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M E M O R A N D U M

TO: Department of Health and Welfare
Juvenile Detention Administrators
Idaho Judiciary
Idaho Juvenile Justice Commission
State Legislators

FROM: Sharon Harrigfeld, Director

DATE: February 12, 2010

SUBJECT: Detention Clinician Project Research Findings

State fiscal year 2009 marked the second year of a successful collaboration between the state departments of Health and Welfare and Juvenile Corrections. The Detention Clinician project brought both departments together in partnership with county juvenile detention facilities, probation, and courts. This project built on the strengths of the Department of Health and Welfare with its expertise in children's mental health, and on the strength of the Department of Juvenile Corrections with its expertise partnering with counties and community stakeholders.

The information revealed in the attached report developed and presented by Dr. Tedd McDonald from the Boise State University Center for Health Policy points to the critical need for clinical services within juvenile detention facilities.

Some of the highlights of this project revealed in the report include:

- 3 of 4 juveniles entering detention facilities have mental health issues, substance abuse issues, or both.
- Over 17% of the juveniles entering detention facilities were identified by the clinicians as having mental health and/or substance abuse issues previously unknown.
- Over half the juveniles who were recommended for community-based mental health and/or substance abuse issues accessed those services within 15-30 days post release.
- 85% of probation officers and judges reported that information from the clinician affected their decisions for handling cases
- 100% of judges and probation officers indicated strong a desire to see the clinician program continue.
- Nearly 75% of parents reported their child had received at least one of the services recommended by the clinician.

Data collected by IDJC during juvenile detention facility inspections reveals a drop in critical incidents as well as admissions. During a presentation of this report on February 2, 2010, Juvenile Detention Administrators credited the drop in incidents and admissions to the presence of clinicians in the facilities. They also reported increased morale, confidence, and competence of facility staff due to the training and support provided by clinicians.

This report is available on the IDJC Website at: www.idjc.idaho.gov.

Year Two Assessment of the Idaho Department of Juvenile Corrections' Clinical Services Program

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Prepared for the Idaho
Department of Juvenile Corrections

by

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Executive Summary

During the past several years, a program known as the clinical services program (CSP) has housed a mental health clinician in each of the 12 juvenile detention centers (JDCs) in Idaho. During 2007, the CSP was conducted as a pilot with one clinician working in the JDC in Bonneville County; on the basis of encouraging results, the program was expanded to the other 11 JDCs in Idaho for both 2008 and 2009. The principal component of the CSP is to allow clinicians to screen detained juveniles for mental health and substance abuse problems when they are processed into JDCs, and to make provisional diagnoses of these problems when warranted. Other key components of the CSP are for the clinicians to recommend services in the community for juveniles with provisionally diagnosed mental health or substance abuse problems when they were released, and to provide treatment recommendations to judges and juvenile probation officers (JPOs) who work directly with the juveniles. An internal evaluation of the pilot program, conducted in 2007 by clinician Brian Mecham at the JDC in Bonneville County, and a formal evaluation of the expanded program, conducted in 2008 by researchers at the Center for Health Policy at Boise State University, both strongly indicated a need for continued clinical services for detained juveniles. For example, both evaluations indicated that over 80% of detained juveniles who completed diagnostic inventories (the mental health and substance abuse subscales of the Alaska Screening Tool, or AST) and a clinical interview with JDC clinicians, were provisionally diagnosed with at least one mental health or substance abuse disorder. Both evaluations also indicated that the program is well received and supported by the judges and JPOs contacted by the JDC clinicians.

The favorable evaluations from 2007 and 2008 enabled the CSP to be funded for another year, and in 2009 it continued in the 12 JDCs in Idaho. The CSP retained its collaborative nature as a partnership among the Idaho Department of Juvenile Corrections (IDJC), the Juvenile Justice Children's Mental Health Workgroup (JJCMH), and the Idaho Department of Health and Welfare (IDHW). IDJC, which continued to be responsible for oversight of the project, again contracted with researchers from the Center for Health Policy to conduct the Year 2 Assessment (Y2). Similar to the Year 1 Assessment (Y1), the evaluation consisted of data collected in several waves. The first wave involved the collection of data from clinicians at the JDCs; this information included booking charges, mental health and substance abuse screening information, information on previous and provisional diagnoses of mental health and substance abuse problems, and information on service recommendations made by the clinicians. The second wave of data collection involved information gleaned from telephone surveys of parents of juveniles recently released from the JDCs; these surveys asked questions about whether the parents had been contacted by clinicians and given recommendations for services for their children, and whether their children had accessed any recommended services. The third wave of data collection involved information captured from surveys of judges and JPOs, which asked questions about contact by JDC clinicians, the value of recommendations made and information provided, and the value of the program as a whole. The fourth and final wave of data collection, which is new to the evaluation protocol (i.e., it has not been used in either the pilot study or Y1), will involve an internet-based survey of recently released juveniles who had received at least one recommendation for community-based services from a JDC

clinician. IDJC is making this report available prior to the completion of Wave Four. The Wave Four data and their analysis will be published as an addendum and made available on the IDJC website in the spring of 2010.

Key findings from each of the first three waves of data collection are presented below.

<u>JDC Clinician Data:</u>

- **Data were submitted on a total of 1,941 juveniles**
  - **Over 72% of the juveniles on whom data were collected were boys, and less than 28% were girls**
  - **Data on detained juveniles were submitted by clinicians at all 12 JDCs. Data from the JDC in Lemhi County were ultimately not used because the number of cases was so small that confidentiality could have been compromised (thus, the data in this assessment are from 11 JDCs)**
  - **The JDCs that submitted the most data cases included those in Canyon (17%), Kootenai (15%), Twin Falls (14%), and Minidoka (10%) counties. The JDCs that submitted the fewest data cases included those in Valley (1%), Fremont (2%), and Bonner (3%) counties**

- **The most common booking charges for juveniles across all 11 JDCs were "Other crimes" not easily fitting one of the four Uniform Crime Recording codes (many of these were probation violations), property crimes, crimes against persons, and drug crimes**

- **Nearly 60% of all juveniles screened with the Alaska Screening Tool's (AST) mental health and substance abuse subscales met the diagnostic criteria for having a mental health problem**
  - **Girls (at over 71%) were statistically significantly more likely to meet the AST criteria for a mental health problem than were boys (54%)**
  - **Juveniles met the AST criteria for having a mental health problem at statistically significantly different rates across the 11 JDCs**
    - **Indications of mental health problems were highest among juveniles screened at the JDCs in Fremont (76%), Canyon (69%), and Twin Falls (65%) counties. Indications of mental health problems were lowest among juveniles screened at the JDCs in Ada (42%), Valley (50%), and Minidoka (51%) counties**

- **Nearly 46% of all juveniles screened with the AST met the diagnostic criteria for having a substance abuse problem**
  - **Boys (at nearly 48%) were statistically significantly more likely to meet the AST criteria for a substance abuse disorder than girls (less than 41%)**
  - **Juveniles met the AST criteria for having a substance abuse problem at statistically significantly different rates across the 11 JDCs**

- **Indications of substance abuse problems were highest among juveniles screened at the JDCs in Valley (75%), Nez Perce (61%), and Canyon (57%) counties. Indications of substance abuse problems were lowest among juveniles screened at the JDCs in Minidoka (25%), Bonner (32%), and Kootenai (37%) counties**

- **When the combination of AST indications of mental health and substance abuse problems were evaluated, it was found that 75% of all screened juveniles had a mental health problem, a substance abuse problem, or both**
  - **Having indications for both a mental health and substance abuse problem was the most common single combination (at 30%), followed by having a mental health problem only (29%), having neither a mental health nor a substance abuse problem (25%), and having a substance abuse problem only (16%)**
  - **A statistically significant difference existed in combination of mental health and substance abuse indications between boys and girls. Whereas boys were more likely than girls to have indications of neither a mental health nor a substance abuse problem (27% to 21%) and a substance abuse problem only (19% to 8%), girls were more likely than boys to have indications of a mental health problem only (39% to 25%) and both a mental health and substance abuse problem (33% to 29%)**
  - **A statistically significant difference also existed in combination of mental health and substance abuse indications as a function of JDC location**
    - **The most common single combination of indications for juveniles in four JDCs (in Bannock, Canyon, Nez Perce, and Valley counties) was having both a mental health and substance abuse problem. Having a mental health problem only was the most common combination in four JDCs (in Bonner, Fremont, Kootenai, and Twin Falls counties), and having neither type of problem was the most common combination in three JDCs (in Ada, Bonneville, and Minidoka counties)**
    - **Whereas the least common single combination of indications for juveniles in nine JDCs was having a substance abuse problem only, the least common combination in the JDC in Bonner County was having both a mental health and a substance abuse problem, and the least common combination in the JDC in Valley County was having a mental health problem only**

- **Nearly 68% of the juveniles across all JDCs reported during a clinical interview that they had been diagnosed previously with at least one mental health or substance abuse problem. The mean number of previous diagnoses for previously diagnosed juveniles was 1.22**
  - **Boys and girls reported similar mean numbers of previous diagnoses (1.21 and 1.25, respectively)**
  - **A statistically significant difference in mean number of previous diagnoses was found as a function of JDC location**
    - **Mean numbers of previous diagnoses were highest among juveniles in the JDCs in Bonner (1.60), Twin Falls (1.42), and Valley (1.39) counties.**

Mean numbers of previous diagnoses were lowest among juveniles in the JDCs in Fremont (1.00), Kootenai (1.05), and Bonneville (1.06) counties

- **Nearly 86% of juveniles who were screened with the AST and completed a clinical interview were given at least one provisional diagnosis of a mental health or substance abuse disorder. The mean number of provisional diagnoses for all juveniles with at least one provisional diagnosis was 1.43**
  - **A statistically significant difference in mean number of provisional diagnoses given was found between boys and girls. Girls were given more provisional diagnoses (1.51) of mental health or substance abuse problems than were boys (1.39)**
  - **A statistically significant difference in mean number of provisional diagnoses given was also found as a function of JDC location**
    - **The highest mean numbers of provisional diagnoses given were to juveniles in the JDCs in Nez Perce (1.83), Twin Falls (1.75), and Valley (1.72) counties. The lowest mean numbers of provisional diagnoses were given to juveniles in the JDCs in Kootenai (1.05), Bonneville (1.20), and Minidoka (1.26) counties**

- **The most commonly given provisional diagnosis was for a mood disorder, which appeared to affect nearly 48% of the provisionally diagnosed juveniles. Other common provisional diagnoses included substance abuse disorders (39% of those provisionally diagnosed), disruptive behavior disorders (24%), anxiety disorders (17%), and attention deficit disorders (14%)**

- **Recommendations for at least one service in the community were made for 1,567 juveniles, or over 94% of those juveniles who received a provisional diagnosis. The mean number of service recommendations for juveniles who received at least one service recommendation was 1.73**
  - **There was a statistically significant difference in the mean numbers of recommendations for services as a function of JDC location**
    - **The highest mean numbers of recommended services were given to juveniles in the JDCs in Twin Falls (2.52), Bannock (2.24), and Bonner and Fremont (both 1.95) counties. The lowest mean numbers of recommended services were given to juveniles in the JDCs in Ada (1.16), Bonneville (1.20), and Canyon (1.37) counties**

- **The most commonly given recommendation for services was a recommendation for individual counseling (89% of juveniles who were given at least one service recommendation received a recommendation for counseling). Other commonly received service recommendations were for a substance abuse assessment (23%), psychological/mental evaluation (23%), and substance abuse counseling/treatment (17%)**

- **According to information gained by clinicians during a 15-day post-release follow-up call, 834 juveniles, or 53.2% of those who received at least one recommendation for a**

service, had accessed at least one recommended service. The mean number of accessed recommended services among juveniles who received at least one recommendation was .83

- **No statistically significant difference in mean number of recommended services accessed was found between boys (.82) and girls (.85)**
- **A statistically significant difference in mean numbers of recommended services accessed was found as a function of JDC location**
  - **The highest mean numbers of recommended services accessed were found among juveniles released from the JDCs in Bannock (1.70), Twin Falls (1.27), and Kootenai (.96) counties. The lowest mean numbers of recommended services accessed were found among juveniles released from the JDCs in Nez Perce (.00), Minidoka (.05), and Valley (.45) counties**

Parent Survey Data:

- **A total of 273 parents were contacted via telephone by callers from the Idaho Federation of Families for Children's Mental Health. The response rate to the survey was excellent at 72.8%**

- **Twenty-six percent of the parents who responded reported that they had been contacted by the JDC clinician and informed that their child had been identified as a person who could benefit from community-based mental health and/or substance abuse services**

- **Of the parents who reported being informed that their child had been identified as someone who could benefit from services, 76% reported that they were given recommendations for community-based services for their child**

- **The services parents most often reported their children being recommended included mental health evaluation/treatment (37%) and substance abuse treatment/support groups (27%). Over 18% of the parents reported they could not remember what services had been recommended**

- **Nearly 74% of the parents who received at least one service recommendation for their child reported that their child had accessed at least one service**

- **Thirteen parents reported barriers to their children accessing the services they were recommended. Four of these (30.4%) reported that their child refused to access the service, and four reported that the provider refused to provide the recommended service**

Judge/Juvenile Probation Officer Survey

- **The response rate to the survey sent to judges/juvenile probation officers (JPOs) was 30.7%, as 40 of the 130 judges/juvenile probation officers who were sent a survey returned a survey**

- **Eighty percent of the judges/JPOs who completed a survey reported that they were aware that the JDC nearest to them had a mental health clinician working in it**

- **Of the judges/JPOs who were aware of the clinical services program, nearly 73% reported having been contacted by a clinician regarding one of the youth they were working with**
    - **Levels of satisfaction with the contact from the JDC clinicians were very high, as nearly 90% of those judges/JPOs who reported having been contacted were very satisfied (nearly 52%) or satisfied (nearly 38%) with the contact**

- **Of the judges/JPOs who had been contacted by a JDC clinician, 90% reported having been given a recommendation on treatment or decisions from this clinician**
    - **Levels of satisfaction with recommendations provided by the JDC clinicians were high, as nearly 86% of those judges/JPOs who reported receiving at least one recommendation were satisfied (50%) or very satisfied (nearly 36%) with the recommendation(s)**

- **Among the judges/JPOs who reported having received recommendations from the clinicians, 85% reported that the recommendation they received affected a decision or treatment advised for the youth**

- **When asked to judge how beneficial the clinical services program was, the most common response made by the judges/JPOs was "extremely beneficial" (70%), followed by "rather beneficial" (23%). Two judges/JPOs (less than 7%) gave a neutral response, and none reported it to be "not very beneficial" or "not at all beneficial"**

- **When asked whether they would like to see the CSP continue, 100% of the judges/JPOs reported wishing to see it continue**

Comparisons with Year 1 Assessment

The results from Y2 were similar in perhaps most respects with those from Y1. Some noteworthy differences were found, however. These differences are described below.

JDC Clinician Data:

- **In Y1, drug crimes (at nearly 23%) were a more common booking charge than in Y2 (less than 15%)**

- **AST indications of both mental health and substance abuse were higher in Y1 than in Y2**
  - **Mental health indications fell from 68% in Y1 to 59% in Y2**
  - **Substance abuse indications fell from 54% in Y1 to 46% in Y2**

- **Unlike in Y1, in Y2 boys (at 48%) were found to meet the AST criteria for a substance abuse problem significantly more often than girls (41%)**

- **In Y1, meeting the criteria for a mental health and a substance abuse disorder was clearly the most common pattern for juveniles (at 41%, followed by mental health problem only at 28%, neither type of problem at 18%, and substance abuse problem only at 14%). In Y2, the distribution was less clear-cut with meeting the criteria for both mental health and substance abuse disorders remaining a slight plurality at 30%, followed closely by mental health problem only at 29%, and meeting the criteria for neither type of problem at 25%. Having a substance abuse problem only remained less common at 16%**

- **Whereas the largest group of girls in Y1 (44%) met the criteria for having both a mental health and substance abuse disorder, in Y2 the largest group (39%) met the criteria for having a mental health problem only. Also, whereas boys meeting the criteria for a mental health problem only comprised the second-largest group in Y1, the second-largest group in Y2 was boys meeting the criteria for neither type of problem**

- **In Y1, meeting the diagnostic criteria for both a mental health and substance abuse disorder was the single most common diagnostic combination in nine of 11 JDCs. In Y2, the results were more varied with meeting the criteria for both types of problems being the most common combination in four JDCs, with four other JDCs having mental health problem only as the most common combination, and three others having meeting the criteria for neither type of problem as the most common combination**

- **Disruptive behavior disorders, which were provisionally diagnosed in 32% juveniles in Y1, were noticeably less often diagnosed in Y2 (at 24%)**

- **Clinician recommendations for individual counseling rose dramatically from Y1 (70%) to Y2 (89%). Recommendations for a psychological/mental evaluation dropped appreciably from Y1 (36%) to Y2 (23%)**

Parent Survey Data:

- **The parent survey administered by telephone in Y2 captured many more responses (273) than the one administered by mail in Y1 (48). Because of the relatively few parent responses in Y1, it was not considered appropriate to compare responses across the two assessment years**

Judge/Juvenile Probation Officer Survey

- **Awareness of the clinical services program was higher in Y2, when 80% of judges/JPOs knew there was a clinician in the nearest JDC, than in Y1, when only 66% knew of the CSP**

- **A somewhat lower percentage of judges/JPOs reported having been contacted by clinicians in Y2 (73%) than Y1 (79%)**

- **Compared with Y1, in Y2 a somewhat higher percentage of judges/JPOs who reported receiving recommendations reported being satisfied with these recommendations (79% were satisfied in Y1 and 86% were satisfied in Y2)**

- **A higher percentage of judges/JPOs reported that clinicians' recommendations affected their decisions in Y2 (83%) than Y1 (74%)**

- **In Y2, 93% of judges/JPOs reported the clinical services program to be either very or rather beneficial, compared to 78% in Y1. Whereas 11% of judges/JPOs in Y1 reported the program to be not very or not at all beneficial, no judges/JPOs in Y2 responded this way**

- **Every judge/JPO (or 100%) who answered the germane item in Y2 reported wanting to see the clinical services program continue, besting the 92% who reported wanting to see it continue in Y1**

Overview

The clinical services program (CSP) has been housing clinicians in juvenile detention centers (JDCs) in Idaho for several years. It first began in August 2006, when the Idaho Department Health and Welfare (IDHW) first provided funding for a pilot project housing a mental health clinician in the juvenile detention center in Bonneville County (known in the Idaho juvenile correction community as the "3B Detention Center"). On the basis of a positive internal evaluation conducted by Brian Mecham, a licensed clinical social worker affiliated with Behavior Consultation Services, the pilot program was expanded to provide for clinicians in the other 11 JDCs in Idaho. These JDCs included those in Ada, Bannock, Bonner, Canyon, Fremont, Kootenai, Lemhi, Minidoka, Nez Perce, Twin Falls, and Valley counties. Clinicians began to be hired and trained in December 2007, and this process continued throughout early 2008. IDJC contracted with researchers at the Center for Health Policy at Boise State University (BSU) to conduct an external evaluation of the expanded program between January 1, 2008 and December 31, 2008. A report on the expanded program (McDonald, Williams, Osgood, & VanNess, 2009) was issued in January 2009.

In the expanded CSP, clinicians working in the 12 JDCs provided mental health and substance abuse screening, using the Alaska Screening Tool (AST) and clinical interviews, to determine whether or not juveniles appeared to have one or more mental health or substance abuse problems. They noted, in a comprehensive database developed in conjunction with personnel from the Idaho Department of Juvenile Corrections (IDJC), important information such as screened juveniles' gender, booking charges, whether or not they met the AST diagnostic criteria for a mental health and/or substance abuse problem, whether they had previously been diagnosed with a mental health and/or substance abuse problem, whether the clinician provisionally diagnosed the juvenile with a mental health and/or substance abuse problem, what any provisional diagnoses were, whether any recommendations were made for community-based services upon release, what those recommendations were, and whether or not the juveniles had accessed them. To further evaluate the value of the CSP, surveys were sent to members of two constituencies that were considered particularly important to the success of the program: the parents of the juveniles and the judges and juvenile probation officers (JPOs) who work with the youth. A survey was mailed to parents, asking them about they had been contacted by clinicians and informed that their children had been identified as someone who could benefit from community-based mental health and/or substance abuse services, whether the clinician had provided recommendations for such services, whether they had accessed recommended services, and whether they had experienced barriers to this access. Judges and JPOs were mailed a survey asking them whether they were aware of the clinical services program, whether they had been contacted by the clinician working in the nearest JDC, whether they had been satisfied with the contact, whether the clinicians' recommendations had affected any decisions they made involving youth, how beneficial they thought it was to have a clinician in the JDCs, and whether they would like to see the program continue.

The evaluation of the expanded CSP revealed a number of interesting findings. For example, it was found that, among the over 2,000 juveniles on whom data were collected, more than 68% met the AST criteria for a mental health problem and nearly 55% met the AST criteria for a substance abuse problem. Eighty-two percent of the juveniles met the criteria for at least one

type of problem, and 41% met the criteria for having both types of problems. Provisional diagnoses were made for 84% of the juveniles, meaning only around 16% of the juveniles were believed to have no mental health or substance abuse problem that was in need of treatment. Girls tended to be more often diagnosed with mental health problems than boys, and rates of diagnosis differed significantly as a function of JDC location. The most commonly diagnosed type of problem was a mood disorder, followed by substance abuse disorders and disruptive behavior disorders. Nearly 90% of the juveniles who received a provisional diagnosis were given at least one recommendation for a community-based service, and over half of those who received at least one service recommendation had accessed at least one service by the time the JDC clinicians made their 15-day post-release follow-up calls. Responses to the judges'/JPOs' survey indicated positive perceptions of the CSP, as most of the respondents reported being aware of the program, having had contact with JDC clinicians, and receiving recommendations for youth. Nearly 80% of those judges and JPOs who were aware of the program believed it to be beneficial, and over 90% reported wanting to see it continue. The response rate to the mailed parent survey was so poor at 5.4% that the results were considered ungeneralizable.

The CSP was granted funding for a second year, and IDJC contracted with the same team of BSU researchers to evaluate it. The 2009 evaluation was performed on data collected at the JDCs between October 1, 2008 and June 30, 2009. The procedures for collecting data for the clinicians' and judges'/JPOs' portions of the evaluation were identical to those used in the 2008 evaluation. A parent survey was again used, however, during the 2009 evaluation the parents were contacted by telephone by callers from the Idaho Federation of Families for Children's Mental Health, which garnered a much higher number of completed surveys than the mail survey procedure used the previous year. An additional component was added to the evaluation, which will involve a web-based survey of recently released juveniles; this survey will focus particularly on juveniles' perceptions of the CSP, whether they received recommendations for community-based services, and whether they accessed those services (in many respects, the juveniles' survey will be very similar to the parents' survey).

The information in this report describes the findings from the first three waves of data collection. IDJC is making this report available prior to the completion of Wave Four. The Wave Four data and their analysis will be published as an addendum and made available on the IDJC website in the spring of 2010.

Methodology

Similar to the Year 1 Assessment (Y1), data were collected in several separate waves in this Year 2 Assessment (Y2); however, whereas data were collected in three waves in Y1, there were four waves of data collection planned in Y2. The first wave involved personnel at IDJC collecting data directly from clinicians at the JDCs and, after stripping all personally identifying information, providing the data to the researchers at Boise State University (BSU). This wave of data collection was virtually identical in both Y1 and Y2. The second wave involved surveying the parents of juveniles who had been recently released from JDCs after receiving recommendations from clinicians for community-based services. The survey used was virtually identical in Y1 and Y2, although, as discussed below, the methodology for delivering the survey was improved in the current evaluation. The third wave involved surveys being mailed from the researchers at BSU to judges/juvenile probation officers (JPOs) who worked with juveniles recently released from the JDCs; this wave of data collection was identical in Y1 and Y2. The fourth wave of data collection, which is unique to Y2, will involve a web-based (i.e., "over the Internet") survey of juveniles who had been recently released from the JDCs. Each wave will be discussed sequentially below.

Wave One: JDC Data

The first wave of data collection involved gathering information on detained juveniles directly from clinicians at the JDCs. When juveniles are detained at a JDC, a variety of information about them is collected at intake. Each individual piece of information is described below.

Juvenile ID: A unique ID number is assigned to each juvenile when he or she is detained in a JDC. These numbers are not linked in any meaningful way to juveniles (e.g., they are not the juveniles' social security numbers, birth dates, ect.), so providing them to the BSU researchers did not violate any confidentiality protections. The real value of the Juvenile ID numbers was twofold. First, having the ID code allowed the researchers to determine when juveniles had been booked multiple times (it was clear when juveniles had been booked several times during the study period, as the ID code appeared twice in the database). Second, the booking number was preceded by a two-letter code indicating what county JDC they had been detained in (for example, the two-letter code "1A" indicated that a juvenile had been detained in the Ada County JDC), which allowed for appropriate categorizing of the data for comparisons among JDCs.

Gender: All data was coded by the gender of the detained juvenile. This information was used for demographic purposes (to describe the gender distribution of the detained juveniles) and for analytical purposes (to compare important outcome variables, such as mental health and substance abuse diagnoses, as a function of gender).

Booking Charge(s): The booking charge or charges for all juveniles were typed into the database by clinicians. Up to four separate booking charges could be coded through a content analysis procedure aggregating conceptually similar booking charges into common themes (for example, combining "vandalism", "destruction of property", and "theft" into a larger category of "Property Crimes") and entered into the final data set used for analysis. This information was

used primarily for demographic purposes, specifically for describing what types of crimes the juveniles had been detained for.

Mental Health and Substance Abuse Screening Outcomes: As was discussed in the Y1 evaluation report (McDonald et al., 2009), Brian Mecham, in his 2007 pilot study in the Bonneville County (3B) JDC, systematically evaluated several different standardized mental health and substance abuse inventories in an effort to select the one best suited for use by JDC clinicians. Mr. Mecham reported that the Alaska Screening Tool (AST) was superior to the other assessment inventories, and the AST was ultimately used in both the pilot study and in Y1. Although the AST contains three subscales—one for mental health problems, one for substance abuse problems, and one for traumatic brain injury—only scores from the mental health and substance abuse subscales were used in the Y1 and Y2 evaluations. All AST screening information was entered into the clinician database as "True" or "False". A designation of "True" meant that a juvenile met the criteria for the relevant problem (i.e., a mental health or substance abuse problem), whereas a designation of "False" meant that a juvenile did not meet the criteria for the problem.

Previous Diagnoses: During the clinical interview each detained juvenile had with the JDC clinician, each juvenile was asked whether he or she had ever been diagnosed with a mental health or substance abuse problem in the past. If the juvenile reported that he or she had been diagnosed in the past, he or she was asked how many diagnoses were given. The number of diagnoses was documented in the clinician database.

Provisional Diagnoses: A primary purpose of the entire clinical interview was to determine whether or not detained juveniles suffered from mental health and/or substance abuse problems. Clinicians made decisions about provisional diagnoses based on several pieces of information. Two such pieces of information were the AST mental health and substance abuse subscales; if juveniles met the diagnostic criteria for a mental health or substance abuse problem, it was highly likely that they would be provisionally diagnosed with the relevant problem. The other pieces of information were largely responses the juveniles made to questions posed by clinicians during the clinical interviews. A combination of all pieces of information was used by the clinicians to make their provisional diagnoses. The use of the word "provisional" is key in this context, as all clinicians, IDJC personnel, and BSU researchers involved in this project understood that a full clinical diagnosis takes more time to develop than the JDC clinicians had at their disposal during the intake interview.

In the clinician database, the clinicians first simply noted the number of provisional diagnoses made for each juvenile. Then, they entered information about what the diagnosis was (or diagnoses were, in the case of multiple diagnoses). A drop-down menu featured some generic options for clinicians to use if he or she chose (these generic options included "Mood Disorder", "Substance Abuse Disorder", and the like), however, the clinicians could also elect to type in their provisional diagnoses (and many chose to do so, particularly when they thought specificity was important). Prior to tabulating the numbers and percentages for each type of mental health or substance abuse problem, the researchers used a content analysis procedure to aggregate conceptually similar diagnoses (for example, combining "depression", "major depression", and

"bipolar disorder" into a larger category of "Mood Disorders"). Up to four provisional diagnoses were coded for each juvenile.

Number of Recommended Services: When juveniles were diagnosed with a mental health and/or substance abuse problem, the clinicians were to make recommendations for them to access community-based services upon their release (for example, if a juvenile was provisionally diagnosed as having depression, a clinician might recommend accessing counseling upon his or her release from the JDC). In the database, clinicians were asked to list the number of services that were recommended.

Services Recommended: All clinicians were asked to type in what type of service(s) they recommended for juveniles who had been given a provisional diagnosis. The researchers used a content analysis procedure to aggregate conceptually similar types of recommended services (for example, combining "complete clinical diagnosis", "full mental evaluation", and "psychiatric evaluation" into a larger category of "Psychological/Mental Evaluation"), and then tabulated the numbers and percentages for each type of recommended service. Up to four recommended services were coded for each juvenile.

Recommended Services Accessed: It was considered critical in this evaluation to gain some sense of how many recently released juveniles accessed at least some of the services that had been recommended for them by clinicians. To develop preliminary information on this, the clinicians asked the juveniles' parents about whether they had accessed recommended services when they placed their follow-up calls to juveniles' homes approximately 15 days after the juveniles were released from the JDC. When only one service had been recommended, the clinicians simply asked if that service had been accessed; when more than one service had been recommended, the clinicians asked how many of those services had been accessed. The number of services accessed was entered into the clinician database.

The first wave of data collection took place between October 1, 2008 and June 30, 2009. Data were submitted from all 12 JDCs, however, the data from the JDC in Lemhi County were not included in the final, aggregated dataset because there were so few juveniles detained at this facility that confidentiality could not be guaranteed. Clinician data were sent directly to personnel at IDJC, who combined the data into a single Excel spreadsheet and ensured that all identifying information was removed before sending it to the BSU researchers for analysis. In total, data cases were provided for 1,941 juveniles.

Wave Two: Parent Survey Data

The second wave of data collection involved the use of a survey of parents of juveniles who were recently released from a JDC. As was discussed in the Y1 report (McDonald et al., 2009), a survey of parents had not been used in the pilot study, and because parent feedback on the clinical services program (CSP) was deemed highly desirable, a mail survey of parents of juveniles for whom community-based mental health or substance abuse services had been recommended was used in Y1. Unfortunately, the response rate to the Y1 parent survey was very low, yielding data that were not useful for analysis. In an attempt to increase the number of responses to the parent survey in Y2, IDJC contracted with the Idaho Federation of Families for

Children's Mental Health (IFF) to conduct a telephone survey of parents whose children had received recommendations for community-based services when they had recently been released from a JDC. The survey featured five questions identical to those used in the Y1 mail survey; these questions had been developed jointly by the BSU researchers and IDJC personnel. These questions asked the parents: 1) whether they had been contacted by the JDC clinician and informed that their child had been identified as a person who might benefit from community-based mental health or substance abuse treatment; 2) whether the JDC clinician had given recommendations about what services their child should access in the community; 3) what services had been recommended for their child; 4) whether their child accessed at least one service recommended for him or her; and 5) why, if the child had not accessed the recommended service, he or she had not. Slight modifications were made to the Y2 survey to accommodate the questions being asked by a second party, rather than read directly by the respondents (these slight modifications did not alter the questions themselves, but rather the directions for completing them and the wording of some of the response options).

Personnel at IDJC, working with JDC clinicians to gather the names of parents whose children had received recommendations for community-based services prior to their release from the JDCs, sent telephone contact information for the parents to IFF. IFF workers called the parents during the fall of 2009, and wrote the parents' responses directly on paper copies of the survey. IFF returned the paper copies of 273 completed surveys to IDJC in November 2009, and IDJC personnel released these surveys to the BSU researchers for data entry and analysis. No names or other identifying information (e.g., telephone numbers, county of residence) were on the surveys, protecting the confidentiality of the respondents.

Callers from IFF successfully contacted 375 parents of recently released juveniles. Of these, 273 parents agreed to complete the survey, for a response rate of 72.8%. This is an excellent response rate, and far better than the 5.4% response rate to the parent mail survey in Y1. As a result, the external validity (generalizability) of the parent survey results is far higher than it was in Y1.

Wave Three: Judges/Juvenile Probation Officers Survey Data

The third wave of data collected for this project involved information gathered through a survey of judges and JPOs who worked with youth released from the county JDCs. As discussed in the Y1 report (McDonald et al., 2009), a strategy for surveying judges and JPOs was developed by Brian Mecham and used in the pilot study in 2007, and a slightly modified version of his original survey was used in Y1. The Y1 survey was again used in Y2. This survey consisted of seven items (several of which had follow-up questions), asking the judges/JPOs: 1) if they were aware that the nearest JDC had a mental health clinician during the past year; 2) whether they had been contacted by the JDC clinician regarding one of their youth; 3) if they had been contacted, how satisfied they were with the contact (response options to this item ranged from "Very dissatisfied" to "Very satisfied"); 4) if they received recommendations on how to help youth with mental health issues; 5) if they had received recommendations, how satisfied they were with the recommendations (again, the response options ranged from "Very dissatisfied" to "Very satisfied"); 6) whether the recommendations they received affected any of the decisions or treatment they advised for youth; 7) how beneficial they thought it was to have a mental health

clinician in the JDC (response options for this item ranged from "Not at all beneficial" to "Extremely beneficial"); and 8) whether they would like to see the clinical services program continue. They were also invited to share comments or recommendations related to the program.

Personnel at IDJC identified 130 judges/JPOs for the BSU researchers to send survey packets to, and they also provided the BSU researchers with the names and addresses for these persons (it was determined that because the names and addresses of the judges/JPOs were public record, there would be no confidentiality concerns incurred by the BSU researchers sending the surveys themselves). The researchers at BSU prepared the survey packets, which included a mailing envelope, cover letter explaining the project as well as the voluntary and anonymous nature of participation, and a self-addressed postage-paid envelope for the judges/JPOs to return the surveys directly to the researchers at BSU. A total of 40 completed surveys were returned by judges/JPOs prior the end of the data collection period, for a response rate of 30.8%. This response rate is fairly good for an unsolicited survey, and thus the results from the judges'/JPOs' survey are considered to be representativeness of the population. It is noteworthy that the response rate to the judges/JPO survey was substantially higher in Y1, when over 44% of potential respondents completed surveys.

Wave Four: Juvenile Survey Data

The wave of data collection that is unique to Y2 is that which will involve the web-based surveying of juveniles who have been recently released from a JDC and for whom at least one recommendation for community-based mental health or substance abuse treatment had been made. After Y1, it was recognized that the parents of formerly detained juveniles might have a different perception, or perhaps a different recollection, about the services recommended by JDC clinicians than the formerly detained juveniles themselves. For example, the parents might not remember whether services were recommended, or what those services were, but the juveniles might (or vice versa). Parents and juveniles might have different perceptions of barriers to service access as well. For example, parents might report that juveniles failed to access recommended services because the juveniles refused to go, whereas the juveniles might report not accessing recommended services because they did not think they needed them. In recognition of potentially different perceptions between parents and juveniles, a survey of juveniles seemed a prudent addition to the Y2 evaluation strategy.

Conducting research with minors, particularly those deemed members of an additional vulnerable population such as offenders, often requires enhanced efforts to maintain confidentiality. To maximize confidentiality, the research team and IDJC personnel collaboratively decided to use a web-based survey procedure in which juveniles could anonymously complete a survey and submit it, either from their home computers or any other computers with internet access (for example, in a school or public library). To allow for comparison to parent survey responses, most of the questions on the survey are simply modified versions of those used for the parent surveys. They will ask the juveniles: 1) if they met with a counselor when they were in the JDC; 2) whether the counselor told them that they might have a mental health or substance abuse problem; 3) whether they already had services such as counseling in place, or at least scheduled, prior to meeting with a counselor in the JDC; 4) whether the counselor recommended any mental health or substance abuse services in the

community that might be helpful to them when they were released; 5) what any recommended services were; 6) whether they were currently using any services recommended by the counselor, and if not, why not; 7) whether the accessed recommended services had been helpful with any problems they had; 8) if they had not accessed the recommended services, why they had not; and 9) if they were still using any service recommended to them, and if not, why not.

The procedure for facilitating access to the survey will be to provide information sheets to JPOs who interacted with the juveniles after their release from the JDCs. The information sheet, which will be provided directly to the juveniles, will describe the study and discuss the voluntary and anonymous nature of participation. Near the bottom of the information sheet will be a web link to the survey (which will be developed by the research team, created using the Qualtrics web-based survey software, and hosted on BSU's server) and a password to access the site. A separate information sheet has been created to provide to the juveniles' parents, in the recognition that they will also want to know about the study their children are being invited to participate in. Juveniles will be informed that they could only complete the survey with their parents' permission.

IDJC is making this report available prior to the completion of Wave Four. The Wave Four data and their analysis will be published as an addendum and made available on the IDJC website in the spring of 2010.

Results and Analyses

Analysis of JDC Data

Demographic Information

The data in this report are gleaned from the cases of 1,941 cases of juveniles detained at one of 11 JDCs throughout Idaho. Gender codes were entered for 1,938 juveniles. Of these, 1,404 or 72.4% were boys and 534 or 27.6% were girls. The total number of cases was very similar to that of the Year 1 Assessment (Y1) (2,060), with similar percentages of boys and girls (nearly 71% and just over 29%, respectively).

All cases submitted for analysis were coded to reflect the JDC in which each juvenile was booked. All 12 JDCs were asked to submit data from October 1, 2008 (the period after data collection ended for the previous year's evaluation) to June 30, 2009 (the end of the fiscal year). One JDC that submitted data for the study, which is in Lemhi County, was not included in the report because there were too few cases to guarantee anonymity. The remaining 11 JDCs that submitted data are included below in Table 1.

As seen below in Table 1, the largest percentage of cases submitted was from the JDC in Canyon County (with 17% of the total cases), followed by the JDCs in Kootenai (over 15%), Twin Falls (over 14%), and Minidoka (over 10%) counties. On the other hand, the smallest percentages of cases were submitted from the JDCs in Valley (1%), Fremont (just over 2%), and Bonner (just less than 3%) counties. It is noteworthy that in Y1 the JDCs in both Kootenai and Twin Falls counties were among those that submitted the largest number of cases, and the JDCs in Valley and Fremont counties were among those that submitted the smallest number of cases.

Table 1: Number of Cases by Juvenile Detention Center (JDC) Location

JDC Location	Number of Cases	Percentage of Total Cases
Ada County	189	9.7
Bannock County	175	9.0
Bonner County	57	2.9
Bonneville County (3B)	190	9.8
Canyon County	329	17.0
Fremont County (5C)	41	2.1
Kootenai County	295	15.2
Minidoka County	198	10.2
Nez Perce County	168	8.7
Twin Falls County (Snake River)	279	14.4
Valley County	20	1.0

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

Clinicians were asked to note the booking charge or charges for all juveniles whose information was entered into the database. At least one booking charge was noted for 1,882 of the juveniles,

or 97.0% of all juveniles on whom data were collected, and two or more booking charges were noted for 114 (5.9%) juveniles. All booking charges were coded in accordance with the Uniform Crime Reporting (UCR) categories. As seen in Table 2, the most common class of booking charge was for "other" crimes that did not easily fit a UCR category (nearly 52% of the booking charges fit most appropriately in this "Other" category) Of these "other crimes", 36.3% were explicitly noted to be probation violations. Also as seen in Table 2, substantial numbers of juveniles were booked for drug crimes (nearly 23%), property crimes (22%), and crimes against persons (over 15%). Sex crimes were relatively uncommon among booking codes (accounting for less than 3% of all codes). The researchers were unable to classify over 6% of the booking codes entered by clinicians, often because the booking codes were typed as abbreviations that the researchers were unable to decipher. The pattern of booking charges was fairly similar to those recorded in Y1, in which "Other" crimes were the most common (at nearly 54%) and sex crimes were quite uncommon (at less than 3%). One area of difference is that in Y1, drug crimes were substantially more common (at nearly 23%) than in the Year 2 Assessment (Y2).

Table 2: Most Common Booking Charges

Booking Charge	Number of Cases	Percentage of Total Cases
"Other" crimes not easily fitting a category (e.g., probation violation, runaway, incorrigible, disturbing the peace)	969	51.5
Property crimes	373	19.8
Crimes against persons	286	15.2
Drug crimes	271	14.4
Sex crimes	57	3.0
Unable to classify (e.g., discretionary days)	40	2.1

Note. The percentages in this table are calculated out of the 1,882 juveniles who were assigned at least one booking charge in the IDJC database. Because up to four booking charges were coded for each individual, the total percentages in this table may exceed 100.

AST Scores

As discussed earlier in this report, the Alaska Screening Tool (AST) was the primary instrument used for screening for mental health and substance abuse problems in the juveniles detained in the 11 JDCs. Also as discussed earlier, only data collected from the mental health and substance abuse subscales (not the traumatic brain injury subscale) were analyzed in this study and are reported upon in this report.

As seen below in Table 3, nearly 60% of the juveniles who were screened using the AST met the criteria for having a mental health problem. Also as seen in Table 3, over 45% of the juveniles screened with the AST met the criteria for having a substance abuse problem. It is perhaps noteworthy that both of these percentages are lower than those reported in Y1, when over 68% and 54% of the juveniles met the criteria for mental health and substance abuse problems, respectively.

Table 3: AST Indications of Mental Health and Substance Abuse Problems		
Condition	**Number of Cases**	**Percentage of Total Screened Cases**
Mental health problem	962	58.8
Substance abuse problem	747	45.6

Note. The percentages in this table are calculated out of the juveniles who were screened with the AST for the relevant condition.

To better understand whether boys and girls appeared to have mental health or substance abuse problems at a similar rate, we analyzed the distribution of diagnoses separately by juvenile gender. We will discuss each type of problem sequentially, beginning with mental health. In Y1, girls were found to meet the diagnostic criteria for a mental health problem at a statistically significant, higher level than boys (over 76% to 65%). As seen below in Table 4, in Y2, over 71% of the girls who were screened using the AST met the criteria for having a mental health problem, whereas 54% of the boys appeared to have a mental health problem. A chi-square test revealed that the difference in mental health problems (at least as measured using the AST) was statistically significant, χ^2 (df = 1) = 39.86, $p < .001$. Comparisons with percentages reported in Y1 revealed that a smaller percentage of both girls and boys met the diagnostic criteria for mental health problems in Y2. Specifically, the percentage of girls meeting the criteria for a mental health problem dropped from over 76% in Y1 to over 71% in Y2, and the percentage of boys meeting the same criteria dropped from 65% in Y1 to 54% in Y2.

Unlike in Y1, when there was no gender difference in the extent to which juveniles met the AST criteria for having a substance abuse disorder, such a gender difference was found in Y2, with boys (at nearly 48%) more often meeting the criteria for a substance abuse problem than girls (less than 41%). A chi-square test also revealed this difference to be statistically significant, χ^2 (df = 1) = 6.36, $p < .05$. Comparisons with percentages in Y1 and Y2 revealed that a smaller percentage of girls and boys met the diagnostic criteria for substance abuse problems in Y2. Specifically, the percentage of girls meeting the criteria for a substance abuse problem dropped from 53% in Y1 to less than 41% in Y2, and the percentage of boys meeting the same criteria dropped from 55% in Y1 to less than 48% in Y2.

Table 4: AST Indications of Mental Health and Substance Abuse Problems, by Gender				
Condition	**Number of Cases**		**Percentage of Total Screened Cases**	
	Male	**Female**	**Male**	**Female**
Mental health problem	642	318	*54.0*	*71.3*
Substance abuse problem	565	181	*47.6*	*40.6*

Note. The percentages in this table are calculated out of the juveniles who were screened with the AST for the relevant condition. Contrasts in italics denote statistically significant differences.

Percentages of juveniles meeting the criteria for suffering from mental health and substance abuse disorders were also separated by JDC location, to determine whether the juveniles met the diagnostic criteria at similar rates across the 11 JDCs. As seen below in Table 5, there was a rather large spread of percentages for mental health problems as measured by the AST, ranging from slightly over 40% to over 75% of the juveniles in an individual JDC. The three JDCs with the highest percentages of juveniles meeting the AST criteria for having a mental health problem were Fremont County (where over 75% of screened juveniles met the criteria for a mental health problem), Canyon County (nearly 70%), and Twin Falls County (nearly 65%). The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a mental health problem were Ada County (less than 42%), Valley County (50%), and Minidoka County (just under 51%). A chi-square test revealed that the differential rate of mental health problems as a function of JDC location was statistically significant, χ^2 (df = 10) = 51.22, $p < .001$.

Table 5: AST Indications of Mental Health Problems by JDC Location

JDC Location	Number of Cases	Percentage of Total Screened Cases
Ada County	71	*41.5*
Bannock County	91	54.8
Bonner County	14	56.0
Bonneville County (3B)	99	55.6
Canyon County	225	**69.0**
Fremont County (5C)	31	**75.6**
Kootenai County	131	53.9
Minidoka County	34	*50.7*
Nez Perce County	88	62.9
Twin Falls County (Snake River)	168	**64.9**
Valley County	10	*50.0*

Note. The percentages in this table are calculated out of the juveniles at each JDC who were screened with the AST for the relevant condition. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

As seen below in Table 6, there were also some noteworthy differences as a function of JDC location in the percentages of juveniles meeting the AST criteria for having a substance abuse problem. The three JDCs with the highest percentages of juveniles meeting the AST criteria for having a substance abuse problem were Valley County (where 75% of the screened juveniles met the criteria for a substance abuse problem), Nez Perce County (nearly 62%), and Canyon County (over 57%). The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a substance abuse problem were Minidoka County (less than 26%), Bonner County (32%), and Kootenai County (less than 37%). A chi-square test revealed that the differential rate of substance abuse problems as a function of JDC location was statistically significant, χ^2 (df = 10) = 65.89, $p < .001$.

Table 6: AST Indications of Substance Problems by JDC Location		
JDC Location	**Number of Cases**	**Percentage of Total Screened Cases**
Ada County	68	39.8
Bannock County	81	48.8
Bonner County	8	*32.0*
Bonneville County (3B)	72	40.4
Canyon County	187	**57.4**
Fremont County (5C)	18	43.9
Kootenai County	89	*36.6*
Minidoka County	17	*25.4*
Nez Perce County	85	**60.7**
Twin Falls County (Snake River)	107	41.2
Valley County	15	**75.0**

Note. The percentages in this table are calculated out of the juveniles at each JDC who were screened with the AST for the relevant condition. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

To gain a better understanding of the extent to which juveniles in detention in Idaho suffer from mental health problems and substance abuse problems separately and together (i.e., a dual diagnosis), we combined the information on mental health and substance abuse problems for each juvenile. In this way, juveniles were coded as having: 1) neither a mental health nor substance abuse problem (i.e., they met the AST criteria for neither condition); 2) a mental health problem only (i.e., they met the AST criteria for a mental health problem, but not a substance abuse problem); 3) a substance abuse problem (i.e., they met the AST criteria for a substance abuse problem, but not a mental health problem); and 4) both a mental health problem and a substance abuse problem (i.e., they met the AST criteria for both types of problems). As seen below in Table 7, the single-largest group of the juveniles (nearly 30%) who were screened with the AST met the diagnostic criteria for both a mental health and substance abuse disorder. The next largest group of juveniles (just over 29%) met the AST criteria for a mental health problem only, followed by juveniles who met the criteria for neither type of problem (more than 25%). The smallest group of juveniles (just under 14%) met the criteria for a substance abuse problem only. The similar proportions of juveniles meeting the criteria for both mental health and substance abuse problems, a mental health problem only, and neither type of problem is interesting, and it is noteworthy that this pattern deviates from Y1, in which a clear plurality of juveniles (nearly 41%) met the AST criteria for both mental health and substance abuse problems, and smaller percentages of juveniles met the criteria for a mental health problem only (nearly 28%), neither type of problem (nearly 18%), and a substance abuse problem only (nearly 14%).

Table 7: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both		
Condition	**Number of Cases**	**Percentage of Total Screened Cases**
Neither mental health nor substance abuse problem	416	25.4
Mental health problem only	474	29.0
Substance abuse problem only	261	15.9
Both mental health and substance abuse problem	486	29.7

Note. The percentages in this table are calculated out of the juveniles who were screened with the AST for both conditions. Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

Again to determine whether boys and girls differentially met the diagnostic criteria for mental health and substance abuse problems (or neither or both), we analyzed how male and female juveniles were distributed across the four diagnostic categories (neither type of problem, a mental health problem only, a substance abuse problem only, and both types of problems). As seen below in Table 8, differences in the rates in which boys and girls fell into the four categories were found, and a chi-square test revealed that these differences were statistically significant, χ^2 (df = 3) = 51.17, $p < .001$. The largest difference was in rates of meeting the diagnostic criteria for having a mental health problem only; nearly 39% of girls fell into this diagnostic category, compared to 25% of boys. Boys (at nearly 19%) were twice as likely as girls (slightly over 8%) to meet the diagnostic criteria for a substance abuse problem only, and boys were also more likely to be diagnosed with neither type of problem than girls (over 27% to nearly 21%, respectively). Girls (nearly 33%) were somewhat more likely than boys (nearly 29%) to be diagnosed with both a mental health and substance abuse problem. The overall pattern of results was mostly similar to those found in Y1, when a statistically significant difference in distribution across diagnostic categories was also found. There were two exceptions to the pattern, however. First, whereas in Y1 the largest group (over 44%) of girls fell into the "both mental health and substance abuse" diagnostic category, in Y2 the largest group fell into the "mental health only" category. Second, whereas in Y1 the second-largest group (nearly 26%) of boys fell into the "mental health only" category, in Y2 the second-largest group of boys fell into the "neither type of problem" category.

Table 8: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both, by Gender				
Condition	**Number of Cases**		**Percentage of Total Screened Cases**	
	Male	**Female**	**Male**	**Female**
Neither mental health nor substance abuse problem	324	92	27.2	20.6
Mental health problem only	301	173	25.3	38.8
Substance abuse problem only	224	36	18.8	8.1
Both mental health and substance abuse problem	341	145	28.7	32.5

Note. The percentages in this table are calculated out of the juveniles who were screened with the AST for both conditions.

The pattern by which the juveniles met the respective criteria for the same four diagnostic categories was also examined as a function of JDC location. As seen below in Table 9, differences in the rates in which juveniles at the 11 JDCs fell into the four categories were found, and a chi-square test revealed that these differences were statistically significant, χ^2 (df = 30) = 144.73, $p < .001$. These differences may most easily be seen in visual analysis of the most and least common diagnostic categories that emerged for each JDC. The most common diagnostic category often differed by JDC location. Juveniles meeting the diagnostic criteria for a mental health problem only were the single largest group in four JDCs (in Bonner, Fremont, Kootenai, and Twin Falls counties), juveniles meeting the criteria for both mental health and substance abuse problems were the single largest group in four JDCs (in Bannock, Canyon, Nez Perce, and Valley counties, and juveniles meeting the criteria for neither type of problem were the single largest group in three JDCs (in Ada, Bonneville, and Minidoka Counties). The least common diagnostic category was more uniform across JDCs, juveniles meeting the criteria for a substance abuse problem only being the single smallest group in nine of the 11 JDCs (the exceptions were the JDC in Valley County, where juveniles meeting the criteria for a mental health problem only were the single smallest group, and the JDC in Bonner County, where juveniles meeting the criteria for both problems were the single smallest group). A statistically significant difference in rates at which juveniles fell into different categories as a function of JDC had also been found in Y1. In this first assessment, juveniles meeting the criteria for both a mental health and substance abuse problem were the single largest group in nine of the 11 JDCs—a much more uniform pattern than that found in Y2. On the other hand, a similarity between the two assessments was found in that juveniles meeting the criteria for a substance abuse problem only were the smallest group in nine of 11 JDCs in both Y1 and Y2.

Table 9: AST Indications of Mental Health Problems, Substance Abuse Problems, and Comorbid Existence of Both, by JDC Location				
JDC Location	**Neither MH nor SA**	**MH only**	**SA only**	**Both MH and SA**
Ada County	**39.8 (N = 68)**	20.5 (N = 35)	*18.7 (N = 32)*	21.1 (N = 36)
Bannock County	24.1 (N = 40)	27.1 (N = 45)	*21.1 (N = 35)*	**27.7 (N = 46)**
Bonner County	24.0 (N = 6)	**44.0 (N = 11)**	20.0 (N = 5)	*12.0 (N = 3)*
Bonneville County (3B)	**30.3 (N = 54)**	29.2 (N = 52)	*14.0 (N = 25)*	26.4 (N = 47)
Canyon County	16.3 (N = 53)	26.4 (N = 86)	*14.7 (N = 48)*	**42.6 (N = 139)**
Fremont County (5C)	9.8 (N = 4)	**46.3 (N = 19)**	*14.6 (N = 6)*	29.3 (N = 12)
Kootenai County	29.6 (N = 72)	**33.7 (N = 82)**	*16.5 (N = 40)*	20.2 (N = 49)
Minidoka County	**47.8 (N = 33)**	27.5 (N = 19)	*2.9 (N = 2)*	21.7 (N = 15)
Nez Perce County	21.4 (N = 30)	17.9 (N = 25)	*15.7 (N = 22)*	**45.0 (N = 63)**
Twin Falls County (Snake River)	20.4 (N = 53)	**38.5 (N = 100)**	*15.0 (N = 39)*	26.2 (N = 68)
Valley County	15.0 (N = 3)	*10.0 (N = 2)*	35.0 (N = 7)	**40.0 (N = 8)**

Note. The percentages in this table are calculated out of the juveniles at each JDC who were screened with the AST for both conditions. N denotes the number of cases in each table cell. Percentages are rounded to the first decimal place, so the total percentage across rows may not equal 100. The highest row percentages are presented in bold, and the lowest row percentages are presented in italics.

Previous and Provisional Diagnoses

During the clinical interview for each juvenile, the clinicians at each JDC asked whether the juvenile had ever been diagnosed with a mental health or substance abuse problem in the past. If the juveniles reported that they had been diagnosed with such a problem in the past, the clinicians asked them how many separate diagnoses they had been given. This information was used to create a number of "previous diagnoses" for each juvenile.

At least one previous diagnosis of a mental health or substance abuse disorder was recorded for 1,318 juveniles, or 67.9% of all juveniles on whom data was collected (this percentage is noticeably higher than the 59.1% reported in Y1). The mean number of previous diagnoses for juveniles (of both genders and across the 11 JDCs) with at least one previous diagnosis was 1.22,

with a standard deviation of .52 (these numbers were very similar to Y1, in which the mean number of previous diagnoses was 1.26, with a standard deviation of .55). The range of previous diagnoses spanned from none to five. As in Y1, the mean numbers of previous diagnoses were found to be similar in Y2 for boys (1.21) and girls (1.25), and no significant difference was found between them. The mean number of previous diagnoses did differ significantly, however, as a function of JDC location, F (10, 1307) = 10.15, $p < .001$ (this result again was similar to that in Y1). As seen below in Table 10, the JDCs with the highest number of mean previous diagnoses were those in Bonner, Twin Falls, and Valley counties. The JDCs with the lowest number of mean previous diagnoses were in Fremont, Bonneville, and Kootenai counties.

Table 10: Number of Previous Diagnoses by JDC Location

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	75	1.21	.41
Bannock County	143	1.36	.67
Bonner County	5	**1.60**	1.34
Bonneville County (3B)	181	*1.06*	.23
Canyon County	327	1.24	.53
Fremont County (5C)	1	*1.00*	0.00
Kootenai County	256	*1.05*	.28
Minidoka County	11	1.09	.30
Nez Perce County	142	1.36	.56
Twin Falls County (Snake River)	159	**1.42**	.70
Valley County	18	**1.39**	.61

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

Clinicians at all JDCs used the diagnostic information from each juvenile's AST scores and information from a brief clinical interview to determine whether to make a "provisional diagnosis" of a mental health or substance abuse problem for that juvenile (the term "provisional diagnosis" was used rather than simply "diagnosis" in recognition that a full clinical diagnosis could not reasonably be made in such a short interview). In cases in which clinicians felt that more than one provisional diagnosis was warranted (for example, if a clinician believed a juvenile had depression and a substance abuse problem), they could give multiple provisional diagnoses.

At least one provisional diagnosis of a mental health or substance abuse disorder was recorded for 1,661 juveniles, or 85.6% of all juveniles on whom data was collected (this percentage was similar to the 83.5% reported in Y1). The mean number of provisional diagnoses for juveniles (of both genders and across the 11 JDCs) with at least one provisional diagnosis was 1.43, with a standard deviation of .66 (this number is slightly lower in Y1, in which the mean was 1.56, with a standard deviation of .76). The range of provisional diagnoses spanned from none to six. As was the case in Y1, a statistically significant difference in mean number of provisional diagnoses was found to exist between boys (1.39) and girls (1.51), with girls receiving significantly more provisional diagnoses than boys, t (1566) = -3.18, $p < .01$. Also as was the case in Y1, the mean

number of provisional diagnoses significantly differed as a function of JDC location, F (10, 1650) = 28.13, $p < .001$. As seen below in Table 11, the JDC with the highest number of mean provisional diagnoses was in Nez Perce County, followed by the JDCs in Twin Falls and Valley counties. The JDC with the lowest number of mean provisional diagnoses was in Kootenai County, followed by the JDCs in Bonneville and Minidoka counties.

Table 11: Number of Provisional Diagnoses by JDC Location

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	86	1.47	.57
Bannock County	138	1.39	.60
Bonner County	21	1.43	.51
Bonneville County (3B)	179	*1.20*	.40
Canyon County	327	1.47	.62
Fremont County (5C)	41	1.49	.51
Kootenai County	254	*1.05*	.22
Minidoka County	186	*1.26*	.59
Nez Perce County	151	**1.83**	.82
Twin Falls County (Snake River)	260	**1.75**	.84
Valley County	18	**1.72**	.75

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

All clinicians who made provisional diagnoses were asked to indicate what the diagnoses were for each individual. This was not done in all cases; although, as noted above, 1,661 juveniles were reportedly given at least one provisional diagnosis, in only 1,281 of these cases did clinicians indicate what the diagnosis was (or diagnoses were, if multiple diagnoses were made). Although some basic categories were provided in drop-down menus in the clinicians' Access databases, they were allowed to type in the provisional diagnoses given, and often chose to do so. A content analysis procedure was used to classify all typed answers into conceptually consistent themes. As seen below in Table 12, by far the most common diagnosis given was for a mood disorder; nearly 48% of the juveniles for whom a provisional diagnosis was listed were diagnosed with a mood disorder. Two other diagnoses that were given with some frequency were substance abuse disorders and disruptive behavior disorders. The former was given to nearly 39% of juveniles for whom a provisional diagnosis was listed. The latter (which was a broad category encompassing several more specific disorders including oppositional defiant disorder and disruptive disorder) was given to nearly 24% of the juveniles for whom a provisional diagnosis was listed. Two other classes of disorders that were listed with some frequency were anxiety disorders (e.g., post-traumatic stress disorder, panic disorder) and attention deficit disorders (e.g., attention deficit hyperactivity disorder). Interestingly, the five most common provisional diagnoses in Y2 were the same as in Y1—in exactly the same order. The only percentage that was noticeably different between the two years was for disruptive behavior disorders, which were diagnosed in more than 32% of diagnosed juveniles in Y1.

Table 12: Most Common Provisional Diagnoses		
Provisional Diagnosis	**Number of Cases**	**Percentage of Total Cases**
Mood disorders (e.g., depression, bipolar disorder)	613	47.9%
Substance abuse disorders (e.g., marijuana or alcohol abuse)	490	38.8%
Disruptive behavior disorders (e.g., oppositional defiant disorder, disruptive disorder, conduct disorder)	305	23.8%
Anxiety disorders (e.g., post-traumatic stress disorder)	212	16.6%
Attention deficit disorders (e.g., ADHD/ADD)	175	13.7%

Note. The percentages in this table are calculated out of 1,281 juveniles for whom at least one provisional diagnosis was noted in the IDJC database. Because up to four provisional diagnoses were coded for each individual, the total percentages in this table may exceed 100.

Recommendations for Services

At least one recommendation for services was recorded for 1,567 juveniles, or 94.3% of the 1,661 juveniles for whom at least one provisional diagnosis was made (this percentage is somewhat higher than the 88.6% reported in Y1). The mean number of recommended services for those juveniles (of both genders and across the 11 JDCs) who were given at least one service recommendation was 1.73, with a standard deviation of 1.04 (this mean number is very similar to the 1.77 reported in Y2). The range of recommended services spanned from none to seven. Unlike in Y1, no statistically significant difference in the number of recommended services was found between boys and girls. However, similar to Y1, the mean number of recommended services was found to differ significantly as a function of JDC location, F (10, 1556) = 44.25, $p <$ .001. As seen below in Table 13, the JDC with the highest number of mean recommended services was in Twin Falls County, followed by the JDCs in Bannock, Bonner, and Fremont counties. The JDC with the lowest number of mean recommended services was in Ada County, followed by the JDCs in Bonneville and Canyon counties.

Table 13: Number of Recommended Services by JDC Location			
JDC Location	**Number of Cases**	**Mean**	**Standard Deviation**
Ada County	61	*1.16*	.37
Bannock County	166	**2.24**	1.30
Bonner County	39	**1.95**	1.00
Bonneville County (3B)	186	*1.20*	.49
Canyon County	327	*1.37*	.59
Fremont County (5C)	39	**1.95**	.95
Kootenai County	286	1.39	.68
Minidoka County	62	1.89	1.06
Nez Perce County	103	1.89	.93
Twin Falls County (Snake River)	279	**2.52**	1.34
Valley County	19	1.84	.83

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

All clinicians who indicated that they had recommended at least one service for a juvenile were asked to indicate what the recommended service(s) was. This was not accomplished in all cases; although, as noted above, 1,567 juveniles were reportedly given at least one recommendation for a service, in only 1,324 of these cases did clinicians indicate what the recommended service was (or recommended services were, if multiple recommendations were given). Although some basic categories were provided in drop-down menus in the clinicians' Access databases, they were allowed to type in the service recommendation(s) given, and often chose to do so. A content analysis procedure was used to classify all typed answers into conceptually consistent themes. As seen below in Table 14, by far the most common recommendation given was for individual counseling; nearly 90% of the juveniles for whom a recommended service was listed were recommended to access individual counseling. Recommendations for substance abuse assessments and psychological/mental health evaluations were both made for approximately 23% of the juveniles for whom a recommendation was made, followed by substance abuse counseling/treatment (over 17%), family counseling (nearly 8%), and medication evaluation (nearly 7%). To some extent, the percentages for the most common recommendations differ from what was found in Y1. For example, in Y1, the percentage of juveniles recommended to seek individual counseling was nearly 70%. Although it was still the most common recommendation in Y1, individual counseling was recommended far less often than in Y2. Also, in Y1, a psychological/mental evaluation was recommended for over 36% of the juveniles for whom a recommendation was made, which is far higher than the 23% reported in Y2. When the two discrepancies are considered together, a trend appears: Counseling was recommended more in Y2, and evaluation was recommended less. One reasonable explanation for this pattern is that in Y2, clinicians were more confident in their provisional diagnoses, and therefore recommended treatment rather than evaluation for many of the youth they saw.

Table 14: Most Common Service Recommendations		
Service Recommendation	**Number of Cases**	**Percentage of Total Cases**
Individual counseling (e.g., Cognitive Behavioral Therapy)	1179	89.1%
Substance abuse assessment	310	23.4%
Psychological/mental evaluation	301	22.7%
Substance abuse counseling/treatment	230	17.4%
Family counseling	104	7.9%
Medication evaluation	91	6.8%

Note. The percentages in this table are calculated out of the 1,324 juveniles who were assigned at least one service recommendation in the IDJC database. Because up to three service recommendations were coded for each individual, the total percentages in this table may exceed 100.

Recommended Services Accessed

All clinicians who made at least one recommendation for services were asked, when they completed follow-up calls to a parent/guardian of each juvenile 15 days after release, whether or not the recommended service(s) had been accessed. The mean number of recommended services accessed, for those juveniles (of both genders and across the 11 JDCs) who were given at least one service recommendation, was .83, with a standard deviation of 1.01 (this mean is very similar to the .86 reported in Y1). The range of recommended services accessed spanned from none (46.9% of the juveniles receiving at least one service recommendation had not yet accessed a service) to seven. As was also the case in Y1, no statistically significant difference in mean number of recommended services accessed was found between boys (.82) and girls (.85), suggesting that juveniles accessed services similarly regardless of their gender. The mean number of recommended services did differ significantly, however, as a function of JDC location, F (10, 1561) = 43.38, $p < .001$ (this had also been the case in Y1). As seen below in Table 15, the JDC with the highest number of mean recommended services accessed was in Bannock County, followed by the JDCs in Twin Falls and Kootenai counties. The JDC with the lowest number of mean recommended services accessed was in Nez Perce County, followed by the JDCs in Minidoka and Valley counties.

Table 15: Number of Recommended Services Accessed by JDC Location			
JDC Location	**Number of Cases**	**Mean**	**Standard Deviation**
Ada County	61	.56	.65
Bannock County	167	**1.70**	1.28
Bonner County	40	.90	.96
Bonneville County (3B)	186	.68	.68
Canyon County	327	.48	.72
Fremont County (5C)	39	.77	1.20
Kootenai County	286	**.96**	.79
Minidoka County	62	*.05*	.22
Nez Perce County	105	*0.00*	0.00
Twin Falls County (Snake River)	279	**1.27**	1.23
Valley County	20	*.45*	.76

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

Parent Survey

As discussed earlier in this report, the second phase of data collection involved conducting a survey of parents of recently released juveniles who had been given at least one provisional diagnosis of a mental health or substance abuse problem to determine whether or not they had been contacted by JDC clinicians and provided with recommendations for services for their children. Part of the protocol used by JDC clinicians was to provide each provisionally diagnosed juvenile who was being released with at least one recommendation for services, and then to follow up with each juvenile's parent by telephone 15 days after release. During this follow-up contact, the JDC clinicians were to ask each parent if he or she was aware of any recommendation that had been made, and if he or she was, to inquire whether the juvenile had accessed the recommended service. A principal part of the rationale for the parent survey was to determine if the parents of recently released juveniles had been contacted by the appropriate JDC clinician and whether or not the juveniles had accessed the recommended services. Because it was recognized by the research team that not many of the juveniles would have had time to access recommended services by the time the 15-day follow-up call had been placed (largely due the time required to schedule an appointment), it was believed that the parent survey would provide a much more accurate portrait of the number of juveniles who accessed the recommended service.

A total of 273 parents were contacted by callers from the Idaho Federation of Families (IFF). The results described below were gleaned from the responses from these parents.

JDC Clinician Calls

The first question on the parent survey simply asked the respondents whether the JDC clinician had made them aware that their child had been identified as someone who could benefit from community-based mental health or substance abuse treatment. All 273 parents who completed a survey answered this question. Of these parents, 71 (26.0%) responded "Yes" that they had been made aware of this, and 202 (74.0%) responded "No" that they had not been made aware. The callers from the IFF were instructed to inform those who responded "No" to this first question that the survey was completed. Parents who responded "Yes" were asked the next question.

The second question on the survey asked the respondents whether the JDC clinician made recommendations for what services their child should access in the community. Of the 70 parents who completed this item, 53 (or 75.7%) reported that they had received recommendations for services. The callers from the IFF were instructed to inform those who responded "No" to this second question that the survey was completed. Parents who responded "Yes" were asked the next question.

Recommended Services

The third question asked the respondents what recommendations for services they received from the JDC clinicians; the callers for the IFF wrote down what the respondents reported. All written answers were analyzed with a content analysis procedure, and when possible were clustered into conceptually similar themes. A total of 49 parents reported at least one recommended service, and five reported two. As seen below in Table 16, the most commonly reported service recommendation was for mental health evaluation/treatment, which was reported by nearly 37% of the parents who reported receiving at least one service recommendation. The other service recommendation that was reported with some consistency was substance abuse assessment/treatment, which was reported by over 26% of the parents. The remaining services were a smattering of services that were too few or difficult to classify, including "psychosocial rehabilitation," "doctor's appointment," and "parenting classes." Interestingly, the callers from the IFF documented that over 18% of the respondents could not remember what services had been recommended for their child.

Table 16: Most Commonly Received Service Recommendations

Service Recommendation	Number of Cases	Percentage of Total Cases
Mental health evaluation/treatment	18	36.7
Substance abuse treatment/support groups	13	26.5
Can't remember	9	18.4

Note. The percentages in this table are calculated out of the 49 parents who reported that their child received at least one service recommendation.

The fourth question asked parents whether or not their children had accessed the service(s) that had been recommended to them. Of the 53 parents who completed this item, 39 (or 73.6%) reported that their children had accessed at least one recommended service.

Barriers to Access

The final question on the survey asked the parents to report any barriers to accessing services, if their child had not accessed at least one recommended service. Thirteen respondents completed this item. The two most common responses, both reported by four respondents (or 30.8%) were that their child refused to access or use the recommended service, or that the provider refused to provide the recommended service.

Judges and Probation Officers Survey

As discussed earlier in this report, the third phase of data collection involved a survey of judges and juvenile probation officers (JPOs) who worked with youth detained in one of the JDCs. Because one of the goals of the clinical services program is to provide helpful information to law enforcement personnel who work with detained youth, the perceptions of these judges and JPOs were considered very important. The judges'/JPOs' survey consisted of seven questions asking about contact with the JDC clinicians, the value of information received from JDC clinicians, and the overall value of the program. The responses to these items from the 40 judges and JPOs are discussed below.

Program Awareness

The first item on the survey simply asked the judges/JPOs whether or not they were aware that the closest JDC had a mental health clinician in the past year. Of the 40 judges/JPOs who completed this item, 32 (or 80.0%) reported that they were aware that the closest JDC had a clinician in it. A statement on the survey informed those who responded "No" to this first question that they were not required to complete the remaining items, and to simply return the survey as it was. Judges/JPOs who responded "Yes" were asked to complete the next item. It is noteworthy that awareness of the clinical services program was substantially higher in Y2 than in Y1, when only 66% of the judges/JPOs surveyed were aware of the program.

Satisfaction With Contact

The second item on the survey asked the judges/JPOs whether they had been contacted by the JDC clinician regarding one of the juveniles they worked with. Of the 35 judges/JPOs who completed this item, 29 (or 72.5%) reported that they had been contacted by the JDC clinician about at least one of their juveniles (this percentage is somewhat lower than the 79% reported by judges/JPOs in Y1). A statement on the survey informed those who responded "No" to this second question that they were not required to complete the remaining items, and to simply return the survey as it was. Judges/JPOs who responded "Yes" were asked to complete the remaining items.

Those judges/JPOs who reported having been contacted by the JDC clinician about at least one of their youth were asked to indicate how satisfied they were with this contact. They were allowed to indicate their satisfaction on a five-point Likert-type scale with values ranging from 1 = Very Dissatisfied to 5 = Very Satisfied. As seen below in Table 17, nearly 90% of those

judges/JPOs who completed this item reported being very satisfied (nearly 52%) or satisfied (nearly 38%) with the contact with the JDC clinician. Three judges/JPOs (or slightly over 10% of all who completed this item) reported being very dissatisfied with contact with JDC clinicians. The satisfaction rate of nearly 90%, with half of judges/JPOs being very satisfied, is nearly identical to what was found in Y1.

Table 17: Satisfaction with Contact with JDC Clinicians

Item	Very Dissatisfied	Dissatisfied	Not Satisfied or Dissatisfied	Satisfied	Very Satisfied
How satisfied were you with the contact you had with the mental health clinician?	10.3% (N = 3)	0.0% (N = 0)	0.0% (N = 0)	37.9% (N = 11)	51.7% (N = 15)

Note. The percentages in this table are calculated out of the 29 judges/JPOs who reported a level of satisfaction with contact with a JDC clinician. Percentages are rounded to the first decimal place, so the total row percentage may not equal 100.

The third item asked the judges/JPOs whether they received recommendations from the JDC clinicians to help youth with mental health issues. Of the 30 judges/JPOs who completed this item, 27 (or 90.0%) reported that they had received such recommendations (the percentage of judges who reported receiving recommendations in Y1 was very similar, at nearly 93%). All judges/JPOs who reported having received recommendations were asked to indicate on a five-point Likert-type scale how satisfied they were with the recommendations made. As seen below in Table 18, nearly 86% of the judges/JPOs who completed this item reported being either satisfied (fully 50%) or very satisfied (nearly 36%); this percentage reflected an improvement over the 79% satisfaction rate in Y1. Only three judges/JPOs, representing less than 11% of the total who responded to this question, reported being very dissatisfied with clinicians' recommendations. One judge or JPO, representing less than 4% off all who responded, reported not being satisfied or dissatisfied with the recommendations.

Table 18: Satisfaction with Recommendations from JDC Clinicians

Item	Very Dissatisfied	Dissatisfied	Not Satisfied or Dissatisfied	Satisfied	Very Satisfied
How satisfied were you with the recommendations made by the mental health clinician?	10.7% (N = 3)	0.0% (N = 0)	3.6% (N = 1)	50.0% (N = 14)	35.7% (N = 10)

Note. The percentages in this table are calculated out of the 28 judges/JPOs who reported a level of satisfaction with recommendations from JDC clinicians. Percentages are rounded to the first decimal place, so the total row percentage may not equal 100.

The fourth item asked the judges/JPOs who reported receiving recommendations from JDC clinicians whether these recommendations had affected any of the decisions or treatment they advised for their youth. Of the 27 judges/JPOs who completed this item, 23 (or 85.2%) reported that the recommendations they received had affected a decision or treatment advised for the youth. This percentage of having decisions affected by clinician recommendations is considerably higher than that of the 74% of judges/JPOs in Y1. Those respondents who answered "No" to this item were asked to write (in a blank provided on the survey) why the

recommendations did not affect their decisions or advised treatment. Only one judge or JPO wrote a comment in response in the blank, and it indicated that the youth was already receiving services in the community.

The fifth item on the survey asked the judges/JPOs how beneficial they thought it was to have a clinician in the nearest JDC. The judges/JPOs were allowed to indicate how beneficial they thought it was to have clinicians in the JDCs on a five-point Likert-type scale with values ranging from 1 = Not at all beneficial to 5 = Extremely beneficial. As seen below in Table 19, fully 70% of the judges/JPOs who completed this item reported thinking it was very beneficial to have a clinician in the nearest JDC, and another 23% reported it to be beneficial (for an overall beneficial rate of over 93%). Two judges/JPOs, representing less than 7% of the total sample, reported a neutral response. It is noteworthy that not one judge or JPO reported the clinical services program to be "non-beneficial." The results in Y2 also reflect a substantial improvement over Y1, when the total beneficial rate was approximately 78%, with over 11% of judges/JPOs reporting the program to be not very beneficial or not at all beneficial.

Table 19: How Beneficial It Is to Have a Clinician in the JDCs

Item	Not at all Beneficial	Not Very Beneficial	Neutral	Rather Beneficial	Extremely Beneficial
How beneficial do you think it is to have a mental health clinician in the detention center?	0.0% (N = 0)	0.0% (N = 0)	6.7% (N = 2)	23.3% (N = 7)	70.0% (N = 21)

Note. The percentages in this table are calculated out of the 30 judges/JPOs who reported on how beneficial it is to have a clinician in the JDCs. Percentages are rounded to the first decimal place, so the total row percentage may not equal 100.

The final item on the survey asked the judges/JPOs whether they would like to see the program housing clinicians in the JDCs continue. All 28 judges/JPOs who completed this item reported that they would like to see the clinical services program continue (this 100% approval rate bested the 92% approval rate in Y1). All judges/juvenile probation officers were then asked to explain why they would or would not like to see the program continue, and seven chose to do so. Six written responses commented on positive perceived elements of the program as evidence for why it should continue (e.g., "The position should be permanently funded and continued for the kids, family, staff, and JPO all benefit from this," "It is working very well," "[I recommend] they had more hours, so they could do more work with the juveniles," "Keep funding it and educate lawmakers as to the benefit to the community," "Fund it for full-time"), and one of the comments was somewhat negative in tone ("I receive assessments on kids but they don't tell me anything, they are brief and not descriptive and only once did I get a recommendation and it simply said treatment was recommended. It wasn't specific in any way. I would like to see them doing more specific counseling with kids when needed or recommended").

Summary and Conclusions

The material in this report describes the results of the second-year, multimodal evaluation of the IDJC's clinical services program (CSP). In this report, the evaluation methodology of four waves of data collection, and results generated through the first three waves of data collection are presented. To this point, the results have been discussed with a focus on individual findings, without much attempt to understand them as a more coherent whole. In the final section of this report, a more comprehensive overview of the results and their implications will be presented, with special emphasis on several themes, including the methodology, mental health and substance abuse issues, service recommendations and service access, and stakeholder perceptions.

Methodology

One of the benefits of conducting a second-year evaluation is that any methodological shortcomings experienced in an initial evaluation can be identified and improved upon, and strategies that were found to be sound can be used again. As articulated in the report describing the Year One Assessment (Y1) (McDonald et al., 2009), the parent mail survey was found to be the weakest element of the evaluation. The response rate to the survey was so low as to seriously jeopardize the external validity (generalizability) of the results. For this reason, the methodology for data collection was altered in the Year Two Assessment (Y2), with the same survey being used but instead of being delivered by mail it was administered by callers from the Idaho Federation of Families for Children's Mental Health (IFF). The benefits of this change were at least twofold, and are also verified by the much larger number of completed surveys in Y2 (over 270) compared to Y1 (less than 50). One benefit was that the parents surveyed were contacted directly by an organization they likely knew and trusted; IFF has worked with IDJC on parent surveys in the past, so even if the parents called did not know the people surveying them, they likely did know of the organization. This was almost certainly an improvement over the mail survey used in Y1, which was mailed from juvenile corrections personnel but was asked to be returned to BSU (this very likely appeared unusual to potential respondents, and may have kept some from responding). Another benefit is that with telephone surveys, if a person is not reached for surveying (or he or she elects not to respond), another person can be called immediately to replace the first in the sample. This is impossible to do in mail survey research, in which researchers simply have to wait and hope that a reasonable number of surveys will be returned. The much improved response rate (nearly 73%) to the Y2 telephone survey—as opposed to the less than 6% response rate to the parent mail survey in Y1—certainly enhances the extent to which the results can be confidently generalized to the greater parent population.

Because it was determined that both the clinician data collection and the judges/juvenile probation officers (JPO) survey procedure worked well in Y1, these processes were not substantially altered. In fact, the judges/JPO survey procedure was identical to that used in Y1, and it again yielded a good response rate. Although the clinician data collection procedure was identical (the clinicians used the same Access database, and entered the same information), the quality of the data was improved—largely through the identification of some inconsistencies in data entry from the previous year. For example, when the Y1 results were presented, several

clinicians indicated they had sometimes been unsure of whether they were supposed to leave blank a data field when juveniles did not meet any of the Alaska Screening Tool (AST) criteria for diagnosis, or whether they should enter a response specifically to indicate that the juvenile did not meet the diagnostic criteria. Because problems such as this were addressed prior to Y2 there were substantially fewer blank fields in the Y2 dataset, which indicates the Y2 clinician data are even more reliable and valid than the Y1 data. In all, it can be concluded that the methodology for the clinician data collection and the judges/JPO survey were at least as sound in Y2 as they were in Y1, and probably more so.

Mental Health and Substance Abuse Issues

In the Y1 evaluation report (McDonald et al., 2009), we presented our belief that one of the main findings of the study was that the majority of juveniles screened in the JDCs appeared to have a mental health problem, a substance abuse problem, or both. This appeared to be true regardless of whether diagnoses were made strictly on the basis of AST scores or the clinical interviews performed in the JDCs. In short, a major finding was that a very large percentage of detained juveniles likely suffered from a mental health and/or substance abuse problem. The same finding was observed in Y2, yielding reliability to these results. Although somewhat smaller percentages of juveniles met the AST criteria for mental health and substance abuse disorders in Y2 (59% and 46%, respectively) than in Y1 (68% and 54%, respectively), a clear majority of juveniles in Y2 still suffered from mental health problems, and nearly half suffered from substance abuse problems (and nearly a third suffered from both). Fully 75% of the juveniles were revealed, on the basis of AST scores alone, to have a mental health and/or a substance abuse problem. When the clinical interview was also included, a total of 86% of juveniles received at least one provisional diagnosis of a mental health or substance abuse problem. Thus, it appears that *at most* 25% (on the basis of AST scores alone) of the juveniles who entered a JDC in late 2008 or the first half of 2009 did not suffer from a least one mental health or substance abuse problem, and that more likely slightly less than 15% did not (as indicated by clinicians' provisional diagnoses). In sum, it appears that the conclusions formed after Y1, namely that the vast majority of juveniles entering a JDC appear to be suffering from at least some type of mental health or substance abuse problem, are confirmed in Y2.

Another noteworthy finding in Y1 was that a rather high percentage (nearly 60%) of the juveniles reported that had been previously diagnosed with a mental health and/or substance abuse problem before they had been detained in the JDC (in other words, for 60% of the juveniles, some community professional—whether a psychologist, psychiatrist, school counselor, or whomever—had recognized he or she had a mental health problem prior to each juvenile falling into custody). This high percentage was confirmed in Y2; in fact, in the second year, nearly 68% (i.e., over two-thirds) of the juveniles reported that they had been previously diagnosed with a mental health and/or substance abuse problem prior to being detained. Thus, as we reported after Y1, at least two findings seem clear. First, prior to at least their most recent detention, most of these juveniles had already been identified with a mental health or substance abuse problem. Second, many juveniles who had never been diagnosed with a mental health or substance abuse problem were identified as having one through the administration of the AST, the completion of the clinical interview, or both. These two points, as well as their implications, merit elaboration that appears below.

In the Y1 report (McDonald et al., 2009), we noted that an increased effort toward community-based screening and intervention seemed warranted by our results. This certainly seems true again after Y2. It seems very likely that at least many of the 68% of juveniles who were diagnosed with a mental health and/or substance abuse problem prior to detention could have avoided eventual detention had their problems been effectively addressed in the community. In other words, had effective treatment followed the diagnosis of a problem in some of the 1,318 juveniles who had a previous diagnosis, the course of those juveniles' lives could have been changed in such a way that they may never have been detained at all. Had they avoided detention, the quality of their lives (as well as the quality of the lives of anyone they victimized in the process of warranting detention) would have been substantially improved, and costs to the state as a result of their detention would have been avoided. Thus, we recommend again, as we did in our Y1 report, that IDJC or JDC personnel who have the ability to impress upon school district and other community professionals (e.g., counselors, nurses, teachers, child protection workers) the importance of identifying and treating juveniles who suffer from mental health or substance abuse problems, do so in the hopes that these juveniles can ultimately be steered on a path away from criminal offense and eventual incarceration in one of the JDCs.

The second point reveals that, through the CSP, JDC clinicians continue to identify mental health and/or substance abuse problems in substantial numbers of previously undiagnosed youth. As mentioned in our earlier report (McDonald et al., 2009), in Y1 JDC clinicians identified at least one previously undiagnosed mental health or substance abuse problem in 501—or over 24%—of the juveniles in their total sample. In Y2, JDC clinicians identified at least one previously undiagnosed mental health or substance abuse problem in 324—or 17.7%—of the juveniles in the total sample. The fact that a smaller percentage of previously undiagnosed juveniles was identified in Y2 is probably due to a higher percentage of previously diagnosed juveniles that were found in Y2 (68%) compared to Y1 (59%). In other words, because more juveniles in Y2 had been diagnosed prior to detention, a smaller percentage of those found by JDC clinicians to have at least one mental health or substance abuse problem were previously undiagnosed. In any case, that JDC clinicians identified previously undiagnosed mental health or substance abuse problems in nearly 18% of the sample shows that these clinicians perform a very important function in their own right—and provides a great deal of evidence for the value of the CSP. One can hope that the identification of these problems in previously undiagnosed juveniles will help facilitate their treatment in the future and ultimately reduce the likelihood that, after release, these juveniles will have continued contact with the juvenile (and adult) justice system.

Two findings that were not elaborated on in the Y1 report (McDonald et al., 2009) were observed again in Y2, and therefore likely deserve some discussion here. These findings are that the diagnosis of mental health and substance abuse problems differed first by gender and second by JDC location. In Y1, it was found that girls, compared to boys, were: 1) significantly more likely to meet the AST criteria for a mental health problem; 2) significantly more likely to meet the AST criteria for both a mental health and substance abuse problem; and 3) given significantly more provisional diagnoses. In Y2, the first and third results were again found (although girls were again more likely than boys to meet the AST criteria for both a mental health and substance abuse problem, the difference was fairly small). In both Y1 and Y2, boys significantly more often met the AST diagnostic criteria for having a substance abuse problem only, and more often

met the AST criteria for neither type of problem. That girls are more often diagnosed with mental health problems, and boys with substance abuse problems, seems important from both a screening and a treatment standpoint. Although some scholars (e.g., Bertakis et al., 2001; Hartung & Widiger, 1998) have reported that females may be diagnosed with certain mental health problems (most notably anxiety and depression) more often than males due to gender bias, this seems unlikely to be the case in these evaluations. This is because gender bias should only influence clinicians' perceptions, and these are only reflected in the issuance of provisional diagnoses; the extent to which the juveniles meet the AST diagnostic criteria is not affected by clinicians' perceptions, and girls met the AST criteria for mental health problems more often than boys to a statistically significant degree. It may be that mental health problems more often bring girls than boys into contact with the juvenile justice system, and that substance abuse problems more often bring boys into contact with the same system than girls. In any case, knowing that, at least in Y1 and Y2, girls entering JDCs may need more specialized treatment for mental health problems, and boys may need more specialized treatment for substance abuse problems, may help clinicians provide and recommend appropriate treatment services.

As mentioned above, in both Y1 and Y2 it was found that juveniles met the diagnostic criteria for mental health and substance abuse problems differentially across the 11 JDCs. Some variation among sites is to be expected, however, the fact that the differences were found in both years and that they were so large as to be statistically significant suggests this variation is not due to random chance. Furthermore, assessing across the two years (i.e., Y1 and Y2) some evidence of a systematic pattern exists. For example, with respect to juveniles meeting the AST diagnostic criteria for a mental health problem, the percentages in the JDCs in Canyon and Fremont counties were among the three highest in both Y1 and Y2 (100% and 69% in Canyon County and 79% and 76% in Fremont County), and the percentages in the JDC in Valley County were among the three lowest in both Y1 and Y2 (53% and 50%). With respect to juveniles meeting the AST diagnostic criteria for a substance abuse disorder, the JDCs in Nez Perce and Canyon counties were among the three highest in both Y1 and Y2 (72% and 61% in Nez Perce County and 67% and 57%), and the percentages in the JDC in Minidoka County were among the three lowest in Y1 and Y2 (31% and 25%). Because these percentages were based on AST scores rather than clinician interviews, clinician bias in pattern of diagnosis does not seem likely to be a cause of the differences. Rather, it seems more likely that, for some reason, certain types of problems (i.e., mental health and substance abuse problems) seem more prevalent in certain areas of the state. The fact that the JDC in Canyon County in particular had one of the top three percentages for juveniles meeting the AST criteria for both mental health and substance abuse problems suggests that some targeted interventions to address these problems among juveniles in Canyon County are warranted.

If clinician bias in patterns of diagnosis exist, they would be most easy to observe in the number of provisional diagnoses that were given—as provisional diagnoses were made not only on the basis of AST scores but also on the basis of clinical interviews. One finding that is interesting in this respect is that in Y2 the three JDCs in which juveniles were given the highest mean number of provisional diagnoses were in Nez Perce (1.83), Twin Falls (1.75), and Valley (1.72) counties. Only in the JDC in Nez Perce County had juveniles been among the most likely to be meet the AST criteria for having a substance abuse problem; juveniles in the JDCs in Twin Falls and Valley counties had not been among the most likely to meet the AST criteria for either type of

problem (in fact, juveniles in the JDC in Valley County were among those most likely to *not* meet the criteria for a substance abuse problem). One way to explain this apparent discrepancy is to consider previous diagnoses (i.e., the number of juveniles who reported having been previously diagnosed with a mental health or substance abuse problem). In Nez Perce and Valley counties, juveniles reported the highest mean number of previous diagnoses (1.42 and 1.39, respectively). Therefore, it is likely at least in those two county JDCs that the higher mean number of provisional diagnoses is due to the fact that more juveniles were detained in those facilities with previously diagnosed problems.

Service Recommendations and Access

Although a fundamental component of the CSP involves the screening and diagnosis of mental health and substance abuse problems, screening and diagnosis by themselves are not enough to reduce these problems in youth. In order for the problems to be addressed, the juveniles must have access to treatment once they leave the JDCs. As articulated in this report, one of the key roles of JDC clinicians is to provide recommendations for treatment when youth who received at least one provisional diagnosis of a mental health or substance problem are released from detention. Then, they were tasked with following up with the juveniles and their parents approximately 15 days after release to determine whether or not the juveniles had accessed any services. The success of clinicians in facilitating mental health and/or substance abuse treatment for provisionally diagnosed juveniles can be measured in several ways, as we noted in our Y1 report (McDonald et al., 2009). One measure of success is the percentage of individuals who were given at least one provisional diagnosis and who also received at least one recommendation for a community-based service. Another is the percentage of juveniles who received at least one service recommendation and who also accessed at least one service.

As noted earlier in this report, at least one provisional diagnosis of a mental health or substance abuse problem was made for 1,661 juveniles. At least one recommendation for a community-based service or treatment was made for 1,567. Taken together, these figures suggest that over 94% of the juveniles who were provisionally diagnosed with a problem had service recommendations made for them. This percentage represents an improvement over the strong 88% "recommendation rate" reported in Y1, and seems to reflect an excellent performance on the part of the JDC clinicians. An interesting finding regarding service recommendations is that, compared to Y1, in Y2 the clinicians more often recommended specific services (such as counseling) and less often recommended further assessment or evaluation by community-based mental health or substance abuse professionals. This seems to reflect greater confidence, or perhaps even greater expertise, among the clinicians; in order for them to make specific recommendations, they had to be confident in their own assessments and their ability to correctly ascertain the nature and magnitude of the juveniles' problems.

It seems that the clinicians had approximately the same level of success in Y2 as Y1 in terms of facilitating early access to recommended services. In Y2, as in Y1, it was found that approximately 53% of the juveniles for whom at least one service recommendation had been made had accessed at least one service by the time of the 15-day follow-up call. How to interpret this information is somewhat difficult. On one hand, it could be surmised that barely over half of the juveniles are accessing the services recommended for them. This interpretation

could cast some doubt about the value of the CSP. However, as we noted in our Y1 report (McDonald et al., 2009), the percentage of juveniles who had accessed at least one service by 15 days post-release very likely represents only a subset of the juveniles who will eventually access a service. It is very likely that at least a portion of the 47% of juveniles who had not yet accessed a recommended service would eventually do so; 15 days is a very short period to schedule and attend an appointment, particularly for specialized services (psychiatrists, for example, often are booked several months in advance). It seems advisable in future iterations of the CSP to have the clinicians note in the Access database whether the juveniles or their family members report having scheduled an appointment for the recommended service, as this would help provide a more accurate description of how many juveniles actually receive a recommended service (simply asking juveniles and their parents whether they intend to access recommended services would also be a solid, if indirect, proxy for service access). One of the purposes for surveying parents was to get a later measure of the percentage of juveniles who eventually accessed at least one recommended service (as the parent survey was conducted months after the juveniles were released from a JDC). It is noteworthy that nearly 74% of the parents who reported that their children received at least one service recommendation also reported that their children had accessed at least one recommended service. This percentage may be a more accurate representation of the percentage of juveniles who eventually access a service recommended for them, and if so, suggests a good deal of success in linking juveniles who have mental health and/or substance abuse problems with appropriate community-based services.

Stakeholder Perceptions

As was the case in Y1, a major area of interest for the IDJC personnel who commissioned this study was to understand whether some of the key stakeholders—namely parents of detained juveniles and the law enforcement personnel who work with the juveniles—were satisfied with the CSP and consider it to be effective. Without the support of members of these stakeholder groups, the CSP is not likely to garner the types of support needed to continue. As noted elsewhere in this report (as well as the Y1 report), one of the most vexing shortcomings of the Y1 study was that so few parents responded to the mail survey that it was almost impossible to attempt to draw any valid conclusions about their perceptions as a group. Fortunately, a much larger group of parents responded to the IFF telephone survey in Y2, which allows for much more confidence in the ability to generalize their responses to the greater population of parents.

Overall, it is somewhat difficult to interpret one of the main findings of the parent survey—that 74% of the parents reported they had not been made aware that their child had been identified as someone who could benefit from community-based mental health or substance abuse treatment. If it is true that the IFF callers were given only the telephone numbers of parents whose children had been given a provisional diagnosis by JDC clinicians, then this number does not reflect well on this element of the CSP. Because this element of the project was outside of the control of the BSU researchers writing the report, we do not know for certain whether some of the parents who were surveyed had children who had not been provisionally diagnosed; if their children had not been provisionally diagnosed, it makes sense that they would not have been informed of this by the JDC clinicians. In future iterations of this research, it would make sense to ensure that callers only have names and telephone numbers for parents of children who were provisionally diagnosed and who had received recommendations for community-based services upon release

from the JDCs. With respect to the 26% of parents who responded that they had been informed by a JDC clinician that their child could benefit from mental health and/or substance abuse treatment, the findings comment more favorably on the CSP. Three-quarters of the parents who were so informed reported that the JDC clinician recommended services to them from which their child could benefit. Nearly 74% reported that their children had accessed at least one recommended service. These percentages suggest that, at least among parents who were informed that their child could benefit from community-based services, most of them received specific recommendations and most of their children had accessed at least some of the recommended services.

The perceptions of the judges and JPOs were less ambiguous than those of the parents, and much easier to interpret. In short, it is impossible to conclude anything other than that these law enforcement personnel had very favorable impressions of the CSP. Eighty percent of them were aware of the program, and over 70% had been contacted by JDC clinicians about at least one of the juveniles in their charge. Ninety percent of those contacted reported receiving at least one community-based service recommendation for those juveniles. Nearly 90% of the judges/JPOs reported satisfaction (usually at high levels) with the contacts, and over 85% reported satisfaction with the service recommendations. Slightly over 85% of those judges/JPOs who received at least one service recommendation reported that it affected the decision or treatment advised for juveniles. Over 93% of the judges/JPOs reported the CSP to be beneficial (70% alone reported it to be "very beneficial"), and 100% of those who responded to an item on program continuation reported thinking that the CSP should be continued in the future. Not only are these very favorable responses, many of them represent improvements over responses in Y1 (which were also clearly favorable). In short, it seems that the relevant law enforcement personnel affected by the CSP have very positive impressions of the program, and these seem to be growing more positive as the program continues.

As described earlier, IDJC is making this report available prior to the completion of Wave Four. The Wave Four data and their analysis will be published as an addendum and made available on the IDJC website in the spring of 2010. Thus, a description of juveniles' perceptions of the CSP will be available in the near future.

Concluding Comments

This second year evaluation provides an excellent opportunity to determine whether findings reported in Y1 were an anomaly or whether they represent a fairly stable state of affairs with respect to mental health and substance abuse problems among juveniles detained in Idaho's JDCs. Based on what was found in both Y1 and Y2, it seems prudent to conclude that a high percentage of the juveniles who are detained in the JDCs have some very real problems with respect to mental health and substance abuse. Although the percentage of juveniles meeting the AST criteria for mental health and substance abuse problems were both higher in Y1 than Y2, averaged between the two years the percentages were approximately 64% for mental health problems and 50% for substance abuse problems. In terms of percentages of juveniles who were given provisional diagnoses of at least some type of problem, the numbers for Y1 and Y2 were nearly identical—nearly 84% in Y1 and nearly 86% in Y2. Taken together, all of these numbers

show that when juveniles are processed into JDCs, they should be assumed to have at least some type of mental health or substance abuse problem that needs treatment. The screening process, including the administration of the AST and the clinical interview, are important elements to clarify whether a mental health or substance problem indeed exists, and if so, what the nature (or natures, in the case of multiple problems) of the problem is. The CSP has demonstrated itself to be successful for two consecutive years not only in helping to confirm previous diagnoses made by community-based professionals, but also in provisionally diagnosing previously undetected mental health and substance abuse problems—and providing community-based treatment recommendations for juveniles with these problems. As we mentioned in our Y1 report (McDonald et al., 2009), early detection and treatment of mental health and substance abuse problems have been repeatedly demonstrated to help arrest the further development of these problems and reduce or eliminate the social (e.g., crime, underemployment, use of public health services such as Medicaid) and personal (e.g., misery, diminished quality of life) costs of untreated mental health and substance abuse problems. Thus, the CSP clearly appears to offer benefits to the state and some of its most vulnerable citizens.

For the CSP to be successful in reaching the ultimate, long-range goal of reducing the social and personal costs of untreated mental health and substance abuse problems, quality and accessible community-based mental health and substance abuse services must exist. The value of clinicians identifying problems, and making recommendations for their treatment, is relatively low if juveniles cannot access services to provide that treatment once they leave the JDCs (this seems a particularly important concern in the current economic and funding climate, in which many public services are being reduced or eliminated). Although we have a better sense of whether juveniles are accessing services in Y2 than we did in Y1, we still know next to nothing about the quality of the accessed services or whether they are helpful to the juveniles in terms of reducing the magnitude of the problems that were provisionally diagnosed. We also do not know whether the fundamental features of the CSP (i.e., identifying mental health and substance abuse problems and making recommendations for community-based treatment) have resulted in reduced recidivism rates. Being able to answer this question seems an important "next step" in terms of research on the CSP. Although continued tracking of screening, diagnosis, and recommendation processes will be important and is encouraged, some mechanism for attempting to assess—and perhaps quantify—the social and personal benefits of the CSP seems warranted. This could perhaps be accomplished through the selective tracking of a subset of juveniles who were provisionally diagnosed and had treatment recommendations made for them, and comparing important outcome indicators (e.g., future contact with the criminal justice system, employment, use of public health and other publicly funded social services) with those of juveniles who were detained in JDCs prior to the implementation of the CSP. To the extent that program success is a key criterion on which future funding decisions are made, such long-term assessment plans may be desirable. Without question, the CSP is successful in identifying mental health and substance abuse problems, and recommendations for community-based treatment are clearly being made. Determining whether identification and recommendations lead to the desired outcomes seems the logical next step.

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