51
PHYSICAL AND SEXUAL ABUSE:	
INSIDE OF FAMILY	14
OUTSIDE OF FAMILY	4
BOTH INSIDE AND OUTSIDE OF FAMILY	22
SUBTOTAL	40

SERVICE ENHANCEMENTS UNDER JJMHI

On the macro level, what services did the existence of the Juvenile Justice / Mental Health Initiative actually add to the mix of services available to youth agencies in the program? What types of care were available to youth and their families that would not have otherwise been available?

This was determined from the participating agencies at the end of the first year of the grant duration. Program representatives were asked to complete a simple checklist which is appended in Appendix D.

The agencies that participated were considered to be more or less full service in their communities. There is some variation in the number of agencies, however, depending upon the particular service. As such, many types of services were offered on a very limited basis by some organizations. But, not to these youngsters as a general rule. The range of services offered by the agencies is shown in Table 26.

**TABLE 26: SERVICES OFFERED BY AGENCIES
BEFORE JJMHI**

TYPE OF SERVICE	NUMBER OF AGENCIES	RELATIVE PERCENTAGE
CASE MANAGEMENT	22	100.00
INDIVIDUAL THERAPY	17	73.91
FAMILY THERAPY	19	82.61
INDIVIDUAL / FAMILY COUNSELING	17	73.91
INDIVIDUAL COUNSELING	21	91.30
FAMILY COUNSELING	21	91.30
PEER GROUPS	14	60.87
URINE TESTING	6	20.09
CRISIS INTERVENTION	19	78.26
INDIVIDUAL PSYCHOTHERAPY	12	52.17
GROUP PSYCHOTHERAPY	10	47.48
LEGAL SERVICES	4	17.39
VOCATIONAL / EMPLOYMENT SERVICES	10	47.48
GENERAL MEDICAL CARE	7	30.43
12 STEP ALCOHOLICS ANONYMOUS / NARCOTICS ANONYMOUS	4	17.39
SOCIAL SKILLS TRAINING	17	73.91
PSYCHOPHARMACOTHERAPY FOR DRUG ADDICTION	8	34.48
PSYCHOPHARMACOTHERAPY FOR MENTAL HEALTH	12	52.17
MENTAL HEALTH ASSESSMENT	17	73.91
OTHER	3	13.04

The programs could then either “expand” the service and offer it to a greater number of youth specifically from JJMHI, or add a “new” service to provide services to JJMHI youth. The intent of the JJMHI program was to make psychiatric services available to these “at risk” youth.

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The types of mental health services and other services available through JJMHI after the grant was initiated is shown in Table 27. Take particular note of the highlighted cell in the double digits for new and enhanced services. These expanded and new services are the direct result of JJMHI.

**TABLE 27: SERVICES OFFERED BY AGENCIES
AFTER JJMHI**

TYPE OF SERVICE	NUMBER OF AGENCIES WHERE “NEW”	NUMBER OF AGENCIES WHERE “EXPANDED”	TOTAL “EXPANDED” PLUS “NEW”
CASE MANAGEMENT	0	15	15
INDIVIDUAL THERAPY	2	15	17
FAMILY THERAPY	4	14	18
INDIVIDUAL / FAMILY COUNSELING	3	12	15
INDIVIDUAL COUNSELING	1	13	14
FAMILY COUNSELING	1	14	14
PEER GROUPS	0	5	5
URINE TESTING	0	1	1
CRISIS INTERVENTION	0	6	6
INDIVIDUAL PSYCHOTHERAPY	1	10	11
GROUP PSYCHOTHERAPY	0	4	4
LEGAL SERVICES	0	2	2
VOCATIONAL / EMPLOYMENT SERVICES	0	3	3
GENERAL MEDICAL CARE	0	3	3
12 STEP ALCOHOLICS ANONYMOUS / NARCOTICS ANONYMOUS	0	4	4
SOCIAL SKILLS TRAINING	0	8	8
PSYCHOPHARMACOTHERAPY FOR DRUG ADDICTION	0	6	6
PSYCHOPHARMACOTHERAPY FOR MENTAL HEALTH	3	8	11
MENTAL HEALTH ASSESSMENT	4	15	19
OTHER	7	1	8

PERCEIVED CHALLENGES AND SUCCESSES

One of the ways that YNC staff kept track of the difficulties faced by different organizations was to ask the straightforward question at periodic Cohort Meetings: “Tell us about your successes and challenges.” This inquiry was asked of the staff present at each meeting during the duration of the grant. There were a total of ten Cohort Meetings. This meant that each Cohort (i.e., the Northern Cohort and the Southern Cohort) met five times. The Lead Evaluator was present at six meetings out of the ten, i.e., three from each cohort. In addition, the Lead Evaluator reviewed the formal written notes taken by the YNC Staff at each meeting.

The successes clearly were quite numerous on the part of the line staff from the beginning of the program. The major perceived successes are summarized in Exhibit 2. The line staff were positively influenced to consider the mental health issues which faced them. The challenges are more centered around staffing issues, reporting issues, and the characteristics of mental health problems. The major perceived challenges are enumerated in Exhibit 3.

The exchange of these sessions was useful to the group. The extreme distances from Chicago or Springfield, where the meetings were held, was difficult for some, but the group attended these meetings to share their collective thoughts. As experiences and challenges are exchanged in this manner, a community of practice develops of shared social interaction patterns between members that sustains organizational knowledge (Aldridge, 1999).

EXHIBIT 1: PERCEIVED STRENGTHS

- The on-time start of the program with the short start-up delay.
- The level of communication [among programs and with YNC staff].
- The diversity of programs and the similar concepts [between program].
- The response from clients and families.
- Clients transitioned to regular school.
- Additional enhanced services.
- Finding gaps within the [individual] organization [and filling them].
- Incorporating psychiatric and psychological care.
- An influx of telephone calls from Probation Officers.
- Engaging youth that would not normally be engaged [by an organized community-based program].
- The Providers have a heightened awareness of mental health issues.
- More referrals from Probation and the States' Attorney.
- It became easier to do reports [over time, i.e., there was a learning curve].
- Getting youth hooked into a dual staff, i.e., a bachelor's level case management staff and a master's level therapist.
- Partnership for mental health services to youth (a win-win situation), furthering the mission of organizations, extending services and service areas.
- A great program combining juvenile justice and mental health. Parents and police all have good things to say about it.
- QMHPs learned to [i.e., became more proficient at] diagnosing mental illness.

EXHIBIT 1 (CONTINUED): PERCEIVED STRENGTHS

- There is a lower rate of recidivism with youth who receive these services.
- Youth who do show up have significant “remarkable” changes once receiving counseling.
- Alliances with police and local court system.
- Judges will order youth into program for YASI and MHA [mental health assessment].
- New relationships within the community.
- Youth stabilized because of JJMHI.
- Executives [viz., Executive Directors] of organizations have bought into program and will continue.
- Heightened awareness of other staff [i.e., those not doing JJMHI] of mental health issues.
- Program provided resources to folks who would not normally pursued services.

EXHIBIT 2: PERCEIVED CHALLENGES

- ❖ Learning curve.
- ❖ Reports were an enormous undertaking. Reports are different than other types of forms.
- ❖ Learning new reports [are a] big challenge.
- ❖ Reluctant parents [are resistant to] youth being “labeled”.
- ❖ A needier population [makes] more work.
- ❖ Finding therapists.
- ❖ Difficulty getting referrals from the juvenile justice system.
- ❖ Youth are coming from dysfunctional families. They are more difficult to work with.
- ❖ Mental health factors make the work more complicated.
- ❖ Parents don’t understand the mental health need.
- ❖ Staff turn-over.
- ❖ Difficulty in finding trained staff.
- ❖ Not enough staff to provide quality services.
- ❖ Substance abuse in combination with mental health issues [adds difficulty].
- ❖ Difficult to collaborate with the courts.
- ❖ Difficult to get [appropriate] referrals for the program.
- ❖ Volume of youth who are eligible for JJMHI is overwhelming at the local level.

This was an innovative approach to the extensive mental health needs of these clients and their immediate (and often, their extended) families. Unless the members of the family are involved, and buy-in as stakeholders, the care of their child will fail. For many years, public health interventions have used a socio-ecological framework in which the origins of the public health problem are identified at multiple levels (individual, family, organization, community, and public policy). This type of program is a human services intervention which is quite parallel to the traditional public health approach. Therefore, it is not incorrect to put JJMHI in a similar socio-ecological framework.

Perhaps the greatest strength of JJMHI was to initiate a statewide program for an unrecognized special population in Illinois. Access to comprehensive mental health care for a critical need, such as those exhibited by the youth, has not been supported by traditional funding streams in the past (Glisson and Green, 2006). JJMHI carved out this challenge and demonstrated its approach to juvenile justice, mental health, and at-risk youngsters.

The nature of the start-up of this program is quite remarkable for youth-serving agencies. Yet, it is even more remarkable for collaboration with health organizations, in general, and more so with partners in the mental health and psychiatric field.

There has been an expanding literature that makes clear that pediatricians, family practitioners, and other medically-qualified personnel have played a key role in treating children with mental health problems (Barnes, Stein, and Rosenberg, 1999; Pincus, Tanelian, and

Marcus, 2002). However, few on the community-based youth providers side have attempted to build their capacity to join their mental health colleagues.

DISCUSSION

For now, the grant funding for the Juvenile Justice / Mental Health Initiative of Youth Network Council has ended. The time has come to make some hard judgments about the effectiveness of the overall program. These judgments must be rooted firmly in the evidence for the activities if they are to be meaningful and initiate expansion of the program.

WHAT PROBLEMS DID THE PROGRAMS ENCOUNTER?

JJMHI was well-coordinated throughout the grant period. The program staff at YNC was extremely responsive to difficulties encountered by programs. But, running a program from conceptualization to development of a reasonable logic model to implementation is a fine balancing act (Whittaker, Greene, Schubert, et al, 2006). When the start-up phase has to be hurried along because the grant duration is limited, there is no time for delay. Youth Network Council was to learn many lessons along the way.

There is much documentation in the operational and organizational literature to support YNC's rapid start-up approach. Much had to be done at the outset. It is not unusual for six months to a year being the common time frame for a start-up effort in the grant-supported human services field. YNC did not have that kind of luxury and could have had major difficulties with launching program activities. Instead, most agencies "hit the ground running", the other agencies caught up relatively quickly, and clients began to be enrolled in JJMHI. To its credit,

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Youth Network Council suggested and implemented a model for organizational change. Many agencies had extensive experience with the complexities of the mental health process. Others had substantially less practical experience.

There is an inherent degree of instability in a complex organization. Many fields of endeavor are affected, not the least of which is the youth field. It is difficult to train a staff, develop their role to an acceptable level, and then lose them to other or “better” positions. However, Youth Network Council is acutely aware of the issues in this area. Several years ago, it was the recipient of funding from the U.S. Department of Labor to credential youth workers as a means of dealing with the turnover rate. Changing the system demands evidence and increased efforts to build an infrastructure. The mental health world is not any different in regard the fixed nature of its territory (Ellis, Miranda, and Bruce, 2004).

Reporting was a time-consuming process for the staffs of the agencies. There were very stringent data requirements set out for this program. Despite skills in recordkeeping generally possessed by staff members, the JJMHI need for data sometime was considered an added burden. Few staff members thought in terms of evidence-based data collection and the need for such evidence (Barnes, Stein, and Rosenberg, 1999). However, most mental health practices have not been evaluated for similar reasons and others. It always is difficult to require already overburdened staff to complete information requests to assess a program.

DID THE SERVICE BREAKDOWN ANYWHERE?

Youth Network Council acted as a collaborating partner in the JJMHI project. It tried to make operations run smoothly. But, it did not have administrative oversight over day-to-day operations of the participating agencies. This must be strengthened and/or negotiated in future expansion of this program. Individual organizations had autonomy over their day-to-day operations. But, they also were part of a collaborative program.

WHAT DO THE PROGRAMS NEED TO GO FORWARD?

The participating organizations need at least four things to advance in the future. These are psychiatric support, more QMHPs, funding, and training. First, YNC must make psychiatrists even more available to the participating agencies by various strategies. This means even more resources available to procure the clinical services of psychiatrists. Preferably these will be appropriately trained child and adolescent psychiatrists. Prescribing medications may be part of their role, but they need to be available to do more. In the alternative, perhaps a innovative telecommunications system approach might be feasible. There have been some attempts to use these kinds of approaches in rural areas (e.g., Vought, Grisby, Adams et al, 2000; Ryan, Stathis, Smith et al, 2005; Neufeld, Yellowlees, Hilty et al, 2007). Second, the programs need more QMHPs. Third, the programs need the ability to collect reimbursement for enhanced mental health services to reinvest in expansion of these services. This funding stream is being pursued. Fourth, the staff need additional training in childhood and adolescent mental health

issues. It has been shown that the better members of a staff are trained, an important difference in understanding of the assessment of need is evident. Even if the professional staff appear knowledgeable, the availability of additional in-service sessions specifically about mental health issues and the psychopathology of children and adolescents is justified.

WERE THE LEVELS OF SEVERITY OF THE YOUTH APPROPRIATE?

The diagnostic process in the mental health specialties depends on the level of intensity of the practitioner. That may well be reflected in the extent of the labor-intensive services that were frequently part of this program. The agencies need more direct service providers who interact with the client and family. The wide variety of psychopathology seen in the diagnostic breakdown is evidence that there is clinical need. There is a critical shortage of practitioners in the mental health professions (Huang, Macbeth, Dodge, et al. 2004).

The YASI identification process indicated a large group of moderate-to-severe individuals who ultimately were shown to have confirmed psychiatric conditions. Although there were no formal tests of the association between the identification scheme and the condition, it seems to have pointed out youngsters who benefited by participating in JJMHI.

HOW DID THE PROGRAMS OFFER MENTAL HEALTH SERVICES?

About half of the agencies had a psychiatrist available to them before JJMHI. However, usually this was for as little as 1 hour per week to handle everything in the agency. This was not provision of adequate time for the agencies.

After JJMHI, this commitment became dedicated to the problems of the children. Usually, programs were able to make individual arrangements to have psychiatrists provide more work for the agency. Private psychiatrists or those working in community mental health centers were brought on for limited extra periods. With only few exceptions, agencies now were able “to buy” limited additional psychiatric support. The amount of time provided varied, but amounted to as much as five hours per week for some agencies.

Agencies, therefore, were able to add at least one psychiatrist on a limited part-time basis. JJMHI made that possible. A few (i.e., five) used the psychiatrist for making diagnostic decisions. Three agencies used their fill-in personnel for case review and advising line staff. There was little individual therapy, but more group therapy. This leads to the belief that groups allowed psychiatric resources to be maximized, reaching more clients and their families. All psychiatrists were trained adequately. However, there was not review of their credentials and curricula vitae.

Agencies also tended to take the less expensive route and contract for additional part-time QMHPs. Each organization had a normal staff of 1 to 24 QMHPs who were split between full-

and-part-time positions. Additional staffing was added about 5 to 10 hours per week dedicated strictly to JJMHI clients. Their responsibilities parallel those mentioned before.

Executive Directors, therefore, chose to rearrange their existing staff and supplement with the new support rather than simply add more psychiatric time. The important message seems to be “Put forward the most mental health services with limited resources via staffing rearrangement”. This contributed to greater service for JJMHI and a creative use of available funds. For the majority of agencies, this did not mean a drastic change in the way services were delivered.

DID JJMHI PROVIDE THE SERVICES IT STATED?

The agencies which together comprised JJMHI had two agendas: The first, treating the client, essentially was pursued without any “interference” from Youth Network Council. The second, related to the collaborative duties as a working partner in the overall PROGRAM. The goals included increased local capacity and higher utilization rates for existing mental health services. It effectively provided both types of services.

CONCLUSIONS

Based upon the contents of this Evaluation Report, one can draw the following conclusions about the program activities of the Juvenile Justice / Mental Health Initiative (JIMHI) of Youth Network Council / Illinois Collaboration On Youth (YNC / ICOY), as well as about the participating agencies and the model presented for assessment:

1. There is substantial unmet need for mental health services, including proper mental health assessment, among the 10-17 year olds with one or more prior juvenile justice contacts.
2. Many youth-serving human services agencies and programs around the State of Illinois will refer clients to JIMHI although these relationships could be improved further. CCBYS is a major internal referral source.
3. JIMHI drew its clients from 34 counties throughout the State of Illinois, including urban, rural, and collar counties, as well as Cook County.
4. The range of psychiatric diagnoses is extensive with conduct disorder, oppositional defiant disorder, and ADD/ADHD being the most frequent problems, followed by substance abuse, depression, bipolar disorder, and mood disorder.

5. JJMHI provided 18,791 service units to youth who otherwise would not have been served. A service unit does not take into account the actual time involved, but demonstrates the service was labor-intensive.
6. Almost 80.00% of the clients are insured. Private third-party payers account for about 30.00% while 50.00% are insured through Medicaid.
7. A combination of mental health providers reached the confirmed final diagnosis: Psychiatrists (31.17%); Qualified Mental Health Professionals or QMHPs (46.68%); the V-DISC, a computerized diagnostic instrument (18.67%); as well as Non- Psychiatrist Physicians (2.21%); Clinical Psychologists (1.26%).
8. Diagnostic services were provided and finalized in 632 of 698 clients (90.54%).
9. Among clients, 356 youth accounted for 898 status offenses.
10. There were 350 youth who accounted for 953 contacts with the police. Of these, leaving out single episodes, the remaining 205 had multiple contacts which accounted for 808 involvements with the police.

11. Rated by an independent evaluator, JJMHI clients “improved” (64.49%), “did not change” (30.56%), or “got worse” (4.97%).
12. Specific services were expanded or added in community-based youth-serving human services agencies throughout the State of Illinois’ Youth Service System.
13. The model advanced by Youth Network Council / Illinois Collaboration On Youth (YNC/ICOY) is innovative and effectively deals with the unmet mental health needs of youth 10-17 with prior juvenile justice contacts, or those at moderate-to-severe risk of becoming involved with the juvenile justice system.

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APPENDIX A

JJMHI REPORTING MATERIAL (PART ONE)

YNC/ICOY
JUVENILE JUSTICE MENTAL HEALTH INITIATIVE
REPORTING INFORMATION
(PART ONE)

Developed for YNC by Gary B. Beringer, Dr. P.H.
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Based on the YASI

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➤ DEMOGRAPHIC INFORMATION:

SITE NUMBER (enter 3 digits) _____

CLIENT NUMBER (enter 4 digits) _____

DATE OF BIRTH (enter 6 digits)
(enter mm/dd/yy) _____

GENDER (enter 1 digit) _____

1 = Male

2 = Female

9 = Not indicated

RACE (enter 1 digit) _____

1 = Black/African American

2 = Caucasian

3 = Hispanic/Latino

4 = Asian/Asian American

5 = American Indian

6 = Alaskan Native

7 = Other (Specify: _____)

9 = Not indicated

EDUCATION: (highest grade achieved) (enter 2 digits) _____

PROGRAM (in which program involved) (enter 2 digits) _____

01 = Juvenile Justice Intervention (Title II)

02 = Juvenile Detention Alternatives Initiative

03 = Disproportionate Minority Confinement

04 = Communities for Youth

05 = JAIBG

06 = Intervention

07 = Crossroads

08 = Prevention

09 = CCBYS

10 = UDIS

11 = Release Upon Request

12 = Re-Deploy Illinois

13 = Station Adjustment (Title V)

14 = Other (Specify: _____)

99 = Not Indicated

ZIP CODE (enter 5 digits)
(for youth's usual home residence) _____

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COUNTY (enter 3 digits) * _____
 (for youth's usual home residence; see list of counties sent separately)

TYPE OF ASSESSMENT (enter 1 digit) _____
 1 = Initial
 2 = Re-assessment
 3 = Closing assessment
 4 = Other disposition for treatment
 5 = Withdrew
 6 = Other (Specify: _____)
 9 = Not indicated

➤ SECTION 1: LEGAL HISTORY

TOTAL NUMBER OF STATUS OFFENSES (enter 2 digits) _____
 (include TINS, consumption of alcohol, curfew violations,
 runaway, lockouts, limited custody)

AGE AT FIRST OFFENSE (NON-STATUS/DELINQUENCY) (enter 2 digits) _____

TOTAL NUMBER OF REFERRALS FOR OFFENSES (enter 2 digits) _____
 (any non-status/delinquency offenses that resulted in a conviction,
 diversion/station adjustment, deferred adjudication, or
 deferred disposition (regardless of whether successfully completed))

KNOWN REFERRALS FOR FELONY OFFENSES (enter 2 digits) _____

ADULT REFERRALS (enter 2 digit) _____
 Total number of referrals to adult court

TOTAL NUMBER OF WEAPONS OFFENSES (enter 2 digits) _____
 (includes convictions, diversion/station adjustment, deferred
 adjudication, or deferred disposition (regardless of whether
 successfully completed))

REFERRAL FOR OFFENSES AGAINST OTHER PERSONS (enter 2 digits) _____
 (includes convictions, diversion/station adjustment, deferred
 adjudication, or deferred disposition (regardless of whether
 successfully completed. Includes threats, force, or physical harm

to another person such as homicide, murder, manslaughter, rape, or assault, sexual offense, robbery, kidnapping, domestic violence, coercion, harassment, intimidation, obscene or harassing phone call, etc.)

KNOWN REFERRALS FOR FELONY AGAINST ANOTHER PERSON _____

(enter 2 digits)

(includes convictions, diversion/station adjustment, deferred adjudication, or deferred disposition (regardless of whether successfully completed.)

PLACEMENTS (enter 2 digits) _____

(includes DCFS placements. Court services, CCBYS, or other placements)

CUSTODY (enter 2 digits) _____

(includes Dock placements for any reason)

FAILURE-TO-APPEAR IN COURT (enter 2 digits) _____

(includes failures-to-appear in adult and juvenile court that resulted in a warrant being issued)

➤ SECTION 2: FAMILY AND ENVIRONMENT:

RUNAWAY (enter 1 digit) _____

(includes times youth did not voluntarily return within 24 hours.)

0 = None

Enter number up to a maximum of 5

8 = Not applicable

9 = Not indicate

LOCKED OUT OF HOME (enter 1 digit) _____

(includes times youth did not voluntarily return within 24 hours.)

0 = None

Enter number up to a maximum of 5

8 = Not applicable

9 = Not indicated

CURRENT CIRCUMSTANCES OF FAMILY MEMBERS *
IMPORTANT: Complete for each family member

MOTHER (enter 1 digit) * _____

1 = No problems

2 = Alcohol/drug/mental health problems

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8 = Not applicable

9 = Not indicated

MOTHER (enter 1 digit) *

4 = JD/criminal record or Violent JD/criminal record

8 = Not applicable

9 = Not indicated

FATHER (enter 1 digit) *

1 = No problems

2 = Alcohol/drug/mental health problems

8 = Not applicable

9 = Not indicated

FATHER (enter 1 digit) *

4 = JD/criminal record or Violent JD/criminal record

8 = Not applicable

9 = Not indicated

SIBLING (enter 1 digit) *

1 = No problems

2 = Alcohol/drug/mental health problems

8 = Not applicable

9 = Not indicated

SIBLING (enter 1 digit)*

4 = JD/criminal record or Violent JD/criminal record

8 = Not applicable

9 = Not indicated

OTHER (enter 1 digit) *

1 = No problems

2 = Alcohol/drug/ mental health problems

8 = Not applicable

9 = Not indicated

OTHER (enter 1 digit) *

4 = JD/criminal record or Violent JD/criminal record

8 = Not applicable

9 = Not indicated

HISTORIC PROBLEMS OF FAMILY MEMBERS *

IMPORTANT: Complete for each family member

MOTHER (enter 1 digit) *

1 = No problems

2 = Alcohol/drug/mental health problems

8 = Not applicable

9 = Not indicated

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APPENDICES – JJMHI FINAL EVALUATION

MOTHER (enter 1 digit) * _____
 4 = JD/criminal record or Violent JD/criminal record
 8 = Not applicable
 9 = Not indicated

FATHER (enter 1 digit) * _____
 1 = No problems
 2 = Alcohol/drug/mental health problems
 8 = Not applicable
 9 = Not indicated

FATHER (enter 1 digit) * _____
 4 = JD/criminal record or Violent JD/criminal record
 8 = Not applicable
 9 = Not indicated

SIBLING (enter 1 digit) * _____
 1 = No problems
 2 = Alcohol/drug/mental health problems
 8 = Not applicable
 9 = Not indicated

SIBLING (enter 1 digit)* _____
 4 = JD/criminal record or Violent JD/criminal record
 8 = Not applicable
 9 = Not indicated

OTHER (enter 1 digit) * _____
 1 = No problems
 2 = Alcohol/drug/ mental health problems
 8 = Not applicable
 9 = Not indicated

OTHER (enter 1 digit) * _____
 4 = JD/criminal record or Violent JD/criminal record
 8 = Not applicable
 9 = Not indicated

YOUTH'S CURRENT LIVING ARRANGEMENTS *
 Check most frequent arrangement (enter 6 digits)

PRIMARY (most frequent) _____

SECONDARY (i.e., next most frequent) _____

TERTIARY (i.e., next most frequent) _____

For all three questions above, use the following scheme:
 01 = Mother (biological or adoptive)

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- 02 = Father (biological or adoptive)
- 03 = Stepparent
- 04 = Siblings
- 05 = Other relatives
- 06 = Other adult
- 07 = Grandparents
- 08 = Foster/group home
- 09 = Independent
- 10 = No permanent address/shelter
- 11 = Other (Specify: _____)
- 98 = Not applicable
- 99 = Not indicated

ANNUAL HOUSEHOLD INCOME (enter 2 digits) _____

- 01 = Under \$5,000
- 02 = \$5,000 to \$9,999
- 03 = \$10,000 to \$14,999
- 04 = \$15,000 to \$19,999
- 05 = \$20,000 to \$24,999
- 06 = \$25,000 to \$29,999
- 07 = \$30,000 to \$34,999
- 08 = \$35,000 to \$39,999
- 09 = \$40,000 to \$44,999
- 10 = \$45,000 to \$49,999
- 11 = \$50,000 to \$54,999
- 12 = \$55,000 to \$59,999
- 13 = \$60,000 to \$64,999
- 14 = \$65,000 to \$69,999
- 15 = \$70,000 and over
- 99 = Refused or Not Indicated

HEALTH INSURANCE AND MEDICAID ELIGIBILITY (enter 1 digit) _____

- 1 = Has health insurance
- 2 = Currently receiving Medicaid/Kid Care
- 3 = Eligible for Medicaid/Kid Care
- 4 = No insurance and not eligible for Medicaid
- 9 = Not indicated

PARENTAL SUPERVISION (enter 1 digit) _____

Parents know who youth is with, when youth will return, where youth is going, and what youth is doing

APPROPRIATE CONSEQUENCES FOR BAD BEHAVIOR (enter 1 digit) _____

Appropriate means clear communication, timely response, and

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response proportionate to conduct

- 1 = Usually appropriate consequences
- 2 = Sometimes appropriate consequences
- 3 = Not appropriate consequences
- 9 = Not indicated

APPROPRIATE RESEPNSE FOR GOOD BEHAVIOR (enter 1 digit) _____

Rewards include affection, praise, or other tangible means

- 1 = Usually appropriate rewards
- 2 = Sometimes appropriate rewards
- 3 = Not appropriate rewards
- 9 = Not indicated

SUPPORT NETWORK FOR FAMILY (enter 1 digit) _____

Extended family and friends who can provide additional support

- 1 = Strong family support network
- 2 = Some family support
- 3 = No family support
- 9 = Not indicated

➤ SECTION 3: SCHOOL

YOUTH'S CURRENT ENROLLMENT STATUS (enter 1 digit) _____

- 1 = Graduated, GED
- 2 = Enrolled, full-time
- 3 = Enrolled, part-time
- 4 = Dropped out
- 5 = Suspended
- 9 = Not indicated

YOUTH'S ATTENDANCE IN MOST RECENT SCHOOL YEAR (enter 1 digit) _____

- 1 = Attends regularly
- 2 = Some partial-day excused absences
- 3 = Some full-day excused absences
- 4 = Five or more full-day unexcused absences per quarter
- 5 = Truancy petition filed
- 9 = Not indicated

YOUTH'S CONDUCT IN MOST RECENT SCHOOL YEAR (enter 1 digit) _____

- 1 = Positive behavioral adjustment
- 2 = No problems reported
- 3 = Infractions reported
- 4 = Intervention by school (calls to parents, principal/superintendent involvement, hearing)
- 5 = Police reports filed by school

9 = Not indicated

YOUTH'S ACADEMIC PERFORMANCE IN MOST RECENT YEAR _____

(enter 1 digit)

- 1 = B+ or above
- 2 = C or better
- 3 = C- or lower
- 4 = Failing some classes
- 5 = Failing all classes
- 9 = Not indicated

YOUTH'S ACADEMIC PERFORMANCE IN MOST RECENT YEAR
COMPARED TO PERFORMANCE IN PREVIOUS SCHOOL YEAR _____

(enter 1 digit)

- 1 = Consistent, stable
- 2 = Performance improved
- 3 = Performance worsened
- 9 = Not indicated

TYPE OF SCHOOL IN WHICH YOUTH IS ENROLLED (enter 1 digits) _____

- 1 = Public Academic
- 2 = Vocational
- 3 = Alternative
- 4 = GED Program
- 5 = Private Academic
- 6 = Home School
- 7 = College
- 8 = Other (Specify: _____)
- 9 = Not indicated

NUMBER OF OUT-OF-SCHOOL SUSPENSIONS
IN THE LAST TWO YEARS (enter 2 digits) _____

- Enter number 0 – 10 none = 0 and maximum = 10
- 99 = Not indicated

NUMBER OF IN-SCHOOL SUSPENSIONS
IN THE LAST TWO YEARS (enter 2 digits) _____

- Enter number 0 – 10 none = 0 and maximum = 1
- 99 = Not indicated

NUMBER OF EXPULSIONS SINCE THE FIRST GRADE (enter 2 digits) _____

- Enter number 0 – 10, none = 0 and maximum = 10
- 99 = Not indicated

AGE AT FIRST EXPULSION (enter 2 digits) _____

- Enter 00 if never expelled
- 99 = Not indicated

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➤ SECTION 4: COMMUNITY/PEER RELATIONSHIPS

MONTHS HAS ASSOCIATED WITH DELINQUENT FRIENDS _____

(enter 2 digits)

Enter 00 if no delinquent friends

Enter number 01-98 for months with delinquent friends, maximum 98

99 = Not indicated

MONTHS HAS ASSOCIATED WITH A GANG _____

(enter 2 digits)

Enter 00 if no gang

Enter number 01-98 for months with gang, maximum 98

99 = Not indicated

NUMBER OF EXISTING POSITIVE ADULT RELATIONSHIPS _____

IN THE COMMUNITY (enter 1 digit)

Enter 0 for none

Enter number 1 – 5 for adults, maximum 5

9 = Not indicated

➤ SECTION 5: ALCOHOL AND DRUGS

ALCOHOL PROBLEMS * (enter 1 digit) _____

- 1 = No indications present
- 2 = Indications present
- 9 = Not indicated

DRUG USE * (enter 1 digit) _____

- 1 = No indications present
- 2 = Indications present
- 9 = Not indicated

➤ SECTION 6: PHYSICAL/MENTAL HEALTH

MENTAL HEALTH PROBLEMS (enter 4 digits, 1 at a time)

FIRST DIGIT _____

- 1 = None
- 2 = Diagnosed with mental health problem
- 9 = Not indicated

SECOND DIGIT AS MOVE RIGHT _____

- 1 = Medication prescribed
- 9 = Not indicated

THIRD DIGIT AS MOVE RIGHT _____

- 1 = Past mental health treatment
- 9 = Not indicated

FOURTH DIGIT AS MOVE RIGHT _____

- 1 = Self-injury / mutilation
- 2 = Eating disorders
- 3 = Both self injury /mutilation AND eating disorders
- 9 = Not indicated

HOMICIDAL IDEATION (enter 1 digit) _____

- 1 = No indications present
- 2 = Indications present
- 9 = Not indicate

SUICIDAL IDEATION (enter 1 digit) _____

- 1 = No indications present
- 2 = Suicidal thoughts
- 3 = Suicide attempt
- 4 = Other indications present, not otherwise specified
- 9 = Not indicated

VIOLENCE * (enter 1 digit) _____

- 1 = No indications present
- 2 = Indications present
- 9 = Not indicated

HISTORY OF PHYSICAL OR SEXUAL ABUSE *

(enter two digits for parents, sibling, other family, and those outside family)

FOR PARENT * _____

(include biological parents, stepparents, adopted parents, and legal guardian)

- 11 = None by parent
- 12 = Only physical abuse by parent
- 13 = Only sexual abuse by parent
- 14 = Both physical and sexual abuse by parent
- 19 = Not indicated for parent

FOR SIBLING * _____

- 21 = None by sibling
- 22 = Only physical abuse by sibling
- 23 = Only sexual abuse by sibling
- 24 = Both physical and sexual abuse by sibling
- 29 = Not indicated for sibling

OTHER FAMILY * _____

- 31 = None by other family
- 32 = Only physical abuse by other family
- 33 = Only sexual abuse by other family
- 34 = Both physical and sexual abuse by other family
- 39 = Not indicated for other family

OUTSIDE FAMILY * _____

- 41 = None by outside family
- 42 = Only physical abuse by outside family
- 43 = Only sexual abuse by outside family
- 44 = Both physical and sexual abuse by outside family
- 49 = Not indicated for outside family

YOUTH'S GENERAL PHYSICAL HEALTH (enter 1 digit) _____

- 1 = Excellent

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- 2 = Good (only minor complaints)
- 3 = Fair (serious concerns)
- 4 = Poor
- 9 = Not indicated

➤ SECTION 7: EMPLOYMENT

NUMBER OF TIMES YOUTH HAS BEEN EMPLOYED (enter 1 digit) _____

Enter 0 if not employed

Enter number 1-8 for times employed, maximum 8

9 = Not indicated

➤ YASI SCORES AT INTAKE

TOTAL YASI SCORE (NUMBER) * (enter 3 digits) _____

Use numbers when feasible, if possible;

Otherwise, use 98 = Not Applicable

99 = Not Indicated

TOTAL YASI SCORE (RANGE) * (enter 3 digits) _____

Use: 01 = Low

02 = Moderate

03 = High

98 = Does Not Apply

99 = Not Indicated

STATIC RISK (RANGE) * (enter 3 digits) _____

STATIC RISK (NUMBER) * (enter 3 digits) _____

DYNAMIC RISK (RANGE) * (enter 3 digits) _____

DYNAMIC RISK (NUMBER) * (enter 3 digits) _____

STATIC PROTECTIVE (RANGE) * (enter 3 digits) _____

STATIC PROTECTIVE (NUMBER) * (enter 3 digits) _____

DYNAMIC PROTECTIVE (RANGE) * (enter 3 digits) _____

DYNAMIC PROTECTIVE (NUMBER) * (enter 3 digits) _____

NUMBER OF POLICE CONTACTS * (enter 3 digits) _____

NUMBER OF COURT CONTACTS * (enter 3 digits) _____

APPENDIX B

JJMHI TRACKING SUMMARY (PART TWO)

**YNC/ICOY
JUVENILE JUSTICE MENTAL HEALTH INITIATIVE
REPORTING INFORMATION
(PART TWO)**

TRACKING SUMMARY

SITE NUMBER (enter 3 digits) _____

CASE NUMBER (enter 4 digits) _____

TODAY 'S DATE (enter 6 digits) _____

DAYS SINCE INTAKE (enter 3 digits) _____

DAYS SINCE LAST REPORT (enter 3 digits) _____

TREATMENT/REFERRAL:

SITE NUMBER – CLIENT NUMBER _____ - _____

APPENDIX C

JJMHI CONSENT FORM FOR YOUTH NETWORK COUNCIL

CONSENT FOR PARTICIPATION AND RELEASE OF INFORMATION

Youth Network Council (YNC) is a capacity-building organization that collaborates with other youth agencies. YNC serves to enhance the capacity of those organizations and individuals that provide services, opportunities, and other means of support to young people and their families at the community level.

YNC was incorporated as a 501(c)3 not-for-profit corporation in 1972. From its inception, YNC has been supporting youth serving organizations and enhancing their capacity through its multi-faceted programs. The Illinois Collaboration on Youth (ICOY) was begun as a statewide program of Youth Network Council in 1979. Its mission is to support and enhance the capacity of Illinois' community-based youth services system.

ICOY now is coordinating participation by this agency and others throughout Illinois in an effort to build an enhanced program to reduce recidivism and contacts with the juvenile justice system among at-risk youth.

I give my consent for participation by _____ (*name of youth*) in the Juvenile Justice/Mental Health Initiative coordinated by ICOY/Youth Network Council. It is an enhanced program in addition to the services of _____ (*name of agency*), hereafter referred to as the Service Site.

I have completed the consent forms of the Service Site, understand these forms, and have been given copies of these forms for my information. I also have been given a copy of this form for my information.

My participation includes information about the Youth Assessment Screening Instrument (YASI), case planning, the type of services provided in treatment and referral, juvenile justice contacts, the V-DISC (if applicable), and other assessment instruments. All information will be identified by a number known only to the Service Site.

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Consent For Participation
Page Two

All information will be held confidential and all applicable federal, state, and local laws will be observed. I will hold ICOY/Youth Network Council harmless for all actions taken in accordance with the terms of this consent.

This consent is valid for one year from the date of signature below, and may be revoked at any time. If revoked, it will not apply to any action already taken. This consent will expire on _____ (*insert date*), unless otherwise ended by the client.

Participating in this coordinated effort will not affect treatment by the agency, nor will refusal to participate in the collection of such data affect treatment.

If you have any question, they should be directed to the Service Site, or to: JJMHI Coordinator, ICOY/Youth Network Council, 200 North Michigan Avenue, Suite 400, Chicago, Illinois, 60601, telephone: 312-704-1257.

This form will become a part of the client record.

I fully understand this consent as it has been explained to me. I also understand that participation in this program and its services is voluntary. If I have any questions, I may ask about them.

_____ Date _____
Parent/Guardian Signature

_____ Date _____
Youth Signature (10 – 17 years)

_____ Date _____

APPENDIX D

SERVICES BEFORE AND AFTER EARMARK

SITE NAME: _____
 SITE NUMBER: _____

Instructions: Please describe the services the earmark offers clients. Place an "X" by the services offered by the services offered by the JJMHI. If services existed prior to the earmark, but were enhanced by the grant, please check both columns.

TYPE OF SERVICE	SERVICE EXISTED PRIOR TO TE EARMARK	NEW OR ENHANCED SERVICES PROVIDED UNDER THE EARMARK
CASE MANAGEMENT		
INDIVIDUAL THERAPY		
FAMILY THERAPY		
INDIVIDUAL/FAMILY THERAPY		
INDIVIDUAL THERAPY		
FAMILY COUNSELING		
PEER GROUP		
URINALYSIS		
CRISIS INTERVENTION		
INDIVIDUAL PSYCHOTHERAPY		
GROUP PSYCHOTHERAPY		
LEGAL SERVICES		
VOCATIONAL/EMPLOYMENT SERVICES		
GENERAL MEDICAL CARE		
12 STEP AA / NA		
SOCIAL SKILLS TRAINING		
PHARMACOTHERAPY FOR DRUG ABUSE		
PHARMACOTHERAPY FOR MENTAL HEALTH		
MENTAL HEALTH ASSESSMENT		
OTHER: (SPECIFY)		

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APPENDIX E

**SURVEY ABOUT PSYCHIATRISTS AND
QUALIFIED MENTAL HEALTH
PROFESSIONALS**

**QUESTIONNAIRE ABOUT MENTAL HEALTH SERVICES THROUGH
JJMHI**

Please return by fax to Shelley Milosevich at 312-704-1257

Agency _____

Site Number _____

Questionnaire filled out by (check one):

Executive Director _____

JJMHI Coordinator at agency _____

Other (specify: _____) _____

**QUESTIONNAIRE ABOUT MENTAL HEALTH SERVICES THROUGH
JJMHI**

Agency Name: _____

Site Number: _____

1. Before JJMHI, did you have the services of a psychiatrist or psychiatrists available? YES NO

2. If so, how many? _____

3. After JJMHI began, did your agency hire a contract psychiatrist for JJMHI clients or otherwise get the services of a psychiatrist? YES NO

4. How much time did the psychiatrist provide?
(e.g. 20 hours per month, or 5 hours per week for instance;
be sure to include the time periods) _____ hours per _____

5. Where did you get any additional psychiatrist(s) who worked in JJMHI?
 - a. Hired a contract psychiatrist as a consultant YES NO
 - b. Other consulting arrangement (e.g., fee for services rendered, etc) YES NO
 - c. Private psychiatrist in the community YES NO
 - d. Hospital-based psychiatrist YES NO
 - e. Mental health facility – based psychiatrist YES NO

Agency Name: _____

Site Number: _____

6. How did your agency use the psychiatrist(s)?

- | | | |
|-----------------------------|-----|----|
| a. Case reviews? | YES | NO |
| b. Finalize the diagnosis? | YES | NO |
| c. Advise line staff? | YES | NO |
| d. Individual therapy? | YES | NO |
| e. Family therapy? | YES | NO |
| f. To prescribe medication? | YES | NO |
| g. Other (specify: _____) | YES | NO |

- 7. Was the psychiatrist(s) specially trained AND certified as a child/adolescent psychiatrist?**
- NO YES

Agency Name: _____

Site Number: _____

16. How did your agency use the QMHP(s)?

- | | | |
|--------------------------------------|-----|----|
| a. Case reviews? | YES | NO |
| b. Finalize the diagnosis? | YES | NO |
| c. Advise line staff? | YES | NO |
| d. Individual therapy or counseling? | YES | NO |
| e. Family therapy or counseling? | YES | NO |
| f. Other (specify: _____) | YES | NO |

17. Was the QMHP(s) specially trained in child/adolescent issues?

YES NO

APPENDIX F

**VOLUNTARY REPORTING FORM
FOR AFTER JJ/MHI TERMINATED**

Legal History				Treatment	
Number of Offenses prior to Youth Services		Number of Dispositions prior to Youth Services		Number of Services During Quarter	
Status	Delinquent	1-None		1- Case Management	
1-None	1-None	2- Pending		2- Crisis Intervention	
2- Runaway	2- Battery	3- No Charge		3- Consultation	
3- Curfew Violation	3- Theft	4- Charge Dropped		4- Family Counseling	
4- Truancy	4- Assault	5- Adjudicatory Hearing		5- Family Therapy	
5- Controlled Substance	5- Fighting	6- Court Appearance		6- Individual Therapy	
6- Locked Out of Home	6- Domestic violence	7- Limited Custody		7- Individual & Family Therapy	
7- Other (list below)	7- Police Intervention	8- Station Adjustment		8- Individual Counseling	
	8- Violation of probation	9- Community Service		9- MD/DO Prescription	
	9- Other (list below)	10- Peer Jury		10- Mental Health Assessment	
		11- Pay Restitution		11- Peer Group	
		12- Warrant for Arrest		12- Psychiatric Direct Contact	
		13- Court Supervision		13- Psychiatric Case Review	
		14- Probation		14- Psychiatric Other Contact	
		15- Detention		15- Psychiatric Prescription	
		16- DOC		16- Psychological Direct Contact	
		17- Other (list below)		17- Psychological Case Review	
				18- Psychological Other Contact	
				19- QMHP Direct Contact	
				20- QMHP Case Review	
				21 -QMHP Other Contact	
Number of Offenses during Current Quarter		Number of Dispositions during Current Quarter		22- Treatment Plan Review	
Status	Delinquent	1-None		23- Urinalysis	
1-None	1-None	2- Pending		24- Other (list below)	
2- Runaway	2- Battery	3- No Charge			
3- Curfew Violation	3- Theft	4- Charge Dropped			
4- Truancy	4- Assault	5- Adjudicatory Hearing		<i>TOTAL</i>	
5- Controlled Substance	5- Fighting	6- Court Appearance			
6- Locked Out of Home	6- Domestic violence	7- Limited Custody			
7- Other (list below)	7- Police Intervention	8- Station Adjustment			
	8- Violation of probation	9- Community Service			
	9- Other (list below)	10- Peer Jury			
		11- Pay Restitution			
		12- Warrant for Arrest			
		13- Court Supervision			
		14- Probation			
		15- Detention			
		16- DOC			

17- Other (list below)

Mental Health

Prior to Youth Services		Diagnosis		
		Provisional	Confirmed	
1- Seen Psychologist				
2- Seen Psychiatrist		1-ADHD		19
3- Prescribed Psychiatric Medication		2- Conduct Disorder		20
4- Hospitalized for Substance Abuse		3- Oppositional Defiant Disorder		21
5- Hospitalized for Psychiatric Disorder		4- Disruptive Behavior Disorder		22
		5- Separation Anxiety Disorder		23
During Quarter		6- Substance-Related Disorder		24
1- Seen Psychologist		7- Polysubstance-Related Disorder		25
2- Seen Psychiatrist		8- Major Depressive Disorder		26
3- Prescribed Psychiatric Medication		9- Dysthymic Disorder		27
4- Provisional Diagnosis		10- Depressive Disorder		28
5- Confirmed Diagnosis		11- Bipolar Disorder		29
6- Referred to other mental health program		12- Mood Disorder		30
		13- Obsessive-Compulsive Disorder		31
7- Hospitalized Substance Abuse		14- Posttraumatic Stress Disorder		32
8- Hospitalized for Psychiatric Disorder		15- Generalized Anxiety Disorder		33
		16- Anxiety Disorder		34
		17- Adjustment Disorders		35
		18- Other (list below)		36

J.JMHI Voluntary Reporting Instructions

Complete one reporting form per client, per quarter.

Site Number: Continue using the same site number as JJMHI.

Client Number: Continue using the same client numbering system as JJMHI.

Intake Date: The date the youth's case opened.

Closure Date: The date the youth's case closed; if the case is still open during the current quarter, put "N/A".

Today's Date: The date the form was completed.

Gender: Put an "X" next to the female if the youth is female, or next to male if the youth is male.

Race: Put an "X" in the box next to the race of the youth.

Education: Put an "X" in the box next to the highest grade level achieved by the youth.

Program: Put an "X" in the box next to the program(s) in which the youth is currently involved.

Number of Offenses prior to Youth Services: Put the number of times the youth committed each offense next to the box. If the youth committed offenses that are not listed, type in the offense(s) under "Other" and put the number of times the youth committed that offense. If the youth has not offended put an "X" next to the "None" box.

Number of Dispositions prior to Youth Services: Put the number of times the youth received each disposition next to the box. If the youth has never received a disposition put an "X" next to "None." If the youth received dispositions not listed, type in the dispositions under "Other" and put the number of times the youth received that disposition.

Number of Offenses during Current Quarter: These are only offenses committed during the current quarter. Put the number of times the youth committed each offense next to the box. If the youth committed offenses that are not listed, type in the offenses

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under "Other" and put the number of times the youth committed that offense. If the youth has not offended during the current quarter, put an "X" next to the "None" box.

Number of Dispositions during Current Quarter: These are only dispositions received during the current quarter. Put the number of times the youth received each disposition next to the box. If the youth did not receive a disposition during the current quarter, put an "X" next to "None." If the youth received a disposition not listed, type in the disposition under "Other" and put the number of times the youth received that disposition.

Treatment: Put the number of contacts next to each type of service the youth received during the current quarter.

Mental Health prior to Youth Services: Type in the number of Mental Health services the youth received prior to Youth Services.

Mental Health during Current Quarter: Type in the number of Mental Health services the youth received during the current quarter.

Mental Health Diagnosis: Put an "X" in the box next to the youth's current diagnosis(es), ensuring it corresponds to the appropriate status (provisional or confirmed).

YASI scores at Intake and Closure: Put an "X" next to the overall YASI score (Low, Medium or High). If the case is still open and the final YASI has not been completed, put an "X" next to "Not Available."

Dynamic Scores: Type in the Total YASI Dynamic Risk score (found by adding the Dynamic Risk scores from all the sYASI domains) and Dynamic Protective score (found by adding the Dynamic Protective scores from all the YASI domains). If the case is still open and the final YASI has not been completed, put an "X" next to "Not Available."

Physical Mental Health Risk Score: Put an "X" next to the YASI score in the Physical/ Mental Health domain (Low, Medium or High). If the case is still open and the final YASI has not been completed, put an "X" next to "Not Available".

Case Closure: Put an "X" next to the reason for case closure/ termination. If the case closes due to Youth moving, please type in the circumstances for the move, and place an "X" next to the reason. If the case closed for a reason not listed, please type in the reason below "Other", and place an "X" next to the reason.

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