FRONT-END DIVERSION INITIATIVE PROGRAM

Policy and Procedure Manual Overview

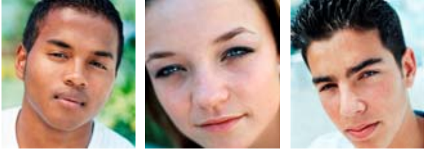

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Table of Contents

Section I: General Information and Overview

General History 1
Future Goals 2

Section II: Program Implementation

Program Guidelines 2
Case Management 4
Data Collection 6
Data Analysis 6
Technical Assistance 6
Outcome Measures 6

SECTION III: Attachments

Attachment A: The Case for Specialized Supervision in Juvenile Justice 7
Attachment B: Program Overview Bexar County 15
Attachment C: Program Overview Dallas County 16
Attachment D: Program Overview Lubbock County 18
Attachment E: Program Overview Travis County 20
Attachment F: Ohio Scale - Youth 22
Attachment G: Ohio Scale - Parent 24
Attachment H: Ohio Scale - Worker 26
Attachment I: Ohio Scale – Scoring Guidelines 28

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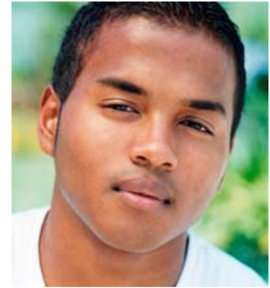
SECTION 1:

GENERAL INFORMATION AND OVERVIEW



General History

In September 2007, the Texas Juvenile Probation Commission (TJPC) in collaboration with the Texas Youth Commission (TYC), the Health and Human Services Commission (HHSC), the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), the Bexar County Juvenile Probation Department, and the Tarrant County Juvenile Probation Department replied to a request for participation in the *Models for Change* Mental Health/Juvenile Justice Action Network. Of the 21 applications received, Texas was one of four states selected to join the existing four *Models for Change* states to form the Mental Health/Juvenile Justice Action Network funded by the John D. and Catherine T. MacArthur Foundation and coordinated by the National Center on Mental Health and Juvenile Justice. The initiative is aimed at developing innovative solutions and strategies to better address the mental health needs of youth involved with the juvenile justice system.

As a part of the effort, the Front-End Diversion Strategic Intervention Group (SIG) was formed. This SIG has focused its efforts on the pre-adjudicatory diversion of youth with mental health needs from the earliest points of contact with the juvenile justice system. The originating planning group identified three critical points of contact to target with a diversion strategy: law enforcement, schools and intake.

Texas chose to take the intake based option for diversion by creating the Front-End Diversion Initiative (FEDI). This approach has focused on providing motivational interviewing, family engagement, crisis intervention, and mental health training to specialized juvenile probation officers to help them better identify and work with youth who have mental health problems. Intake (either probation or juvenile court) is often viewed as the gatekeeper to juvenile court, and as such, represents an ideal point for applying a pre-adjudicatory diversion strategy, particularly for youth with mental health needs.

Building on the work that has been done in the adult probation system (Skeem, Emike-Francis & Louden, 2006), this approach will:

- implement an intake-based diversion strategy using specialized juvenile probation officers who have received substantial mental health training to enable them to work effectively with youth with mental health needs;
- have establish exclusive mental health caseloads for specialized juvenile probation officers that are smaller than the caseloads of traditional juvenile probation officers;
- provide intensive case management and support to youth and their families; *and*
- provide community-based linkages with service providers to link youth and their families to the mental health services and other supports they need.

These specialized officers serve as a case manager working with a reduced case load that targets the officer's efforts on engaging families, linking the youth to community services and providing support to divert the youth and family from the adjudication process. The demonstration sites for FEDI include Bexar, Dallas, Lubbock, and Travis County Juvenile Probation Departments.

Future Goals

All data and initiative reviews will be consolidated by Texas Juvenile Probation Commission (TJPC) to report the status of the Front-End Diversion Initiative (FEDI) to the oversight board of the TJPC as requested by the Executive Director of TJPC, and to the National Center on Mental Health and Juvenile Justice (NCMHJJ) by December 2009. Prior to the end of fiscal year 2010, a comprehensive report evaluating the impact of FEDI will be compiled by unit staff of TJPC and submitted to NCMHJJ, the oversight board of TJPC, and to all identified stake holders involved with the efforts of the Texas Mental Health and Juvenile Justice Action Network.

SECTION 2:

PROGRAM IMPLEMENTATION

Specialized supervision with specially trained probation officers carrying a reduced caseload has been proven to be cost effective and efficient toward rehabilitating the adult mentally ill offender. These programs apply the theory of "therapeutic jurisprudence" and are designed to be treatment-oriented on the assumption that, for mentally ill offenders, problem-solving responses to violations of probation conditions are more appropriate than strict enforcement of those conditions (Wexler, 2000a, 2000b; Winick, 2003).

The specialized officer collaborates with the offender on identifying the problem(s) that occurred and generates a plan or contract with the offender (and in the case of a juvenile offender, the offender and his or her family) to address the behavior through a new course of action (Skeem et. al., 2006). The most common components of the problem solving process includes "(a) having a fair, two – way conversation about treatment non-compliance and its likely causes; (b) generating alternative strategies for addressing the problem; and (c) mutually agreeing on a plan for solving the problem to achieve compliance" (Skeem et al., 2006, p. 180).

Program Guidelines

Each demonstration site has collaborated with TJPC in the development of the minimum program implementation guidelines for FEDI. Although there are some variances in implementation of FEDI across locations, the following guidelines are the universal operating guidelines followed by each site. The purpose of this initiative is to coordinate access to effective services in order to divert the youth from adjudication.

a. **Target population.** Youth who will be served through this initiative are those who:

   i. Have received or are deemed by the local department as being eligible for deferred prosecution, deferred disposition, or are pending adjudication under court ordered conditions of release, and are being supervised in the community by the juvenile court; *and*
   ii. Are found to have a DSM-IV Axis I diagnosis or are screened as potentially having a DSM-IV Axis I diagnosis other than or in addition to substance abuse, mental retardation, autism, or pervasive developmental disorder; *and*
   iii. Are at risk of adjudication; *and*
   iv. Have at least one family member or other adult in the household who is willing to actively participate in the program.

b. **Referral into the Front-End Diversion Initiative.** Each of the following activities shall be completed to determine eligibility for the program:

   i. **Mental Health Screening:** In order to identify all potential youth for diversion, each youth should be screened at intake. This screening process may take several forms as follows:

      1. **Massachusetts Youth Screening Inventory (MAYSI-2)**. In 2001, State of Texas has adopted the MAYSI-2 as the mandatory mental health screening for all youth referred to local juvenile probation departments. Those youth who meet the set "cut off" criteria on the MAYSI-2 are eligible for FED.I

      2. **Existing Diagnosis.** Some youth may have had a prior mental health assessment. However they may not be currently active in treatment. If the family indicates the youth had a prior assessment resulting in an existing diagnosis, then that youth is eligible for FEDI.

      3. **Special Education.** If the family indicates that the youth is in special education due to emotional disturbances, then that youth is eligible for FEDI.

      4. **Juvenile Mental Health History.** If the family indicates that the youth has had previous mental health treatment, such as hospitalization, psychiatric services, or has received services from a community mental health provider, the youth is eligible for FEDI.

      5. **Family Mental Health History.** Some youth may be referred to the local juvenile probation department with no previous diagnosis or mental health history. They may also not be flagged by the MAYSI-2 as meeting the established "cut offs" to indicate a need for further assessment. However, if their family has a history of mental health related issues, the youth is at risk as well. If the family indicates that they have a history of mental health related problems, the youth is eligible for FEDI.

   ii. **Family Suitability Interview (FSI)**. FEDI is a family based intervention. Family engagement is a prerequisite for helping the family achieve its goals. Effective strategies for engagement include collaboration through supportive home-based interventions such as skill-building, broad-based case management with concrete resources, and family involvement in the youth's progress. In addition, specialized officer traits such as empathy, trust, and respect for families have been found to promote positive family engagement. The FSI sets the stage for all future interventions. The purpose of this interview is to determine whether the youth has a family member available to participate. At a minimum the following must be conducted by the specialized juvenile probation officer during the interview:

      1. A family suitability interview shall be completed for each youth found to meet the requirements for services through this program.
      2. At a minimum the family suitability interview must include the following components:
         A. Provide an overview of the initiative to the youth and their family; *and*
         B. Determine whether the youth and family voluntarily agree to participate.
      3. If there is no supportive family member or other adult available to participate in the initiative, the youth should be referred for services through another program.

iii. **Medicaid/Chip Screening**. All youth accepted or enrolled into FEDI shall be screened for medical insurance coverage when they are accepted into the initiative.

1. The specialized juvenile probation officer shall ensure that any youth not actively covered by current medical insurance are referred to the appropriate agency to complete an application for Medicaid or the Children's Health Insurance Program (CHIP) is completed.

Case Management Guidelines

Specialized supervision is a non-traditional case management style that involves interactive service coordination between both internal (within the probation department) and external or community based resources to link the offender to services for their many needs. Within this context, specialized juvenile probation officers do not simply refer and monitor the referral for services, rather, they actively build relationships and interact with mental health clinicians, service providers, and advocates to link the offender to resources needed to assist them in stabilizing their mental health need (Dauphinot, 1996; Skeem et. al., 2006; & Solomon et. al., 2002).

a. **Program Requirements**. The specialized officer assigned to FEDI shall provide quality case management and service coordination for each youth and family under their supervision. The following are the minimum guidelines for the FEDI:

i. **Specialized Officer Associated with FEDI Shall**:

1. Have completed the Specialized Officer Certificate Program, or be in the process thereof.
2. Maintain an exclusive caseload of no more than 15 youth.
3. Meet with the youth and/or family weekly during supervision to plan and coordinate the provision of services.
4. Ensure that the points of contact with the youth and family are driven by the identified need(s) of the youth and family and conducted at a place convenient for the family.
5. Provide services to the youth and family for a period consistent with a deferred prosecution agreement (Typically 3 to 6 months).
6. Use empathetic motivational interviewing techniques that establish a safe and open environment that is conducive to examining issues and eliciting personal reasons and methods for change and should include the following:
   a. Understanding each youth and family's unique perspective, feelings, and values.
   b. Communicate respect for and acceptance of clients and their feelings.
   c. Encourage a nonjudgmental, collaborative relationship.

ii. **Problem Severity and Functionality Assessment: The Ohio Scales**. The Ohio Scales were developed to be a practical, multi-content, multi-source measure of outcome for children and adolescents receiving mental health services. Initial studies suggest that the Ohio Scales are promising (reliable, valid, and sensitive to change) measures that can be used to track the effectiveness of behavioral health interventions for youth with serious emotional disorders. In 2007, the Texas Legislature mandated the use of the Ohio Scales for all youth referred to the community Mental Health and Mental Retardation (MHMR) system. Therefore, the use of the Ohio Scales within the juvenile justice system is not only a sound practice for measuring out comes for the FEDI, but also a very practical approach toward diverting youth from adjudication to the mental health system.

1. The Parent, Child and Worker versions of the Ohio Scales shall be administered by the specialized juvenile probation officer as follows:
    a. Upon acceptance of the youth into the initiative, *and*
    b. Upon discharge from the initiative.

iii. **Case Planning**.

1. The specialized juvenile probation officer assigned to FEDI shall meet with the youth and family to develop a case plan at the time the youth is formally accepted into FEDI.
2. The case plan shall outline services and referral resources that will be made available to the youth and family to assist them in acquiring skills and resources to meet their needs.
3. The case plan shall include a crisis stabilization plan.
    a. The crisis plan may include the 24 hour community mental health crisis hotline number.
    b. The crisis plan shall include a plan for accessibility to the specialized juvenile probation officer by the youth and family should crisis occur after normal working hours.
4. The case plan shall assist the youth and family in developing long-term community supports by involving extended family members, local churches, and other community service agencies.
    a. The family's input shall be included regarding the needs and resources identified.
5. Case plans should emphasize and build on a family's strengths and support systems.
6. Case plans shall be reviewed and updated monthly with the youth and family.
7. Case plans shall be written in terms that are meaningful to the family, and a copy of the plan and each review shall be provided to them.

iv. **Service Coordination**. The goal of service coordination is to enable the youth and family to function effectively without the continued intervention from the juvenile court resulting in adjudication.

1. The specialized officer assigned to FEDI shall coordinate the referral of the youth to a community mental health provider.
2. The specialized officer assigned to FEDI shall ensure the coordination of services necessary to meet the families' identified needs.
    a. These services may include mentors, parent support groups, services to a sibling, life skills classes, assistance with transportation for medical/psychological services, substance abuse services, individual and family recreation, education liaison services, and assistance with accessing other community resources.
3. These goals shall be reflected within the context of the written case plan and supported in case file documentation.

v. **Aftercare**. Aftercare planning is an integral part of planning, and should begin at the time of the youth is accepted into FEDI. The aftercare plan shall reflect multidisciplinary input and provides continuity of care from supervision to other community resources. The plan shall be formulated in collaboration with the youth and family. Upon completion of the aftercare care plan, the youth's case is considered closed to FEDI.

1. A written aftercare plan outlining ongoing support systems and resources for the youth and family shall be developed with the youth and family's input.
2. A copy of the aftercare plan shall be given to the youth and family upon discharge from FEDI.

Data Collection

The Behavioral Health Division of TJPC will conduct data collection and analysis.

a. **Data Collection**. Data collected will be used to determine the effectiveness of the initiative. An online database has been developed to assist in the coordination of data collection. The database can be accessed at the following link: https://www.tjpc.state.tx.us/fedi

b. The following are the minimum requirements for FEDI data collection:
   i. Each site is required to enter the data points requested and submit a copy of Ohio Scales completed during the previous month by the 10th of the month.
   ii. The FEDI online database will be reviewed monthly by staff at TJPC to ensure the data is completed accurately and timely.

Data Analysis

TJPC will review the data submitted by the demonstration sites for FEDI, and shall compile a report of the data that will be made available to the sites as well as to other interested parties that request the information.

Technical Assistance

TJPC will provide regular and on-going training and technical assistance regarding program implementation, collaboration, and techniques for serving the juvenile offender with mental health needs. Each demonstration site will receive at least one on-site visit for technical assistance.

Outcome Measures

Tracking change and monitoring outcomes associated with the implementation of the SIG recommendations will be critical. Following are some of the possible short and long-term outcomes expected as a result of SIG implementation:

a. **Short-Term Outcomes:**
   i. The delivery of specialized training to probation officers
   ii. The identification and development of specialized probation officers with designated specialized caseloads
   iii. Increased access to treatment for youth on the specialized caseloads
   iv. Increased awareness of community-based mental health services
   v. Improved collaboration and linkages between probation and mental health

b. **Long-Term Outcomes**
   i. Improved youth and family functioning
   ii. Decreases in youth psychiatric symptoms
   iii. Increases in cases diverted from juvenile court
   iv. Decreases in youth adjudications

SECTION 3:
ATTACHMENTS

Attachment A: The Case for Specialized Supervision in Juvenile Justice

Running Head: MERGING CARE AND CONTROL

Merging care with control: A need for specialized supervision in juvenile justice

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Introduction

Recently, identification of youth with mental health needs in the juvenile justice system has experienced increased attention. These youth create unique obstacles toward achieving successful completion of supervision. They enter a justice system that within its traditional approach is not equipped to appropriately handle the multiple diagnosis and multi systemic issues facing this offender population. For instance, antisocial behaviors include everything from serious acts of delinquency such as drug abuse, burglary, vandalism, and assault to minor status offenses such as truancy and runaway (Henggler, Schoenwald, Rowland, & Cunningham, 1998). Additionally, there is considerable overlap in the anti-social behaviors of delinquent youth and conduct-disordered youth such that treatment needs of youth in the juvenile justice system are the same as those for youth in the mental health system (Melton & Pagliocca, 1992). Some would even argue that the same youth appear in both systems (Atkins, Jeffers, Montgomery, Nybro, Pumariega, Sease, & Rogers, 1999; Cocozza & Skowyra, 2000; Teplin Abram, McClelland, Dulcan, & Mericle 2002 & Wasserman, McReynolds, Lucas, Fisher, & Santos 2002). Specialized supervision has been a proven approach toward merging care with control by rehabilitating the mentally ill offender and ensuring that they successfully complete their probation among adult probationers who meet criteria for a psychiatric disorder and should be expanded to the juvenile justice personnel.

In 2000, the Coalition for Juvenile Justice published a report indicating that 20% of general population youth have a mental health need with up to 13% of those youth having a serious disorder (Hubner & Wofson, 2000). National estimates of youth in the juvenile justice system with mental health needs indicate a much higher rate of prevalence with a range from 50% to 75%, and approximately 20% having a serious disorder (Cocozza et al., 2000). The vast majority of individuals arrested are placed on probation (Bureau of Justice Statistics, 2006), and those with identified mental health disorders are typically required to participate in treatment as a condition of their probation (Ditton, 1999; U.S. Probation and Pretrial Services, 2001). When compared to offenders without mental health needs, those suffering from mental health disorders are more likely to be unsuccessful under community supervision and be revoked to an institution (Pourporino & Motiuk, 1995; & Dauphinot, 1996). More specifically, relative to offenders without a diagnosed disorder, those with co-morbid disorders are at double the risk of having formal treatment conditions imposed on them (Monahanet Steadman, Robbins, Appelbaum, Banks, & Grisso, 2005).

A similar picture emerges with the informal pressure to participate in treatment. Case managers within the treatment milieu are likely to use treatment pressures with patients who have severe symptoms, recent drug use, and arrest histories (Neale & Rosenheck, 2000). Case managers for probationers often fall prey to the “treater-turned monitor” phenomenon, whereby the case manger’s activities become primarily that of monitoring for treatment non-compliance and elevating probationers’ risk of incarceration on a technical violation (Solomon, Draine, & Marcus,

2002). Therefore, mental health services can be generally associated with some level of coercion whether by the criminal justice system or the treatment provider (Carroll, 1991; Draine & Solomon, 1997; & Lidz, 1998). More significantly, offenders with the triple stigma of a primary mental disorder, substance abuse, and criminal justice involvement, treatment relationships are often infused with social control (Hartwell, 2004).

This problem has recently garnered the attention of key national agencies. In 2003, the American Probation and Parole Association urged its members to develop programs and policies aimed at improving the system's response to offenders with mental health and co-morbid substance use disorders (APPA, 2003). Additionally, the perceived increase in juvenile crime has fueled debates as to how youth involved in the juvenile justice system should be rehabilitated. Many scholars have also debated as to whether specialized programming for juvenile offenders results in rehabilitation (Howell, 2003).

Youth with mental health disorders who engage in delinquent behavior often have multifaceted and multisystemic problems (Grisso, 2008). They present symptoms of their problems in multiple settings including the school, community, and home. Subsequently, they pose a challenge to the traditional model of supervision in juvenile justice. However, despite the increasing amount of literature evaluating the prevalence of mental illness among youth involved in the juvenile justice system, and the juvenile probation officer's (JPO) role in the supervision of those offenders, there is very little research on how JPO's monitor or encourage treatment compliance.

Mental Health Disorders and Delinquency

Academic attention to the prevalence and issues related to mental disorders among incarcerated adults began in the 1970s (Metzner, Cohen, & Grossman, 1998; Lamb, Wienberger, & Gross, 1998). However, the issues specific to juvenile offenders with mental illness have recently gained momentum. In 2002 Teplin, found that 66% of the males and 74% of the females among a sample of youth detainees in a large city met diagnostic criteria for at least one mental health diagnosis (Teplin, Abram, Mclelland, Dulcan, & Mericle, 2002). For substance abuse, almost half the entire sample, both male and female, met criteria. A 2001 study evaluated youth involved with both the juvenile justice and child welfare systems. The study found that 52% of a sample of youths with prior juvenile justice involvement met criteria for a psychiatric diagnosis, while the child welfare involved youth indicated a rate of 54% (Garland, Hough, McCabe, Yeh, Wood, & Aarons, 2001).

Similarly, using the Diagnostic Interview Schedule for Children (DISC) 2.3, Atkins found that 86% of hospitalized youth met criteria for at least one mental health diagnosis (Atkins et al, 1999). Of the youth in the study receiving treatment in the community from the local mental health center, 60% met criteria for at least one psychiatric disorder (Atkins et al, 1999). In comparison, 72% of youth who were incarcerated in a juvenile justice setting met criteria for at least one psychiatric disorder suggesting that incarceration of youth in the juvenile justice system is an intermediate step for mental health treatment between the community mental health and the mental health hospital systems (Atkins et al, 1999).

Youth involved with the juvenile justice system often have not one but several co-morbid psychiatric disorders. Abram, Teplin, McLelland and Dulcan (2003) indicated that 46% of males and 57% of females in detention had at least two diagnosable mental health disorders, compared to the 17% of females and 20% of males who met criteria for only one disorder. Wasserman (2005) found a prevalence of youth who met criteria for at least one psychiatric disorder of 39% with 16% of the total sample with three or more disorders. However, when co-occurring substance abuse was included 48% reported at least one disorder. Regarding rates of suicide ideation, 14% reported a suicide attempt in their lifetime. More significantly 11% of males and 20% of females reported thinking about completing the act of suicide within the past week (Wasserman, Katz, Ko, McReynolds, & Carpenter, 2005).

Impact on the Administration of Juvenile Justice Systems

Like adult criminal justice agencies, the juvenile justice system was not originally designed to address the challenges of youth with mental health disorders. Juvenile offenders and their families present unique challenges to supervising juvenile probation officers. Additionally, when the youth's mental illness limits their ability to function, they may have difficulty following the basic conditions of their probation (Orlando- Morningstar, Skoler, & Holliday,

1999) and their parents may have difficulty in assisting their efforts. Moreover, these juvenile offenders typically will be mandated to participate in treatment as a condition of probation (Dauphinot, 1996; Ditton, 1999; & Skeem, Emke-Frances, & Louden 2006). Special conditions of probation require the juvenile probation officer (JPO) to supervise and enforce mental health treatment, despite the limited community resources and/or family support to address the identified mental health issues.

Enforcing and monitoring compliance with treatment is viewed as a probation officer's primary assignment in supervising offenders with mental illness. However, there are a limited number of standardized guidelines to assist an officer on how to supervise youth with mental health disorders, and the few that are available have primarily focused on the adult system (Skeem, Encandela, & Eno-Louden, 2003). Thus the interaction of juvenile justice and mental health systems for these offenders can become rather complicated. Studies indicate that involvement with probation officers and mental health treatment providers is correlated with increased risk of incarceration with the incarceration being administered as a form of mental health treatment (Solomon & Draine, 1995; Solomon, Rogers, Draine, & Meyerson, 1995).

Incarceration is traditionally viewed as the primary tool available to officers in enforcing probation stipulations. Additionally, there is some evidence that it has been used as well to assure adherence to or to provide access to mental health services for clients who are involved in the mental health system (US House of Representatives, 2004). It is not uncommon for judges to add conditions to probation that require compliance with medication, therapy, or mental health service programs (Draine & Solomon, 2001). This allows officers to use technical violations to incarcerate individuals for violating a court order on behaviors that, by themselves, would not be illegal for the general population.

Thus the discrepancy between the needs of offenders with mental illness and the basic structure and operations of criminal and juvenile justice systems may explain the failure rate for probationer's with mental illness. In a three year study of adult probationers, Dauphinot (1996) found that the rates of rearrest for offenders with mental illness (54%) were significantly greater than that of probationers without mental health disorders (30%). In response to the growing amount of evidence indicating that probation systems have become a de facto mental health care system (Regier, Narrow, Rae, Manderscheid, Locke, & Goodwin, 1993), some jurisdictions have developed specialized caseloads for offenders with mental illness. A report of the Criminal Justice/Mental Health Project (Council of State Governments, 2002) recommended that probation departments specifically assign offenders with mental illness to specialized probation officers who have received some mental health training and supervise case relatively smaller caseloads than the traditional approach. This differs from the traditional practice of assigning mentally ill offenders to an officer as part of a large non-specialized caseload.

What is Specialized Supervision?

Specialized supervision with specially trained probation officers carrying a reduced caseload has been proven to be cost effective and efficient toward rehabilitating the adult mentally ill offender. These programs apply the theory of "therapeutic jurisprudence" and are designed to be treatment-oriented on the assumption that, for mentally ill offenders, problem-solving responses to violations of probation conditions are more appropriate than strict enforcement of those conditions (Wexler, 2000a, 2000b; Winick, 2003). The intent of specialized caseloads is not only to rehabilitate the offender, but for the probation officer to gain expertise in handling the specific problem area, improve coordination across justice and social service agencies, improve efficiency, increase predictability of the court proceedings, and ultimately improve the quality of justice (Gilbert, Grim, & Parnham, 2001; Hora, Schma, & Rosenthal, 1999).

Skeem (2006) identified three critical features that differentiate a specialized mental health caseload from that of a traditional model. The key structural features of reduced caseloads of exclusively mentally ill offenders and substantial and ongoing officer training appear to be the best asset to offender success (Skeem, Emke-Frances, & Louden, 2006). Studies indicate that as caseload size increases, specialized officers were more likely to resort to traditional coercive techniques toward enforcing the mentally ill offender's treatment mandates. These coercive

techniques have been correlated to increases in incarceration of offenders with psychiatric disorders for technical violations (Draine, 2001; Solomon, Draine, & Marcus, 2002). Mixed caseloads of traditional offenders and offenders with mental health disorders dilute the focus of the officer on resources and service coordination for the offender and dilute the ability of the officer to research informal ways to supervise atypical cases (Skeem, et al., 2006).

The fourth key element of specialized supervision is a non-traditional case management style that involves interactive service coordination between both internal (within the probation department) and external or community based resources. This service coordination links the offender to services for their many needs. Within this context, probation officers do not simply refer and monitor the referral for services, rather, they actively build relationships and interact with mental health clinicians, service providers, and advocates to actively link the offender to resources in assisting them in stabilizing their mental health need and in successfully completing their terms of probation (Dauphinot, 1996; Skeem et. al., 2006; & Solomon et. al., 2002).

The final element of specialized supervision is the use of problem-solving strategies as the primary intervention when addressing non-compliance with either treatment or other conditions of probation. Basically, the specialized officer collaborates with the offender on identifying the problem(s) that occurred and generates a plan or contract with the offender (and in the case of a juvenile offender, the offender and his or her family) to address the behavior through a new course of action (Skeem et. al., 2006). The most common components of the problem solving process includes "(a) having a fair, two – way conversation about treatment non-compliance and its likely causes; (b) generating alternative strategies for addressing the problem; and (c) mutually agreeing on a plan for solving the problem to achieve compliance" (Skeem et al., 2006, p. 180).

The Case for Specialized Supervision

The main argument for specialized supervision is that specialty caseloads facilitate offenders with mental illness' linkage to services, improve the offender's level of functioning, and reduce the number of non-compliance revocations of probation. However, to date there have been no published comparisons of the effectiveness of specialty and traditional probation services for juvenile offenders with psychiatric disorders. Probation is a practitioner-led enterprise (Klaus, 1998) in that the philosophies and practices of probation departments in both the juvenile and criminal justice systems vary considerably. Recently, there has been a growth in research on specialized supervision for adult offenders who meet criteria for a mental illness.

Using their Dual-Role Relationship Inventory (DRI-R), Skeem found that the relationship between the offender and the specialized officer predict compliance of the offender with the rules of probation and ultimately reduces the incidents of revocation for technical violations (Skeem & Louden, 2007). The officers supervised lower caseloads with offenders who predominantly had mental health and co-occurring substance abuse disorders, and had received specific training on how to work with this population of offender. The officer's primary functions focused less on the traditional roles of monitoring and enforcement to allow the officers to function more like case managers. In this capacity, the officers coordinated service delivery, advocated for social services, and assisted the offender in achieving their treatment as well as supervision goals (Skeem et al, 2007).

The results indicated that within the concept of mandated treatment, the relationship of the officer with the offender had a significant impact on the offender's success under supervision. Similar to Carl Klocker's (Klocker, 1972) synthetic officer, Skeem discovered that the specialized officer who obtains compliance with mandated treatment by using both therapeutic and social controls was more successful than the traditional law enforcement officer who focused more on rule enforcement rather than structured support.

Additionally, a meta-analysis conducted in 2006 reviewed eight publication databases for articles published between January 1975 and April 2005 on offenders with mental illness under community supervision (Skeem, Emke-Frances, & Louden, 2006). The results indicated three studies that represented the relationship between mental illness and failure of supervision by the offender. The studies found the relationship to be complex and indirect, with two studies indicated that offenders and other stakeholders perceived that specialized caseloads were more effective than traditional ones in linking offenders to treatment and improving their ability to succeed under supervision (Skeem et

al, 2006). In addition, when comparing the perceived effectiveness as viewed by the supervisors of both traditional and specialized probation officers, supervisors viewed the key features of the specialized caseloads as very effective in assisting and supervising offenders with mental illness as well as those with co-morbid issues such as substance abuse or multiple mental health diagnoses (Skeem et al, 2006).

Conclusion

An increasing number of mentally ill youth are being identified in the juvenile justice system creating unique challenges for the juvenile justice system. These youth, like their adult counterparts, enter a justice system that within its traditional approach is ill equipped to cope with the multiple diagnosis and multi systemic issues facing this offender population. Specifically, officers who supervise offenders with mental illness identify the most daunting issue regarding successful supervision of those offenders as accessing and coordinating social services to meet their multifaceted needs. Additionally, juvenile offenders with mental health needs may have difficulty following the basic conditions of probation (Orlando- Morningstar, Skoler, & Holliday, 1999) and their families may have difficulty in assisting them in their efforts. Such conditions obligate the traditional juvenile probation officer with a large caseload to supervise and enforce treatment mandates, despite limited community resources, family and offender support, time to research intervention options, and resources to support alternative problem solving options. Therefore, the traditional approach is likely to result in higher rates of incarceration for offender behavior that would not have been resulted in incarceration if the probationer had not been under supervision.

Specialized supervision has been proven to be cost effective and efficient toward rehabilitating the mentally ill offender and in ensuring that they successfully complete their probation within the community among adult probationers who meet criteria for a psychiatric disorder and should be expanded to the juvenile justice personnel. Specialized juvenile probation officers, who have received specific training on how to work with this population of offender, should supervise lower caseloads with youthful offenders who predominantly have mental health and co-occurring substance abuse disorders. Additionally, they should implement interactive problem solving case management model that emphasizes the coordination of services rather than applying the traditional enforcement based officer/offender relationship.

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Attachment B: Program Overview Bexar County

The Front End Diversionary Initiative (FEDI) is a pre-adjudication diversionary program for young juvenile offenders and their families. All program services are based on a wraparound philosophy of team treatment planning and case management. The Probation/MHA team strives to support the child and family through the provision of services primarily in the home, school, or community. The core team shall consist of at least the specialized juvenile probation officer and one Qualified Mental Health Professional and may include a Family Partner or Substance Abuse Treatment Provider if deemed appropriate through the assessment process. At least one member of the core team shall be available in person, by pager, office phone or cell phone to the family 24 hours a day, seven days a week and 365 days a year for assistance with crisis intervention.

Services include parent advocacy and support, benefit coordination to assist with Medicaid or CHIP enrollment, group and individual counseling, skills training, education and treatment case management, psychiatric services, substance abuse treatment, and transition planning to prepare for discharge from the program. Participating families and children are supported via weekly face to face contacts.

The program is designed for youth (ages 10-14) that have a previous mental health diagnosis or demonstrate indications of possible mental health related issues. These children have been referred to Bexar County Juvenile Probation Department (BCPJD) for delinquent conduct or conduct indicating a need for supervision. The core team shall provide services to the child and family for a period of no less than three (3) months and no longer than six (6) months from the date of the child's enrollment into the program.

The core team shall make contact with the child and/or family at least 3 to 5 times per week. The FEDI team shall conduct at least 3 face-to-face visits per week with the child family. The location of contacts determined by the presenting issues of the child:

- School-based Issues: 2 contacts at school, 1 group or community-based contact
- Family-based Issues: 2 contacts at home, 1 parent group contact
- Substance-use Issues: 2 contacts in treatment, 1 contact at home or school

The child and family, in conjunction with the FEDI team, will determine the appropriate location of contacts and will outline these contacts in the case plan and case plan reviews. The case/treatment plan shall be written in terms that are specific and measurable and shall document each of the following criteria:

- Critical areas of need for the child and family
- What activity/intervention is to be completed
- Who is responsible for completing the activity/intervention
- When the activity/intervention is to be conducted and/or completed
- How the activity/intervention is to be conducted
- What services will be made available to the child and/or family to assist them in acquiring the skills and resources to meet their needs
- What long-term community supports will be utilized

The program is designed to divert youth from the juvenile court process using a wraparound philosophy of team treatment planning and case management. The program will support and enhance the availability and connection to community-based services who are focused on meeting the needs of children and their families.

Attachment C: Program Overview Dallas County

This is a diversionary program designed for the mental health population in the Juvenile Department. Its' purpose is to divert children with a mental health diagnosis from entering into formal Court proceedings. This will allow the FEDI program to assist the child and family in linking community based programs that can best meet their identified needs and avoid future referrals into the Juvenile Justice System. The FEDI program is designed to increase the availability of effective services to juvenile offenders with mental health illnesses.

Referral to the Front End Diversionary Initiative Program (FEDI)
Intake Officers, Psychological Staff, Deferred Prosecution Officers, Field Assessment Officers, and the Detention Referee shall refer youth if any of the following criteria apply:

a. A psychological screening or evaluation reveals that the youth is appropriate for the program;
b. After Intake screening, the child has been identified as having mental health needs and could benefit from on-going therapy in the community;
c. A child that is currently participating in therapy and/or counseling in the community and further mental health services are deemed appropriate;
d. A psychiatric screening reveals a mental health diagnosis;
e. School documentation indicates that the youth has been diagnosed with ADHD or ADD and have previously or currently in Special Education for a learning disorder;
f. The parent, guardian, or custodian indicates that the child has a mental health diagnosis; or has previously been hospitalized in a mental health facility;
g. A psychological evaluation indicates an AXIS I diagnosis with a GAF score of 50;
h. The MAYSI indicates a caution or warning in the area of suicidal ideation, depression, or anxious. And the youth or parent verifies that the youth has indicated suicide ideation, depressed or anxious thoughts.

A face sheet, Maysi, case history, social history, psychological evaluation/screen (if available) must be submitted to the FEDI supervisor for appropriateness. If the case is determined as appropriate for the program, the FEDI supervisor will assign to a Probation Officer for an assessment.

The program length will be from four (minimum) to six months, depending on the identified needs of the child and family.

Family Suitability Interview (FSI)
The case will be assigned to one of the two FEDI officers so that a FSI can be scheduled. The assigned officer will interview the child/parent to determine whether the case is appropriate for the program. If the case is deemed appropriate, the child will be enrolled in the program. At this time, the officer will assess the needs of the child by use of the Ohio Scales for Children.

If the child/family is accepted into the FEDI program, the FEDI Probation Officer will complete an Initial Case plan and initiate supervision.

If the case was originally referred by an Assessment Officer, they will be notified of acceptance by the FEDI Officer. The Assessment Officer will then notify the Court and District Attorney of the acceptance during the Pre-Trail setting. If the Court agrees to non-suit the pending referral, then the case will be transferred to the FEDI Unit for supervision and completion of Initial Case Plan. If the child/family is unsuccessful in compliance with the FEDI program, the case will be resubmitted to the court for filing of the original case.

Case Management

Initial Case Plan
Upon completion of the FSI and case enrollment, the assigned Probation officer will complete the initial case plan within 72 hours. This plan will consist of identifying goals and community services for both the child and family to work towards completing. In addition, the educational needs of the child will be addressed through appropriate school program. The plan will identify strengths, values, and needs of the child based on information gathered and input from the child and family. A safety and crisis plan will also be incorporated.

Case Plan Reviews
The case plan must be reviewed monthly while the child is in the program. During these reviews, the goals will be evaluated to determine progress and/or completion. When the identified goal outlined in the case plan is completed, the assigned officer is to determine new goals based on the child's needs. The reviews will incorporate community resources to address the identified needs.

Discharge Plan
Upon successful completion of the program, the assigned officer will create a discharge plan linking the child and family with ongoing community resources. The child and family will have input in the completion of this discharge plan as it will identify needs beyond the FEDI program.

A pre and post survey will be completed to determine the feedback of the program from the child and family. This survey will serve as feedback as well as to determine if the program and resources were successful in meeting their needs. This survey can be accessed on line and once completed, will be placed in a data base where TJPC can refer to statistics and success of the program.

Contacts
The FEDI unit will have two (2) officers supervising no more than fifteen (15) cases each. These officers will be responsible for identifying the needs of each child/family and making the appropriate service referrals in the community. In addition, the FEDI officer will have contact with the community provider to ensure that the child and family have followed up and are in the appropriate service program. Routine follow up will also be done by the officer to verify continued attendance. If medication has been identified as a necessity for the child, the officer will ensure that the medical team is engaged in the process of medication management.

School contacts are made by the officer based on the level of the child's need. The officer is responsible for making an initial school visit within the first week of the child being enrolled in the program. These school contacts/visits must be made very early in the program process to ensure that the child is placed in the appropriate education program. If it is determined that the child is not enrolled in the appropriate school program, the officer will initiate and ARD meeting with the child/parent and school.

Attachment D: Program Overview Lubbock County

I. Intake

A. CARE Match

1. FEDI officer prints list of ALL new referrals and sends the list to the regional MHMR.
2. MHMR cross-references the referrals list with their CARE list and sends the FEDI officer an email with the list of all CARE matches.
3. FEDI officer meets with intake officers to determine which juveniles on the CARE match list qualify for 6 month DPA.

B. Past/Current Mental Health Services

1. If a juvenile has in the past or is currently in mental health services and the juvenile is marked as 6 month DPA, the file is marked as possible FEDI and will be reviewed by FEDI officer and team leader.

C. MAYSI Warning

1. Any juveniles coming through intake that qualifies for DPA and has warnings on the MAYSI are marked for possible FEDI and reviewed by FEDI officer and team leader.

D. Miscellaneous

1. Even if a juvenile does not come up on the CARE match, does not have prior mental health services and does not show warning on the MAYSI, that case can be marked as possible FEDI by the intake officer if the intake officer has concerns following their initial meeting with the juvenile and their family. The juvenile is placed on standard DPA but referred to MHMR to be assessed for the FEDI program. Acceptance into the FEDI program is dependent on the results of the assessment.
2. The Behavioral Health Coordinator at the LCJJC may refer juveniles to the FEDI program after meeting with the juveniles in detention. The juvenile will be referred to MHMR for assessment if that juvenile does not already have a previous mental health assessment or they are not already receiving mental health services from a private community provider.

II. FEDI Program

A. Ohio Scales/Individual Case Plan

1. When a juvenile is marked as possible FEDI, the FEDI officer meets with the juvenile and their family. This initial meeting is called the Family Suitability Interview and is usually conducted as part of the intake process. The intake officer will review and sign the DPA, and then the FEDI officer will meet with the juvenile and the family to discuss the FEDI program. If the family is willing to participate in the program, the FEDI officer obtains information for the FEDI database, including information about the household and specific information regarding the juvenile. If the juvenile is being referred to MHMR, officer inquires about the status of Medicaid. ** If possible, the Ohio Scales are completed during this meeting as well.
2. Generally within the first week, the FEDI officer completes an Individual Case Plan that is used to help track goals individualized to this particular juvenile. The officer meets with the juvenile and guardian to discuss the case plan and add or change anything deemed necessary. When the case plan is complete, all parties involved sign and receive a copy.

B. Contact

1. In the FEDI program there are 3 levels or phases. The number of weekly contacts is determined by the juvenile's phase in the program.
    a. Phase I (2 months): Initial phase. Contact with the juvenile at least 3 times a week. Contact with the parent/guardian at least twice a week. Contact with the mental health provider at least once a week.
    b. Phase II (2 months): Contact with the juvenile at least twice a week. Contact with the parent/guardian at least once a week. Contact with the mental health provider at least once a week.
    c. Phase III (2 months): Contact with the juvenile at least once a week. Contact with the parent/guardian at least once a week. Contact with the mental health provider at least once a week.

C. Diversion

1. Successful – The juvenile is linked with a mental health provider and provided every opportunity to receive medication and therapy to reduce or eliminate delinquent behavior. After the 6 months of the DPA are completed, the juvenile is released from supervision and the Ohio Scales are completed once again.
2. Unsuccessful – The juvenile continues delinquent behavior and is placed on official probation or in some other way removed from the FEDI program.

**MHMR will not enter any juvenile into services without Medicaid. If the juvenile does not have Medicaid, they will be placed on a waiting list.

Attachment E: Program Overview Travis County

COPE Mental Health Court and Intake Based Diversion Program

Travis County Juvenile Probation Department (TCJPD) understands the importance of diverting non-adjudicated youth with mental health needs from the juvenile justice system. To achieve the goals of front-end diversion, TCJPD proposes to divert such cases at two pre-adjudication points: shortly after the initial intake and during the pre-trial phase. The pre-trial diversion encompasses the use of a specialized mental health court as a component of the model.

Intake Diversion

As part of a front-end diversion initiative, TCJPD proposes to divert first offender, misdemeanants with mental health concerns shortly after the initial intake. To this end, our Intake unit will do the following:

- Screen every referred child with the MAYSI-2
- Perform a health screen
- Obtain social history
- Inform parent if the MAYSI-2 screening, other screenings and/or the child's history suggests a need for an in-depth mental health assessment
- Determine whether the family has private insurance, Medicaid/CHIP or no insurance
- If private insurance, recommend that the parent schedule a mental health assessment for their child through their provider
- If Medicaid/CHIP or no insurance, offer to obtain an MHMR appointment for the child through our MHMR liaison
- If no insurance, provide the family with Insure-a-Kid information so they can apply for health coverage and case management, and assist them with the application process if needed
- Provide families who are ineligible for Medicaid/Chip with Insure-a-Kid's list of health care resources
- Follow-up with the parent with the time and date of the MHMR appointment
- Close the case as "Counsel and Release" or close it once the child has completed his assigned community service/restitution

Pre-Trial Diversion

TCJPD is already accomplishing diversion during the pre-trial phase through one of our deferred prosecution programs called Collaborative Opportunities for Positive Experiences (COPE). Participation in COPE diverts young offenders with certain mental health diagnoses from the formal court system. COPE is composed of a specialized team that is sensitive to the unique needs of these children and can connect them with appropriate mental health services. The COPE Team consists of a Mental Health Court Project Judge, an Assistant District Attorney, a Juvenile Public Defender, a COPE Coordinator, two Deferred Prosecution Officers dedicated to COPE cases, and a TCJPD psychologist. COPE not only improves access to mental health services but the process also facilitates collaboration between the juvenile justice system and the mental health treatment system.

The COPE Probation Officers make weekly home visits, school visits and collaborate with community service providers and other agencies in the community to assure continuity of services.

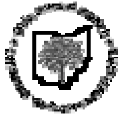
Most COPE cases follow a similar path into the program. Initially, a case is transferred from Intake to a court services probation officer. If the client's MAYSI-2 indicates that the case has "mental health flags," a Mental Health Assessment (MHA) is conducted. Once the MHA is complete, the juvenile's case is staffed by the COPE Team for program eligibility. Referrals originate primarily from our department's assessment team but they may also come from probation officers, attorneys, judges and community stakeholders. Each referral to COPE is considered and a decision is made whether to accept the juvenile into the program. Once in the program, cases are reviewed by the COPE team and community providers before each family meeting. The team decides whether to advance or graduate successful clients or to terminate unsuccessful clients. Clients with complex mental health needs may receive additional assessments.

The frequency of family meetings are based on the juvenile's level in the program. Clients who do not have health insurance are screened by the COPE Coordinator for eligibility for Medicaid/CHIP using Insure-A-Kid's "Medicator" database. Eligible families are assigned an Insure-A-Kid caseworker who can help them complete Medicaid/CHIP's lengthy application. TCJPD has a psychiatrist on staff to meet the medication needs of each COPE client until the local mental health authority can take over, or other community options are found. If the family does not qualify for insurance, various community agencies are available to assist in meeting their mental health care needs. When uninsured/indigent families need assistance obtaining medications, COPE will request assistance from pharmaceutical companies.

The assigned probation officer has a specialized caseload that consists only of COPE cases. The caseloads are maintained at approximately 15 cases in order to insure the JPO can provide the specialized case management that is necessary for these types of cases. The COPE coordinator and the probation officer consider the family's dynamics and the juvenile's needs in order to assist the family in choosing the best course of action to improve the overall health of the family. In-home individual and family therapy are provided through a contracted COPE provider for the duration of the program. During the program, the Coordinator schedules an intake with the local mental health authority. Each domain (health, mental health, education, relationships) of the child's life is reviewed and points of contact with other stakeholders are developed. Community providers are put in place for each specific need. Probation officers serve as case managers for the youth and family throughout the program. The youth, family and COPE become a team to assure the level of services are obtained as quickly as possible and fit the needs of the family. It is the intent of the COPE Team that linkages to community providers will be created and stabilized during the program to insure that the youth's continuity of care will not be compromised once they graduate from the program.

COPE clients participate in the program for a minimum of six months and up to one year. How quickly a juvenile completes the program is determined by the juvenile's success on the COPE level system. If the juvenile is repeatedly non-compliant in following the case plan, he will be discharged from the program as unsuccessful and the case forwarded to the Assistant District Attorney for review for adjudication proceedings.

Attachment F: Ohio Scale - Youth



Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales
Youth Rating – Short Form (Ages 12-18)

Y

Name: ______________________ Date: ____________ Grade: ______ ID#: ________________ (Completed by Agency)

Date of Birth: __________________ Sex: ❑ Male ❑ Female Race: ________________

Instructions: Please rate the degree to which you have experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total ________

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January 2000 (Youth-1)

02/16/2000 .... Page 1 of 2

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your life right now?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How energetic and healthy do you feel right now?
    1. Extremely healthy
    2. Moderately healthy
    3. Somewhat healthy
    4. Somewhat unhealthy
    5. Moderately unhealthy
    6. Extremely unhealthy
3. How much stress or pressure is in your life right now?
    1. Very little stress
    2. Some stress
    3. Quite a bit of stress
    4. A moderate amount of stress
    5. A great deal of stress
    6. Unbearable amounts of stress
4. How optimistic are you about the future?
    1. The future looks very bright
    2. The future looks somewhat bright
    3. The future looks OK
    4. The future looks both good and bad
    5. The future looks bad
    6. The future looks very bad

Total: ________

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services you have received so far?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How much are you included in deciding your treatment?
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
3. Mental health workers involved in my case listen to me and know what I want.
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
4. I have a lot of say about what happens in my treatment.
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all

Total: ________

Instructions: Below are some ways your problems might get in the way of your ability to do everyday activities. Read each item and circle the number that best describes your current situation.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total ________

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January 2000 (Youth-1)

Attachment G: Ohio Scale - Parent

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales
Parent Rating – Short Form

P

Child's Name: ______________________ Date: __________ Child's Grade: ___ ID#: ________________ (Completed by Agency)

Child's Date of Birth: ________________ Child's Sex: ☐ Male ☐ Female Child's Race: ______________

Form Completed By: ☐ Mother ☐ Father ☐ Step-mother ☐ Step-father ☐ Other: ________________

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total ________

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Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your relationship with your child right now?
   1. Extremely satisfied
   2. Moderately satisfied
   3. Somewhat satisfied
   4. Somewhat dissatisfied
   5. Moderately dissatisfied
   6. Extremely dissatisfied
2. How capable of dealing with your child's problems do you feel right now?
   1. Extremely capable
   2. Moderately capable
   3. Somewhat capable
   4. Somewhat incapable
   5. Moderately incapable
   6. Extremely incapable
3. How much stress or pressure is in your life right now?
   1. Very little
   2. Some
   3. Quite a bit
   4. A moderate amount
   5. A great deal
   6. Unbearable amounts
4. How optimistic are you about your child's future right now?
   1. The future looks very bright
   2. The future looks somewhat bright
   3. The future looks OK
   4. The future looks both good and bad
   5. The future looks bad
   6. The future looks very bad

Total: ________

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services your child has received so far?
   1. Extremely satisfied
   2. Moderately satisfied
   3. Somewhat satisfied
   4. Somewhat dissatisfied
   5. Moderately dissatisfied
   6. Extremely dissatisfied
2. To what degree have you been included in the treatment planning process for your child?
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all
3. Mental health workers involved in my case listen to and value my ideas about treatment planning for my child.
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all
4. To what extent does your child's treatment plan include your ideas about your child's treatment needs?
   1. A great deal
   2. Moderately
   3. Quite a bit
   4. Somewhat
   5. A little
   6. Not at all

Total: ________

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

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(Add ratings together) Total ________

Attachment H: Ohio Scale - Worker

Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem, Functioning, and Satisfaction Scales **W**
Agency Worker Rating – Short Form

Child's Name: ____________________ Date: __________ Child's Grade: ___ ID#: ________________

Child's Date of Birth: _______________ Child's Sex: ☐ Male ☐ Female Child's Race: _____________

Form Completed By: __________________ ☐ Case Manager ☐ Therapist ☐ Other: ________________

Instructions: Please rate the degree to which the designated child has experienced the following problems in the past 30 days.	Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1. Arguing with others	0	1	2	3	4	5
2. Getting into fights	0	1	2	3	4	5
3. Yelling, swearing, or screaming at others	0	1	2	3	4	5
4. Fits of anger	0	1	2	3	4	5
5. Refusing to do things teachers or parents ask	0	1	2	3	4	5
6. Causing trouble for no reason	0	1	2	3	4	5
7. Using drugs or alcohol	0	1	2	3	4	5
8. Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9. Skipping school or classes	0	1	2	3	4	5
10. Lying	0	1	2	3	4	5
11. Can't seem to sit still, having too much energy	0	1	2	3	4	5
12. Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13. Talking or thinking about death	0	1	2	3	4	5
14. Feeling worthless or useless	0	1	2	3	4	5
15. Feeling lonely and having no friends	0	1	2	3	4	5
16. Feeling anxious or fearful	0	1	2	3	4	5
17. Worrying that something bad is going to happen	0	1	2	3	4	5
18. Feeling sad or depressed	0	1	2	3	4	5
19. Nightmares	0	1	2	3	4	5
20. Eating problems	0	1	2	3	4	5

(Add ratings together) Total ________

Markers:

School Placement: ____

Current Psychoactive Medications: ____

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01/01/2007 .... Page 1 of 2

Markers (Continued): **Number in Past 90 Days**

Marker	Number in Past 90 Days
Arrests *(any arrest by police or officer of the court)*	________
Suspensions from School *(count of all instances of suspension from school by school officials)*	________
Days in Detention *(days in a detention facility)*	________
Days of School Missed *(all school days missed for any reason)*	________
Self-Harm Attempts *(count of all instances of self-harm attempts that are reported or observed)*	________

ROLES: Enter the number of days the youth was placed in each of the following settings during the past 90 days. (For example, the youth may have been in a detention center for 3 days, a group home for 7 days and with the biological mother for 80 days.)

Days	Setting	Days	Setting
________	Jail	________	Foster Care
________	Juvenile Detention Center	________	Supervised Independent Living
________	Inpatient Psychiatric Hospital	________	Home of a Family Friend
________	Drug/Alcohol Rehabilitation Center	________	Adoptive Home
________	Medical Hospital	________	Home of a Relative
________	Residential Treatment	________	School Dormitory
________	Group Emergency Shelter	________	Biological Father
________	Residential Job Corp/Vocational Center	________	Biological Mother
________	Group Home	________	Two Biological Parents
________	Therapeutic Foster Care	________	Independent Living with Friend
________	Individual Home Emergency Shelter	________	Independent Living by Self
________	Specialized Foster Care	90	***(Total for the two columns should equal 90)***

Instructions: Please circle the number corresponding to the designated youth's current level of functioning in each area.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing projects	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

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(Add ratings together) Total ________

Attachment I: Ohio Scale - Scoring Guidelines

Ohio Mental Health Consumer Outcomes System

Scoring Guidelines

The purpose of this document is to describe the rules that should be followed when computing scores associated with the Outcomes instruments. All of the scales listed in this document are included in the Outcomes data specifications and are computed automatically by the ODMH Data Entry and Reports Template except for the Quality of Life – Overall and Overall Community Functioning scales (shaded in gray). These scales are not currently required but it is anticipated that they will be included in the Outcomes data specifications in the future.

Providers should examine the scoring rules provided below and build these rules into the software that they use to collect and store Outcomes data. It is the responsibility of Providers to compute the correct subscale scores at the local level. When a production Outcomes record is received at ODMH, subscale scores are computed again in order to verify that they have been scored accurately. Subscale scores submitted by Providers that differ more than one-tenth (or 1 for whole number scales) from the state-generated scores will be replaced with the state-generated score in the statewide database.

A Note About Reverse Scoring

Some items on the adult instruments are worded such that a given response (e.g., "never") represents a desirable or positive response for one question, but a less desirable response for another. In order to compare items or combine items into a numeric subscale, certain items may need to be "reverse scored" for consistency. When reverse scoring an item, the highest and lowest numerical values are substituted for each other, the next highest and next lowest values are substituted for each other, and so on. Keep in mind that items that represent non-scaled values (e.g., missing, not-applicable) should not be included in either reverse scoring or computation of subscales. When reviewing the guidelines, an asterisk indicates that a scale contains one or more reverse scored items, and the actual items that should be reverse scored are bolded.

Example:

Four-Point Scale Original Score	Four-Point Scale Reverse Score
1	4
2	3
3	2
4	1

Five-Point Scale Original Score	Five-Point Scale Reverse Score
1	5
2	4
3	3
4	2
5	1

Adult Consumer Form A

Scale	Field Name	Items used to compute score	How to compute score	How to handle missing items	Valid scores	How to interpret score
Quality of Life - Financial Status	FINAN	2 - 4	• Sum responses • Divide by 3	• If one or more responses are missing, do not compute.	1.00 – 5.00	Higher scores indicate more positive feelings about financial status.
Empowerment - Self-esteem/ Self-Efficacy[1]	SELFEST	**38, 39, 42, 45, 47, 51, 52, 57, 59**	• Reverse score the bolded items • Sum responses • Divide by 9	• If one response is missing, compute the score using the completed items. • If two or more responses are missing, do not compute.	1.00 – 4.00	Higher scores indicate higher self-esteem/self-efficacy.
Empowerment - Power/ Powerlessness	POWER	40, 41, 43, 49, 50, 54, 55, 56	• Sum responses • Divide by 8	• If one response is missing, compute the score using the completed items. • If two or more responses are missing, do not compute.	1.00 – 4.00	Higher scores indicate higher sense of power, lower scores indicate sense of powerlessness.
Empowerment - Community Activism & Autonomy[1]	COMM	**36, 44, 53, 58, 60, 61**	• Reverse score the bolded items • Sum responses • Divide by 6	• If one response is missing, compute the score using the completed items. • If two or more responses are missing, do not compute.	1.00 – 4.00	Higher scores indicate higher levels of community activism/autonomy.
Empowerment - Optimism & Control Over the Future	OPTIM	**34, 35, 46, 60**	• Sum responses • Divide by 4	• If one or more responses are missing, do not compute.	1.00 – 4.00	Higher scores indicate higher levels of optimism/control over future.
Empowerment - Righteous Anger[1]	ANGER	37, 40, 43, **48**	• Reverse score the bolded items • Sum responses • Divide by 4	• If one or more responses are missing, do not compute.	1.00 – 4.00	Higher scores indicate higher levels of righteous anger.
Empowerment - Overall[1]	EMPOWER	34 - 61	• Reverse score appropriate items • Sum responses • Divide by 28	• If less than five responses are missing, compute the score using the completed items. • If five or more responses are missing, do not compute.	1.00 – 4.00	Higher scores indicate higher levels of empowerment, lower scores indicate lower levels of empowerment.
Symptom Distress - Overall	SDS	17 - 31	• Sum responses	• If less than five responses are missing, compute the mean score using the completed items, insert the mean for missing responses, and sum. • If five or more responses are missing, do not compute.	15 - 75	Higher scores indicate higher levels of distress, lower scores indicate lower levels of distress.
Quality of Life - Overall[2]	QOL	1 - 12	• Sum responses • Divide by 12	• If one response is missing, compute the score using the completed items. • If more than one response is missing, do not compute.	1.00 – 5.00	Higher scores indicate more positive feelings about quality of life.

Provider Adult Form A						
Scale	**Field Name**	**Items used to compute score**	**How to compute score**	**How to handle missing items**	**Valid scores**	**How to interpret score**
Overall Activities of Daily Living	ADL	6A - 6H	• Sum responses • Divide by 8	• If one response is missing, compute the score using the completed items. • If more than one response is missing, do not compute.	1.00 – 5.00	Higher scores indicate higher functioning level with regard to daily living activities.
Overall Community Functioning[2]	CFUNC	1 - 11	• See instructions on page 6 of this document	• If less than four responses are missing, compute the mean score using the completed items, insert the mean for missing responses, and sum. • If four or more responses are missing, do not compute.	11 - 55	Higher scores indicate higher level of community functioning.
Adult Consumer Form B						
Scale	**Field Name**	**Items used to compute score**	**How to compute score**	**How to handle missing items**	**Valid scores**	**How to interpret score**
Quality of Life - Financial Status	FINAN	2 - 4	• Sum responses • Divide by 3	• If one or more responses are missing, do not compute.	1.00 – 5.00	Higher scores indicate more positive feelings about financial status.
Symptom Distress - Overall	SDS	17 - 31	• Sum responses	• If less than five responses are missing, compute the mean score using the completed items, insert the mean for missing responses, and sum. • If five or more responses are missing, do not compute.	15 - 75	Higher scores indicate higher levels of distress, lower scores indicate lower levels of distress.
Quality of Life - Overall[2]	QOL	1 - 12	• Sum responses • Divide by 12	• If one response is missing, compute the score using the completed items. • If more than one response is missing, do not compute.	1.00 – 5.00	Higher scores indicate more positive feelings about quality of life.
Ohio Scales - Youth Version						
Scale	**Field Name**	**Items used to compute score**	**How to compute score**	**How to handle missing items**	**Valid scores**	**How to interpret score**
Problem Severity	PSEVER	1 - 20 on first page	• Sum responses	• If less than five responses are missing, compute the mean score using the completed items, insert the mean for missing responses, and sum. • If five or more responses are missing, do not compute.	000 - 100	Higher scores indicate more severe problems, lower scores indicate less severe problems.
Functioning	FUNC	1 - 20 on second page	• Sum responses	• If less than five responses are missing, insert a score of "3" for the missing responses and sum. • If five or more responses are missing, do not compute.	00 - 80	Higher scores indicate higher functioning level, lower scores indicate lower functioning level.

Ohio Scales - Youth Version (continued)

Scale	Field Name	Items used to compute score	How to compute score	How to handle missing items	Valid scores	How to interpret score
Hopefulness	HOPE	1 - 4 on second page, left upper corner	• Sum responses	• If one or more responses are missing, do not compute.	04 - 24	Higher scores indicate less hopefulness, lower scores indicate more hopefulness.
Satisfaction	SATIS	1 - 4 on second page, right upper corner	• Sum responses	• If one or more responses are missing, do not compute.	04 - 24	Higher scores indicate less satisfaction, lower scores indicate more satisfaction.

Ohio Scales - Parent Version

Scale	Field Name	Items used to compute score	How to compute score	How to handle missing items	Valid scores	How to interpret score
Problem Severity	PSEVER	1 - 20 on first page	• Sum responses	• If less than five responses are missing, compute the mean score using the completed items, insert the mean for missing responses, and sum. • If five or more responses are missing, do not compute.	000 - 100	Higher scores indicate more severe problems, lower scores indicate less severe problems.
Functioning	FUNC	1 - 20 on second page	• Sum responses	• If less than five responses are missing, insert a score of "3" for the missing responses and sum. • If five or more responses are missing, do not compute.	00 - 80	Higher scores indicate higher functioning level, lower scores indicate lower functioning level.
Hopefulness	HOPE	1 - 4 on second page, left upper corner	• Sum responses	• If one or more responses are missing, do not compute.	04 - 24	Higher scores indicate less hopefulness, lower scores indicate more hopefulness.
Satisfaction	SATIS	1 - 4 on second page, right upper corner	• Sum responses	• If one or more responses are missing, do not compute.	04 - 24	Higher scores indicate less satisfaction, lower scores indicate more satisfaction.

Ohio Scales - Worker Version

Scale	Field Name	Items used to compute score	How to compute score	How to handle missing items	Valid scores	How to interpret score
Problem Severity	PSEVER	1 - 20 on first page	• Sum responses	• If less than five responses are missing, compute the mean score using the completed items, insert the mean for missing responses, and sum. • If five or more responses are missing, do not compute.	000 - 100	Higher scores indicate more severe problems, lower scores indicate less severe problems.

Ohio Scales - Worker Version (continued)

Scale	Field Name	Items used to compute score	How to compute score	How to handle missing items	Valid scores	How to interpret score
Functioning	FUNC	1 - 20 on second page	• Sum responses	• If less than five responses are missing, insert a score of "3" for the missing responses and sum. • If five or more responses are missing, do not compute.	00 - 80	Higher scores indicate higher functioning level, lower scores indicate lower functioning level.
Restrictiveness of Living Environments Scale	ROLES	23 categories of residential settings on top of second page	See instructions on page 7 of this document	• Total days must add up to 90	00.5 – 10.0	Higher scores indicate more restrictive environments, lower scores indicate less restrictive environments.

Computation of the Community Functioning Scale from Provider Adult Form A

The first 11 items from the Provider Adult Form A can be combined to compute a Community Functioning score. The process has several steps, as follows:

1. Recode all items marked "Unsure" or "Not Applicable" to "Missing."
2. Because of the different nature of the various questions, some "standardization" is required before the responses can be combined into a single Community Functioning score.

   Item 1 (Social Contact) should be recoded as follows:

   - 1 = Withdrawn/Isolated
   - 2 = Minimal Contact
   - 3 = Moderate Contact
   - 5 = Optimal Contact

   Items 5 (Forced Moves), and 11 (Aggressive Behavior) should be recoded as follows:

   - 1 = Yes
   - 5 = No

   Item 10 (Criminal Justice) should be recoded as follows:

   - 5 = Yes
   - 1 = No

3. Compute the Overall Activities of Daily Living Subscale Score. The Activities of Daily Living subscale score is an arithmetic average. To compute the subscale score, sum the responses to questions 6A through 6H that have values of 1, 2, 3, 4 or 5 and divide the sum by the number of questions the provider has answered. If one item is missing or marked "Unsure," the subscale score should be calculated based on the remaining seven items. If more than one item is missing or marked "Unsure," the subscale should not be calculated.
4. Compute the Meaningful Activities Composite Score. The Meaningful Activities composite score is an arithmetic average. To compute the score, sum the responses to questions 7A through 7F that have values of 1, 2, 3, 4 or 5 and divide the sum by the number of questions the provider has answered. The Meaningful Activities composite score can be computed with up to five missing items.
5. Compute the Community Functioning Score. The Community Functioning score is a total. To compute the score, sum the responses to the following:

   Community Functioning **=** Question 1 (Recoded) **+** Question 2 **+** Question 3 **+** Question 4 **+** Question 5 (Recoded) **+**
   Overall Activities of Daily Living Subscale **+** Meaningful Activities Composite Score **+**
   Question 8 **+** Question 9 **+** Question 10 (Recoded) **+** Question 11 (Recoded)

   If three or fewer items are missing, the individual's mean score on all the other items should be substituted for each missing item before the total score is calculated. If four or more items are missing, the total score should not be calculated.

Computation of the Restrictiveness of Living Environments Scale (ROLES) from The Ohio Scales – Worker Version

The ROLES consists of a list of 23 categories of residential settings. Next to each specific setting is a blank line on which the agency worker writes the number of days (during the past 90 days) the youth was residing in that setting (The total of all the days will therefore add to 90). Scoring for this scale is not included on the form, but it is possible to compute a score if the worker thinks it would be a meaningful measure of the child's treatment progress. Each setting is given a statistical 'weight' as listed in the table below. To get the ROLES total score, each weight is multiplied by the number of days in the blank next to the setting. The sum of these products is then calculated to get a total. The total is then divided by 90 to get the average restrictiveness for the previous 90 days.

Setting	Weight
Jail	10.0
Juvenile detention/youth corrections	9.0
Inpatient psychiatric hospital	8.5
Drug/alcohol rehabilitation center	8.0
Medical hospital	7.5
Residential treatment	6.5
Group emergency shelter	6.0
Vocational center	5.5
Group home	5.5
Therapeutic foster care	5.0
Individual home emergency shelter	5.0
Specialized foster care	4.5
Foster care	4.0
Supervised independent living	3.5
Home of a family friend	2.5
Adoptive home	2.5
Home of a relative	2.5
School dormitory	2.0
Biological father	2.0
Biological mother	2.0
Two biological parents	2.0
Independent living with friend	1.5

Example: If during the last 90 days a child was placed in a juvenile detention facility for 2 days, a group home for 12 days, and with the biological father for 76 days, the ROLES score would be calculated in this way:

Setting	Days		Weight		Product
Detention Center	2	x	9.0	=	18.0
Group Home	12	x	5.5	=	66.0
With Father	76	x	2.0	=	152.0
Total	90				236.0

236 / 90 = 2.62 – The ROLES score for the past 90 days is 2.62.