

**Special Education and Juvenile Justice:
An Overview and Analysis of Prevention and
Intervention Policy and Program Developments**

December 2006

**A Report of The Ohio Coalition for the Education of Children with
Disabilities**

ABOUT THE OHIO COALITION FOR THE EDUCATION OF CHILDREN WITH DISABILITIES

Mission

The mission of the Ohio Coalition for the Education of Children with Disabilities (OCECD) is to endorse and promote efforts to provide appropriate quality education for children and youth with disabilities. This is done in the belief that all children have a right to a meaningful and relevant education. This belief affirms the dignity of each child or youth with disabilities, whose needs are unique and must be met equally and appropriately.

OCECD is dedicated to insuring that every child with disabilities is provided a free, appropriate public education. The Coalition continually strives to encourage the provision of high quality educational services for all children with disabilities in Ohio.

History

Established in 1972, OCECD is a statewide, non-profit organization dedicated to advancing the education interests of children with disabilities. OCECD is composed of over 44 parent and professional organizations representing over 50,000 individuals and collaborates with local parent support organizations to offer information, training and support to parents of children with disabilities. OCECD also provides important training programs and services to professionals and professional organizations.

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Introduction

The Ohio Department of Education (ODE) contracted in 2006 with the Ohio Coalition for the Education of Children with Disabilities (OCECD) to develop a report that: a) enhances understanding of the incidence of and reasons for students with special educational needs being at risk of juvenile justice incarceration; and b) provides an overview and analysis of representative Ohio and national policy and program developments regarding initiatives to address the significant number of children with special educational needs at risk of being incarcerated in local or state juvenile detention and correction facilities.

Source materials used in the report include: Government and private nonprofit organization data, program information and reports; relevant state statutes and regulations; journal, magazine and newspaper articles; discussions with policy leaders and experts; and a stakeholder advisory group forum the summary notes of which are contained in Appendix C.

Report Outline

The OCECD report includes five sections as outlined below.

1. **Section One** – Problem Definition: Ohio and National Overview
2. **Section Two** – Intervention and Prevention Efforts in Ohio: State Initiatives and Program Profile
3. **Section Three** – Best Practice Identification
4. **Section Four** – State Policy Issues and Findings
5. **Section Five** – Conclusion: Key Policy Questions and Implications

1. Problem Definition: Ohio and National Overview

Overrepresentation of Special Needs Youth in Juvenile Justice Systems Nationally

Numerous national, state and local studies have indicated the significant overrepresentation of children with disabilities in the nation's youth correctional facilities. Yet, few of these efforts have yielded true representative estimates of the prevalence of disabilities among children at risk of engaging in delinquent activities because national studies have not systematically examined both disabilities and delinquency within the same study.

The National Center on Education, Disability and Juvenile Justice (EDJJ) reports that more than one in three youths entering correctional facilities have previously received special education services and that youths with emotional disturbance and learning disabilities make up 42% and 45%, respectively, of those incarcerated.

Accompanying the lack of consistent and accurate tracking of the overpopulation of special needs youth in correctional facilities is a lack of consistency in the use of terms and labels among various agencies. In addition to inconsistent definitions of disabilities, other reasons for varying disability estimates include: inadequate special education screening and assessment procedures in the public schools and correctional facilities; failure to obtain school records upon intake; truancy or sporadic school attendance precluding the completion of special education procedures necessary for special education identification; and difficulties in implementing special education programs in correctional settings serving as a deterrent to accurate identification.

While proof exists that there is an overpopulation of students with disabilities in the juvenile justice system, there is little solid research to explain why this overpopulation exists. Absent the research, there is strong consensus that students with disabilities are much more likely to do poorly in school and that this poor performance can be indicative of delinquency.

Ohio's Incarcerated Youth Profile: The Overrepresentation of Special Needs Youth in Ohio's Juvenile Justice Systems

The overrepresentation picture for Ohio is quite similar to what is occurring nationally. According to FY2004 data from Ohio Department of Education (ODE), there are 1,806,802 students enrolled in Ohio schools. Of those students, 226,064 (12.5%) are identified special needs students. The category with the largest representation of students (66.59%) is category 2, which includes students who are specific learning disabled (SLD), developmentally handicapped (DH), and Other Health Impaired – Minor (OH-Minor).

Conversely, according to June 2004 data from the Ohio Department of Youth Services (DYS), there were 1,778 youth (daily average) incarcerated on any given day in the system. Of these youth offenders, 799 (42%) are designated as special needs students. Not surprisingly, the largest category of special education students incarcerated in DHS is in category 3 (49.9%), which includes the severe behaviorally handicapped students. The second largest is category 2 (47.9%).

Students within the same disability categories outlined above are also over-represented in the number of discipline cases that occur in Ohio's schools. Students with disabilities are also more likely to drop out of school; about one third of all students with disabilities drop out of school. Students in the categories mentioned above are more likely than other disability categories to drop out of school. Of those students with disabilities that drop out of school, 53% are students with emotional disturbance.

As seen on the national level, the prevalence of mental disorders among youth in juvenile justice facilities is high in Ohio. According to a report by Voices for Children of Greater Cleveland, the prevalence of mental disorders among youth in juvenile justice facilities ranges from 50% to 75% compared to 20% of children and youth in the general population. At least half of incarcerated youths with mental health disorders have co-occurring substance abuse disorders; nearly two-thirds of incarcerated youth with substance abuse disorders have at least one other mental health disorder. Many youth with mental health needs also have other underlying issues, including physical abuse, sexual abuse, parental drug or alcohol use, poor school performance or

truancy, family disorder, and learning disabilities. This makes diagnosing and treating these youth that much more challenging. Many of the new state-level proposals are directed at this population.

2. Intervention and Prevention Efforts in Ohio: A State Initiative & Program Inventory

How Does Ohio Compare?

A review of Ohio's statewide intervention and prevention efforts reveals numerous programs and initiatives that target students most at-risk of developing behavioral health issues and, ultimately, coming into contact with the juvenile justice system. That being said, few if any focus exclusively on special education students. However, the state of Ohio has put several initiatives in place focused on prevention activities. Under the Shared State Agency Framework outlined below, Ohio defines prevention as a proactive continuum of services which empowers individuals, families and communities to meet the challenges of life events and transitions by creating and reinforcing conditions that impact physical, social, emotional, spiritual, and cognitive well being and promote safe and healthy behaviors and lifestyles. This definition is reflected in the services provided under the various initiatives.

Outlined below are some state-level reform efforts targeted at improving service delivery in Ohio for at-risk children in order to prevent juvenile incarceration and some examples of inter-agency collaboration currently under way in the state.

Collaborative Statewide Intervention and Prevention Initiatives for Ohio's Special Needs and At-Risk Youth

Numerous state agencies play a role in providing services to at-risk children and youth who have either come into contact with, or are at risk of coming into contact with, the juvenile justice system. Those state agencies include the Ohio Department of Health (ODH), the Ohio Department of Mental Health (ODMH), the Ohio Department of Jobs and Family Services (ODJFS), ODE and DYS.

Increasingly, these state agencies have become interested in collaborating to improve prevention and intervention services for children in need of their respective services, including those who are at-risk of juvenile justice incarceration. Examples of this collaborative approach and related developments are referenced below.

The Center for Learning Excellence

Some of these state efforts are coordinated through the Ohio Center for Learning Excellence located within the John Glenn Institute for Public Policy at the Ohio State University. The mission of the Center for Learning Excellence is to promote dialogue between education projects and supporting community partners and to provide access to research findings, practice recommendations, and current topics useful to projects and schools.

Ohio's Shared State Agency Prevention Framework

In addition to the programs supported through the Center for Learning Excellence, the State of Ohio, under the direction of Governor Bob Taft, established a State Interagency Prevention Partnership consisting of representatives from the Governor's Office and eleven State departments and agencies involved in prevention. The goal of the group, established in January 2002, was to provide recommendations to the Governor for a Shared State Agency Prevention Framework for establishing program criteria for prevention that will provide for greater consistency and coordination of state resources in meeting community prevention and early intervention needs. The Partnership used existing prevention systems as a foundation to work towards a more cohesive and collaborative system that coordinates and maximizes resources. In the end, the Shared State Agency Prevention Framework is designed to serve as a blueprint for better communication and collaboration among state agencies that promote safe and healthy behaviors and lifestyles.

Striving Readers Program

In March 2006, DYS was awarded a \$14 million "Striving Readers" grant from the U.S. Department of Education to raise the reading achievement levels of youth committed to Ohio's juvenile correction facilities. The "Striving Readers" program, an interagency initiative administered through DYS, will provide literacy intervention to struggling readers and provide training for teachers to improve the quality of literacy instruction.

Single Agency Intervention and Prevention Initiatives

In addition to the statewide inter-agency collaborations currently under way in Ohio, there are also several single-agency programs as outlined below.

ODE Initiative

The Ohio Community Collaboration Model (OCC): ODE has developed, as part of the federally-funded 21st Century Learning Grants, an expanded model for school improvement that moves beyond traditional models. The main idea is for educators and schools to develop strategic connections with family and community resources to gain improvements in academic achievement, increased school safety, enhanced youth development and reductions in youths' problem behaviors.

Special Education Regional Resource Centers (SERRCs) Initiative

Ohio Integrated Systems Model (OISM): Ohio's sixteen SERRC centers provide support to school districts statewide in the implementation of the Ohio Integrated Systems Model and are charged with assisting school districts in the implementation of academic and behavior supports, including the development and implementation of school-wide positive behavior support plans and the provision of appropriate mental health services.

ODMH Mental Health Initiative

CAPS Action Task Force: In 2004, the Ohio Department of Mental Health (ODMH) established a broad-based workgroup including psychiatrists, pediatricians, family practice physicians, children's hospitals, mental health boards, families and consumers and other providers to focus on improving child and adolescent clinical care. The CAPS Task Force is expected to issue its recommendations by August 2007.

DYS Initiatives

Mental Health Services/Bureau of Behavioral Health Services: For those students already incarcerated within the DYS system, the Ohio Bureau of Behavioral Health Services is responsible for the provision of psychology and psychiatry services. The bureau also provides oversight to these services when youth are on aftercare.

Bureau of Subsidies and Grants - Title II, Title V: The bureau oversees federal grants management and state subsidies. Each year, Ohio also receives funding from the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP) for three grant programs, two of which – Title II formula grants and Title V incentive grants – include an intervention and prevention component.

3. Best Practices: Representative Examples

In addition to the review of current state-level programs and services aimed at intervention and prevention services for children with disabilities, this study includes a review of national and Ohio organizations to ascertain what information, programs and/or services might be available that could help reduce the overpopulation of special needs youth in juvenile justice facilities. This section ends with a listing of representative “best practice” programs.

4. Key Policy Questions and Implications

The study concludes with policy questions and implications that include the following issues.

State Commission Special Education and Juvenile Justice. The study raises significant policy questions that deserve further focus and attention. As a result, the central recommendation of this report, which is focused fundamentally on problem definitional work and an initial overview of efforts to evaluate the efficacy of relevant prevention and intervention programs, is the call for the creation of a state level Commission on Special Education and Juvenile Justice. This recommendation serves as an initial step to broaden educational outreach to state policymakers and other relevant stakeholders about the overpopulation of children with disabilities in the state's juvenile justice system.

A state commission can provide an effective forum to bring experts and stakeholders together to gain a more thorough understanding of how students with special educational needs who are at-risk of juvenile justice incarceration are treated currently and how this treatment can be improved

through more effective educational programming, including prevention and intervention initiatives, to reduce their ongoing overrepresentation in the juvenile justice system. The proposed Commission could be convened by either statute or by Executive Order of the governor.

Special Education and Juvenile Justice: An Overview and Analysis of Prevention and Intervention Policy and Program Developments

This report provides an overview and analysis of recent Ohio and national policy and program developments regarding initiatives to address the fact that there are a significant number of children with special educational needs at-risk of being incarcerated in local or state juvenile detention and correction facilities. As outlined below, this reality results in a major overrepresentation of children with disabilities being placed in juvenile facilities in Ohio and nationally.

In addition to documenting these realities and in so doing bringing greater awareness of the problem to policy makers and practitioners, this report identifies promising prevention and intervention policy and program developments that can lead to better outcomes for at-risk youth, including a reduction in juvenile incarcerations.

The connection between juvenile justice and special education in Ohio is both sobering and substantial. Over 44% of youth incarcerated in the Ohio Department of Youth Services (DYS) correctional system are designated as being in need of special education and related services, compared to a statewide average of approximately 1 in 7 students (14%) identified as disabled. This means there are over three times as many special education students in DYS facilities as there are in the general school population.

Within this population are disability categories that are even further overrepresented. For instance, 49.7% of incarcerated special needs students are emotionally disturbed (compared to approximately 9% in the general special education school population). The second largest category is Specific Learning Disabled (SLD) students at 24.3%.

These findings raise serious policy questions regarding the reasons for this overrepresentation and whether effective educational intervention and prevention programs are in place so that fewer students with special educational needs are incarcerated in the state's juvenile detention and correctional facilities.

Report Outline

This report includes five sections as outlined below:

Section One – Problem Definition: National and Ohio Overview. This section will provide introductory and overview information that documents the reality that there is a significant group of children with special educational needs who are at-risk of incarceration in state and/or local juvenile justice facilities in Ohio and nationally. The section is divided into three parts: a) the national scene; b) the Ohio scene; and c) an organizational profile of Ohio's juvenile justice system with a specific focus on its roles and responsibilities regarding the provision of educational services.

Section Two – Intervention and Prevention Program Inventory in Ohio. This section provides a policy and programmatic profile regarding the development of state prevention and intervention policies and program initiatives that address the challenges facing at-risk youth, including those with special educational needs who are likely to be incarcerated. It is designed to enhance understanding of the educational and related needs of special education students at-risk of juvenile justice system incarceration as well as how quality intervention and prevention programs can help meet those needs thus resulting in a number of positive developments such as an increase in educational success and a decrease in juvenile justice incarcerations. The review includes programs designed to assist students with mental health related disabilities. This section will be informed by relevant state information and interviews with relevant Ohio policy and programs leaders, parents and practitioners.

Section Three – Best Practice Identification. This section identifies national developments relative to the independent evaluation of prevention and intervention programs for at-risk students, including those with special educational needs. These developments are consistent with federal government initiatives to encourage the creation and utilization of evidence-based educational research. It will provide an overview of these developments, including leading examples of quality programs as defined by independent evaluators, such as the RAND Corporation.

The authors of this report recommend that if there is a subsequent effort by OCECD to research policies and practices in this area, efforts be made to identify the programs most often deemed successful, look at what other states are doing and cull out the programmatic success criteria from model programs to identify common criteria that, taken together, can form the foundation for best practice standards related to prevention and intervention programs for students with special needs who are at-risk of becoming involved with the juvenile justice system. Given the fact that children with mental health problems are, as a group, particularly prone to juvenile justice incarceration, specific focus should be given to programs for students with mental health conditions who are part of the most over-represented special needs population group currently represented in the juvenile justice system in Ohio and nationally. Programs to be included in this new study should each have been rated highly after an independent evaluation from a professional evaluation organization. This analysis should help policy makers and program professionals better understand which intervention and prevention programs work and what program elements help make this the case.

Section Four – State Policy Issues and Implications. This section will outline state policy and program implications, including relevant system change issues that emerge from the report.

Section Five – Conclusion: Key Policy Questions and Implications. This section will summarize the report’s major findings and, in so doing, lay the foundation for an outreach and awareness program aimed at further educating public policy makers and other key stakeholders, such as parents, teachers, school administrators, other practitioners, police officers, attorneys and judges, about the challenges and opportunities associated with preventing students with special needs from engaging in the type of behavior that results in sanctions by the juvenile justice

system. It will also help ensure that those who do become involved in the juvenile justice system receive appropriate programs and services.

1. Problem Definition: National and Ohio Overview

A. Overrepresentation of Special Needs Youth in Juvenile Justice Systems: The National Scene

Numerous national, state and local studies have indicated the significant overrepresentation of children with disabilities in juvenile correctional facilities. Yet, few of these efforts have yielded true representative estimates of the prevalence of disabilities among children at risk of engaging in delinquent activities. This tends to be the case because, as the National Council on Disability (NCD) explains in its May 2003 report, *Addressing the Needs of Youth with Disabilities in the Juvenile Justice System: The Current Status of Evidence-Based Research*, national studies do not systematically examine disabilities and delinquency within the same study; thus, there is a lack of direct assessment of the relative prevalence of disabilities among delinquents, or of delinquency among youth with disabilities. Professor Joseph Tulman, Professor of Law at the University of the District of Columbia, in his paper *Disability and Delinquency: How Failures to Identify, Accommodate and Serve Youth with Education-Related Disabilities Leads to Their Disproportionate Representation in the Delinquency System*, agrees and emphasizes that while researchers and journalists have documented the disproportionate representation and disparate, discriminatory treatment of children based upon race and class, such representation and treatment within the delinquency system of children with disabilities has not been sufficiently studied and documented.¹

While the contributing factors associated with overrepresentation are not fully understood, evidence suggests that parents, teachers, school administrators, police officers, attorneys and judges are typically uninformed or unaware of the characteristics associated with disabilities. In an effort to increase the level of awareness among various stakeholders, a statistical profile follows, citing various sources, of the national picture as it relates to students with disabilities and the juvenile justice system.

The NCD finds that learning disabilities and serious emotional disorders are far more common among incarcerated youths than among youths in schools. The National Center on Education, Disability and Juvenile Justice (EDJJ), in its May 2000 publication *Special Education in Correctional Facilities*, reports that more than one in three youths entering correctional facilities have previously received special education services and that youths with emotional disturbance and learning disabilities make up 42% and 45 %, respectively, of those incarcerated. Using the U.S. Department of Education, Office of Special Education Programs Data Analysis System as its source, EDJJ points out that from 1992 to 1997, the number of students with disabilities in correctional facilities rose at over twice the rate as the overall special education population – by 28 % vs. 13 %.

In a paper entitled *Students with Disabilities in Correctional Facilities* for the ERIC Clearinghouse on Disabilities and Gifted Education, the authors cite a 1990 meta-analysis by Pamela Casey and Ingo Keilitz of various studies which found that 35.6 % of youth in juvenile

¹ Because of lack of data, it is sometimes difficult to separate information, data, programs, recommendations, etc. for special needs youth from that for “at risk” youth in general.

correction facilities had learning disabilities and 12.6% were mentally retarded. This paper also reports on the findings of a national survey conducted by the Center for Effective Collaboration and Practice at the American Institutes for Research (CECP), in collaboration with EDJJ, on the prevalence of youth with disabilities in juvenile detention and correctional facilities shows that 37% of incarcerated youth are disabled. The survey also shows that 46 % of these disabled youth had a primary diagnosis of specific learning disability and 45 % were emotionally disturbed. It says that these percentages suggest that these youth are more vulnerable to placements in the correctional system than are students in the general population. CECP also says that national studies show a minimum of 30 % to 50 % of youth involved in juvenile crimes have special needs.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) in its July 2000 Bulletin *Special Education and the Juvenile Justice System* quotes studies that reveal as many as 70 % of incarcerated youth suffer from disabling conditions and that as many as 20 % of youth with emotional disabilities are arrested at least once before they leave school as compared with 6 % of all students. *Make Behavioral Health for Youth a Priority*, a project of the National Association of Psychiatric Health Systems, published a 2000 report containing an estimate that 20 % of all youths have behavioral disorders and approximately 9-13% experience serious emotional disturbances. Voices for Children of Greater Cleveland, in its 2006 guide, *Juvenile Justice is Youth Development*, maintains that studies show the prevalence of youth with mental disorders in the juvenile justice system ranges from 50% to 75 % compared to 20 % of youth in the general population and that one quarter to one third of confined youth have an anxiety disorder.

Accompanying the lack of consistent and accurate tracking of the overpopulation of special needs youth in correctional facilities and probably contributing to it, is a lack of consistency in the use of terms and labels among various agencies. For example, a 2002 monograph in the EDJJ monograph series developed by CECP, *Youth with Disabilities in the Correctional System: Prevalence Rates and Identification Issues*, points out that labels used in special education differ from those used by the mental health field. It also points out that each state can interpret federal identification guidelines somewhat differently, enabling them to use slightly different terminologies for specific learning disability, emotional disturbance and mental retardation – the three major special education disability groups represented in the juvenile correctional system. Thus, a youth could have a special education label in one state, but not in another. Also, definitions of disabilities and qualifications for eligibility vary among states. And, while federal law sets minimum eligibility standards, states can set more inclusive criteria for who can be served through special education so prevalence rates will differ among states.

In addition to inconsistent definitions of disabilities, other reasons for discrepancies in disability estimates include: inadequate special education screening and assessment procedures in the public schools and correctional facilities; the failure to obtain school records upon intake; truancy or sporadic school attendance precluding the completion of special education procedures necessary for special education identification; and the difficulty in implementing special education programs in correctional settings serving as a deterrent to accurate identification.

Another contributing factor is that students with mental and emotional disorders are among the most under-identified and under-served students with disabilities. A Bazelon Center 2003 issue brief entitled *Failing to Qualify: The First Step to Failure in School?* points out that:

For more than two decades, the national rate of students identified with emotional disturbance hovered just under 1 %. In stark contrast, the U.S. Surgeon General estimated that nationwide 5 % of all school-age children have mental disorders with “extreme functional impairment” and 11 % have mental disorders with “significant functional impairment” The low overall rate of identification under IDEA hides the fact that some states identify almost no children as having mental or emotional disorders. Rates of identification have consistently varied considerably by state.

While proof exists that there is an overpopulation of students with disabilities in the juvenile justice system, there is little solid research to explain why this overpopulation exists. As previously reported in a fall 2004 OCECD *Forum* article, theories and explanations are wide-ranging and cover the entire period from birth to incarceration. But, NCD finds that few studies systematically address the disability-delinquency link using data that could definitively assess whether or not disabilities cause delinquency.

Absent the research, there is a strong consensus that students with disabilities are much more likely to do poorly in school and that this poor performance can be indicative of delinquency. It should be noted that the ongoing *National Early Intervention Longitudinal Study* conducted for the U.S. Department of Education’s Office of Special Education, and made possible by Part C of IDEA, found both an overrepresentation of minorities in special education and a possible underrepresentation of infants and toddlers from minority groups in early intervention efforts.

The fall 2004 OCECD *Forum* article also pointed out that researchers have identified risk factors, the presence of which predict delinquency for both youth with and without learning disabilities. The risk factors are multi-faceted, interrelated, can be inherent to the individual, families, schools and communities. These factors include, for example: poverty/low socioeconomic status; poor prenatal care, pregnancy and delivery trauma and low birth weight; brain circuitry dysfunction, cognitive deficits, hyperactivity, restlessness, and aggressiveness; minority race; foster placement; and inappropriate pedagogy and curriculum, lack of early identification and intervention, poor teachers and teachers unprepared to manage students with emotional and behavioral disorders, inadequate support for teachers.

No single risk factor leads a child to delinquency, but some factors are mentioned more often than others such as early anti-social behavior and hyperactivity. The larger the number of risk factors a child is exposed to, the greater the likelihood that the child will engage in deviant behavior.

B. Overrepresentation of Special Needs Youth in Juvenile Justice Systems: The Ohio Scene

This section investigates the pervasiveness of youth with special educational needs and mental or behavioral health issues who are at increased risk of becoming incarcerated in youth or adult correctional facilities in Ohio. Because little focus or attention has been placed on a review of successful intervention and prevention programs, this section attempts to provide a profile of Ohio's juvenile offenders, including the prevalence of youth with disabilities and the types of disabilities represented, as well as the current state level intervention and prevention initiatives underway across the state.

I. Incarcerated Youth Profile: The Ohio Scene

According to information from the National Evaluation and Technical Assistance Center for the Education of Children and Youth Who Are Neglected, Delinquent, or At Risk, there were 4,176 juveniles in residential placement in Ohio in 2003. The Office of Juvenile Justice Detention and Prevention's (OJJDP) detailed offense profile indicates that of the 4,176, 70.55% (2,946) were committed, 1,224 (29.31%) were detained, and 6 (0.14%) underwent some type of diversion program. Committed juveniles were those placed in a facility as part of a court ordered disposition. Detained juveniles include those awaiting a court hearing, adjudication, disposition or placement elsewhere. Diverted youth include those voluntarily admitted to a facility in lieu of adjudication as part of a diversion agreement. Likewise, according to a November 20, 2006, *Columbus Dispatch* article, Ohio has the sixth-highest youth incarceration rate in the nation. As of September, 1,788 young people were in state facilities and 1,463 were under community parole supervision. Nearly three of four have severe drug problems, more than half have a relative in prison and many need special education. This system is often a "pipeline" to adult incarceration. On the adult side, Ohio has the seventh-largest prison system in the country, but ranks 24th in imprisonment rates. As of September 2006, Ohio's 32 prisons held 47,258 inmates, 93% of them male and 52% white.

Ohio's incarcerated youth were charged with offenses related to either offenses against the person (*criminal homicide, sexual assault, robbery, assault, other*), property (*burglary, theft, arson, other*), drug (*trafficking, other*), public order (*weapons, alcohol, other*), or status offenses (*truancy, runaway, curfew violation, underage drinking*). Nearly thirty-eight percent (37.72%) of offenses in 2003 were offenses against the person, with sexual assault representing 35% of such offenses; 27.58% were property offenses; 6.47% were drug related; 10.13% were public order offenses, nearly 40 percent of which were weapons charges; 16.31% were technical violations; and 1.77% were status offenses. There is no reason to believe that Ohio's youth criminal statistics in this regard differ greatly from those nationwide. *According to the National Center on Secondary Education and Transition, only 5-8% of youth, nationally, are chronic offenders, yet they commit 50-70% of all serious and violent juvenile crime.*

A review of DYS website reveals additional information about the individuals incarcerated in Ohio's DYS-operated juvenile facilities. For example, the average length of stay for the 1,778 incarcerated on any given day (average daily) is 10.4 months. Of those committed to DYS facilities, 47% were white, 47% black, 3% bi-racial, 2% Hispanic, and 1% other. In reviewing commitments by gender, 1,556 of those committed were male, while only 162 or 9.4% were

female. There is a strong likelihood of these individuals re-offending within one year of their release from DYS. DYS reports a 31% recidivism rate, meaning that of the 1,778 committed, 531 will likely be re-committed within a year of release.

II. Special Education Over-representation and Categories Defined.

The overrepresentation picture for Ohio is quite similar to what is occurring nationally. According to FY2004 data from ODE, there are 1,806,802 students enrolled in Ohio schools. Of those students, 226,064 (12.5%) are identified special needs students. Conversely, of the 1,778 youth offenders in the DYS system on any given day (FY 2004), 799 (44.9%) are designated as special needs students. Of these youth offenders, 799 (42%) are designated as special needs students.

Special needs students are assigned for funding purposes to six different categories of disabilities as listed in Table 1 below. The disabilities included in these six categories are defined as follows:

- **Speech Only** refers to speech related services provided to students who have disabilities that are limited to speech and language related deficiencies.
- **Specific Learning Disabled (SLD)** refers to a disorder in which one or more of the basic psychological processes involved in understanding or in using language, spoken or written is impaired, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural or economic disadvantage. For tracking and funding purposes, those students with specific learning disabilities are counted under category 2.
- **Developmentally Handicapped (DH)**, or mentally retarded, means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior manifested during the developmental period, which adversely affects a child's educational performance. Developmentally handicapped students fall under category 2 for tracking and funding purposes.
- **Other Health Handicapped (OH)** indicates limited strength, vitality or alertness due to chronic or acute health problems such as a heard condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia or diabetes, which adversely affects a child's educational performance. OH Minor students fall under category 2, while OH Major students are counted under category 4 for tracking and funding purposes.
- **Emotionally Disturbed (ED)**, also known as severely behaviorally handicapped, or SBH, is a term used to describe a condition exhibiting one or more of the following characteristics

over a long period of time and to a marked degree, which adversely affects educational performance:

- An inability to learn which cannot be explained by intellectual, sensory or health factors;
- An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- Inappropriate types of behavior or feelings under normal circumstances;
- A general persuasive mood of unhappiness or depression; or
- A tendency to develop physical symptoms or fears associated with personal or school problems.

The term does not refer to children who are socially maladjusted unless it is determined that they are severely handicapped. For tracking and funding purposes, ED students are counted under category 3.

- **Hearing Impaired** means a hearing impairment, whether permanent or fluctuating, which adversely affects a child’s educational performance but which is not included under the definition of deaf as defined in Ohio’s special education rules. For tracking and funding purposes the hearing impaired fall under category 3.
- **Visually Impaired** means a visual impairment which, even with correction, adversely affects a child’s educational performance. The term includes both partially seeing and blind children. For tracking and funding purposes, the visually impaired fall under category 3.
- **Orthopedic Impairment** indicates the presence of a severe orthopedic impairment which adversely affects a child’s educational performance. The term includes impairments caused by congenital anomaly (e.g., clubfoot, spina bifida, absence of some member), impairments caused by disease (e.g., polio-myelitis, muscular dystrophy, bone tuberculosis), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns which cause contractures). For tracking and funding purposes, students with orthopedic impairments are counted under category 4.
- **Multiple Disabilities** means such a severe impairment, and/or such concomitant impairments, that the child’s educational problems make it impossible to accommodate the needs of the child in any program but a program for multi-handicapped children. This category does not include deaf blind, traumatic brain injury, or autism, all of which fall under category 6. For tracking and funding purposes, students with multiple disabilities are counted under category 5.

Table 1: Children with Disabilities in General School Population

Category	# of Students	% of special ed. population
Category 1 – Speech Only	35,149	(15.55%)
Category 2 – SLD, DH, OH Minor	150,507	(66.59%)
Category 3 – ED, Hearing or Visual Impairment	21,240	(9.40%)
Category 4 – OH Major, Orthopedic Impairment	2,727	(1.21%)

Category 5 – Multiple Disabilities (Other than deaf-blind)	10,785	(4.76%)
Category 6 – Deaf Blind, Traumatic Brain Injury, Autism	5,656	(2.50%)

The category with the largest representation of students (66.59%) is category 2, which includes students that are specific learning disabled (SLD), developmentally handicapped (DH) and Other Health Impaired – Minor (OH-Minor).

Table 2: Children with Disabilities in DYS Facilities

Category	# of Students	% of special ed. population
Category 1 – Speech Only	2	(.25%)
Category 2 – SLD, DH, OH Minor	383	(47.90%)
Category 3 – ED, Hearing or Visual Impairment	399	(49.90%)
Category 4 – OH Major, Orthopedic Impairment	4	(.50%)
Category 5 – Multiple Disabilities (Other than deaf-blind)	3	(.38%)
Category 6 – Deaf Blind, Traumatic Brain Injury, Autism	0	(.00%)

It is evident, with 42% of the DYS population identified as special needs (*compared to 12.8% in the general school population*), that there is a significant overrepresentation of special needs students incarcerated in DYS system. Not surprisingly, the largest category of special education students incarcerated in DYS is category 3 (49.9%) which includes the severe behaviorally handicapped students. The second largest is category 2 (47.9%) which includes the specific learning disabled, developmentally handicapped and other health impaired minor.

While one third of all students with disabilities drop out of school, students within disability categories 2 and 3 are more likely than other disability categories to drop out of school and are over-represented in the number of discipline cases that occur in Ohio’s schools. Of those, 53% are students with emotional disturbance. According to the National Center on Secondary Education and Transition, 20% of youth with emotional/behavioral disabilities will be arrested at least once before they leave school versus 6% of mainstream students, and 58% will be arrested by the time they are 3-5 years out of school.

III. Mental Health Disorders and Over-representation in the Juvenile Justice System

The prevalence of mental disorders among youth in Ohio’s juvenile justice facilities is particularly high. According to a report by Voices for Children of Greater Cleveland, the prevalence of mental disorders among youths in juvenile justice facilities ranges from 50% to 75%, compared to 20% of youths in the general population. According to a July 19, 2006 article in the *Columbus Dispatch*, each incarcerated child with a diagnosed mental illness costs the DYS \$57,440/year. According to the Ohio Kids Coalition, 33% of children committed to DYS in Ohio require mental health treatment. At least half of incarcerated youths with mental health disorders have co-occurring substance abuse disorders; nearly two-thirds of incarcerated youth with substance abuse disorders have at least one other mental health disorder. Many youth with mental health needs have other underlying issues, including physical abuse, sexual abuse, parental drug or alcohol use, poor school performance or truancy, family disorder and learning disabilities making diagnosing and treating these youth that much more challenging. A Children’s Defense Fund report reveals that many minority youth with mental health needs

entering the juvenile justice system have either not been treated or have been insufficiently served by systems in their community. Black youth, particularly males, are more likely to be referred to the juvenile justice system than a treatment system and are less likely than their white counterparts to have previously received mental health treatment services.

C. Local School and DYS/Local Juvenile Detention Systems: Educational Roles, Responsibilities and Challenges Regarding Provision of Services

In Ohio, delinquent youth, those with and without special needs, work their way through the system in different ways depending on the county in which they are being tried. For instance, ten of Ohio's 88 counties have separate juvenile court divisions, while the remaining counties combine juvenile courts with domestic or probate courts. Once they have been adjudicated, juvenile offenders are subject to various types of incarceration: DYS operates eight juvenile correctional facilities and administers six regional parole offices; there are 12 DYS-funded, county-operated secure community correctional facilities (CCF), 18 county rehabilitation centers and 40 detention centers for temporary placement of youth. There is also one private correctional facility – Paint Creek Youth Center (LYC-PC) – that houses juvenile offenders. LYC-PC is a private nonprofit residential treatment facility for 49 males between the ages of 15 and 18 committed to DYS for felony 1 or felony 2 offenses.

To better understand the environment these youth face upon entering the juvenile justice system, it is important to understand the various roles and responsibilities these facilities are called upon to fill as well as what role, if any, the local school districts have in providing educational programming.

I. Local Juvenile Detention Facilities

a. Statutory Authorization

Local juvenile detention facilities are authorized by RC 2152.41. The statute provides that upon the recommendation of the juvenile court judge, the board of county commissioners shall provide for a detention facility within a convenient distance of the juvenile court. Multi-county facilities are created by the boards of county commissioners of two or more neighboring counties upon the joint recommendation of the juvenile judges presiding in those counties.

b. Education Programming Requirements

The educational responsibilities of local juvenile detention facilities are not extensively laid out in statute. RC 2152.42(c) provides only that:

During the school year, when possible, a comparable educational program with competent and trained staff shall be provided for children of school age who are in the facility. A sufficient number of trained recreational personnel shall be included among the staff. Medical and mental health services shall be made available.

Each independent, local facility is responsible for the provision of educational programming within the parameters established in RC 2152.42(c). RC 2152.42(c) states that “when possible, a comparable educational program with competent and trained staff shall be provided” The statute does not elaborate on the meaning of this provision. Presumably, the local authorities are responsible for deciding how to structure an educational program that is “comparable” and what “when possible” means. As each facility is given a great deal of discretion in fashioning its own program and often faces a lack of resources, there is a lack of uniformity across the facilities.

c. Local School Districts’ Role

Local juvenile detention facilities are used to:

1. detain children who are alleged to be delinquent until final disposition for evaluation pursuant to RC 2152.04;
2. confine children who are adjudicated delinquent children and placed in the facility pursuant to RC 2152.19(A)(3); and
3. confine children who are adjudicated juvenile traffic offenders and committed to the facility under RC 2152.21(A)(5) or (6). See RC 2152.41.

There is no language in RC 2152.04, 2152.19, 2152.21 or 2152.41 that vests the local juvenile detention facilities with legal or permanent custody of the children in their care.

It is important to note that local juvenile detention facilities do not receive legal or permanent custody of the children as custody plays a role in determining the local school districts’ responsibilities for these children. Under RC 2152.01(C), all the provisions of Chapter 2151, to the extent they do not conflict, apply to proceeding under Chapter 2152. Accordingly, RC 2151.06 applies and dictates that “a child has the same residence or legal settlement as his parents, legal guardian of his person, or his custodian who stands in the relation of loco parentis.” A child’s residence dictates in which school district a child is entitled to attend school.

RC 3313.64(B) states in pertinent part:

(B) . . .

(1) A child shall be admitted to the schools of the school district in which the child's parent resides.

(2) A child who does not reside in the district where the child’s parent resides shall be admitted to the schools of the district in which the child resides if any of the following applies:

- a. The child is in the legal or permanent custody of a government agency or a person other than the child's natural or adoptive parent.
- b. The child resides in a home.
- c. The child requires special education.

As local juvenile detention facilities do not receive legal or permanent custody of children in their facilities and children are deemed to reside where their parents reside pursuant to RC 2151.06, these children would still be students of the district where their parent resides, as provided in RC 3313.64(B)(1). The interplay between the provision that determines the child's appropriate school district and RC 2152.42(c), which outlines local juvenile detention facility educational responsibilities, indicates that these children are still students of their school district and that the local juvenile detention facilities are to take over the responsibility of providing educational programming while the child is in the facility.

While the local juvenile detention facilities assume the school district's responsibility for providing educational programming, the local school districts remain financially responsible for the education of its children placed in those facilities. Under RC 2151.357:

Whenever a child is placed in a detention facility established under section 2152.41 of the Revised Code or a juvenile facility established under section 2151.65 of the Revised Code, the child's school district as determined by the court shall pay the cost of educating the child based on the per capita cost of the educational facility within the detention home or juvenile facility.

Although these statutes are relatively clear on their face, in practice, a great deal of confusion has developed concerning the roles of the local school districts in regard to the local juvenile detention facilities. The OCECD October 2005 report found communication between school districts and facilities was often poor and payments under RC 2151.357 either are not appropriately ordered by the court or school districts refuse to pay them.

d. Special Education

There are two areas where other state and federal laws affect the educational programs that local juvenile detention facilities should be providing to youth housed there. First, RC 2152.42 requires that the education programs have competent and trained staff. Presumably, this requires the hiring of certified teachers, though this is not explicit in the text of RC 2152.42. Teacher certification is a matter for the state's Board of Education and ODE. Any teaching staff hired by detention facilities is subject to the statutes and regulations concerning teacher certification. This condition applies to all teachers, including teachers providing special education services.

The second area is in the provision of special education services as required by the federal Individuals with Disabilities Education Improvement Act (IDEIA), 20 U.S. §1400 et seq. and state statutes enacted pursuant to IDEIA. The IDEIA requires that "all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for employment and independent living." 20 U.S. 1400(d)(1)(A). In order for states to receive federal funding for special education programs, as the state of Ohio in fact does, the state must ensure that:

[a] free appropriate public education is available to all children with disabilities residing in the State between the ages of 3 and 21,

inclusive, including children with disabilities who have been suspended or expelled from school.
20 U.S. 1411(a)(1)(A).

IDEIA is a constraint on local juvenile detention facilities as federal law preempts contradictory or inconsistent state law. As RC 2152.42 mandates only a comparable education when possible, it is inconsistent with federal special education legislation that requires disabled children to receive appropriate special education and related services tailored to their individual needs. IDEIA's requirements are designed to apply regardless of where a child is receiving an education. Ohio has enacted statutes designed to implement the mandates of IDEIA. These statutes are found in Chapter 3323 of the Revised Code. These provisions would also apply to the structure and requirements of all special education services provided by local juvenile detention facilities. Thus, local juvenile detention facilities should be following federal and state law and providing special education services according to each child's Individualized Education Plan (IEP).

II. Department of Youth Services

a. Statutory Authority

DYS was created by RC 5139.01. The department is headed by a director appointed by the governor with the advice and consent of the Senate. RC 5139.01. The primary duty of the department is to “[r]eceive custody of all children committed to it under Chapter 2152 of the Revised Code, cause a study to be made of those children, and issue any orders, as it considers best suited to the needs of any of those children and the interest of the public, for the treatment of each of those children.” RC 5139.04. To that end, the department “control[s] and manage[s] all state institutions or facilities established or created for the training or rehabilitation of delinquent children committed to the department, except where the control and management of an institution or facility is vested by law in another agency.” RC 5139.03.

The court, as a sentencing option, may commit children to DYS. See RC 2152.16, 2152.17. “Commitment” is defined as the “transfer of the physical custody of a child or youth from the court to the department of youth services.” RC 5139.01(A)(1). When a child is permanently committed, legal custody of a child is transferred to DYS. RC 5139.01(A)(2). When the department is granted legal custody of a child, the department incurs a multitude of rights and responsibilities, including the responsibility to provide the child with an education. RC 5139.01(A)(3). The department has created schools within their facilities to provide these children with an education. These schools have been organized as a school district that falls under the authority of ODE. Any child committed to the department would then be deemed to reside within the DYS school district. [See RC 3313.64(A)(4) and (B) – a child’s district of residence changes when placed in a “home,” which is defined to include an institution maintained by DYS.]

b. Education Programming Requirements

Each DYS facility maintains a school to serve the educational needs of youths residing in the facility. There are eight DYS schools, most serving grades 7-12. The smallest school served approximately 100 students and the largest has over 300.

Given the constraints of providing educational programming within a correctional setting, ODE has promulgated regulations that specifically address educational program standards within DYS facilities. These standards are found in Ohio Administrative Code Chapter 3301-30. These regulations address a variety of topics including, but not limited to: testing, courses to be taught, graduation requirements, hours of the school day and number of school days per instructional year, teacher requirements and the provision of special education programming. Each school is required to have an educational administrator who is to annually evaluate the educational programming at their location. OAC 3301-30-03(E). This evaluation is then reviewed by ODE, which is also supposed to conduct an on-site evaluation every three years.

As the schools within the DYS are organized as a school district, subject to ODE regulations, all schools are required to be in compliance with the IDEIA and all Ohio statutes and regulations concerning the provision of special education programming and related services.

It is clear that local juvenile detention facilities and DYS facilities are required by both federal and state law to provide special education and related services. However, their ability to do so is constrained by having two competing services to provide: correctional services and educational standards. The correctional services mission often wins out, creating a system where educational programming is curtailed to fit the correctional purposes of the facilities. Special education services are particularly at risk of being short-changed as was seen in the October 2005 OCECD report, as referenced below, about the limits of special education programming in Ohio's local juvenile detention facilities.

III. Findings and Recommendations of Investigation into Ohio's Local Juvenile Detention Facilities

In addition to being vastly overrepresented in the incarcerated juvenile population, special education students often do not receive adequate special education and related services. In October 2005, the Ohio Coalition for the Education of Children with Disabilities (OCECD) delivered a report to the Ohio Department of Education entitled *Services for Students with Disabilities in Ohio's Local Juvenile Detention Facilities*. This report provided the results of a survey of 36 of Ohio's 40 local juvenile detention facilities. The October 2005 report provided information on the availability of special education programming in these facilities and found that local juvenile detention facilities are often not providing special education services to students. While there are a variety of reasons for this lack of programming, including resource limitations, the results helped prompt this current examination of policies and programs designed to keep children with disabilities out of the juvenile corrections system.

Some of the key findings and recommendations directly relevant to juvenile justice and special education contained in the October 2005 report are summarized below. These findings help illustrate that the juvenile justice system is not a place designed to address the educational needs of special education students. In addition to issues specific to the provision of special education

services, there were several issues related to educational programming in general, primarily because in so many of these facilities special education students are being served in general education classrooms.

- 1. Wide Variety in the Length of the School Day.** The length of the school day varied greatly, from 2.5 hours to 6.5 hours. Most facilities (25 out of 36) fell between 3 hours and 5.5 hours. By way of comparison, the Ohio Department of Education requires that children in grades one through six receive at least five hours of instruction each day and children in grades seven through twelve are supposed to receive at least 5.5 hours per day. R.C. 3313.48 (2006); Ohio Adm. Code 3301-35-06 (2006).
- 2. Long Waiting Period Before Placed in School.** While twenty-five (25) facilities reported that students are placed in school immediately following admission, some facilities require a waiting period before placing the students in class. Examples of these waiting periods include one facility where students were not placed in classes until after their first court appearance and two facilities that did not place students until after a 48-hour holding period. This is a particularly significant issue given the short duration of most students stay, with twenty-four (24) of the facilities surveyed reporting an average length of stay between 6 to 15 days.
- 3. Large Funding Disparity for Educational Programming.** The report also revealed a funding disparity between facilities for their educational programming. Educational programming is supposed to be paid for by billing the student's local school district on a per diem basis. R.C. 2151.357 (2006). The amount that the facilities were billing varied greatly, from \$13.50 to \$52 per day (\$2,457 per 182-day year to \$9,464 per 182-day year). Five facilities reported that they did not bill the local school districts at all. Several facilities noted that they often had to cover portions of their educational programming through their facility budgets. The facilities also reported that they had difficulty collecting the per diem from local school districts as some of the districts often refuse to pay, despite the court order.
- 4. Facilities Do Not Receive or Utilize Students' Individual Education Plans (IEPs).** Facility directors were unable to report the number of special education students in their facilities, with estimates ranging from 10% to as high as 80%. A primary reason that directors might not know how many special education students they serve is that the facilities do not receive educational records on the students, including a special education student's Individual Education Plan (IEP). Thirteen facilities reported that they never receive IEPs. Only four facilities reported receiving IEPs on a regular basis. Twenty-three (23) facility teachers reported having access to IEPs when local school agencies sent them. Only 14 teachers reported that they attempted to integrate parts of the IEPs into their instruction. Of the 36 facilities, only two regularly conducted IEP meetings to redraft IEPs for students admitted to the facility.
- 5. Lack of Special Education Classrooms and Certified Special Education Teachers.** Of the 36 facilities surveyed, only one facility has a self-contained special education classroom. In all other facilities, special education students are educated in the same classrooms as

nondisabled students. While all facilities are staffed with certified teachers, only 11 out of the 36 facilities, approximately 31%, have a certified special education teacher on staff.

- 6. No Provision of Related Special Education Services.** Most facilities do not provide related special education services, such as physical therapy, occupational therapy and psychological services. Only four facilities reported that one or more related services were available through the local school agency if needed. While facilities do have access to counseling services, these services were not directly tied to students' IEPs.

As a result of these findings, the October 2005 report made several recommendations for action to be taken by the Ohio Department of Education, local juvenile detention facilities and local school districts. The recommendations focused on clarifying legal roles and responsibilities, requiring facilities to meet current legal requirements, requiring that facilities employ certified special education staff and increasing cooperation and communication among these parties. Progress on these recommendations is crucial to providing adequate services to special education students in local juvenile detention facilities. However, as noted previously, these correctional facilities are not designed primarily to be schools. Even if there is marked improvement in the provision of special education services in juvenile facilities, either local or DYS-operated, these facilities are not the ideal situation for any special education student.

Given the overrepresentation of special education students in the juvenile justice system and its inherent unsuitability in providing services to these students, there is a growing call to keep special education students out of the juvenile justice system.

2. Intervention and Prevention Efforts in Ohio: A State Initiative and Program Profile

A review of Ohio's statewide intervention and prevention efforts reveals numerous programs and initiatives, many outlined below, that target students most at-risk of developing behavioral health issues and, ultimately, coming into contact with the juvenile justice system. That being said, few if any, focus exclusively on special education students only. This reality, however, is not inconsistent with what is happening in other states. In a June 2006 issue of *in Forum* entitled, *Juvenile Justice and Students with Disabilities: State Infrastructure and Initiatives*, the results of a 50-state survey revealed that 28 states are involved in one or more prevention programs designed to keep students with disabilities out of the juvenile justice system; however, all the programs described targeted both students with *and* without disabilities. The survey, conducted by Project Forum in collaboration with the Center on Education, Disabilities and Juvenile Justice (EDJJ) and the National Disability Rights Network (NDRN), had 43 state education agencies respond.

Of the respondents, 14 state education agencies (SEAs) described the use of positive behavioral interventions and supports (PBIS), sometimes within both the juvenile justice system and the K-12 education system. Two additional SEAs described similar programs focusing on behavioral management. Other programs described by the state agencies included: anti-bullying programs, day programs serving students at risk of detention placement, school-based mental health programs, mental health "systems of care," drop-out prevention programs, extended-day programming, school assistance teams, safe schools programs, academic intervention services, high school and middle school reform initiatives and adolescent literacy programs.

Twenty-nine of the 43 respondents indicated they had one more programs or initiatives in place to support students with disabilities in the juvenile justice system. Thirteen states indicated they had no such programs. Examples of programs or statewide initiatives specifically targeting this population included: transition consultants, comprehensive reviews of special education services in correctional facilities, professional development for correctional education staff on how to correct and prevent areas of IDEIA noncompliance, an SEA contract with a local institution of higher education to provide technical assistance to the state's department of juvenile justice, PBIS training for both state education agency staff and department of juvenile justice staff, representation by the director of education for the department of juvenile justice on statewide special education taskforces and/or advisory panels and a request to the state legislature to increase special education funding in correctional facilities.

A. How Does Ohio Compare?

Given the prevalence of special needs students, especially those with emotional disturbance and mental health disorders, among those incarcerated in the juvenile justice system, it is important to review Ohio's intervention and prevention programs targeted at diverting children with, and without, special needs or disabilities from coming into contact with the juvenile justice system. Early identification is important in deflecting them from this path. Successful interventions often require a multi-faceted approach involving mental health and social service agencies, schools

and family members. According to Voices for Children of Greater Cleveland, Ohio supports some of the most innovative, evidenced-based alternative care models for young people in the juvenile justice system such as Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Multidimensional Treatment Foster Care (MTFC). What is less clear, however, is how systemic of an approach is employed to treat those most at risk before they come in contact with the juvenile justice system. Outlined below are those statewide programs and initiatives, some examples of inter-agency collaboration and others not, currently under way in Ohio.

I. Collaborative Statewide Intervention and Prevention Initiatives for Ohio's Special Needs and At-Risk Youth

Numerous state agencies play a role in providing services to at-risk children and youth that have either come into contact with, or are at risk of coming into contact with, the juvenile justice system. Those state agencies include the Ohio Department of Health (ODH), the Ohio Department of Mental Health (ODMH), the Ohio Department of Jobs and Family Services (ODJFS), ODE and DYS.

a. The Center for Learning Excellence

In August 2000, Governor Bob Taft announced the formation of the Center for Learning Excellence at The Ohio State University. The John Glenn Institute for Public Service and Public Policy was selected as the home for the Center, working in partnership with the College of Human Ecology and the College of Education. The Center's creation was made possible through a \$550,000 grant from the Ohio Department of Education. Since its inception, the Center has assumed responsibility for supporting and coordinating several state initiatives that contribute to the school success of Ohio's children. The Center's mission is to promote the use of best practices in various areas that impact student learning, including:

- education
- mental health
- substance abuse
- delinquency and violence prevention
- family supports and engagement

The Center for Learning Excellence supports five programs that serve Ohio's children and families:

1. *Ohio Alternative Education Challenge Grant Program.* The Center supports the work of 127 alternative education programs serving children and adolescents from more than 500 Ohio school districts. The Center identifies and disseminates information about evidence-based practices, provides technical assistance consistent with this evidence-based approach and conducts an annual evaluation of the state-wide program. The Center also provides assistance to the elected officials and agency directors who provide leadership for the program. More than 142,000 students have been helped by the alternative education program.

Alternative schools are essentially specialized educational environments that emphasize small classrooms, high teacher-to-student ratios, individualized instruction, noncompetitive performance assessments and less structured classrooms. The purpose of these schools has evolved to provide academic instruction to students expelled or suspended for disruptive behavior or weapons possession or who are unable to succeed in the mainstream school environment.

Alternative schools originated to help inner city youth stay in school and obtain an education. In theory, students assigned to alternative schools feel more comfortable in this environment and are more motivated to attend school. Students attending these schools are believed to have higher self-esteem, more positive attitudes toward school, improved school attendance, higher academic performance and decreased delinquent behavior. As a result, many alternative schools are being used to target delinquent youth. These schools serve the dual purpose of reinforcing the message that students are accountable for their crimes and removing disruptive students from the mainstream. In general, alternative schools assess academic and social abilities and skills, assign offenders to programs that allow them to succeed while challenging them to reach higher goals and provide assistance through small group and individualized instruction and counseling sessions. In addition, students and their families may be assessed to determine whether social services such as health care, parenting classes and other program services are indicated.

While there is a great degree of variation among alternative schools, research demonstrates that the schools that succeed with this population of youth typically have the following elements:

- Strong leadership
- Lower student-to-staff ratio
- Carefully selected personnel
- Early identification of student risk factors and problem behaviors
- Intensive counseling/mentoring
- Pro-social skills training
- Strict behavior requirements
- Curriculum-based on real-life learning
- Emphasis on parental involvement
- District-wide support of the programs

In Ohio, alternative schools are operated primarily by school districts and educational service agencies, often in partnership with juvenile courts and other community-based health and human services organizations.

While the Center for Learning Excellence and ODE track those alternative schools that receive funding under their respective programs, it is unclear what, if any, tracking of alternative schools funded through other sources (e.g., federal grants, tuition-based) is currently under way in Ohio.

2. *Mental Health Initiatives.* The Center for Learning Excellence partners with ODMH in supporting and implementing some mental health initiatives, including:

- ***Access to Better Care Initiative.*** The Access to Better Care (ABC) Initiative focuses on improving the coordination, availability and accessibility of behavioral health services (mental health, substance abuse) for youths. More specifically, the ABC Initiative addresses the behavioral health challenges of Ohio's child-serving systems including: teen suicide, the impact of adolescent behavioral health and drug and alcohol use on school success, children and youth in foster care/child welfare with behavioral disorders and youth involved in juvenile justice with behavioral, emotional and/or substance abuse disorders.

ABC is aimed at prevention, assessment/early intervention and treatment services, with a focus on the importance for family involvement and advocacy in service planning and identification. The ABC Initiative is built on the three principles of *collaboration, parental and family involvement, and accountability*. Programs under the ABC Initiative that deal specifically with services and support to children with behavioral health issues include: Access to Better Care Treatment and Expansion Services and Support; Positive Parenting Program; Incredible Years; Early Childhood Mental Health Professionals; Devereuz Early Childhood Assessment Program; Ages and Stages Questionnaire: Social/Emotional Screening Pilot Program; School and Community Partnerships Grant; Youth Suicide Prevention/Columbia University's TeenScreen Program; Behavioral Health and Juvenile Justice Grant; and Family and System Team (FAST).

These programs are administered through multiple state agencies including ODMH, ODJFS and ODE. At the regional and local level, Ohio's county-based Family and Children First Councils, supported through ODJFS, are a key component in the coordination and delivery of the services under this initiative.

- ***Eliminating Barriers Initiative.*** The Center also assists ODMH in the implementation of the Eliminating Barriers Initiative which is designed to reduce the stigma of mental illness. The Center is currently engaged in training the youth corps of the Ohio Youth and Adult Speakers Bureau to assist in this effort and has piloted this program at several Ohio schools.

3. Partnership for Success Academy. In 1998, Ohio was chosen as one of the five original participants in OJJDP's *Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders Initiative*. The early successes of the Ohio *Comprehensive Strategy* counties led state leaders to invest in the development of a new generation model, Partnerships for Success (PfS), sponsored by the Ohio Family and Children First Cabinet Council. The Center for Learning Excellence created the Partnerships for Success Academy to help Ohio's county-based Family and Children First Councils develop and implement plans to prevent and respond to child and adolescent problem behavior. State-level leadership for the PfS Initiative is provided by Mrs. Hope Taft, First Lady of Ohio, Thomas Stickrath, Director of DYS, and Dr. Michael Hogan, Director of ODMH. The Center for Learning Excellence provides evidence-based training and technical assistance for 33 counties participating in the initiative. The PfS Academy is also assisting a number of counties that have expanded their use of PfS to address broader issues and

problems associated with child and family well-being. The approach is also being used to support transformation planning associated with the ABC Initiative.

DYS serves as the lead agency responsible for the administration and oversight of the PfS Initiative. Funding for the initiative is provided by ODJFS. In FY 2005, Ohio invested \$1.5 million in the program. The Family and Children First Councils that did not receive funding through the state leveraged an additional \$35.6 million dollars through various community support organizations.

The PfS process has been used to improve program and investment decisions that extend well beyond its original purpose:

- The *Ohio Family and Children First Cabinet Council* utilized the process to frame a plan to address all of Ohio's Commitments to Child Well-being.
- Several county *Family and Children First Councils* are using PfS tools to guide all of their planning and decision making activities, changing how they do business on a day-to-day basis.
- The *Ohio Department of Alcohol and Drug Addiction Services* used the PfS process to develop a statewide plan to address Fetal Alcohol Spectrum Disorder (FASD).
- *ODMH* utilized PfS to assist participating Family and Children First Councils, Alcohol and Drug Addiction Boards and Mental Health Services Boards with developing plans for transforming the systems that deliver behavioral health services to children and adolescents.
- *ODMH* has decided to apply the process to the development and implementation of a statewide plan to prevent child and adolescent behavioral health problems from occurring.
- *ODJFS* is using the PfS process to develop a statewide strategic plan to provide services to eligible youth sponsored by the federal Workforce Investment Act (WIA).²

4. Learning Work Connection. The Center for Learning Excellence also operates the Learning Work Connection (LWC), which assists ODJFS in connecting people with the knowledge needed to build an effective youth employment system. LWC is a slight name change from Ohio Learning Work Connection (OLWC), which was a continuation of the School-to-Work/Workforce Development Clearinghouse created in 1996 as part of the State University Education Deans of Ohio Systems Integration Coalition. The Clearinghouse had an established history of providing comprehensive, high-quality information to all stakeholders in the Ohio School-to-Work System, a record of excellence continued by OLWC and LWC. LWC is currently funded by a grant from ODJFS.

LWC clients are local youth councils and other local youth collaboratives who seek to create communities where young people are valued and are given opportunities to make significant, positive contributions. LWC works with a number of partners, including ODE, ODJFS, the

² The Workforce Investment Act of 1998 reformed federal employment, training, adult education and vocational rehabilitation programs by creating an integrated "one-stop" system of workforce investment and education services for adults, dislocated workers and youth.

Strategy Group and the Academy for Educational Development, to provide the highest quality information and practices to their clients.

In cooperation with their partners, LWC serves their clients through technology and expert consultation to deliver key information and practices to prepare all youth for success in school, career and community by:

- Providing online resources, including a library of full-text articles of interest to youth development professionals
- Delivering professional development for system building
- Convening gatherings of practitioners to share effective practices
- Sponsoring innovative projects that pilot new ways engaging youth in their communities

Specific areas of focus under the LWC program include assisting the children of incarcerated parents (a targeted population under the New Strategic Vision for the Delivery of Youth Services), strategies to help youth transition to high-skill, high-wage, high-demand occupations by addressing the needs and concerns of employers, strategies and resources to help WIA staff address the special challenges and needs of foster youth, recruiting and retaining out-of-school youth (truant and drop-out), and ideas for integrating summer employment with school-year services to meet WIA requirements for year-round programming.

5. *Fetal Alcohol Spectrum Disorders Initiative.* The Center for Learning Excellence also provides support for the Ohio Department of Alcohol and Drug Addiction Services and the Fetal Alcohol Spectrum Disorders (FASD) Interagency Steering Committee in the development and implementation of a strategic plan to guide FASD prevention, identification, and treatment efforts statewide. The Center provides technical assistance to the state agencies participating in the initiative, helps in the development and dissemination of prevention messages, and helps to evaluate efforts at the state and local levels.

b. Ohio's Shared State Agency Prevention Framework

In addition to the programs supported through the Center for Learning Excellence, the state of Ohio has also created, in January 2006, the Shared State Agency Prevention Framework. The Shared State Agency Prevention Framework is designed to serve as a blueprint to facilitate better communication and collaboration among state agencies that promote safe and healthy behaviors and lifestyles.

The Framework incorporates 17 strategies identified by an Interagency Prevention Partnership that was developed as a result of a federal State Incentive Grant received by the state for prevention efforts in Ohio. The strategies include: clearly communicated standards, mandates and policies; leveraging financial resources; ongoing prevention training; research-based decision-making; and continued evaluation and analysis.

Many of the youth committed to Ohio's juvenile prisons struggle with alcohol and other drug abuse and mental health issues – issues the Shared Framework are meant to address in order to

intervene before felonious behavior begins. The state agencies involved in the Framework are the Ohio Departments of Alcohol and Drug Addiction Services, ODE, ODH, ODJFS, ODMH, Mental Retardation and Developmental Disabilities (MR/DD), Public Safety, DYS, the Attorney General's Office, the Office of Criminal Justice Services and Ohio Family and Children First.

c. Striving Readers Program

In March 2006, DYS was awarded a \$14 million "Striving Readers" grant from the U.S. Department of Education to raise the reading achievement levels of youth committed to Ohio's juvenile correction facilities. The "Striving Readers" program, an interagency initiative administered through DYS, will provide literacy intervention to struggling readers and provide training for teachers to improve the quality of literacy instruction. According to DYS, youth committed to DYS, on average, read four grade levels below other children their age.

The program is an intensive, daily 90-minute class, in which a group of 12-15 students rotate in to different stations for short blocks of time. The stations include video software, student/teacher one-on-ones, audio books and paperbacks to ensure that students, regardless of learning method, are able to benefit. In addition, literacy instruction will be reinforced and integrated into every academic subject the youth encounters.

DYS will collaborate with ODE to provide a training curriculum for DYS instructors. The Center for Learning Excellence will develop the research evaluation component of the project. As DYS was the only correctional system in the nation to apply for this grant, the results of this study could be the benchmark for literacy programs in juvenile justice systems nationwide. The program is expected to be fully implemented starting in the fall of 2006.

II. Single Agency Intervention and Prevention Initiatives

In addition to the statewide inter-agency collaborations currently under way in Ohio, there are also several single-agency programs, including:

a. ODE Initiative - The Ohio Community Collaboration Model (OCC). ODE has developed, as part of the federally-funded 21st Century Learning Grants, an expanded model for school improvement that moves beyond traditional models. The OCC Model for School Improvement is designed to close achievement gaps, increase graduation rates and improve the well being of Ohio's children. The model is built on collaboration among people and partnerships among organizations. This model makes school improvement a family and community priority.

The OCC Model requires local choices and leadership. The model enables local leaders and their constituencies to "tailor" programs to fit each school's and district's special conditions, needs, problems, opportunities and aspirations. The OCC model has two aims: all children succeed in school and all children are prepared for a successful transition to adulthood.

The target of the model is academic achievement, the central priority for every school. However, it also focuses on the family and community resources that need to be identified, mobilized and

maximized in support of academic achievement, school success and successful transitions to adulthood. Core components include community partnerships, health and social services, parent/family engagement and support, and youth development.

Although this model emphasizes family and community resources, i.e., assets, capacities and opportunities external to the school, it does so without losing sight of the each school's primary missions and accountabilities. For example, while it emphasizes strategic relationships with health and social services, it does not aim to make schools the main provider of services in their communities. Although it emphasizes parent/family engagement and support, in this model schools are not assigned the sole responsibility for this important parent and family work. The main idea is for educators and schools to develop strategic connections with family and community resources. Benefits of the model start with improvements in academic achievement and include other important benefits such as increased school safety, enhanced youth development and reductions in youths' problem behaviors.

b. Special Education Regional Resource Centers (SERRCs) - Ohio Integrated Systems Model (OISM). Ohio's sixteen SERRC centers provide support to school districts statewide in the implementation of OISM, a tiered approach to school improvement and related technical assistance services. Within this delivery model, SERRCs are charged with assisting school districts in the implementation of academic and behavior supports including the development and implementation of school-wide positive behavior support plans and the provision of appropriate mental health services in cooperation with ODE's Office for Exceptional Children and its partners.

c. ODMH Initiative - CAPS Action Task Force. In 2004, ODMH established a broad-based workgroup including psychiatrists, pediatricians, family practice physicians, children's hospitals, mental health boards, families, consumers and other providers to focus on improving child and adolescent clinical care. The formation of this task force was in response to a March 2004 *Cincinnati Enquirer* article which highlighted the gaps in child and adolescent psychiatric services. The CAPS Task Force is using an intensive, guided process to create shared learning opportunities among diverse stakeholders to develop a collective understanding of the problem and concrete solutions to the problem. The task force will develop recommendations to increase accessibility and availability of child and adolescent psychiatric services. The CAPS Task Force is expected to issue its recommendations by August of 2007.

d. DYS Initiatives

i. Mental Health Services/Bureau of Behavioral Health Services – For those students already incarcerated within the DYS system, the Bureau of Behavioral Health Services is responsible for the provision of psychology and psychiatry services. The bureau also provides oversight for these services when youth are on aftercare. The youths entering DYS span the entire mental health continuum, from no psychological difficulties to severe mental illness. At any given time an estimated 30% of the youth in DYS institutions are on the mental health caseload. By definition, this means they are being seen on an ongoing basis by psychology and/or psychiatry staff. At the point of entry to the Reception Center, all youth receive a psychological assessment with the possibility of referral to psychiatry for further evaluation for medication if warranted.

Upon transfer to the institution there are varying levels of mental health treatment services available to assist the youth in becoming stable and productive within their institutional environment. Youth on the mental health caseload are classified as severely, moderately, or mildly mentally ill. In general, these youth are matched to a tiered system of delivery of care that consists of:

- An Intensive Mental Health Unit (IMHU) for male youth at Marion Juvenile Correctional Facility.
- An Intensive Mental Health Program for females at Scioto Juvenile Correctional Facility (projected to open June 2007).

ii. Bureau of Subsidies and Grants: Title II, Title V - The bureau oversees federal grants management and state subsidies to juvenile courts which promote the development and expansion of local, community-based options for juvenile offenders while decreasing the number of youth committed to the department. The state subsidies provide funds for a range of community programs, including RECLAIM Ohio and the Youth Services Grant. Each year, Ohio also receives funding from the federal OJJDP for three grant programs. This funding, in cooperation with the Governor's Council on Juvenile Justice, is also administered by DYS's Bureau of Subsidies and Grants and includes the following two programs that include an intervention and prevention component:

- The **Title II Formula Grant** program provides sub-grants to state and local agencies for programming and services through a competitive application process. Programs may be funded under delinquency prevention, family strengthening, substance abuse, mental health, or alternatives to detention.
- The **Title V Incentive Grant for Local Delinquency Prevention Programs** grant provides funding to local communities participating in the Governor's Partnerships for Success initiative. Funding must be used for prevention and early intervention programs for at risk youth, and/or for youth that have had informal contact with the juvenile justice system for non-violent acts or status offenses.

The bureau's responsibilities related to federal grants include reviewing grant applications, monitoring funded programs for compliance with federal regulations, monitoring program activities, monitoring spending and fiscal integrity, providing on-going guidance and technical assistance, and annual on-site monitoring.

B. Intervention and Prevention - Alternative Care Models

Each of the broader initiatives outlined above utilize different models or approaches to the delivery of intervention and prevention programs.

There are at least three broad categories of alternative care models considered to be effective in the intervention and prevention of youth at-risk of incarceration. These three methodologies are Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Multidimensional Treatment Foster Care (MTFC). Each of these approaches is outlined in greater detail below:

I. Multi-Systemic Therapy (MST)

Multi-systemic Therapy (MST) was developed in the late 1970s to address several limitations of existing mental health services for serious juvenile offenders. These limitations included minimal effectiveness, low accountability of service providers for outcomes and high cost.

Treatment efforts, in general, failed to address the complexity of youth needs, traditionally being individually-oriented, narrowly focused and delivered in settings that bear little relation to the problems being addressed (e.g., residential treatment centers, outpatient clinics). Given overwhelming empirical evidence that serious antisocial behavior is determined by the interplay of individual, family, peer, school and neighborhood factors, it is not surprising that traditional treatments for serious anti-social behavior have been largely ineffective. Restrictive out-of-home placements, such as residential treatment, psychiatric hospitalization, and incarceration, fail to address the known determinants of serious antisocial behavior and fail to alter the natural ecology to which the youth will eventually return. Furthermore, mental health and juvenile justice authorities have had virtually no accountability for outcome, a situation that does not enhance performance.

MST is a goal-oriented treatment that specifically targets those factors in each youth's social network that are contributing to his or her anti-social behavior. Thus, MST interventions typically aim to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers, increase youth association with pro-social peers, improve youth school or vocational performance, engage youth in pro-social recreational outlets and develop an indigenous support network of extended family, neighbors and friends to help caregivers achieve and maintain such changes. Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including cognitive behavioral, behavioral and the pragmatic family therapies.

MST services are delivered in the natural environment (e.g., home, school, community). The treatment plan is designed in collaboration with family members and is therefore family driven rather than therapist driven. The ultimate goal of MST is to empower families to build an environment, through the mobilization of indigenous child, family, and community resources, which promotes health. The typical duration of home-based MST services is approximately four months, with multiple therapist-family contacts occurring each week.

II. Functional Family Therapy (FFT)

FFT is a family-based prevention and intervention program that has been applied successfully in a variety of situations to assist youth and their families. The FFT program is supported by 30 years of clinical research as an evidence-based practice for youth with substance abuse problems or antisocial behavior problems. FFT has been applied to a wide range of youth and their families in various multi-ethnic, multicultural contexts, and with pre-adolescents and adolescents diagnosed with conduct disorders, violent acting out and substance abuse.

In December of 2000, OJJDP issued a Juvenile Justice Bulletin on FFT by the founders of FFT. The OJJDP Bulletin cited recidivism rates for the FFT treated population at just over 20% while

the residential treatment cases had a recidivism rate of approximately 90%. Outcome studies suggest that when applied as intended, FFT can reduce recidivism between 25% and 60%. By following key principles, FFT can reduce or prevent recidivism and delinquency. These results can be achieved at treatment costs well below those of traditional services and interventions.

FFT combines and integrates the principles of established clinical theory, empirically supported principles and extensive clinical experience. An FFT team is made up of 3-8 clinicians who receive intensive, sustained training and ongoing phone supervision over a 12-month period. Over the longer term, a FFT Practice-Research Network allows clinical sites to participate in the development and dissemination of FFT model information.

The model consists of a systematic and multi-phase intervention map that provides a framework for clinical decisions, within which the therapist can adjust and adapt the goals of the phase to the individual needs of the family. The three intervention phases are as follows:

Phase 1: Engagement and motivation

Phase 2: Behavioral change

Phase 3: Generalizations are sequentially linked to specific goals for each family interaction.

The range of treatment is three to 30 sessions over a three-month period, with a median timeframe of 12 sessions. This is consistent with current practice and can be applied across agencies for youth with multiple needs. FFT can be conducted in a clinic setting, as a home based model or as a combination of clinic and home visits. FFT program implementation targets teams of up to eight clinicians who work together by regularly staffing cases, attending follow-up training and participating in ongoing telephone supervision.

III. Multidimensional Treatment Foster Care (MTFC)

MTFC is a cost-effective alternative to regular foster care, group or residential treatment and incarceration for youth who have problems with chronic disruptive behavior. The evidence of positive outcomes from this unique multi-modal treatment approach is compelling. The MTFC treatment model can be implemented by any agency or organization providing services to children with serious behavior problems and their families.

The goal of MTFC programs is to decrease problem behavior and to increase developmentally appropriate normative and pro-social behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care, and mental health systems.

MTFC treatment goals are accomplished by providing:

- close supervision
- fair and consistent limits
- predictable consequences for rule breaking
- a supportive relationship with at least one mentoring adult

- reduced exposure to peers with similar problems

The intervention is multi-faceted and occurs in multiple settings. The intervention components may include:

- behavioral parent training and support for MTFC foster parents
- family therapy for biological parents (or other aftercare resources)
- skills training for youth
- supportive therapy for youth
- school-based behavioral interventions and academic support
- psychiatric consultation and medication management, when needed

There are three versions of MTFC designed to be implemented with specific age groups. Each version has been subjected to rigorous scientific evaluations and found to be efficacious. The programs are: preschool-aged children 3-5 years; latency-aged children 6-11 years; and adolescents 12-18 years. In the various types of MTFC programs, youth are generally placed in a family setting for six to nine months. Foster parents are recruited, trained and supported to become part of the treatment team and provide close supervision and implement a structured, individualized program for each youth. The youth's program is designed by a program supervisor with input from the treatment team.

The information outlined above provides a general overview of three alternative care models. Specific model intervention and prevention programs that fall within these three broader categories are explored later in this report.

3. Best Practices: Representative Examples

To ascertain what might be available to help reduce the overpopulation of special needs youth in juvenile justice facilities, a thorough internet search was conducted of national and Ohio organizations involved with this issue to determine what strategies were being discussed, what support there is for the affected youth and, more specifically, what prevention and intervention programs might exist and the results of any evaluations of their effectiveness.³

There are a wealth of organizations concerned with addressing the needs of special needs youth, at-risk youth, juvenile justice, mental health, substance abuse, co-occurring disorders and combinations of these with nearly 200 identified in this report.⁴ There are also numerous prevention and intervention programs identified and categorized by several of the organizations and other experts.⁵ However, these programs are not aimed solely at at-risk, special needs youth, but rather have been designed to target at-risk youth in general, i.e., youth who are either experiencing or likely to experience negative behaviors such as education failure, truancy and juvenile delinquency – behaviors that can also lead to juvenile justice placements. The various sources rating them use different selection criteria and ranking categories and have a range of program descriptions. Regardless of the mission of groups doing evaluations or their ranking categories or target populations, program selection criteria consistently address reducing risk factors known to cause or lead to delinquent behavior.

To provide an overview of these programs, over 150 programs dealing with all areas of problem behavior from early childhood through adolescence were identified from research papers, agencies and experts. In addition, some 20 organizations, combinations of organizations and individuals have provided various rankings of these programs and identified even more programs. While many of the rankings overlap, it seems likely that well over 500 prevention and intervention programs have been devised for at-risk youth. It is not possible to discern with any preciseness how widely these programs are being implemented, but the evaluators' various rankings can be useful in determining best practices. Even though recently there is interest in revealing which programs have not proven effective, nearly all of the ranked programs were viewed to some degree favorably with the notable exception of the DARE program and one or two others.

A. Representative Organizations and Programs

What follows are: a) seven representative examples of the identified organizations involved with problems that relate to the overpopulation of special needs youth in the juvenile justice system and that have provided information on prevention and intervention programs; and b) three examples of programs that have been ranked by these organizations.

³ For accuracy, when describing organizations/sources and programs, language used on web sites has occasionally been used verbatim.

⁴ Please see Appendix A for list of organizations found.

⁵ Please see Appendix B for sources categorizing programs.

I. Organizations

The seven organizations described below were selected for one or more of the following reasons: the organization is well-known; its rankings are comprehensive and frequently referred to; it supports efforts to improve the juvenile justice system, is concerned with mental health, behavior problems or special needs youth; it has an Ohio connection. Electronic access to the organizations and their program guides is provided.

a. The Office of Juvenile Justice and Delinquency Prevention (OJJDP)

Congress established OJJDP in 1974 to support local and state efforts to prevent delinquency and improve the juvenile justice system so that treatment and rehabilitative services tailored to the needs of juveniles and their families would be available. OJJDP provides national leadership, coordination and resources to prevent and respond to juvenile delinquency. It supports states and communities in their efforts to develop and implement effective and coordinated prevention and intervention programs.

OJJDP has established a Model Programs Guide to assist practitioners and communities in implementing evidence-based programs that cover the entire continuum of youth services from prevention through sanctions. The guide contains program descriptions, evaluation design, research findings, references and contact information. Programs are ranked exemplary, effective or promising based on the evaluation literature of specific prevention and intervention programs, a set of methodological criteria and strength of the findings. The guide lists 16 types of prevention programs including academic skills enhancement, family therapy, cognitive behavioral treatment and truancy prevention. For each of the types, a rationale as to why this intervention is important and necessary is included, resources are listed and programs are identified. For example, in the Academic Skills Enhancement category, OJJDP lists 29 programs including Linking the Interests of Families and Teachers (LIFT), Skills, Opportunities and Recognition (SOAR) and Success for All. Of the 29 programs, 15 were rated Promising, 10, Effective and four, Exemplary. Their data base can be searched ten different ways, including gender, race, age, problem behaviors and special populations.

For Organization: ojjdp.ncjrs.org

For Program Guide: www.dsgonline.com/mpg2.5/mpg_index.htm

b. National Association of State Mental Health Program Directors (NASMHPD)

NASMHPD operates under a cooperative agreement with the National Governors Association and is the only national association to represent state mental health commissioners/directors and their agencies. NASMHPD members are involved in the delivery, financing, and evaluation of mental health services. The principal programs operated, funded, and/or regulated by NASMHPD members serve people who have serious mental illnesses, developmental disabilities, and/or substance use disorders. NASMHPD collaborates with other organizations and individuals, consumers, families and state mental health planning and advisory councils in the areas of intergovernmental cooperation, effective management strategies, providing policy

analysis and development, technical assistance and training in critical areas of policy and practice and identifying and sharing models of excellence on a myriad of topics and issues.

The NASMHPD Research Institute's Center for Mental Health Quality and Accountability was funded by the Substance Abuse and Mental Health Administration (SAMHSA) for three years to synthesize and disseminate information on strategies for implementing and disseminating evidence-based practices in mental health. The Center reviewed 21 publications and journal articles authored by researchers and government agencies from 1998 to 2005 and then updated its work in 2006. It compiled a matrix of 92 programs, with each program's goals and objectives, evidence of effectiveness, availability of technical assistance, evaluation methodology, population focus and sources evaluating. Of these 92, over 50 are intervention programs created for a specific population to address a particular disorder/behavior. The Center did not rank programs but included any rankings by its sources. The matrix organizes the reviews under Prevention, Prevention/Intervention, Treatment and Crisis and also settings – Home, School, Community, and Clinic.

For Organization: www.nasmhpd.org/index.cfm

For Program Guide: systemsofcare.samhsa.gov/headermenus/docsHM/MatrixFinal1.pdf

c. Substance Abuse and Mental Health Administration (SAMHSA)

SAMSHA is an agency of the U.S. Department of Health and Human Services. Its mission is to build resilience and facilitate recovery for people with or at risk for mental or substance abuse disorders. SAMHSA is committed to preventing the onset and reducing the progression of mental illness, substance abuse and substance-related problems among all individuals, including youth. With a budget of nearly \$3.3 billion, SAMHSA funds and administers grant programs and contracts that support states' efforts to expand and enhance prevention programs and to improve substance abuse treatment and mental health service in local communities. Its formula and discretionary grant programs are now focusing on performance measurement and management – holding grantees accountable for performance-based outcomes.

SAMSHA provides the National Registry of Programs (NREPP) that is widely consulted and includes the scientific basis for specific programs and interventions to prevent and/or treat mental health and substance use disorders. NREPP is undergoing a revision that will be finished in early 2007. In addition to presenting outcome-specific information about a wider range of interventions, the new NREPP system will support decision making by providing information across multiple dimensions or types of evidence and will help facilitate the appropriate selection and implementation of programs and practices. It will provide more information about the specific behavioral outcomes that are produced by an intervention and highlight the importance of multiple dimensions of evidence that can support informed decision making including research evidence, readiness for dissemination, implementation history, appropriate populations and settings, and estimated costs, as well as a variety of other descriptive elements.

For Organization: www.samhsa.gov/

For Program Guide: modelprograms.samhsa.gov/template.cfm?page=nreppover

d. Center for the Study and Prevention of Violence (CSPV)

A highly inclusive review of programs was done by CSPV, a research program of the Institute of Behavioral Science at the University of Colorado at Boulder. It was founded in 1992 to provide informed assistance to groups committed to understanding and preventing violence, particularly adolescent violence. It began by identifying 11 model programs that had proven to be effective violence prevention programs, which became known as Blueprints. Soon after, OJJDP became an active supporter of the project and began sponsoring program replications in sites across the United States. Blueprints has grown into a large-scale prevention initiative that not only identifies model programs that reduce or eliminate school behavioral problems, delinquency, aggression, substance abuse and adolescent violent crime and the risk factors predictive of these problems, but also provides training and technical assistance to districts wanting to implement these programs.

In 2005, CSPV created the Matrix of Prevention Programs, a table listing over 350 programs that have been rated by 12 federal and private agencies and researchers. This document describes the set of criteria that has been identified for program inclusion by each agency and also describes the focus of each program (i.e., school-based programs, violence programs, substance abuse programs, etc.). The matrix can aid the practitioner by showing how various programs have been rated across different agencies.

For Organization: www.colorado.edu/cspv/index.html

For Program Guide: www.colorado.edu/cspv/blueprints/matrix/overview.html

e. Center for Learning Excellence (CLEX)⁶

As previously mentioned, the Center for Learning Excellence (CLEX) at The Ohio State University was formed in August 2000. Since that time, CLEX has assumed responsibility for supporting several state initiatives that contribute to the school success of Ohio's children. CLEX's mission is to promote the use of best practices in various areas that impact student learning, including: education, mental health, substance abuse, delinquency, violence prevention and family supports and engagement.

CLEX lists nearly 100 evidence-based programs recommended by 12 research-oriented government agencies, non-profit agencies, and independent publications that have evaluated evidence supporting each program's claims of effectiveness. When available, information on programs includes a primary contact person, observed program effects, treatment population and article citations supporting program effects. Its database can be searched in a variety of ways including age, grade, gender, type of neighborhood, ethnicity, target population, delinquency and substance abuse. CLEX emphasizes that it is critically important when districts are selecting programs that they consider not only the evidence about effectiveness of a program, but also the feasibility of implementing it in the district.

For Organization: www.alted-mh.org/index.html

For Program Guide: www.alted-mh.org/ebpd/index.htm

⁶ Described in detail in previous section.

f. The National Association of State Directors of Special Education (NASDSE)

NASDSE was established in 1938 to promote and support education programs and related services for children and youth with disabilities. It provides services to state agencies to maximize educational outcomes for individuals with disabilities. NASDSE establishes and maintains relations between those responsible for the development of statewide and federal special education programs and those responsible for general curriculum planning at the local, state and national levels. NASDSE also provides professional support to its members and others interested in special education. Among its goals are the improvement of educational results for children with disabilities through education reform and public engagement in those reform efforts; aligned educational services; partnership-based, whole-systems collaboration; effective family-school partnerships and professional development. NASDSE is collaborating with the National Disability Rights Network on a joint “white paper” discussing best practice tools and models, see section g, below, for more information.

For Organization: www.nasdse.org

For Program Guide: www.edjj.com

g. The National Disability Rights Network (NDRN)

NDRN is the nonprofit membership organization for the federally mandated Protection and Advocacy (P&A) Systems and Client Assistance Programs (CAP) for individuals with disabilities. Collectively, the P&A/CAP network is the largest provider of legally based advocacy services to people with disabilities in the United States. It serves a wide range of individuals with disabilities including, but not limited to, those with cognitive, mental, sensory and physical disabilities by guarding against abuse; advocating for basic rights; and ensuring accountability in health care, education, employment, housing, transportation, and within the juvenile and criminal justice systems.

In March 2005, a meeting of national organizations, representatives of other entities and scholars was convened to discuss and address the disproportionate number of children with disabilities in the juvenile justice system. This group agreed that it should move forward with a shared agenda and that the first step would be for the NASDSE and the NDRN to combine forces to develop a “white paper” geared to educators. Included in their report, which will be published in the very near future, will be a Tools for Success section cataloging best practice tools and models. Tools for Success will be available on the National Center on Education, Disability and Juvenile Justice (EDJJ) website: www.edjj.com.

For NDRN Organization: www.napas.org

For Program Guide: www.edjj.com

II. Model Programs/Best Practices Examples

Of the 150 programs for at-risk children identified in the internet search portion of this report, 25 were evaluated by a large number of organizations and experts and were each ranked by 8-15 evaluators, nearly always receiving top rankings. Of the 25, three that include a special-needs focus, are highly rated and/or are being piloted or used in Ohio are described below.

a. Incredible Years

Incredible Years is designed to promote emotional and social competence and to prevent, reduce and treat behavioral and emotional problems in children ages 2-8 to reduce the chance of developing later delinquent behaviors. The program provides three multi-faceted and developmentally based curricula – one each for parents, teachers and children. The parent training emphasizes parenting skills that include using strategies to effectively handle misbehavior and help children learn and build collaborative relationships with teachers. The teacher training concentrates on classroom management strategies, promoting children’s pro-social behavior and school readiness (reading skills) and reducing classroom aggression. The child training includes improving skills in interpersonal problem-solving, anger management and how to succeed in school. The program addresses risk factors including anti-social behavior, cognitive and neurological deficits, hyperactivity, mental health problems and conduct disorders.

Incredible Years has been successful with children from various ethnic groups and diverse socioeconomic backgrounds not only in the United States, but also in Canada and the United Kingdom. It has been shown to reduce child and peer aggression in the classroom, reduce conduct problems at home and school, increase children’s cognitive problem-solving strategies and increase parents’ bonding and involvement with teachers and classrooms. For example, according to standardized reports by teachers and parents, 66% of children previously diagnosed with Oppositional Defiant Disorder/Conduct Disorder whose parents received training were in the normal range at both the 1-year and 3-year follow up assessments.

The program is supported by ODMH and is being piloted in 17 Ohio Counties. For more information on the program: www.incredibleyears.com.

b. Multi-Systemic Therapy (MST)⁷

MST is a family-focused, home-based program for chronically violent, substance-abusing juvenile offenders, 12-17 years of age at high risk for out-of-home placement. Its goals are the reduction of youthful antisocial behavior and criminal activity while achieving a cost savings by decreasing incarceration and out-of-home placement rates. MST is based on the philosophy that the best route to helping youth is through helping their families as families are still valuable resources even though they may have serious needs of their own. The multi-systemic approach recognizes that troubled youth are affected by various systems that are interconnected – individual, family, peer, school and neighborhood – and therefore it is often necessary to intervene in more than one system at a time. It places special attention on factors in the

⁷ Also described in previous section. The terms “programs” “strategies” and “approaches” are sometimes used interchangeably in the literature.

adolescent and family's social networks that are linked with antisocial behavior. The home-based interventions are provided by teams of therapists with small caseloads who are available 24 hours a day, 7 days a week. The average treatment involves about 60 hours of contact during a 4-month period.

MST builds on decades of research about the determinants of antisocial behavior. Extensive scientific evaluations show that it results in: decreased adolescent psychiatric symptoms and substance abuse, improved family relations and functioning and increased school attendance. It is credited with reducing long-term re-arrest rates from 70% to 25%, reducing long-term out-of-home placement from 64% to 47% and considerable cost savings over other social services – up to \$131,000 per youth. Numerous studies have shown that it results in reduced crime. It is used in 25 states, Canada, England, Ireland, New Zealand, Norway and Sweden. In Ohio, which has 13 licensed programs, the Center for Innovative Practices (CIP) in Cleveland Heights is heavily involved with the program. More information on it can be found on CIP's web site: www.cipohio.org/mst/ohiospecific.

c. Promoting Alternative Thinking Strategies (PATHS)

PATHS is a comprehensive program for promoting emotional and social competencies and reducing aggression and acting-out behaviors in elementary-school-aged children while at the same time enhancing the educational process in the classroom. Ideally it should be initiated at the entrance to schooling and continued through Grade 5. The PATHS curriculum, taught consistently throughout the school year, provides teachers with systematic, developmentally-based lessons, materials and instructions for teaching their students how to manage feelings, understand the difference between feelings and behaviors, delay gratification, control impulses, reduce stress, read and interpret social cues, understand the perspectives of others and use steps for problem-solving and decision-making. Primarily in grade 5, the program addresses student study skills and work habits such as classroom listening, organization and planning skills, attention span and academic goal setting.

There have been numerous randomized, controlled studies demonstrating the effectiveness of the PATHS curriculum with various populations including a variety of special needs students - deaf, hearing-impaired, learning disabled, emotionally disturbed, mildly mentally delayed, and gifted and among African-American, Pacific Islander, Native American and white children. Findings from various studies include a 32% reduction in teachers' reports of students' aggressive behavior and a 20% increase in student scores on cognitive skills tests. With special needs students, PATHS has been shown to significantly reduce symptoms of anxiety and depression and to reduce conduct problems.

For more information: www.channing-bete.com/prevention-programs/paths.

4. State Policy Issues and Findings

A. The Need For More Effective, Comprehensive Prevention/Intervention Strategies

To reduce the overpopulation of special needs youth in correctional facilities, Ohio policy makers and practitioners must become aware of the need for, and institute, more uniform and comprehensive strategies to address the problem. In its *Blueprint for Juvenile Justice Reform*, the Youth Transition Funders Group (YTTFG), a network of foundations with a strong focus on the nation's most vulnerable youth, points out that few confined teens are serious offenders, but rather most are charged with non-violent property or drug crimes, running away, truancy, public order violations or missing curfew. Given these facts and the many difficulties of meeting the needs of incarcerated youth with disabilities, as explained in a previous section, many experts think that it makes sense to confine only those who have committed serious crimes to reasonable sentences and to use every means possible to prevent other youth from entering the correctional system. Yet, the National Center for Evaluation and Technical Assistance reports that only 1% of adjudicated juveniles are directed away from juvenile justice facilities.

The YTTFG charges that Ohio lacks a meaningful and considered agenda for juvenile justice reform, that there is no common vision of outcomes among public agencies and private providers, that there is a disconnect among counties and programs across the state, as well as a lack of uniform data systems and that there are disparities in how kids are treated and resources allocated. DYS recently announced plans to standardize procedures, but currently, each of Ohio's 88 counties uses a different assessment tool for sentencing, with youth in one county being incarcerated and youth in another county not being incarcerated when convicted of the same crime. There is also the matter of the high rate of recidivism recently acknowledged by DYS – more than 30% on average over a 3-year period. The likelihood of these issues being addressed without consistent strategies being established both on the state and local levels is not great.

The YTTFG asserts that juvenile incarceration rates are driven by juvenile justice politics and policies, not by juvenile crime, citing that in the 1990's, when the rate of juvenile arrests for violent offenses decreased by 33%, there was a 48% increase in juveniles being confined. In too many cases, the approach to dealing with juvenile delinquency has been to ignore causes and indications of future problem behavior, and then to isolate or separate those committing minor offenses such as truancy until a serious crime is committed. The responses are then often punitive, costly to communities, destructive to the individuals and are too often dealing with symptoms rather than causes. Modifying this approach requires the development and adoption of more effective strategies, including expansions and additions to the strategies recently identified by the Interagency Prevention Partnership, examples of which are discussed below.

I. Increasing Awareness of the Cost/Benefits of Incarceration vs. Prevention and Interventions

Policy makers and practitioners need to better understand the costs of such practices. EDJJ, in its paper *School Failure, Race, and Disability: Promoting Positive Outcomes, Decreasing*

Vulnerability for Involvement with the Juvenile Delinquency System, reports that in 1995 dollars, the costs associated with incarcerating one juvenile ranged from \$35,000 to \$70,000 a year. In its *Blueprint for Juvenile Justice Reform*, YTFG says the amount to house youthful offenders ranges between \$100 and \$300 a day. In Ohio, as reported in a June 5, 2006 *Columbus Dispatch* article, *Plan Aims To Boost Prospects For Youth*, on reducing juvenile recidivism, each incarcerated juvenile costs the state nearly \$200 a day (compared to \$69 a day for an adult prisoner) or nearly \$70,000 a year.

What is even more compelling is to weigh these costs with prevention and intervention program costs. RAND researchers in an Issue Brief, *Proven Benefits of Early Childhood Interventions*, summarize scientifically sound research from their recent study on the economic gains that accrue from investing additional resources in early childhood. They estimate that the net benefits of well-designed early childhood interventions per child served range from \$1400 to \$240,000 depending on the program, i.e., for each dollar society invests, the returns range from \$1.80 to \$17.07. Also, it has been documented that for every dollar spent on the long-evaluated High/Scope Perry Preschool project, taxpayers saved more than \$7 in costs to society. Others do not put a dollar figure on their findings, but savings are implicit. The Children's Action Alliance reports that a 15-year longitudinal study of low-income children placed in a district pre-school program experienced a "33% reduction in the rate of juvenile arrests, a 40% reduction in grade retention, a 41% reduction in the need for special education, and a 29% increase in the rate of high-school completion."⁸

The National Center on Secondary Education and Transition (NCSET), in its February 2006 presentation *Early-onset Delinquency: Steps on the Path to Prison and School Dropout* points out another consideration - that there are often several children at risk in one family. It estimates that sibling intervention can save substantial sums and that interventions need to succeed with only a few high-risk child delinquents to repay program costs for all children served.

Ohio's RECLAIM initiative, an intervention program that funds community-based responses and allows delinquent youth to avoid incarceration at DYS facilities, was implemented in 1995. It has been evaluated by the University of Cincinnati's Center for Criminal Justice Research and shown to be a cost effective alternative for low and moderate risk youth.

Some groups have examined the cost benefits of individual programs and reported on which ones fail to generate more benefits than costs and which ones have a generous return on investment. One of the most complete cost/benefit analyses was done by the Washington State Institute for Public Policy. See especially Exhibit 4: www.wsipp.wa.gov/rptfiles/06-10-1201.pdf. Clearly, it is paramount that a strategy be developed for accurately and determining the wisest use of taxpayer dollars to reduce the number of incarcerated youth.

II. Discovering and Funding "What Works" for Whom

A strategy is needed to address the wise selection of programs and approaches to be funded and implemented for the purpose of reducing juvenile delinquency. It is evident that many currently funded programs have not been seriously evaluated. Increasingly, organizations and experts are

⁸ Meghan Andreyck and Melissa Kline, *School Readiness: A Societal Crisis*, University of Maryland, Baltimore School of Social Work.

pointing out that in the past, too little, if any, attention has been paid to the results of programs put into place, and that ineffective programs have been implemented while proven practices have been ignored. For example, NASMHPD's Research Institute points out that assertive community treatment programs are evidenced-based services that have been around for 20 years, yet many states are still not implementing them. Further, Richard Mendel in *Less Hype, More Help: Reducing Juvenile Crime, What Works – and What Doesn't*, for the American Youth Policy Forum (AYPF), says that some of the most popular programs have actually been demonstrated in careful scientific studies to be ineffective, and yet we continue to invest huge sums of money in them.

Ohio's new Interagency Prevention Partnership has begun to address this issue, mostly through the Center for Learning and Excellence, established in 2000 with a \$550,000 grant from ODE to support Ohio school districts' efforts to educate at-risk youth.

It should be noted that in determining "what works" best, there are different theories about how to target resources. For example, the Center on Juvenile and Criminal Justice (CJCJ), in a 2001 paper *Widening the Net in Juvenile Justice and the Dangers of Prevention and Early Intervention*, urges that scarce resources target youths at the greatest risk – who have three or more justice system contacts. The Center maintains that only 6% to 8% of youth born in any given year will be arrested more than twice and these youth are the ones most in need of intervention. Otherwise, resources will be diluted to intervene with low-level offenders, "widening the net" and causing youths most in need to go unserved. NCSET holds that resources should be directed to what will benefit the community the most and that, many times, the most challenging children are the best investment. Others maintain that resources should be used with a much wider range enabling intervention at the earliest signs of problems. Any strategy then should address which approach should receive what portion of available resources and to what extent these decisions should be on the state or local level or shared.

III. Recognizing the Important Role of Schools

While socio-economic factors play a huge role in children's development, public schools also play a crucial role in the success or failure of special needs youth. As the *Cleveland Plain Dealer* points out in a November 1, 2006 article, entitled *Earlier Help for Troubled Kids*: "Local experience and national research show that many of the children who land in the juvenile justice system arrive with special learning needs that have gone unmet in a traditional school setting. If those needs are identified and addressed by educators, the children have a far greater chance of succeeding in school – and staying out of jail."

The Civil Rights Project established at Harvard University entitled its efforts to reduce the numbers of minority youth being incarcerated the *School to Prison Pipeline*. As EDJJ points out, it would seem that the educational system should be an antidote for poor or unstable home environments. Instead, researchers find that some conditions in schools such as inadequate course offerings and weak adult leadership actually contribute to antisocial behavior. OJJDP adds that poor student-teacher relations, norms and values that support antisocial behavior, poorly defined rules and expectations for conduct and inadequate rule enforcement may also be factors. Examples of where schools play a predominant role are outlined below.

a. Readiness Gap

It is no secret that children arrive at school at all different levels of readiness, some far behind others. For instance, a RAND Issue Brief, *Children at Risk: Consequences for School Readiness and Beyond* reports that substantial gaps are evident in reading and mathematics proficiency, pro-social behaviors, behavior problems, and readiness to learn and that these gaps do not close as data that follow children over time reveal early differences actually expand as children progress through school.

Given adequate resources, public schools can do a great deal to help close the gap, or they can perpetuate the gap because of lack of resources, inaction, or, especially, faulty teaching methods.

b. Screening

Schools are in a position to screen students for various problems. It is so important that special needs children are identified as early as possible, yet, we constantly hear of these children being identified late or once they are identified, not receiving all the services that they should. In addition, teachers are in a position to observe students in a variety of settings and are usually the first to notice health, behavioral health and educational problems. Their role in referrals of children is crucial. Measures have even been developed so that teachers can quickly screen students regarding their level of social adaptation. The Teacher Observation of Classroom Adaptation used in several states is one such measurement. School mental health programs can identify at risk students early allowing intervention programs to reduce behavioral problems, absenteeism and drop outs.

c. Program Selection

Schools are instrumental in the selection of intervention programs, yet Mendel emphasizes in the AYPF report that “in a majority of cases, the programs selected lack evidence of effectiveness and are implemented without strong training or technical support...a federally funded study of school-based prevention programming found that few districts seem to know about or consider research findings when planning their prevention programs and few districts conducted formal program evaluations to assess their program’s effectiveness.” AYPF also points out that of the few districts that did conduct evaluations, even fewer used the results. According to Daniel Losen, in *The School to Prison Pipeline*, a PowerPoint presentation of the Civil Rights Project at Harvard University, “[t]he failure to provide appropriate special education services likely contributes to delinquency among students with disabilities.”

d. Literacy

Literacy is essential to success in school and in life and schools definitely bear the responsibility for teaching reading. However, the teaching of reading is an area where evidenced-based methods often are not selected. For example, the Lexia reading program, developed in the mid 1980’s with support from the National Institute for Child Health and Human Development, was designed to help special needs children, especially dyslexic children. It has been strenuously

evaluated and shown to be highly effective; yet, it is used with only a small percentage of students in Ohio. For years, charges have been made that many of students are designated “learning disabled” because educators have neglected to use methods and programs that some learners need to become successful readers.

e. Overly Punitive Policies

Some observers believe that the policies public school systems have established for referring students for infractions are overly punitive. Some jurisdictions report that almost half of all their referrals to juvenile court originate from schools. Several studies discuss the negative impact that “zero tolerance” policies have had. Enacted to prevent dangerous students from bringing guns to school, these policies have been expanded to permit suspensions, expulsions and referrals to law enforcement for minor infractions, yet EDJJ, in a 2003 paper *School Failure, Race, and Disability: Promoting Positive Outcomes, Decreasing Vulnerability for Involvement with the Juvenile Delinquency System*, maintains that there is no credible data that such policies have resulted in improved student behavior or increased school safety. EDJJ also reports that the disproportionate minority representation in school discipline data has been documented consistently for over 25 years. Losen’s Civil Rights Project presentation shows that in Ohio, black males with disabilities are four times as likely to be expelled as whites and the odds of placement in a correctional institution are 10 times that of white students with disabilities. Recent initiatives such as the Franklin County Prosecutor’s move to bring local officials together to tackle truancy in the Columbus Public Schools and the district’s setting up a separate school for students consistently exhibiting unacceptable behavior are steps that should prove helpful.

IV. The Significance of the Latest Brain Research

Brain research is a relatively new field and recent results are largely unknown to many, yet some findings could prove very beneficial to special needs youth and deserve examination. For example, given that so many special needs youth have difficulty learning to read, realizing that researchers have announced the following might lead to better solutions:

- there is now understanding of how the brain functions during the reading process and of the effect reading interventions have on the neural system;
- parts of the brains of poor readers function differently from those of good readers; and
- the brains of poor readers can begin to function like the brains of good readers following a highly intensive reading intervention.

The latest brain imaging studies could be particularly useful in distinguishing between dyslexic children who are born with a glitch in their reading systems and those who are poor readers as a result of experience, aiding in determining appropriate interventions. Another example of the importance of brain research to special needs at-risk youth as it helps to explain behavioral problems and should impact interventions and placements are studies finding that the human brain does not fully mature before reaching adulthood – age 21 – and that those regions most important for regulating impulse control, consideration of consequences, abstract reasoning and moral judgment are the regions that mature last.

While affecting far fewer youth, there is also the matter of traumatic brain injury and its effects. The Cincinnati Children's Hospital Medical Center is currently involved in three federally-funded research studies investigating intervention following pediatric head injury to understand social environmental influences on recovery and to develop theoretically and empirically driven interventions.

V. Improving Collaboration

Collaboration across systems is a must for helping youth with behavioral disorders. However, experts and practitioners tell us integrated programs are rare. YTFG, in a 2005 briefing paper *Youth and Cross-Cutting Problems*, points out that agency databases rarely “talk” to each other for bureaucratic, resource, confidentiality and technological reasons, and that how a youth enters into the government system tends to determine the services received regardless of need, resulting in youth being relegated to separate and somewhat arbitrary “service tunnels.” Losen in his Civil Rights Project Presentation reports that juvenile justice and school systems often work at cross purposes. Pennsylvania is one exception in that not only has it developed a partnership of cabinet level officials, it has also included business leaders, law enforcement, non-profits and foundations to coordinate local, state, and federal efforts. Ohio's recent initiative to improve collaboration – the Interagency Prevention Partnership - includes only state-level agencies and has no representation from business leaders; juvenile judges, foundations, or practitioners such as directors of special education regional resource centers, the educational service centers or the county Family and Children First Councils.

Individual agency services are often insufficient because of inadequate resources or no mandates to provide more comprehensive services. A 2002 American Institutes of Research paper, *Collaboration in the Juvenile Justice System and Youth-serving Agencies: Improving Prevention, Providing More Efficient Services and Reducing Recidivism for Youth with Disabilities*, postulates that services are fragmented as a result of each agency having individual eligibility criteria, case plans, records and a lack of support to communicate or coordinate with other agencies. The authors also explain that although the same needs for a high-risk youth may be identified by all agencies, agencies may view what is needed differently and that the differing views can lead to multiple assessments and duplication of services.

True collaboration to reduce ineffective, fragmented services and provide what is needed will not be easy as it will fundamentally alter traditional agency relationships. But, if early intervention and prevention efforts are to be successful, services will have to be better integrated and that will require effective collaboration among the various agencies. Developing and implementing comprehensive prevention/intervention strategies for reducing the overrepresentation of special needs youth is a major undertaking, one that will need strong and sustained leadership and support of policy makers and practitioners alike. Knowing that there are available strategies that have been proven successful and that more effective prevention/intervention approaches are being identified will help to inform and accomplish this important task.

VI. Limiting the Institutionalization of Youth with Behavioral/Mental Disabilities

a. Warehousing

In 2004, the U.S. House Committee on Government Reform conducted a survey on the warehousing of children with mental illness and presented the results in a report, *Incarceration of Youth Who are Waiting for Community Mental Health Services in the United States*, at hearings of the Senate Committee on Governmental Affairs. Survey results presented to the Committee showed that in 2003, 15,000 children with psychiatric disorders, including children as young as 7, were incarcerated because there were no mental health services available, that two-thirds of juvenile detention facilities hold youth unnecessarily because of that lack of availability and that every day about 2,000 youth are incarcerated simply because community services are unavailable. These figures represent approximately 8% of all youth involved with detention centers. Seventy-one centers in 33 states were holding mentally ill youngsters with no charges. The president of the American Psychiatric Association testified that many kids who get into trouble should have been in treatment but were not because of lack of services. The Director of New Mexico's Department of Children, Youth and Families said that the data shows mental illness is being criminalized. Professor Tulman, in his aforementioned paper on disability and delinquency, points out that while progress has been made in reducing the institutionalization of people in mental health systems, the rate of incarceration in the juvenile delinquency systems has soared with those incarcerated being predominately youth with disabilities. He holds that there has been a shifting of institutionalization and in the process those with less severe disabilities are now being institutionalized more often than traditionally was the case.

A Bazelon Center Fact Sheet reports that the number of children placed in residential treatment centers is growing exponentially, housing more than 50,000 children nationwide; that despite many documented cases of neglect, physical and sexual abuse and a cost of up to \$700 a day, states continue to funnel children with mental illnesses into this most restrictive system because of few alternatives, and that, in so doing, they are draining resources that could be used to provide more effective community-based mental health services.

b. Overpopulation

Estimates from various reports, papers and experts place the rate of serious emotional disturbance among youth in the general population at 9 to 13%. Yet, between 50 to 75% of incarcerated youth have diagnosable mental health problems. EDJJ in their June 2002 report, *Advocating for Children with Behavioral and Cognitive Disabilities*, sites a study of 2,000 adjudicated youth revealed that nearly 50% had histories consistent with attention deficit hyperactivity disorder. The Center for Disease Control and Prevention points out that nearly 5% of U.S. children 4 to 17 years of age were prescribed medication for emotional or behavioral difficulties in 2005 and that about 6% received some kind of mental health treatment other than medication during that period. OJJDP points out that early-onset offenders often begin at very young ages having multiple mental health problems, but many times are not identified until they are arrested or adjudicated.

c. Inadequate Attention

Children's and adolescent mental health needs have historically been inadequately addressed in policy, practice and research. OJJDP reports that conservative estimates and rigorous scientific

research show that 3 to 6% of the school-aged population needs specialized services because of emotional and behavioral disorders yet only 0.74% of all U.S. students are identified as needing such. The Early Warning Guide produced by the U.S. Departments of Education and Juvenile Justice in 2000, reports that 3 to 10% of children experience significant emotional and behavioral problems. The reasons for under-identification include a lack of standardized criteria about what constitutes this disability, the social stigma attached to it, a lack of funding or appropriate services available and limited research about how to go about making placements.

5. Conclusion: Key Policy Questions and Implications

This study raises significant policy questions that deserve further focus and attention. These questions all relate to gaining a deeper understanding of the reasons why there is an overpopulation of children with disabilities in Ohio's youth correctional facilities and what can be done to reduce the need for future incarcerations.

There can be no doubt that there is a serious overpopulation of special needs youth in Ohio's juvenile justice system. As stated earlier, over 44% of youth incarcerated in the Ohio Department of Youth Services (DYS) correctional system are designated as being in need of special education and related services compared to a statewide average of approximately one in seven students (14%) identified as disabled. This means there are over three times as many special education students in DYS facilities as there are in the general school population.

There are numerous assumptions about why this overpopulation is occurring, many of which have been outlined in this report, but there is limited knowledge or data to support or disprove the assumptions. A growing amount of research and independent evaluation regarding the effectiveness of relevant prevention and intervention programs is focused on the needs of students at-risk of incarceration, but very little on special needs, at-risk youth. It is important for Ohio policy makers and practitioners to learn more about the primary means of preventing the incarceration of students with special education needs, which is the focus of the policy questions outlined below.

Policy Questions and Implications

Creation of a Commission on Special Education and Juvenile Justice

The central recommendation of this report, which is focused fundamentally on problem definitional work and an initial overview of efforts to identify relevant prevention and intervention programs, is the call for the creation of a state level Commission on Special Education and Juvenile Justice. This recommendation serves as an initial step to broaden educational outreach to state policymakers and other relevant stakeholders about the overpopulation of children with disabilities in the state's juvenile justice system.

A state commission can provide an effective forum to bring experts and stakeholders together to gain a more thorough understanding of how students with special educational needs who are at-risk of incarceration are treated currently and how this treatment can be improved through more effective educational programming, including prevention and intervention initiatives, to reduce their ongoing over-representation in the juvenile justice system.

The proposed commission could be convened by either statute or by Executive Order of the governor. It should be comprised of representatives of the Ohio Commission on Juvenile Justice established by Executive Order 01-10T, state and local agencies and departments that have the authority to effect necessary changes, and parents and professionals with the expertise to suggest what changes are needed. It should be funded with sufficient dollars to provide a skilled

facilitator and experienced staff support. The commission should also be charged with writing a final report and recommendations.

Proposed Questions for Commission to Study

The information compiled in this report suggests that to find solutions to the overpopulation problem, the Commission will likely need to address the following questions:

1. What steps can the state take to make the public, elected officials, policy makers and practitioners more aware of the problem of overpopulation of children with disabilities in the juvenile justice system?
2. Should the state fund and direct DYS to conduct an independent evaluation of the costs of incarceration versus intervention and prevention in Ohio? How can policymakers gain a better awareness of the cost/benefits of prevention and intervention vs. incarceration? Policymakers and practitioners need to better understand the true costs juvenile incarceration. In Ohio, each incarcerated juvenile costs the state nearly \$200 a day (compared to \$69 a day for an adult prisoner) or nearly \$70,000 a year.
3. Should the state require the Ohio Department of Education to annually report on student discipline, including incidence rates for children with disabilities and review the correlation between disciplinary actions in schools and the students with disabilities that are incarcerated by both type of offense and disability category?
4. What are the most effective ways to discover evidenced-based “best practices” including those that are most cost-effective?
5. What steps should be taken to prevent the unnecessary institutionalization of youth with behavioral/mental problems? In 2004, the U.S. House Committee on Government Reform conducted a survey and held hearings on the warehousing of children with mental illness. It reported that in 2003, 15,000 children with psychiatric disorders, including children as young as seven, were incarcerated because there were no mental health services available, and that two-thirds of juvenile detention facilities hold youth unnecessarily because of that lack of availability.
6. How can the state of Ohio improve both horizontal and vertical collaboration among the various departments and agencies involved in the intervention and prevention of children with disabilities becoming involved in the juvenile justice system? Collaboration across systems is a must for helping youth with behavioral disorders. However, integrated programs are extremely rare. Ohio’s recent initiative to improve collaboration, the Interagency Prevention Partnership, includes only state-level agencies and has no representation from business leaders, juvenile judges, foundations or practitioners, such as directors of special education regional resource centers, the educational service centers or the county Family and Children First Councils. The commission should give consideration to revising and expanding the membership of the Partnership.

7. What can be learned from reviewing the latest brain research, a rapidly evolving field, as it relates to serving this population? Brain research is a relatively new field, so recent discoveries are largely unknown to many educational professionals, yet some findings could prove very beneficial to special needs youth and deserve examination. For example, there is now greater understanding of how the brain functions during the reading process and of the effect reading interventions have on the neural system.
8. To what extent do Ohio public education policies, including those related to prevention and intervention initiatives, expand and/or reduce the rate of incarceration of students with disabilities?
9. Should public school districts be required to report annually to parents the parents' rights under IDEIA? Many parents may not be aware of their rights under IDEIA and may therefore not advocate effectively for the appropriate services for their children.
10. How can current funding for intervention and prevention services for students with disabilities be utilized more effectively? What is the efficacy of providing targeted funding for intervention and prevention programs for over-represented populations, including SLD and emotionally disturbed? Approximately 49.7% of incarcerated special needs students are emotionally disturbed (compared to approximately 9% in the general special education school population). The second largest category is Specific Learning Disabled (SLD) students at 24.3%.
11. What efforts should be made to ensure the appropriate screening of students with disabilities as part of a more effective early intervention and education strategy? And, for those coming in contact with the juvenile justice system? Should some consideration be given to funding programs to support juvenile courts screening juvenile offenders, making referrals to school officials and then tracking what the district does in response.

Education Management Information System (EMIS) Advisory Board Recommendations

One issue that surfaced repeatedly during this study relates to the flow of student data from school districts to juvenile detention centers and DYS facilities and back to school districts both before and after incarceration. A review of current data collection systems is in order to determine how these can be utilized more effectively.

The EMIS Advisory Board has been charged with making recommendations to ODE for improving EMIS operations. Topics to be addressed in the recommendations by the EMIS Advisory Board include: the definitions used for the data maintained in the system, reporting deadlines, rules and guidelines for the operation of the system adopted by the state board of education and any other issues raised by education personnel who work with the system. Should the duties of the advisory board be expanded to include a review of the key policy questions outlined below?

1. What are the current student reporting requirements for school districts, DYS and local detention centers?

2. What data collection systems are currently utilized by the various state, regional and local agencies involved in special education and juvenile justice?
3. Should DYS and juvenile detention centers be required to report student information through EMIS regardless of length of stay?
4. To ensure better identification of students with disabilities and sharing of information across different agencies within the system, should the state of Ohio establish a date by which all future IEPs will be available in electronic format?

The EMIS Advisory Board should report its findings regarding these questions to the proposed Commission on Special Education and Juvenile Justice.

Additional Policy Issues Identified in the OCECD October 2005 Report: Services for Students with Disabilities in Ohio's Local Juvenile Detention Facilities

In addition to the policy questions and implications outlined above in the current report, OCECD also supports the policy recommendations identified in its October 2005 report, *Services for Students with Disabilities in Ohio's Local Juvenile Detention Facilities*, which was also produced for the Ohio Department of Education. The report provided the results of a survey of 36 of Ohio's 40 local juvenile detention facilities. It also provides information on the availability of special education programming in these facilities and finds that local juvenile detention facilities are often not providing special education services to students for the following reasons: (1) there is a wide variety among facilities in the length of the school day; (2) there is often a long waiting period before children are placed in the educational program; (3) there is a large funding disparity for educational programming among facilities; (4) facilities often do not receive or utilize student Individual Education Plans (IEPs); (5) there is a lack of special education classrooms and teachers; and (6) there is no provision of related special education services. All of these issues are exacerbated by the fact that stays in local detention facilities are often very short.

If the state of Ohio is to address the overpopulation problem in a comprehensive manner, given that many youthful offenders return to the public schools and that there is such a high recidivism rate, it seems it should examine the following specific procedures directly related to how the educational system functions in relation to local juvenile detention facilities and the Department of Youth Services. These recommendations, while separate from those in this report, are related to the overall issues of special education and juvenile justice and the services provided to those children.

The primary focus of these recommendations for policy change relates to the need to improve communication and coordination in the assessment, delivery of services, and related activities between the state, local juvenile detention facilities, and school districts including, but not limited to, the following:

- Require local juvenile detention facilities to: identify students with IEPs as a part of the admission assessment process; coordinate admission activities with the Local Education Agencies (LEAs); refer students without IEPs who may have a disability to LEAs for assessment, while making referrals to the pertinent LEA when facility education staff

identifies a student who may have a disability, but who has not yet been identified by the LEA.

- Require the state to build upon an existing system or establish a new system to track student admittance to and discharges from detention facilities, and ensure that intra-agency systems are in place in the LEA so that special education administrators or their designees are informed of communications about admissions and discharges from the detention facilities.
- Require ODE to communicate annually to LEAs their responsibilities to special education students in juvenile detention facilities and to create communication channels between ODE and detention facilities.

Conclusion

Because of the complexity of the subject matter reviewed in this report, further study and analysis is required prior to the development and implementation of any major policy recommendations resulting in substantial reform to the current system. Creating an opportunity for a thorough public dialogue and government analysis, as recommended in this report, will ensure that the most well developed and efficacious recommendations will be advanced to better serve Ohio's children with disabilities.

Cited Sources

The following is a list of sources specifically referenced in this report. It is not intended to be an exhaustive list of all sources used in preparing the report. For further reading and information on this topic, please consult the sources listed in Appendixes A and B.

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APPENDIX A

ORGANIZATIONS

The following organizations are involved with some aspect of the overpopulation of special-needs youth in the juvenile justice system. These organizations are concerned with the wide range of issues related to special-needs youth, at-risk youth, juvenile justice, mental health, substance abuse, co-occurring disorders or combinations of these. They are resources for those in need of information about or assistance with the various populations. While they serve to help prevent youth from entering the juvenile justice system, because their missions are sometimes broad, many of them also can serve youth already adjudicated.

NATIONAL ORGANIZATIONS

ABA Center for Children and the Law: www.abanet.org/child

Administration for Children and Families: www.acf.dhhs.gov

American Academy of Child and Adolescent Psychology: www.aacap.org

American Bar Association Juvenile Justice Committee: www.abanet.org/crimjust/juvjus

American Correctional Institute: www.aca.org

American Psychiatric Association: www.psych.org

American Psychological Association: www.apa.org/ppo/issues/pschoolbased.html

American Public Human Services Association: www.aphsa.org

American Youth Policy Forum: www.aypf.org

Annie E. Casey Foundation: www.aecf.org

Association on Higher Education and Disability: www.asha.org

Bazelon Center for Mental Health Law: www.bazelon.org

Brain Injury Association: www.biausa.org

Building Blocks for Youth: www.buildingblocksforyouth.org

CASEL (The Collaborative for Academic, Social and Emotional Learning): www.casel.org

Center for Behavioral Health, Justice, & Public Policy, University of Maryland School of Medicine: www.umaryland.edu/behavioraljustice

Centers for Disease Control and Prevention: www.cdc.gov

Center for Effective Collaboration and Practice (CECP): cecp.air.org

Center on Juvenile Justice and Criminal Justice: www.cjcyj.org

Center for Mental Health Services (CMHS), A Component of SAMHSA:
www.samhsa.gov/centers/cmhs/cmhs.html

The Center for Mental Health Services & Criminal Justice Research: www.cmhscjr.rutgers.edu

The Center for the Promotion of Mental Health in Juvenile Justice:
www.promotementalhealth.org

Center for Research on the Education of Students Placed at Risk (CRESPAR):
www.csos.jhu.edu/crespar

Center for School Mental Health Assistance: smhp.psych.ucla.edu

Center for the Study and Prevention of Violence: www.colorado.edu/cspv

Center for Violence Research and Prevention: cpmcnet.columbia.edu/dept/sph/cvrvp

Chapin Hall Center for Children: www.chapinhall.org

Child Welfare League of America: www.cwla.org

Child Welfare Information Gateway: www.childwelfare.gov

Children and Adults with Attention deficit Disorders: www.chadd.org

Children's Defense Fund: www.childrensdefense.org

Children's Law Center, Inc.: www.childrenslawky.org

Circles of Care Evaluation Technical Assistance Center (COCETAC):
www.uchsc.edu/ai/coc/program

Civic Research Institute (CRI): www.civicresearchinstitute.com

Civil Rights Project, Harvard University: www.law.harvard.edu/groups/civilrights

Clifford Beers Foundation: www.charity.demon.co.uk/jmain.htm

Coalition for Juvenile Justice: www.juvjustice.org

Columbia University, Division of Child Psychiatry, Center for the Promotion of Mental Health in Juvenile Justice: www.promotementalhealth.org

Connect for Kids: www.connectforkids.org

Coordinating Council on Juvenile Justice and Delinquency Prevention: www.juvenilecouncil.gov

Council for Children with Behavior Disorders (CCBD): www.ccbd.net

Council for Exceptional Children: www.cec.sped.org

The Council of Juvenile Correctional Administrators (CJCA): www.cjca.net

The Council for Learning Disabilities: www.cec.sped.org

Criminal Justice Initiative - Open Society Institute: www.soros.org/initiatives/justice

Economic Policy Institute: www.epinet.org

Families and Advocates Partnership for Education: www.fape.org

Federation of Families for Children's Mental Health: www.ffcmh.org

Gains Center: gainscenter.samhsa.gov

Girls Justice Initiative: www.girlsjusticeinitiative.org

Health Canada Mental Health Promotion: www.hc-sc.gc.ca/hppb/mentalhealth/mhp/index.html

International Dyslexia Association: www.interdys.org

Institute of Education Sciences: www.ed.gov/about/offices/list/ies/index.html

Institute for Mental Health Initiatives - The George Washington University's School of Public Health and Health Services: www.imhi.org

Institute on Violence and Destructive Behavior: www.uoregon.edu/%7Eivdb

John D. & Catherine T. MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice: www.mac-adoldev-juvjustice.org

Joint Center on Poverty Research: www.jcpr.org

Justice Policy Institute: www.justicepolicy.org

Justice Research and Statistics Association: www.jrsa.org

Juvenile Justice: www.mac-adoldev-juvjustice.org

Juvenile Justice Evaluation Center Online: www.jrsa.org/jjec

Juvenile Law Center: www.usakids.org/sites/jlc.html

Learning Disabilities Association of America: www.lidaamerica.org

National Alliance for the Mentally Ill: www.nami.org

National Association for Children's Behavioral Health: www.nacbh.org

National Association of Protection & Advocacy Systems: www.napas.org

National Association of Psychiatric Health Services/National Association for Children's Behavioral Health: www.naphs.org/youth_services

National Association of School Resource Officers: www.nasro.org

National Association of State Mental Health Program Directors Research Institute, Inc.: www.nasmhpd.org/mental_health_resources.cfm

National Evaluation and Technical Assistance Center for the Education for Children and Youth Who Are Neglected, Delinquent or At Risk: www.neglected-delinquent.org

National Center for Children in Poverty: www.nccp.org

National Center on Education, Disability and Juvenile Justice: www.edjj.org

National Center for Family Literacy: www.famlit.org

National Center for Juvenile Justice: www.ncjj.org

National Center for Learning Disabilities: www.nclld.org

National Center for Mental Health and Juvenile Justice: www.ncmhjj.com

National Center for School Engagement: www.schoolengagement.org

National Center on Secondary Education and Transition: www.ncset.org

National Center for Special Education Research: ies.ed.gov/ncser

National Center for State Courts:
www.ncsconline.org/WC/Education/JuvJusGuide.htm#ModelPrograms

National Center for Youth Law: <http://www.youthlaw.org>

The National Child Mental Health Initiative—Participating Organizations:
www.aboutourkids.org/articles/ncmhi_orgs.html

National Child Traumatic Stress Network: www.NCTSNet.org

National Clearinghouse on Child Abuse and Neglect Information: nccanch.acf.hhs.gov

National Clearinghouse on Families and Youth: www.ncfy.com

National Coalition for the Mentally Ill in the Criminal Justice System: www.ncmhjj.com

National Council on Crime and Delinquency: www.nccd-crc.org

National Council on Disability: www.ncd.gov

National Council of Juvenile and Family Court Judges: www.ncjfcj.unr.edu

National Court Appointed Special Advocate Association: www.nationalcasa.org

National Crime Prevention Council: www.ncpc.org

National Criminal Justice Reference Service: www.ncjrs.org

National Disability Rights Network (NDRN): www.ndrn.org

National Dissemination on Disability Research: www.nddr.org

National Early Childhood Technical Assistance Center: www.nectas.unc.edu

National GAINS Center and National GAINS Center for People with Co-occurring Disorders in the Juvenile Justice System, Policy Research Associates, Inc.: www.gainsctr.com

National Dropout Prevention Center: www.dropoutprevention.org

National Information Center for Children and Youth with Disabilities: www.nichcy.org

National Institute of Corrections: www.nicic.org/Juvenile

National Institute for Early Education Research, Formerly associated with ERIC: www.nieer.org

National Institute of Justice, U.S. Department of Justice: www.ojp.usdoj.gov/nij

National Institute of Mental Health: www.nimh.nih.gov

National Institute of Mental Health: Child and Adolescent Mental Health:
www.nimh.nih.gov/healthinformation/childmenu.cfm

National Institutes of Health: www.nih.gov

National Joint Committee on Learning Disabilities:
www.ldonline.org/njcd/preservice_prep.html

National Juvenile Defender Center: www.njdc.info

National Juvenile Detention Association: njda.msu.edu

National Mental Health Association: www.nmha.org

National Technical Assistance Center for Children's Mental Health, Georgetown University
Center for Child and Human Development: www.georgetown.edu/research/gucdc/cassp.html

National Technical Assistance Center on Positive Behavioral Interventions and Supports:
www.pbis.org

Office of Juvenile Justice and Delinquency Prevention: ojjdp.ncjrs.org

Office of Special Education and Rehabilitative Services:
www.ed.gov/about/offices/list/osers/osep

PACER (Parent Advocacy Coalition for Educational Rights): www.pacer.org

President's New Freedom Commission on Mental Health: www.mentalhealthcommission.gov

Promoting Children's Mental Health:
www.nmha.org/children/children_mh_matters/promoting.cfm

Substance Abuse and Mental Health Services Administration (SAMHSA): www.samhsa.gov

The Technical Assistance Partnership for Child and Family Mental Health:
www.air.org/tapartnership

The Urban Institute: www.urban.org

U.S. Department of Education, Office for Civil Rights: www.ed.gov/offices/OCR

U.S. Department of Education, Office of Special Education and Rehabilitative Services:
www.ed.gov/offices/OSERS/OSEP

U.S. Department of Health and Human Services: www.os.dhhs.gov

U.S. Department of Justice, Civil Rights Division: www.usdoj.gov/crt

U.S. Office of Juvenile Justice and Delinquency Prevention:
www.samhsa.gov/centers/cmhs/cmhs.html

Voices for America's Children: www.voicesforamericaschildren.org

W. Haywood Burns Institute: www.burnsinstitute.org

Washington State Institute for Public Policy: www.wsipp.wa.gov

World Foundation for Mental Health: www.wfmh.org

Youth Law Center: www.youthlawcenter.com

OHIO ORGANIZATIONS

Center for Learning Excellence: altdmh.osu.edu/aboutus/aboutus.html

Center for Innovative Practices: www.cipohio.org

Cincinnati Children's Hospital Medical Center, Division of Developmental and Behavioral Disorders: www.cincinnatichildrens.org/svc/alpha/d/disabilities/default.htm

County Family and Children First Council: www.ohiofcf.org

Council for Exceptional Children/Ohio: www.cec-ohio.org

Health Policy Institute of Ohio: www.healthpolicyohio.org

Juvenile Justice Coalition of Ohio: www.juvenilecoalition.org

KidsOhio.org: www.kidsohio.org

Learning Disabilities Association of Ohio:
www.lidaamerica.org/state_chapters/state_info.asp#OH

Miami University Center for School-Based Mental Health Programs:
www.units.muohio.edu/csbmhp

National Alliance for the Mentally Ill. Ohio: www.namiohio.org

Ohio Alternative Education Advisory Council:
altd-mh.org/challengegrant/advisorycouncil.html

Ohio Association of County Behavioral Health Authorities: www.oacbha.org/index.html

Ohio Association of County Boards of MRDD: www.oacbmRDD.org

Ohio Coalition for the Education of Children with Disabilities: www.ocecd.org

Ohio Commission on Dispute Resolution and Conflict Management: disputeresolutionohio.gov

Ohio Council for Exceptional Children: www.cec-ohio.org

Ohio Department of Alcohol and Drug Addiction Services: www.odadas.state.oh.us

Ohio Department of Education: www.ode.state.oh.us

Ohio Department of Health: www.odh.state.oh.us

Ohio Department of Jobs and Family Services: jfs.ohio.gov

Ohio Department of Mental Health: www.mh.state.oh.us

Ohio Department of Ohio Department of Mental Retardation and Developmental Disabilities
(MR/DD): odmRDD.state.oh.us

Ohio Department of Rehabilitation and Correction: www.drc.state.oh.us

Ohio Department of Youth Services: www.dys.ohio.gov

Ohio Developmental Disabilities Council (ODDC): ddc.ohio.gov/Index.htm

Ohio Federation for Children's Mental Health: www.ohfederation.org

Ohio Justice Alliance for Community Corrections: occo.org/prespage.html

Ohio Legal Rights Service: olrs.ohio.gov/asp/HomePage.asp

Ohio Mental Health Counselors Association: www.ohmhca.org

Ohio Office of Criminal Justice Services: www.publicsafety.ohio.gov/ocjs/ocjs_home.asp

Ohio Resource Network: www.ebasedprevention.org

Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence:
www.ohiosamiccoe.case.edu/about/aboutus.html

Public Children's Services of Ohio: www.pcsao.org

Voices for Children of Greater Cleveland: www.voicesforclevelandschildren.org

APPENDIX B

EVALUATION ORGANIZATIONS

The following organizations have identified, evaluated and ranked prevention and intervention programs designed to reduce risk factors associated with problem or delinquent behavior - behavior that can result in youth, including special needs youth, being placed in the juvenile justice system. Some of these programs evaluated are also effective with youth already adjudicated.

* - Ranks identified programs.

- Provides a matrix.

American Youth Policy Forum (AYPF): www.aypf.org;
www.aypf.org/publications/compendium/index.html

Blueprints: www.colorado.edu/cspv/blueprints *#

The Collaborative for Academic, Social and Emotional Learning (CASEL) *
www.casel.org/about_sel/SELprograms.php
www.casel.org/projects_products/safeandsound.php

Center for Effective Collaboration and Practice (CECP): cecp.air.org/prev-ei/best.asp;
cecp.air.org/preventionstrategies/Default.htm; cecp.air.org/links/ei.asp

Center for Learning Excellence (CLEX): www.alted-mh.org/ebpd

Center for Mental Health Service (CMHS): www.prevention.psu.edu #

Center for Substance Abuse Prevention (CSAP/SAMSHA): www.modelprograms.samhsa.gov *

Communities That Care - Developmental Research and Programs (CTCDRP):
www.channing-bete.com/prevention-programs

Helping America's Youth (HAY): www.helpingamericasyouth.gov/programtool.cfm

Mihalic, Aultman-Bettridge. (2004). A Guide to Effective School-Based Prevention Programs. (Refer to William L. Turk, Editor. Policing and School Crime. Englewood Cliffs, NJ Prentice Hall Publishers, 2003)

National Association of State Directors of Special Education (NASDSE): www.nasdse.org

National Association of State Mental Health Program Directors (NAMSHPD):
systemsofcare.samsha.gov/headermenu/docsHM/MatrixFinal1.pdf #

National Council on Disabilities:
www.ncd.gov/newsroom/publications/2004/educationoutcomes.htm

The National Disability Rights Network (NDRN): www.napas.org; www.edjj.com

National Institute on Drug Abuse (NIDA): www.drugabuse.gov/Prevention/examples.html;
www.drugabuse.gov/pdf/prevention/RedBook.pdf

Office of Juvenile Justice and Delinquency Prevention (OJJDP):
www.dsgonline.com/mpg2.5//mpg_index.htm *

RAND Corporation (RAND): www.promisingpractices.net/programs.asp *

Sherman: www.ncjrs.org/works

Strengthening America's Families (Department of Health Promotion and Education, University of Utah): www.strengtheningfamilies.org *#

SGR - Surgeon General's Report (2001): www.surgeongeneral.gov/library/youthviolence *#

APPENDIX C

Juvenile Justice Lunch Meeting Notes 22 September 2006

Outlined below are notes from a discussion conducted with special education and juvenile justice stakeholders about the overrepresentation of special education students in the juvenile justice system.

Attendees

Margaret Burley - OCECD
Angie Ferdinand – OCECD
Mike Thomas – OCECD
Ed Vandenbulke – Summit County Juvenile Court
Mike Kontura – Cuyahoga County Board of MRDD
Charlotte White – Cuyahoga County Board of MRDD
Mary Sidman – Ohio DYS
Elizabeth Jones – Special Education Services
Mary Ey – Columbus Public Schools
Karen Hall – Franklin County ESC
Bill Ward – Jefferson County Juvenile Court
Greg Browning and staff – Capital Partners

Introductions

After introductions were made around the table, Margaret Burley started the meeting with a brief introduction to our topic and how she became involved in the juvenile justice/special education arena.

Sources of the Problem

Greg Browning then provided an introduction and progress report on the current report. None of the members of the group was surprised to learn that there was an over-representation of special education students in the juvenile justice system. This prompted group discussion about potential sources of the problem. Some of the responses of the group were:

- Kids are labeled as trouble after an incident and have a hard time breaking out of that stereotype, which leads to more frequent interaction with the juvenile justice system.
- School's zero tolerance policy, combined with officers in the schools.
- Parents that do not know how to handle their children. The parents do not possess the right skill set or support system. Oftentimes the family is fragmented, one or more parents are incarcerated or have a criminal past and there is a lot of foster care involvement.

- Behavior plans, IEPs, etc., cannot be carried out beyond the walls of the school. There is too often no reinforcement in the home.
- Mental health system services have been reduced, which means that the system is often under-serving children.
- The severely cognitively disabled are sometimes hard to identify because they've learned how to hide in the population. They don't tell anybody about their disabilities.
- The "contamination" effect – as special education students are placed in school and in juvenile facilities with "trouble" kids, the special education students are picking up "bad habits."
- It is often hard to track these kids and their records and support progress due to their mobility. There is a lot of movement between school systems and the records don't always follow the kids.
- Statewide Mental Health initiative, ABC Initiative, does not address needs of those with autism or more severe mental retardation. This may, in part, account for the increase in the incarceration of those with mental retardation.

Identification Issues

Special education students are often not identified before going into the system. There is an array of privacy issues that prevent courts and facilities from receiving students' records, in addition to schools not being aware that there kids are in the system and general communication breakdowns. A huge problem in Cleveland is the lack of records from the Cleveland City Schools. There are reports that Cleveland may be using an antiquated record keeping system and possibly destroying the records of dropouts, which may be illegal. There is a pilot program in Cleveland that is aimed at identifying students in need of special education services at the court level in the hopes of catching students that have gone unidentified and getting them special education services.

The problem with identification is that even if the children are identified, there is often nothing that the legal or juvenile justice system can do. These facilities are not designed to accommodate education, much less special education.

The difficulty with serving special needs kids in county and regional detention centers is that the length of stay can range from a few days to several months. For shorter stays it is difficult to retrieve school records and provide appropriate educational services.

Schools' Role

There was a general agreement around the table that the child's school is a big factor in this mix. The consensus was that inner city schools are generally not great at providing services and supporting their students. The suburban schools do much better, but not always. Rural schools are a mixed bag. In addition to various resource limitations, this is due in part because schools do not always know what to do. Supporting at risk special education kids is time intensive and costly. The focus when funds are tight is on core academic courses, while many of these at-risk kids need more extensive services. As funding is constrained, the schools tend to move first to

cut people like social workers and counselors, the outside support staff. Schools are often lacking in the resources, both money and human capital, to handle this issue effectively.

Columbus Public Schools New Initiative

Columbus Public Schools (CPS) is adopting a new policy intended to cut down on behavior problems in its schools. CPS will be implementing the positive behavior support model in most of its schools this year. This is a research-based program developed at the University of Oregon that is designed to change a school's climate. After identifying target areas and times of problem behavior, the entire staff creates collective guidelines for how to target and deal with behavior problems. The entire staff is involved, including teachers, administrators, support staff and even custodial staff. There is a coordinated and common approach to issues. This approach is part of the Ohio Integrated Systems Model (OISM) currently being promoted by the Ohio Department of Education. The positive behavioral support model includes an environmental assessment, early literacy intervention, evaluation, and early intervention. The effort is supported by OSBA, COSERRC, Columbus Public and ODE. Cincinnati and Akron City Schools have garnered favorable results using this method – including a reduction in suspensions.

Department of Education

The Ohio Department of Education maintains an Office of Correctional Education. However, this “office” currently consists of a single person who apparently has limited support from the Department, according to some observers. This position is currently funded by DYS and the DRC. It was recommended that this office be strengthened and expanded.

Overview of State Programs

A brief overview of statewide programs was provided. It was pointed out that Ohio has numerous statewide intervention and prevention programs and initiatives that target students most at risk of developing behavioral health issues and coming into contact with the juvenile justice system. Few if any of these initiatives focus exclusively on special education students. There appeared to be consensus that while people are generally aware of broader state initiatives, there is little working knowledge of what is happening at regional and local levels, particularly if these programs are not directly linked to state initiatives or funding.

Affecting Change

There was a general consensus that the pressure for change will have to come from the “top,” meaning from those in organizational leadership and policymaking positions. This is mainly due to the complexity of the problems and the ongoing limitation regarding resources and political will. Despite these realities, there are examples of groups trying to make a difference in their corner of the world. The projects in Cleveland to identify students and to target MRDD kids in the system, the innovation of Summit County diversion program, the work going on in the Columbus Public Schools and the initiative of the Jefferson County Detention Center in investing in computers and related educational programming are good examples. There is a great level of interest in addressing this problem. But the general message was that change will

have to be a coordinated effort and coordination will only happen with pressure and support on a statewide, multi-system level despite ongoing local efforts to encourage constructive change.

One recommendation was replication of programs like Community Intervention Training that educates the front-line people, like police, on how to identify and interact with juveniles with special needs including those with mental retardation, mental illness and severe cognitive disabilities.

Another recommendation was the development and use of a state sanctioned intervention model. Professionals would be required to take continuing education courses to maintain professional credentials.