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A Specialty Court for U.S. Youth Impacted by Commercial Sexual Exploitation

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Abstract

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Background: Specialty courts have emerged as a model of care for U.S. youth impacted by commercial sexual exploitation (CSE) to ensure comprehensive service provision. However, there is a lack of published research that documents the extent to which these programs achieve this goal.

Objective: We sought to understand a specialty juvenile justice court's role in identifying mental health and substance use treatment needs, providing linkages to services, and facilitating stability for youth with histories of CSE.

Participants and Setting: We conducted an exhaustive court file review of the 364 participants in a U.S. based juvenile delinquency specialty court for youth affected by CSE. The observation period spanned 2012-2017.

Methods: The research team systematically transferred data from court files into a secure, electronic database. Descriptive statistics and Chisquared tests were calculated to explore potential associations.

Results: Participation in the specialty court for youth impacted by CSE suggests an increase in identification of mental health and substance use needs and linkages and referrals to mental health and substance use treatment services. In addition, there was increased stabilization as indicated by decreased substantiated child welfare allegations, fewer running away episodes, and placements and criminal involvement.

Conclusions: Specialty courts that incorporate a multidisciplinary, trauma-informed approach offer a promising intervention model for meeting the high treatment needs of youth impacted by CSE.

Keywords

Specialty Court; Trafficking Court; Juvenile Justice; Commercial Sexual Exploitation

Introduction

Commercial sexual exploitation (CSE) of children and adolescents is a global social issue that impacts foreign and domestic-born youth residing in the United States (U.S.) (IOM & NRC, 2013). Sex trafficking, a term which overlaps with CSE, is defined by U.S. law as inducing an individual into commercial sexual activity in exchange for anything of value, through the use of force, fraud, and coercion – unless the individual is less than 18 years old (Trafficking Victims Protection Act of 2000, 2000). In California, Senate Bill 855 defined commercially sexually exploited children as minors who were sexually trafficked or who received compensation for performance of sexual acts (2014).

Within the U.S., children and adolescents identified as victims of CSE are predominantly girls of color (Landers, McGrath, Johnson, Armstrong, & Dollard, 2017; Phillips, 2015). Further, research suggests that histories of CSE among cisgender, heterosexual boys as well as individuals who identify as lesbian, gay, bisexual, transgender, and queer are underreported (Moynihan et al., 2018). Youth with suspected or confirmed histories of CSE often have involvement with the child welfare and juvenile justice systems, both as a precursor to CSE and as a result of CSE victimization (Anderson, England, & Davidson,

2017; Mitchell, Finkelhor, & Wolak, 2010; Cimino et al., 2017; Walker, 2013). Other salient risk factors for CSE include histories of childhood abuse or neglect, running away or homelessness, low socioeconomic status, mental health disorders, and substance use (Greenbaum & Crawford-Jakubiak, 2015; IOM & NRC, 2013).

Across the U.S., youth experiencing CSE were historically arrested and detained on "prostitution" charges (Epstein & Edelman, 2014; Finklea, Fernandes-Alcantara, & Siskin, 2015; Walker, 2013). Within the past decade, however, significant efforts have been made through Safe Harbor legislation that decriminalize youth victims of CSE and divert them to specialized services (Barnet et al., 2016). Although there is great variability regional and jurisdictional approaches to implementation, by 2018, 34 U.S. states had implemented Safe Harbor legislation to address the growing challenge of youth impacted by CSE (Barnet et al., 2016; U.S. Department of State, 2018). Unfortunately, despite the strides made by Safe Harbor legislation, many youth impacted by CSE continue to come into contact with the juvenile justice system due to charges of theft, truancy, running away from home, providing law enforcement with false identification, or other status offenses which may be more indicative of CSE than intentional criminal behavior (Anderson, England & Davidson, 2017; Andretta, Woodland,Watkins & Barnes, 2016; Finklea, et al., 2015; Reid & Piquero, 2014; Saar, Epstein, Rosenthal & Vafa, 2015; Sherman, 2013). Furthermore, experiences of CSE can contribute to illicit substance use by youth, often as a coping mechanism or in response to threat or coercion, which can also directly lead to justice involvement (Carpenter & Gates, 2016; Deshpande & Nour, 2013). Traditional responses to these behaviors, such as punitive treatment within the justice system, may inadvertently retraumatize youth victims of CSE, leading to poorer outcomes and higher healthcare needs (Epstein & Edelman, 2014).

The innovation of specialty courts for youth reflects one recent approach by U.S. juvenile justice and child welfare agencies to intervene on behalf of youth impacted by or at-risk for CSE. These specialty courts have emerged in response to: (1) the need to increase identification of youth impacted by CSE (Epstein & Edelman, 2014; Liles, Blacker, Landini & Urquiza, 2016); (2) recognition of the importance of diversion and decriminalization for these youth; and (3) the need to provide multimodal, trauma-informed care, anchored by a multidisciplinary team to facilitate linkage to treatment and services (Powell, Asbill, Louis, & Stoklosa, 2018). Juvenile justice-based specialty courts, which include but are not limited to juvenile mental health courts, juvenile drug courts, and girls' courts, are an emerging model of court supervision which recognizes the behavioral and environmental factors affecting youth and prioritizes treatment and linkage to care. Specialty courts employ a non-adversarial, non-punitive approach to connect youth to rehabilitative and therapeutic services (Callahan, Cocozza, Steadman, & Tillman, 2012; Liles et al., 2016; Porter, Rempel & Mansky, 2010). Specialty courts for youth impacted by CSE are anchored within the larger framework of problem-solving courts within the juvenile justice system and typically aim to address the complex psychosocial problems and multifactorial needs of systems-involved youth and their caregivers (Callahan et al., 2012).

Although there is a paucity of empirical research describing the effectiveness of trauma-informed, gender-specific approaches in juvenile justice courts, some qualitative work exists. Morasch (2016) conducted a qualitative study with 27 adolescent girls involved in a

treatment-oriented juvenile specialty court in the state of Michigan who exhibited similar backgrounds and charges associated with CSE (Andretta, Woodland, Watkins, & Barnes, 2016; Lederer & Wetzel, 2014; Saar, Epstein, Rosenthal, & Vafa, 2015). While some girls reported that interventions solely focused on behavior change were not helpful, they viewed court interventions that referred them to services as helpful in addressing their experiences of victimization. Their perspectives highlight the importance of service referral and provision among justice-involved girls in juvenile courts (Morasch, 2016). Additionally, another qualitative study conducted on a specialty court for youth with histories of CSE in Sacramento County found that court professionals recognized the benefit of consistency within the court, such as having the same judge, public defender, and district attorney, which helped youth establish meaningful connections with their team (Liles, Blacker, Landini, & Urquiza, 2016). The consistency of specialty court professionals provides an environment where survivors may build trusting relationships with adults, which has been suggested by prior research to play an important role in exiting and not returning to CSE (O'Brien, 2018).

Empirical evidence is lacking to guide and measure the application of the specialty court model to youth with histories of CSE. Little is known about the demographic, psychosocial characteristics, and health needs of youth impacted by CSE who are served in these settings (Cook, Barnert, Ijadi-Maghsoodi, Ports, & Bath, 2018). Additional knowledge gaps include the effectiveness of specialized services on psychosocial and legal outcomes for youth who participate in these courts compared to their peers, including potential unintended negative consequences of specialty courts (e.g. longer lengths of systems involvement) and how to measure success. Understanding these aspects can guide best practice approaches for serving youth with histories of CSE within specialty courts, and within juvenile justice settings in general. For youth impacted by CSE, involvement in the juvenile justice system can provide key links to healthcare, and courts can facilitate additional linkages to housing and educational services (Barnet, Kelly, Godoy, Abrams, Rasch, & Bath, 2019; Cook et al., 2018). Additionally, as specialty court settings can provide a means to access a sizable population of youth impacted by CSE, gathering data in partnership with juvenile courts can enhance our understanding of the health and healthcare needs of child and adolescent CSE victims more broadly (Barnet et al., 2019; Cook et al., 2018), as a large proportion of adolescents impacted by CSE pass through the justice system at some point.

Despite the growing trend of juvenile specialty courts, and the more recent trend of specialty courts tailored for youth with histories of CSE, to our knowledge, no prior research team has formally partnered with a specialty court program for youth impacted by CSE to investigate treatment needs and trajectories. The current study offers a preliminary attempt to explore processes and outcomes, especially as related to behavioral health, within a specialty court for juvenile justice-involved youth impacted by CSE. We examined the Succeeding Through Achievement and Resilience (STAR) Court, multidisciplinary, trauma-informed, specialty court program designed to meet the multifactorial and complex needs of judicially-involved youth in Los Angeles County, California. Specifically, we examined processes and outcomes related to: (1) the identification of mental health disorders and substance use; (2) referrals to educational resources and linkage to mental health and substance use treatment; and (3) legal trajectories and proxies of stability, including court involvement, citation history, child welfare involvement, and placement history.

Methods

Setting and Approach

We conducted an exhaustive case file review of all youth entering the Succeeding Through Achievement and Resilience (STAR) Court from 2012 through 2016. The STAR Court is a voluntary, post-adjudication program for youth who are at-risk or have confirmed histories of CSE. Initiated in 2012, the STAR Court is located in Los Angeles (LA) County, which has been identified by the Federal Bureau of Investigations (FBI) as a high-intensity area for CSE of youth (Mount Saint Mary's University, 2015). The STAR Court brings together multiple systems of care and community-based organizations, providing a novel framework that can be exported to other jurisdictions that may be struggling to address the interrelated needs of youth experiencing CSE.

The STAR Court team facilitates weekly multidisciplinary team meetings that focus on the ongoing assessments of the youths' needs and then links youth to rehabilitative and health-related services, promoting continuity of care for youth. These rehabilitative and health-related services seek to ensure that youth have a safe place to live, are enrolled in school programs that match their educational needs, provide access to trauma-informed mental health counseling, and receive the appropriate medical and dental care, among providing others supports. The STAR Court is comprised of a dedicated judge, public defender, and prosecutor, as well as an inter-disciplinary team of providers including probation staff, social workers who serve as liaisons to the child welfare system, educational advocates, and survivor advocates. Team members are trained in trauma-informed, survivor-centered, and harm reduction approaches and are highly knowledgeable about CSE. The team is available to the youth 24 hours a day, 7 days a week for crises intervention and to assist youth in achieving immediate and long-term goals, including satisfying probationary terms. The STAR Court program utilized federal funding from a three-year block grant during the inception and now relies on pro bono contributions and funding from Title IV-E Foster Care of the Social Security Act (Godoy, Sadwick, & Baca, 2016).

To be eligible for STAR Court participation, youth must be post-adjudication and meet at least one of the following criteria: have prostitution-related charges; have disclosed a history of CSE; or have been suspected as victims of CSE or considered high risk for CSE by law enforcement, family members, or service providers. The court serves youth 12 and over who are English-speaking; U.S. citizenship is not a requirement. Participation in the STAR Court specialty program, as opposed to a non-specialty juvenile court, is voluntary for eligible youth during their probation period.

Data Collection and Analysis

All study procedures were approved by the researchers' university Institutional Review Board and by the LA County's Superior Court Juvenile Division. Data domains included information on participants' demographics; histories of mental health, substance use, and educational support; substantiated child welfare allegations and child welfare placements; involvement in the juvenile justice system; and behavioral healthcare utilization. The data were systematically extracted from youths' court files and entered into a longitudinal,

HIPAA-compliant, electronic database (REDCap). Data were extracted from all the available court files of youth who entered the STAR Court from its inception in 2012 through 2016 (N=364). Court files were reviewed and updated through 2017. There were 291 closed cases by the end of the extraction period, meaning that 291 youth had their probation terminated by the court and, thus, were complete files. The remaining 73 cases were still open at the end of data extraction and were updated through 2017, meaning that these youth were still participating in the court and thus, their data during court involvement were not complete.

When creating variables for analyses, extracted data were divided into two time periods: (i) "baseline" data from before each youth's STAR Court entry date, including information as early as birth, and (ii) data after each youth's STAR Court entry date, referred to as post-STAR Court supervision, which includes data throughout the duration of supervision by the Court. Statistical analyses were performed in R Software (R Version 3.0.0, GNU Project). Descriptive statistics were tabulated for characterizing sociodemographic information and health needs of the sample. Paired t-test analyses were conducted to assess for differences between baseline and post-court supervision measures for key indices of stability, measured by number of delinquency citations, substantiated child welfare allegations, runaway episodes, and out-of-home placements.

Differences from baseline to post-STAR Court supervision for various mental health and substance use metrics were compared based on two categories of court exposure length: 1) youth with at least 6-months, and 2) youth with at least 12-months of court supervision. Cumulative incidence (i.e. proportion of youth newly referred to mental health treatment, substance use treatment, or prescribed medications) were derived for the two court exposure lengths. One-sample proportion tests were used to assess whether cumulative incidence proportions for each of the mentioned three aspects had increased. Stability indicators measured by the number of citations received by youth prior to STAR Court and during STAR Court supervision were gathered for all closed cases (n=291). Mental health data were collected from psychiatric evaluations and mental health department reports. Statistics regarding citations were calculated to include all citations received by youth, regardless of whether the citations were substantiated, dismissed, or reduced to a lesser charge. Paired t-test analyses were conducted for assault, theft, prostitution, bench warrant, and burglary charges to assess differences from baseline to post-STAR court supervision.

Results

Table 1 presents sociodemographic information for the STAR Court participants (N=364), which includes all youth who participated in the STAR Court during the study period for whom court records were available. No youth were excluded from the study. Youth who participated in the STAR Court between 2012 and 2016 were almost exclusively girls of color. and had an average age of 16 years. The mean length of court supervision was 494 days (16 months), the median length of court supervision was 406 days (13.5 months); length of court supervision ranged from 2 days to 67.7 months. The majority of the youth (83%) participated in the STAR Court for at least 6 consecutive months and 60% of the youth participated at least 12 consecutive months.

Identification of Mental Health and Substance Use

Table 2 presents mental health diagnoses for the sample. Psychiatric evaluations were available for 233 youth prior to entry into court and for 265 youth overall by the end of court involvement, meaning that 233 had a psychiatric evaluation at baseline and 32 additional youth received an evaluation post-STAR Court supervision. Youth were referred to psychiatric evaluations by the LA County Department of Mental Health when deemed necessary by the STAR Court team. Among the 265 youth with mental health information available, the most common mental health diagnoses were depression (86%), sleep disorder (52%), and mood disorder (50%). Higher percentages of youth had diagnoses at post-STAR Court supervision compared to baseline for all diagnoses, with the exception of bipolar disorder, as displayed in Table 2. After comparing mental health diagnoses documented at baseline with the number of diagnoses documented post-STAR Court supervision, statistically significant cumulative incidence proportions were found for the following mental health categories: sleep problems (24%, $p<0.001$), depression (13%, $p<0.001$), traumatic stress disorder (9%, $p<0.001$), and mood disorder (9%, $p<0.001$).

High rates of substance use, including polysubstance use, were also documented for STAR Court participants; 46% reported the use of 1-2 substances, 35% reported the use of 3-4 substances, and 8% reported the use of 5 or more substances. Further, comorbidity of substance use and mental health conditions was prevalent among participants. Of youth with mental health diagnoses prior to STAR Court (N=233), 16% had one diagnosis and 84% had two or more diagnoses. Of the 84% of youth with two or more diagnoses, 37% had 2-3 diagnoses, 30% had 4-5 diagnoses, and 17% had six or more diagnoses. Of youth with mental health diagnoses at post-STAR Court supervision (n=265), 12% had one diagnosis, 31% of the youth had 2-3 diagnoses, 33% had 4-5 diagnoses, and 24% had six or more diagnoses.

Service Linkage to Mental Health and Substance Use Treatment

As displayed in Table 3, youth demonstrated significant increases in linkages to mental health and substance use treatment services across the duration of STAR Court involvement compared to baseline. Treatment receipt included but was not limited to mental health services such as individual, group, and family therapy and substance use treatment such as Alcoholics Anonymous, 12-step, and Narcotics Anonymous. For varying court exposure lengths, youth had a substantial increase in being newly prescribed medications while under court supervision. Out of all medication types, youth were more likely to newly receive medication for sleep problems (6-month cumulative incidence = 27%, $p <.001$; 12-month cumulative incidence = 31%, $p <.001$). They were less likely to receive newly prescribed medication for ADHD and bipolar disorder (refer to Table 3). With the exception of ADHD and bipolar disorder, youth with at least 12 months of court supervision had higher cumulative incidence for each medication as compared to youth with only at least 6 months of court supervision.

Out of all mental health treatment services, youth had a higher probability of being newly connected to individual counseling (6-month cumulative. incidence = 67%, $p<.001$; 12-month cumulative incidence =73%, $p <.001$). The mental health treatment service that youth

were less likely to be referred to was psychiatric hospitalization services (6-month cumulative incidence = 4%, p <.01; 12-month cumulative incidence = 6%, p<.01). However, incidence still increased compared to baseline. Additionally, youth with at least 6 months and 12 months court supervision had a higher probability of being newly referred to substance use treatment programs in group homes (6-mo cumulative incidence = 21%, p <.001; 12-mo cumulative incidence = 25%, p <.001). Although significant, youth were less likely to be newly referred to substance use treatment programs in the community at 6 months (7%, p<0.001) and 12 months (7%, p<0.001), and detention facilities at 6 months (2%, p<0.01) and 12 months (2%, p<0.05). Finally, although the differences were not statistically significant, trends indicated that youth were connected to educational services at higher rates from entry to exit of STAR Court. Specifically, an increase in youth receiving an educational advocate from court entry (9%) to court exit (38%) was observed, as was an increase in youth receiving individualized education plans (IEPs) from court entry (21%) to court exit (26%).

Stability Indicators: Child Welfare Contact, Running Away, and Legal Involvement

Figure 1 presents changes in stability indicators before and after STAR Court supervision. Stability indicators over the course of STAR Court supervision were considered to be ongoing legal contacts, as measured by citations, substantiated child welfare allegations, placement counts, and running away episodes. The number of probation citations, substantiated child welfare allegations, runaway episodes and placement counts all decreased among youth from STAR Court entry to post-STAR Court supervision. Most notably, paired t-test analyses revealed that there was a statistically significant decrease (p<.001) in the mean number of citations from baseline (mean=3.5) to post-STAR Court supervision (mean=1.7). This decrease was even more pronounced for the number of substantiated child welfare allegations from baseline (mean=2.6) to post-STAR Court supervision (mean=0.05, p<.001). The mean number of placements at baseline (mean=4.3) was significantly higher than those post-STAR Court supervision (mean=1.8, p<.001). Lastly, the mean number of times youth ran away decreased significantly (p<.001) from baseline (mean=2.2) to post-STAR Court supervision (mean=1.8).

Paired t-test analyses also revealed significant decreases in the mean number of citation subtypes from baseline to post-STAR Court supervision. Namely, the mean number of assault citations decreased from 0.7 at baseline to 0.1 post-STAR Court supervision (p<.001). Decrease in citation subtypes from baseline to post-STAR Court supervision were also witnessed for the mean number of burglary (0.22 vs 0.02, p<.001), theft (0.40 vs 0.10, p<.001), prostitution (0.97 vs 0.17, p<.001) and bench warrant (1.21 vs 1.10, p<.001) occurrences.

Discussion

Our analysis of a specialty court program for youth impacted by CSE reveals important sociodemographic characteristics and treatment needs of this population that should be addressed. We expand qualitative findings (Liles, Blacker, Landini, & Urquiza, 2016; Morasch, 2016; O'Brien, 2018) by offering descriptive analyses and significant associations

gathered from quantitative data on a specialty court for youth impacted by CSE in the juvenile justice system. The majority of youth participants in the STAR Court were African-American and biological females who identified as girls. These findings highlight the heightened risk of CSE for girls of color in the juvenile justice system. The low proportion of male and gender nonconforming specialty court-involved youth underscores a need for future exploration of court interventions and efficacy serving a more diverse population of youth impacted by CSE, in both research and practice. Additionally, youth participants in the STAR Court had a high prevalence and severity of mental health conditions and substance use challenges. Together, these findings highlight the vulnerability and intersectionality of risks faced by youth participating in the juvenile specialty court.

Overall, our findings suggest that the STAR Court may benefit juvenile justice-involved youth who have experienced CSE. Specifically, the main components of the STAR Court's strengths suggested by the current study are: identifying mental health and substance use needs, establishing linkages and referrals to mental health and substance use treatment services, and facilitating stability for youth. Specifically, findings suggest that youth participating in the STAR Court have more stability, as indicated by decreased substantiated child welfare allegations, fewer running away episodes, fewer placements, and less criminal involvement. For instance, there were significant increases in the number of mental health diagnoses and substance use behaviors reported while youth were under STAR court supervision, indicating that the court is able to identify these needs among this population. Furthermore, there were significant increases in referrals for all types of mental health counseling and substance use treatment services once youth entered the STAR Court, indicating a strength of the court as linking youth with histories of CSE to needed healthcare services. Notably, these relationships remained consistent and statistically significant at the 6- and 12-month time periods, as did the increase in identification of mental health diagnoses. Given that many justice-involved youth have significant gaps between treatment need and treatment receipt, the sustained and consistent connection to multiple types of mental health care across time points in our results is noteworthy. Additionally, the increases observed in prescribed psychotropic medications and psychiatric hospitalizations throughout the duration of court involvement indicate that the STAR Court may facilitate more access to higher levels of care among this population.

The significant decreases in citations, placements, substantiated child welfare allegations, and running away episodes from entry to post-STAR Court supervision indicate that the STAR Court may have a protective role in stabilizing youth. The observation that longer lengths of stay in court correlated with decreased citation rates suggests that STAR Court participation may reduce recidivism, as youth in the STAR Court had fewer interactions with the judicial system and detention facilities as court supervision continued. Together, these findings suggest that court-based services that are trauma-informed and individualized for justice-involved youth experiencing CSE may better address their complex health needs, behavioral health barriers, and may reduce risky behaviors (Anderson, England, & Davidson, 2017; Bounds, Julion, & Delaney, 2015; Epstein & Edelman, 2014).

Our findings on the processes and outcomes for youth participants in the STAR Court are consistent with the existing literature that underscore the benefits of consistent, healthy

relationships with a dedicated team of court professionals, and the assessment of and follow through with individualized treatment needs (Garcia & Lane, 2010; Liles et al., 2016; O'Brien, 2018; Vieira, Skilling, and Peterson-Badali, 2009). Findings from the current study support the value of specialty court programs and reinforce the need for a coordinated multi-disciplinary, rehabilitative model of care to serve justice-involved youth impacted by CSE.

Limitations

Several limitations exist that may have impacted the results and the generalizability of the findings to the larger population of youth impacted by CSE. First, unmeasurable factors may have influenced self-selection into the voluntary STAR Court program as the lack of an available comparison group hindered our ability to account for them. As such, our study did not produce causal claims about the effect of STAR court, but rather offers exploratory analyses of data gathered from youth prior to and during their involvement in STAR Court. Second, the LA County Juvenile Court system lacks a centralized database, so information gathered at each hearing was not consistent across STAR Court participants. Third, reliance on administrative records may result in underreporting of mental health and substance use prevalence and severity within our dataset. Fourth, while not purposefully excluded, biological boys and transgender youth were underrepresented. Fifth, the specialty court's eligibility criteria may have excluded a proportion of youth who were cited for charges unrelated to prostitution and who remained unidentified as having been impacted by CSE; thus, the dataset may only have captured a specific portion of youth experiencing CSE. Sixth, youth with open (as opposed to closed) cases might have affected the outcome effect. However, analysis without open cases was also completed and patterns for all the outcomes were similar. Hence, the analyses in this paper included all cases with the aforementioned court lengths. Seventh, since participants volunteered to participate in the specialty court, rather than remain in the traditional court system, self-selection bias may effect on the outcomes of youth involved. Thus, results should be interpreted with caution as differences between pre and post court involvement could be attributed to preexisting factors of these youth who voluntarily participated in the specialty court. Finally, recent changes in legislation that pertains to youth with histories of CSE and their justice involvement may have created secular trends that influenced the study findings. Nevertheless, this preliminary study on outcomes for youth impacted by CSE served in a specialty court highlight directions for future inquiry.

Conclusion

Our review of records from participants in the STAR Court suggest that it is a promising intervention model for meeting the treatment needs of justice-involved youth with histories of CSE. Future research is needed to demonstrate the effectiveness of the specialty court model for youth impacted by CSE. This should include comparing the outcomes of justice-involved youth impacted by CSE served in specialty courts to those who do not have access to specialized court services. Additionally, gaps persist in our understanding of the treatment needs and legal trajectories of males and LGTBQ youth impacted by CSE. Multisite collaboration and expansion of research efforts to enroll more diverse populations would be beneficial to address these limitations. More research is also needed to develop best

practices and recommendations for other jurisdictions that are interested in developing specialty courts for youth impacted by CSE. In summary, these findings underscore that judicially involved youth impacted by CSE have high treatment needs and seem to benefit from a specialty court model of care.

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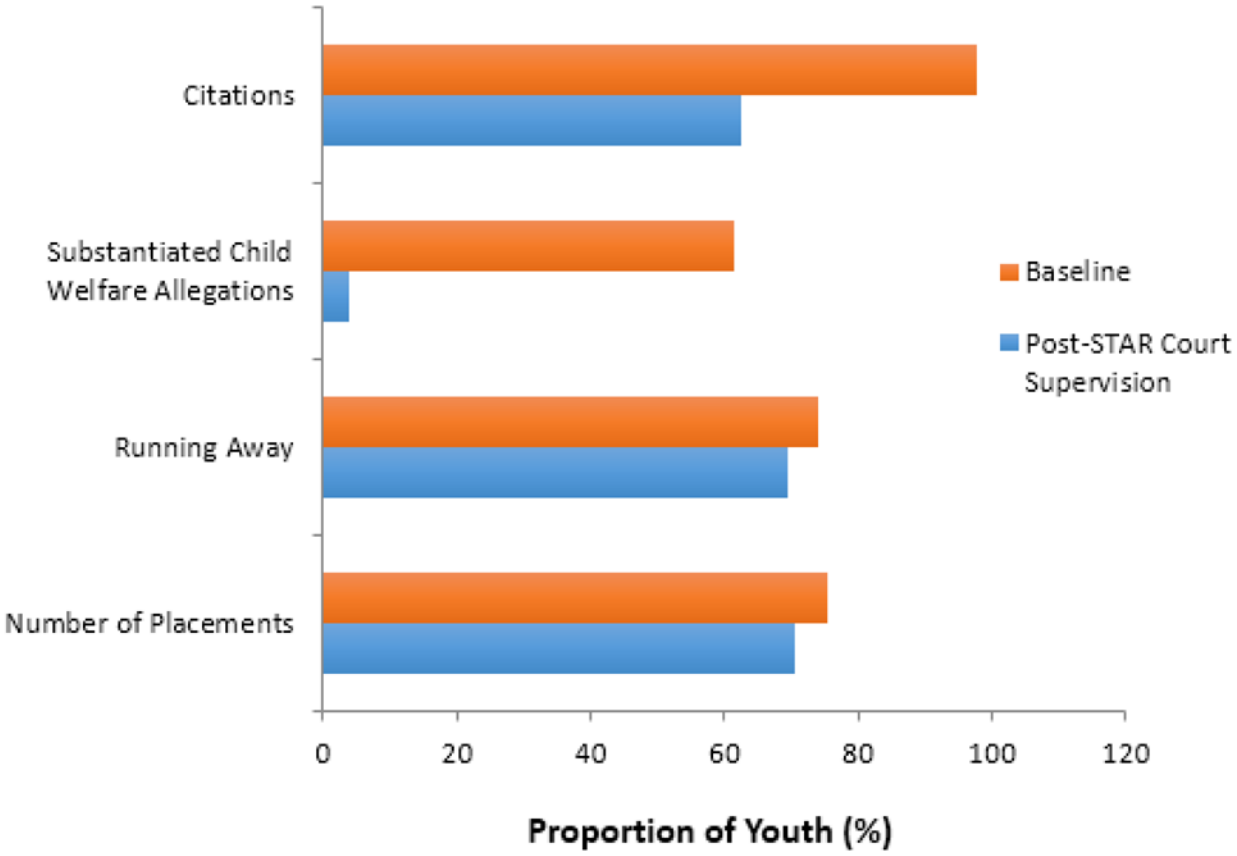

Figure 1.
Indices of Stability for Youth Before and After Court Supervision

Table 1.

Demographic Characteristics

Characteristic	***N***	***%***
Gender		
Female	360	98
Male	2	1
Transgender (M to F)	2	1
Transgender (F to M)	0	0
Race		
African-American	256	70
American Indian	1	<1
Asian	4	1
Other	4	1
White	16	4
Hispanic or Latino		
Yes	83	23
No	281	77
Age (mean±sd)	16	1
Immigration Status		
US Citizen/Naturalized	351	96
Permanent Resident	2	1
Undocumented/Non-Permanent Resident	11	3

Table 2.

Mental Health Diagnoses at Baseline and After Court Supervision (N= 265)

Mental Health Diagnosis	***% Youth at Baseline***	***% Youth Post Court Supervision***
ADHD	30	32
Anxiety	13	19
Bipolar Disorder	32	22
Depression	66	68
Disruptive Behavior Disorder	38	40
Mood Disorder	47	50
Sleep Disorder	30	52
Traumatic Stress Disorder	30	37

Table 3.

Treatment Referrals at 6 and 12 Months (N=364)

	6 months		12 months	
	% Youth	*P-value*	*%Youth*	*P-value*
Mental Health Treatment	--	--	--	--
Anger Management	24	<.001	28	<.001
Family Counseling	45	<.001	52	<.001
Group Counseling	41	<.001	47	<.001
Individual Counseling	67	<.001	73	<.001
Psychiatric Hospitalization	4	<.01	6	<.01
Medication Prescribed Ever	--	--	--	--
ADHD	3	<.01	3	<.05
Anxiety	4	<.001	6	<.001
Bipolar Disorder	3	<.01	3	<.01
Depression	15	<.001	17	<.001
Mood Disorder	8	<.001	11	<.001
Sleep Problems	27	<.001	31	<.001
Traumatic Stress Disorder	4	<.001	5	<.001
Substance Use Referrals	--	--	--	--
Community	7	<.001	7	<.001
Group Home	21	<.001	25	<.001
Incarceration/CAMP	2	<.01	2	<.05