



Idaho Department of Juvenile Corrections

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MEMORANDUM

To: Department of Health and Welfare Idaho Juvenile Justice Commission
Detention Facility Administrators Legislators

From: Sharon Harrigfeld, Director

Date: June 6, 2011

Subject: Detention Clinician Project Research Findings

During the past three years Idaho's juvenile justice system has partnered to fund clinicians in the 12 juvenile detention centers for the purpose of screening detained juveniles for mental health and substance abuse issues and to make recommendations for community based services when the juvenile is released. Based upon a successful pilot project initiated by the Juvenile Justice Children's Mental Health Workgroup (JJCMH) in the Bonneville County (3-B) detention facility; the Idaho state legislature appropriated funding to the Idaho Department of Juvenile Corrections (IDJC) and the Department of Health and Welfare (DHW) to support clinicians in all 12 county detention facilities. This partnership has proven to help juveniles and their families.

Dr. Tedd McDonald from the Boise State University Center for Health Policy analyzed the data entered by clinicians into a database, surveyed stakeholders, and completed an evaluation which is attached. In state fiscal year FY10 over 1,669 juveniles were screened in detention facilities and were the basis for research on the effectiveness of this program. Some highlights from the evaluation include:

- Mental health and substance abuse problems appear very common among juveniles in juvenile detention facilities with over 75% having a diagnosable mental illness, substance abuse issue or both.
- Over 31% of the juveniles entering detention facilities in Idaho have co-occurring disorders (mental health and substance abuse). Conversely, only 24% of the juveniles entering detention facilities have neither mental health nor substance abuse issues.
- Over 55% of the juveniles who were recommended services in the community accessed those services within 2 weeks.
- The extremely high incidence of mental illness and substance abuse for juveniles entering detention facilities indicates clinicians in detention facilities are essential to maintain safety within facilities, determine appropriate care and make referrals to community-based treatment services.
- Juveniles and their families seem motivated to access community services.
- To divert juveniles from deeper involvement in the juvenile justice system, a network of co-occurring capable providers is essential for appropriate treatment in the community.

The third year research report is posted on the IDJC web site and can be downloaded by going to <http://www.idjc.idaho.gov/> and clicking on the Community-based Funds and then the Grant Funds link.

An active partnership with communities

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

Prepared for the Idaho
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May 2011

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 and has been operational for three years (2008-2010). 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 are 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 formal evaluations of the expanded program, conducted in 2008-2009 and 2009-2010 by researchers at the Center for Health Policy (CHP) at Boise State University (BSU), both strongly indicated a need for continued clinical services for detained juveniles. For example, all three 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. All three 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 2007-2009 enabled the CSP to be funded for another year, and in 2010 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 (JJCMHW), 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 CHP to conduct the Year 3 Assessment (Y3). Similar to the Year 1 (Y1) and Year 2 (Y2) Assessments, 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. A fourth and final wave of evaluation, which was new to the Y3 evaluation protocol (i.e., it has not been used in either the pilot study or Y1, and an effort to incorporate it in Y2 was not successful due to procedural

delays), involved an internet-based survey of recently released juveniles who had received at least one recommendation for community-based services from a JDC clinician.

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

Wave One: JDC Clinician Data:

- **Data were submitted on a total of 1,669 juveniles**
 - **Over 71% of the juveniles on whom data were collected were boys, and less than 29% were girls**
 - **Data on detained juveniles were submitted by clinicians at all 12 JDCs. Data from the JDC in Minidoka was corrupted and ultimately deemed unusable (thus, the data in this assessment are from 11 JDCs)**
 - **The JDCs that submitted the most data cases included those in Canyon (19%), Kootenai (18%), Twin Falls (14%), and Bonneville (12%) counties. The JDCs that submitted the fewest data cases included those in Valley (less than 1%), Lemhi (less than 1%), and Bonner (2%) 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, drug crimes, and crimes against persons**

- **Over 62% 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 nearly 73%) were statistically significantly more likely to meet the AST criteria for a mental health problem than were boys (nearly 59%)**
 - **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 Nez Perce (79%), Canyon (77%), and Twin Falls (75%) counties. Indications of mental health problems were lowest among juveniles screened at the JDCs in Bonner (35%), Valley (44%), and Minidoka (45%) counties**

- **Over 44% of all juveniles screened with the AST met the diagnostic criteria for having a substance abuse problem**
 - **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 Nez Perce (75%), Canyon (51%), and Fremont (50%) counties. Indications of substance abuse problems were lowest among juveniles screened at the JDCs in Bonneville (23%), Bonner (35%), and Kootenai (38%) 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 a mental health problem only was the most common single combination (at 32%), followed by having both a mental health and substance abuse problem (31%), having neither a mental health nor a substance abuse problem (24%), and having a substance abuse problem only (13%)**
 - **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 (26% to 19%) and a substance abuse problem only (16% to 8%), girls were more likely than boys to have indications of a mental health problem only (37% to 29%) and both a mental health and substance abuse problem (36% 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 six JDCs (in Ada, Bonner, Bonneville, Lemhi, Kootenai, and Valley counties) was having neither a mental health nor substance abuse problem. Having a mental health problem only was the most common combination in three JDCs (in Bannock, Fremont, and Twin Falls counties), and having both types of problem was the most common combination in two JDCs (in Canyon and Nez Perce counties)**
 - **Whereas the least common single combination of indications for juveniles in eight JDCs was having a substance abuse problem only, the least common combination in the JDCs in Fremont and Nez Perce counties was having neither a mental health nor a substance abuse problem, and the least common combination in the JDC in Bonner County was having both types of problems**
- **Sixty-nine percent 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 1.17**
 - **A statistically significant difference in mean number of previous diagnoses was found between boys and girls, with girls reporting more previous diagnoses (1.27) than boys (1.14)**
 - **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 Lemhi (1.50), Twin Falls (1.44), and Valley (1.33) counties. Mean numbers of previous diagnoses were lowest among juveniles in the JDCs in Bonner (1.00), Fremont (1.05), and Kootenai (1.06) counties**

- **Fully 83% 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 (1.60) of mental health or substance abuse problems than were boys (1.36)**
 - **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 (2.00), Lemhi (1.67), and Twin Falls (1.66) counties. The lowest mean numbers of provisional diagnoses were given to juveniles in the JDCs in Kootenai (1.03), Bonneville (1.18), and Valley (1.33) counties**
- **The most commonly given provisional diagnosis was for a mood disorder, which appeared to affect 43% of the provisionally diagnosed juveniles. Other common provisional diagnoses included substance abuse disorders (34% of those provisionally diagnosed), disruptive behavior disorders (28%), anxiety disorders (17%), and attention deficit disorders (12%)**
- **Recommendations for at least one service in the community were made for 1,490 juveniles—more than the number of juveniles who received a provisional diagnosis. The mean number of service recommendations for juveniles who received at least one service recommendation was 1.70**
 - **There was a statistically significant difference in the mean numbers of recommendations for services given to boys and girls, with girls (1.87) receiving more service recommendations than boys (1.63)**
 - **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 Lemhi (3.33), Bannock (2.67), and Twin Falls (2.48) counties. The lowest mean numbers of recommended services were given to juveniles in the JDCs in Nez Perce (1.14), Kootenai (1.18), and Bonneville (1.28) counties**
- **The most commonly given recommendation for services was a recommendation for individual counseling (57% 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 (21%), psychological/mental evaluation (20%), to continue (unspecified) prior treatment (17%), and substance abuse counseling/treatment and family counseling (both 12%)**
- **According to information gained by clinicians during a 15-day post-release follow-up call, 849 juveniles, or 56.8% 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 .91

- A statistically significant difference was found in the mean number of recommended services accessed, with girls (1.04) accessing more services than boys (.86)
- 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 (2.36), Lemhi (1.67), and Bonner (1.54) counties. The lowest mean numbers of recommended services accessed were found among juveniles released from the JDCs in Fremont (.07), Valley (.20), and Ada (.46) counties

Wave Two: Parent Survey Data:

- A total of 353 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 very good, as 233 parents (or 66% of those contacted) agreed to complete the survey
- Slightly more than 47% 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, 66% reported that they were given recommendations for community-based services for their child
- The services parents most often reported their children being recommended included individual counseling (67%) and substance abuse treatment (21%). Fifteen percent of the parents reported they could not remember what services had been recommended
- Over 82% of the parents who received at least one service recommendation for their child reported that their child had accessed at least one service
- Five parents reported barriers to their children accessing the services they were recommended. Two of these reported that they could not afford the recommended service, and two reported not having the time to take their child to the recommended service

Wave Three: Judge/Juvenile Probation Officer Survey

- **The response rate to the survey sent to judges/juvenile probation officers (JPOs) was 33.1%, as 43 of the 130 judges/juvenile probation officers who were sent a survey returned a survey**
- **Seventy-nine 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, over 91% 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 (over 48%) or satisfied (over 41%) with the contact**
- **Of the judges/JPOs who had been contacted by a JDC clinician, nearly 94% 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 90% of those judges/JPOs who reported receiving at least one recommendation were satisfied (nearly 47%) or very satisfied (over 43%) with the recommendation(s)**
- **Among the judges/JPOs who reported having received recommendations from the clinicians, 73% reported that the recommendation they received affected a decision or treatment advised for the youth**
- **When asked to assess how beneficial the clinical services program was, the most common response made by the judges/JPOs was “extremely beneficial” (61%), followed by “rather beneficial” (23%). Four judges/JPOs (13%) gave a neutral response, and one (3%) reported it to be “not very beneficial”**
- **When asked whether they would like to see the CSP continue, nearly 94% of the judges/JPOs reported wishing to see it continue**

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 of Juvenile Corrections (IDJC) and 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. The expanded program continued for a second year, and a report on the continuation of the program (McDonald, Osgood, & VanNess, 2010) was issued in 2010.

In the two years of 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 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 conducted of 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 presented to parents (by mail in Y1 and by telephone in Y2), 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 in both years 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 two evaluations of the expanded CSP revealed a number of interesting findings. For example, it was found that high percentages of juveniles in both years met the AST diagnostic

for a mental health problem (68% in Y1 and 59% in Y2) and a substance abuse problem (55% in Y1 and 46% in Y2). Very high percentages of juveniles were found to meet the AST criteria for at least one type of problem (82% in Y1 and 75% in Y2), and substantial percentages were found to meet the criteria for both types of problems (41% in Y1 and 30% in Y2). Provisional diagnoses of at least one mental health or substance abuse problem were made for more than four-fifths of the juveniles in both evaluations (84% in Y1 and 86% in Y2). Girls were more often diagnosed with mental health problems than boys in both evaluations, and boys were more often diagnosed with substance abuse problems than girls in Y2 (but not Y1). The most commonly diagnosed problems in both years were mood disorders, substance abuse disorders, and disruptive behavior disorders. The vast majority of juveniles who received a provisional diagnosis received at least one recommendation for a community-based service in both Y1 (90%) and Y2 (94%), and close to half (43% in Y1 and 53% in Y2) of those who received at least one service recommendation had accessed at least one service by the time the JDC clinicians had made their 15-day post-release follow-up calls. The mail survey used for parents in Y1 yielded a response rate so low (less than 6%) that the results were considered ungeneralizable (i.e., not representative of the population), but the telephone survey used in Y2 yielded valuable results. It was found, for example, that many parents were unsure about whether they had received information from clinicians about their child's mental health and substance abuse problems, but over three-quarters of those who reported receiving such information reported that their children had received at least one recommendation for a community-based service. Of those parents who reported receiving a service recommendation, 74% reported that their child had accessed at least one recommended service. Responses to the judges'/JPOs' survey indicated positive perceptions of the CSP in both Y1 and Y2. Most of the respondents reported being aware of the program (66% in Y1 and 80% in Y2), having had contact with JDC clinicians (79% in Y1 and 73% in Y2), and receiving recommendations for youth (93% in Y1 and 90% in Y2). A very high percentage of judges and JPOs who were aware of the program believed it to be beneficial (78% in Y1 and 93% in Y2), and nearly all reported wanting to see it continue (92% in Y1 and 100% in Y2).

The CSP was granted funding for a third year, and IDJC contracted with the same team of BSU researchers to evaluate it. The 2010 evaluation was performed on data collected at the JDCs between July 1, 2009 and June 30, 2010. The procedures for collecting data for the clinicians', parents, and judges'/JPOs' portions of the evaluation were identical to those used in the 2009 evaluation. An additional component was added to the evaluation, which involved a web-based survey of recently released juveniles; this survey focused 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 was very similar to the parents' survey).

Methodology

Similar to the Y1 and Y2 assessments, data were collected in several separate waves in this Y3 assessment; however, whereas data were collected in three waves in Y1 and Y2, there were four waves of data collection in Y3. 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 BSU. This wave of data collection was virtually identical in all three years of evaluation (i.e., Y1, Y2, and Y3). 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 all three years, although, as discussed below, the methodology for delivering the survey differed by evaluation year. The third wave involved surveys being mailed from the researchers at BSU to judges and juvenile probation officers (JPOs) who worked with juveniles recently released from the JDCs; this wave of data collection was identical in all three evaluation years. The fourth wave of data collection, which was unique to Y3 (the strategy had been developed for use in Y2, but was not implemented due to procedural problems), involved the use of 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 two 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 the pilot study, Y1, Y2, and Y3. 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, Y2, and Y3 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 all three evaluations 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 July 1, 2009 and June 30, 2010. Data were submitted from all 12 JDCs, however, the data from the JDC in Minidoka County were not included in the final, aggregated dataset because of file corruption problems that could not be resolved in the time allotted. Clinician data were sent directly to personnel at IDJC, who then forwarded separate Excel spreadsheets (stripped of all identifying information) to the BSU researchers for aggregation and analysis. In total, data cases were provided for 1,669 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 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). Because the telephone survey yielded a much greater number of completed surveys in Y2, the same strategy (again using IFF callers) was employed in Y3.

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 2010, and wrote the parents' responses directly on paper copies of the survey. IFF returned the paper copies of 233 completed surveys to IDJC in November 2010, 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 353 parents of recently released juveniles. Of these, 233 parents agreed to complete the survey, for a very good response rate of 66.0%. This response rate was far higher than the 5% response rate in Y1, but somewhat lower than the 76% response rate in Y2.

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, Y2, and Y3. 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 43 completed surveys were returned by judges/JPOs prior the end of the data collection period, for a response rate of 33.1%. 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. The response rate was lower than in Y1 (44%), but higher than in Y2 (31%).

Wave Four: Juvenile Survey Data

The wave of data collection that was unique to Y3 was one that involved the web-based surveying of juveniles who had 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 and during Y2, 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 later evaluation efforts.

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 were simply modified versions of those used for the parent surveys. They asked 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 involved providing information sheets to JPOs who interacted with the juveniles after their release from the JDCs. The information sheets, which were provided directly to the juveniles, described the study and discussed the voluntary and anonymous nature of participation. Near the bottom of each information sheet there was a web link to the survey, which was developed by the research team and hosted on a contractor's (Washington-based Peak Systems, Inc., a web development and hosting company) website, and a password to access the site. A separate information sheet was created to provide to the juveniles' parents, in the recognition that they would also want to know about the study their children were being invited to participate in. Juveniles were informed that they could only complete the survey with their parents' permission.

Sadly, Wave Four data collection efforts were largely unsuccessful. Although 397 information sheets for distribution to juveniles and their parents were sent to 39 JPOs, only two surveys were completed by juveniles, and both were incomplete. Several reasons for the unsuccessful data collection seem to exist. First, some of the unique passwords provided by Peak Systems, Inc. did not allow access to the website; reports from two JPOs indicated that some of their juveniles had attempted to access the survey, but could not. Second, for reasons not fully understood, it seems that some JPOs did not distribute the information sheets to the juveniles in their charge. In later meetings of clinicians and other staff involved in the CSE, it appeared that some of the JPOs may not have opened the materials sent to them or understood the meaning or reason for the survey.

Results and Analyses

Analysis of JDC Data

Demographic Information

The data in this report are gleaned from the cases of 1,669 cases of juveniles detained at one of 11 JDCs throughout Idaho. Gender codes were entered for 1,657 juveniles. Of these, 1,182 or 71.3% were boys and 475 or 28.7% were girls. The total number of cases was somewhat lower than in the Y1 and Y2 assessments, at 2,060 and 1,941 respectively (due in large part to the Y3 loss of usable data from the JDC in Minidoka County), but the percentages of boys and girls in Y3 were very similar to those in Y1 (nearly 71% and just under 29%, respectively) and Y2 (over 72% and nearly 28%, 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 July 1, 2009 (the period after data collection ended for the previous year's evaluation) to June 30, 2010 (the end of the fiscal year). One JDC that submitted data for the study, which is in Minidoka County, was not due to corruption of the data file. 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 over 19% of the total cases), followed by the JDCs in Kootenai (nearly 18%), Twin Falls (nearly 14%), and Bonneville (over 12%) counties. On the other hand, the smallest percentages of cases were submitted from the JDCs in Valley (less than 1%), Lemhi (less than 1%), and Bonner (less than 2%) counties.

JDC Location	Number of Cases	Percentage of Total Cases
Ada County	197	11.8
Bannock County (District 6)	185	11.1
Bonner County	29	1.7
Bonneville County (3B)	204	12.2
Canyon County (Southwest Idaho)	320	19.2
Fremont County (5C)	40	2.4
Lemhi County	12	< 1.0
Kootenai County (District 1)	294	17.6
Nez Perce County (District 2)	149	8.9
Twin Falls County (Snake River)	230	13.8
Valley County	9	< 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 1,657 of the juveniles,

or 99.3% of all juveniles on whom data were collected, and two booking charges were noted for 113 (6.8%) 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 48% of the booking charges fit most appropriately in this “Other” category); a large number of these were explicitly noted to be probation violations. Also as seen in Table 2, substantial numbers of juveniles were booked for property crimes (over 20%), drug crimes (over 18%), and crimes against persons (nearly 17%). Sex crimes were relatively uncommon among booking codes (accounting for less than 4% of all codes).

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)	791	47.7
Property crimes	333	20.1
Drug crimes	299	18.1
Crimes against persons	277	16.7
Sex crimes	63	3.8
Unable to classify (e.g., discretionary days)	7	> 1.0

Note. The percentages in this table are calculated out of the 1,657 juveniles who were assigned at least one booking charge in the IDJC database. Because up to two 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 summarized in this report.

As seen below in Table 3, over 62% 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 44% of the juveniles screened with the AST met the criteria for having a substance abuse problem.

Condition	Number of Cases	Percentage of Total Screened Cases
Mental health problem	978	62.3
Substance abuse problem	695	44.3

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. As seen below in Table 4, nearly 73% of the girls who were screened using the AST met the criteria for having a mental health problem, whereas 59% 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) = 26.58, $p < .001$. The pattern revealing girls significantly more often meeting the AST criteria for having a mental health problem than boys was also found in Y1 (76% to 65%) and Y2 (71% to 54%). Thus, the gender difference in meeting AST mental health criteria seems a robust finding.

As seen below in Table 4, the percentages of boys and girls meeting the AST criteria for having a substance abuse disorder were nearly identical between 44-45%, and there was no statistically significant difference in meeting these criteria as a function of gender. In Y1, boys and girls also met the AST substance abuse criteria at a similar rate (55% and 53% respectively), however, in Y2 boys met the criteria significantly more often than girls (48% to 41%). Thus, from observing the three-year pattern it is not clear whether boys and girls appear to suffer from substance abuse problems at a differential rate.

Condition	Number of Cases		Percentage of Total Screened Cases	
	Male	Female	Male	Female
Mental health problem	655	318	58.5	72.6
Substance abuse problem	499	194	44.6	44.3

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 less than 35% to nearly 79% 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 Nez Perce County (where nearly 79% of screened juveniles met the criteria for a mental health problem), Canyon County (nearly 77%), and Twin Falls County (over 75%). The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a mental health problem were Bonner County (less than 35%), Valley County (over 44%), and Bonneville County (just under 45%). 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) = 132.04, $p < .001$.

Table 5: AST Indications of Mental Health Problems by JDC Location		
JDC Location	Number of Cases	Percentage of Total Screened Cases
Ada County	103	53.1
Bannock County (District 6)	118	63.8
Bonner County	10	<i>34.5</i>
Bonneville County (3B)	89	<i>44.9</i>
Canyon County (Southwest Idaho)	241	76.8
Fremont County (5C)	27	67.5
Lemhi County	6	50.0
Kootenai County (District 1)	102	45.3
Nez Perce County (District 2)	117	78.5
Twin Falls County (Snake River)	161	75.2
Valley County	4	<i>44.4</i>

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 Nez Perce County (where over 75% of the screened juveniles met the criteria for a substance abuse problem), Canyon County (nearly 51%), and Fremont County (50%). The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a substance abuse problem were Bonneville County (less than 23%), Bonner County (less than 35%), and Kootenai County (less than 38%). 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) = 107.61, $p < .001$.

JDC Location	Number of Cases	Percentage of Total Screened Cases
Ada County	85	43.5
Bannock County (District 6)	85	45.9
Bonner County	10	<i>34.5</i>
Bonneville County (3B)	45	<i>22.7</i>
Canyon County (Southwest Idaho)	159	50.6
Fremont County (5C)	20	50.0
Lemhi County	5	41.7
Kootenai County (District 1)	85	37.8
Nez Perce County (District 2)	112	75.2
Twin Falls County (Snake River)	85	39.7
Valley County	4	44.4

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 32%) who were screened with the AST met the diagnostic criteria for a mental health problem only. The next largest group of juveniles (just under 31%) met the AST criteria for both a mental health and a substance abuse problem, followed by juveniles who met the criteria for neither type of problem (more than 24%). The smallest group of juveniles (under 14%) met the criteria for a substance abuse problem only. The pattern of results differs slightly from the Y1 and Y2 evaluations, in which the single most common category was having both a mental health and substance abuse problem.

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	380	24.2
Mental health problem only	494	31.5
Substance abuse problem only	211	13.4
Both mental health and substance abuse problem	484	30.8

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 problems 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, $\chi^2 (df = 3) = 27.99, p < .001$. The largest difference was in rates of meeting the diagnostic criteria for having a substance abuse problem only; boys (at nearly 16%) were nearly twice as likely as girls (more than 8%) to fall into this category. Boys (at 26%) were also likely to meet the criteria for having neither type of disorder than girls (just under 19%). On the other hand, girls were found to meet the criteria for having a mental health problem only (at nearly 37%) and for having both types of problems (nearly 36%) than boys (just over 29% for both categories). The tendencies for girls to more often than boys meet the criteria for a mental health problem only and both types of problems, and for boys to more often meet the criteria for a substance abuse problem only and neither type of problem were both found in Y1 and Y2. Thus, these seem to be robust results.

Condition	Number of Cases		Percentage of Total Screened Cases	
	Male	Female	Male	Female
Neither mental health nor substance abuse problem	291	83	26.0	18.9
Mental health problem only	329	161	29.4	36.8
Substance abuse problem only	173	37	15.5	8.4
Both mental health and substance abuse problem	326	157	29.1	35.8

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) = 237.18, $p < .001$. 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 neither a mental health problem nor a substance abuse problem were the single largest group in six JDCs (in Ada, Bonner, Bonneville, Lemhi, Kootenai, and Valley counties), juveniles meeting the criteria for a mental health problem only were the single largest group in three JDCs (in Bannock, Fremont, and Twin Falls counties), and juveniles meeting the criteria for both types of problem were the single largest group in two JDCs (in Canyon and Nez Perce counties). The least common diagnostic category was much more uniform across JDCs, with juveniles meeting the criteria for a substance abuse problem only being the single smallest group in eight of the 11 JDCs (the exceptions were the JDCs in Canyon and Twin Falls counties, where juveniles meeting the criteria for neither type of problem was the single smallest group, and Bonner County, where juveniles meeting the criteria for both types of problems was the single smallest group). The pattern of results concerning the single most common category is somewhat different from Y2, when meeting the criteria for a mental health problem only and neither type of problem were tied with the single largest groups in four JDCs each, and very different from Y1, when meeting the criteria for both a mental health and substance abuse problem was the single largest group in nine of 11 JDCs.

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	29.9 (N = 58)	26.3 (N = 51)	<i>17.0</i> (N = 33)	26.8 (N = 52)
Bannock County (District 6)	18.4 (N = 34)	35.7 (N = 66)	<i>17.8</i> (N = 33)	28.1 (N = 52)
Bonner County	41.4 (N = 12)	24.1 (N = 117)	24.1 (N = 7)	<i>10.3</i> (N = 3)
Bonneville County (3B)	46.0 (N = 91)	31.3 (N = 62)	<i>9.1</i> (N = 18)	13.6 (N = 27)
Canyon County (Southwest Idaho)	14.0 (N = 44)	35.4 (N = 111)	9.2 (N = 29)	41.4 (N = 130)
Fremont County (5C)	<i>15.0</i> (N = 6)	35.0 (N = 14)	17.5 (N = 7)	32.5 (N = 13)
Lemhi County	33.3 (N = 4)	25.0 (N = 3)	<i>16.7</i> (N = 2)	25.0 (N = 3)
Kootenai County (District 1)	37.8 (N = 85)	24.4 (N = 55)	<i>16.9</i> (N = 38)	20.9 (N = 47)
Nez Perce County (District 2)	<i>5.4</i> (N = 8)	19.5 (N = 29)	16.1 (N = 24)	59.1 (N = 88)
Twin Falls County (Snake River)	16.4 (N = 35)	43.9 (N = 94)	8.4 (N = 18)	31.3 (N = 67)
Valley County	33.3 (N = 3)	22.2 (N = 2)	22.2 (N = 2)	22.2 (N = 2)

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 1,151 juveniles, or 69.0% of all juveniles on whom data was collected (this percentage is nearly identical to the 68% reported in Y2 and noticeably higher than the 59% 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 1.17, with a standard deviation of .45 (the number of previous diagnoses was slightly lower than the 1.26 in Y1 and 1.22 in Y2). The range of previous diagnoses spanned from none to five. Unlike in Y1 and Y2, when no differences were found in the number of previous diagnoses reported by boys and girls, in Y3 girls (1.27) reported significantly more previous diagnoses than boys (1.14), $t(df = 1138) = -4.44, p < .001$. The mean number of previous diagnoses also differed significantly as a function of JDC location, $F(10, 1440) = 10.03, p < .001$ (this result is similar to that found in both Y1 and Y2). As seen below in Table 10, the JDCs with the highest number of mean previous diagnoses were those in Lemhi, Twin Falls, and Valley counties. The JDCs with the lowest number of mean previous diagnoses were in Bonner, Fremont, and Kootenai counties.

Table 10: Number of Previous Diagnoses by JDC Location			
JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	139	1.12	.33
Bannock County (District 6)	174	1.28	.56
Bonner County	1	<i>1.00</i>	0.00
Bonneville County (3B)	126	1.06	.23
Canyon County (Southwest Idaho)	314	1.16	.47
Fremont County (5C)	5	<i>1.00</i>	0.00
Lemhi County	12	1.50	.52
Kootenai County (District 1)	224	<i>1.04</i>	.19
Nez Perce County (District 2)	22	1.23	.53
Twin Falls County (Snake River)	125	1.44	.63
Valley County	9	1.33	.70

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 1,386 juveniles, or 83.0% of all juveniles on whom data was collected (this percentage was similar to the 83.5% reported in Y1 and slightly lower than the 85.6% reported in Y2). 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 .64 (the mean number of provisional diagnoses was identical to that in Y2, and somewhat lower than the 1.56 in Y1). The range of provisional diagnoses spanned from none to five. As was the case in both Y1 and Y2, a statistically significant difference in mean number of provisional diagnoses was found to exist

between boys (1.36) and girls (1.60), with girls receiving significantly more provisional diagnoses than boys, $t(1372) = -6.53, p < .001$. Also as was the case in Y1 and Y2, the mean number of provisional diagnoses significantly differed as a function of JDC location, $F(10, 1375) = 30.37, p < .001$. 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 Lemhi and Twin Falls counties. The JDC with the lowest number of mean provisional diagnoses was in Kootenai County, followed by the JDCs in Bonneville and Valley counties.

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	123	1.42	.60
Bannock County (District 6)	179	1.39	.60
Bonner County	10	1.40	.52
Bonneville County (3B)	126	<i>1.18</i>	.42
Canyon County (Southwest Idaho)	314	1.42	.63
Fremont County (5C)	36	1.39	.55
Lemhi County	12	1.67	.78
Kootenai County (District 1)	224	<i>1.03</i>	.16
Nez Perce County (District 2)	137	2.00	.64
Twin Falls County (Snake River)	216	1.66	.75
Valley County	9	<i>1.33</i>	.71

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, 1,386 juveniles were reportedly given at least one provisional diagnosis, in only 1,187 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; 43% 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 34% 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 28% 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), which were given to over 17% of juveniles and attention deficit disorders (e.g., attention deficit hyperactivity disorder), which was given to nearly 12% of juveniles. Interestingly, the five most common provisional diagnoses in Y3 were the same as in Y1 and Y2—in exactly the same order.

Provisional Diagnosis	Number of Cases	Percentage of Total Cases
Mood disorders (e.g., depression, bipolar disorder)	510	43.0
Substance abuse disorders (e.g., marijuana or alcohol abuse)	402	33.9
Disruptive behavior disorders (e.g., oppositional defiant disorder, disruptive disorder, conduct disorder)	327	27.6
Anxiety disorders (e.g., post-traumatic stress disorder)	204	17.2
Attention deficit disorders (e.g., ADHD/ADD)	136	11.5

Note. The percentages in this table are calculated out of 1,187 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 1,490 juveniles, which interestingly is a greater number of juveniles than those for whom provisional mental health or substance abuse diagnoses were made (1,386). The percentage of juveniles receiving at least one service recommendation has clearly increased from both Y1 (when only 88.6% of those juveniles provisionally diagnosed received at least one service recommendation) and Y2 (when 94.3% of juveniles provisionally diagnosed received at least one recommendation). 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 1.70, with a standard deviation of 1.10 (this mean number is very similar to the 1.77 reported in Y1 and the 1.73 reported in Y2). The range of recommended services spanned from none to 10. Similar to Y1, but different than Y2, a statistically significant difference in the number of recommended services was found between boys and girls, with girls (1.87) receiving significantly more service recommendations than boys (1.63), $t(df = 1,476) = -3.83, p < .001$. However, similar to both Y1 and Y2, the mean number of recommended services was found to differ significantly as a function of JDC location, $F(10, 1,479) = 63.44, p < .001$. As seen below in Table 13, the JDC with the highest number of mean recommended services was in Lemhi County, followed by the JDCs in Bannock and Twin Falls counties. The JDC with the lowest number of mean recommended services was in Nez Perce County, followed by the JDCs in Kootenai and Bonneville counties.

Table 13: Number of Recommended Services by JDC Location

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	158	1.41	.68
Bannock County (District 6)	183	2.67	1.68
Bonner County	24	2.38	1.06
Bonneville County (3B)	193	<i>1.28</i>	.67
Canyon County (Southwest Idaho)	312	1.39	.69
Fremont County (5C)	30	2.43	.90
Lemhi County	12	3.33	1.30
Kootenai County (District 1)	227	<i>1.18</i>	.44
Nez Perce County (District 2)	119	<i>1.14</i>	.35
Twin Falls County (Snake River)	228	2.48	1.20
Valley County	4	1.75	.96

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, 1,490 juveniles were reportedly given at least one recommendation for a service, in only 1,264 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, the most common recommendation given was for individual counseling; over 57% 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 over 20% of the juveniles for whom a recommendation was made, followed by substance abuse counseling/treatment and family counseling (both 12%). Smaller numbers of recommendations were made a medication evaluation (slightly more than 5%) and residential treatment (slightly less than 5%). A category of "continue (unspecified) prior treatment" was coded in Y3 (unlike Y1 and Y2), and this recommendation was made for nearly 17% of the juveniles for whom a recommendation was made. The most common three recommendations made in Y3 were identical to Y2 (and in the same order), whereas in Y1 the top three recommendations were for individual counseling, psychological/mental evaluation, and substance abuse counseling/treatment.

Service Recommendation	Number of Cases	Percentage of Total Cases
Individual counseling (e.g., Cognitive Behavioral Therapy)	725	57.4
Substance abuse assessment	267	21.1
Psychological/mental evaluation	255	20.2
Continue (unspecified) prior treatment	214	16.9
Substance abuse counseling/treatment	151	12.0
Family counseling	151	12.0
Medication evaluation	66	5.2
Residential treatment	61	4.8

Note. The percentages in this table are calculated out of the 1,264 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 .91, with a standard deviation of 1.10 (this mean is slightly higher than the .86 and .83 reported in Y1 and Y2, respectively). The range of recommended services accessed spanned from none (43.2% of the juveniles receiving at least one service recommendation had not yet accessed a service) to nine. Unlike in Y1 and Y2, when no gender differences in accessed services were found, a significant difference emerged in Y3 showing that girls accessed more mean services (1.04, with a standard deviation of 1.16) than boys (.86, with a standard deviation of 1.06), $t(1482) = -2.29, p < .01$. The mean number of recommended services also differed significantly as a function of JDC location, $F(10, 1485) = 64.02, p < .001$ (as it also did in both Y1 and Y2). 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 Lemhi and Bonner counties. The JDC with the lowest number of mean recommended services accessed was in Fremont County, followed by the JDCs in Valley and Ada counties.

Table 15: Number of Recommended Services Accessed by JDC Location			
JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	159	<i>.46</i>	<i>.67</i>
Bannock County (District 6)	183	2.36	1.44
Bonner County	24	1.54	1.06
Bonneville County (3B)	193	<i>.94</i>	<i>.78</i>
Canyon County (Southwest Idaho)	312	<i>.23</i>	<i>.56</i>
Fremont County (5C)	30	<i>.07</i>	<i>.37</i>
Lemhi County	12	1.67	1.67
Kootenai County (District 1)	227	<i>.76</i>	<i>.67</i>
Nez Perce County (District 2)	122	<i>.74</i>	<i>.67</i>
Twin Falls County (Snake River)	229	1.29	1.11
Valley County	5	<i>.20</i>	<i>.45</i>

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 233 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 233 parents who completed a survey answered this question. Of these parents, 110 (47.2%) responded “Yes” that they had been made aware of this, and 123 (52.8%) responded “No” that they had not been made aware (the percentage of those reporting having been made aware was much higher than the 26% in Y2). 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 110 parents who completed this item, 72 (or 65.5%) reported that they had received recommendations for services (this percentage is somewhat lower than the 76% in Y2). 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 73 parents reported at least one service recommendation. As seen below in Table 16, the most commonly reported recommendation, made for over two-thirds of the youth for whom a recommended service was reported, was for individual counseling for the juveniles. The other commonly reported service recommendation was for substance abuse treatment, which was reported by over 20% of the parents who completed this item. Eleven parents (or 15.1% who answered this question) reported that they could not remember what service or services had been recommended for their child. These three common responses were the same as the top three reported in Y2, although the percentages differed somewhat (in Y2, counseling and substance abuse treatment were reported by 37% and 26% of the parents, respectively, and in Y2 18% of the parents 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
Individual counseling	49	67.1
Substance abuse treatment	15	20.6
Can't remember	11	15.1

Note. The percentages in this table are calculated out of the 73 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 62 parents who completed this item, 51 (or 82.3%) 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. Five respondents completed this item (four others reported that their child could not access recommended services because he or she was still in detention). The two most common responses, both reported by two of the five respondents, were that they could not afford the recommended service and that they did not have time to take the juvenile to the recommended service. One parent reported that his or her child refused to access the recommended service. The number of parents reporting barriers was considerably lower than in Y2 (13), and the top two barriers reported in Y2—that the child refused to access the recommended service and that the provider refused to provide the recommended treatment—clearly were not perceived as major barriers in Y3.

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 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 43 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, 34 (or 79.1%) reported that they were aware that the closest JDC had a clinician in it; the percentage of judges/JPOs aware of the program is very similar to that in Y2 (80%), and substantially higher than in Y1 (66%). 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.

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 34 judges/JPOs who completed this item, 31 (or 91.2%) reported that they had been contacted by the JDC clinician about at least one of their juveniles (this percentage is noticeably higher than the 79% reported by judges/JPOs in Y1 and the 73% in Y2). 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 (over 48%) or satisfied (over 41%) with the contact with the JDC clinician. Three judges/JPOs (or slightly over 10% of all who completed this item) reported being neither satisfied nor dissatisfied with contact with the JDC clinician. The satisfaction rate of nearly 90%, with half of judges/JPOs being very satisfied, is nearly identical to what was found in both Y1 and Y2.

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?	0.0% (N = 0)	0.0% (N = 0)	10.3% (N = 3)	41.4% (N = 12)	48.3% (N = 14)

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 31 judges/JPOs who completed this item, 29 (or 93.5%) reported that they had received such recommendations (the percentage of judges/JPOs who reported receiving recommendations was nearly identical to the 93% in Y1, and slightly higher than the 90% in Y2). 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, fully 90% of the judges/JPOs who completed this item reported being either satisfied (nearly 47%) or very satisfied (more than 43%); this percentage reflected an improvement over the 79% satisfaction rate in Y1 and 85% satisfaction rate in Y2. Two judges/JPOs (less than 7%) reported being neither satisfied nor dissatisfied with the clinician recommendations, and one (over 3%) reported being very dissatisfied.

Item	Very Dissatisfied	Dissatisfied	Not Satisfied or Dissatisfied	Satisfied	Very Satisfied
How satisfied were you with the recommendations made by the mental health clinician?	3.3% (N = 1)	0.0% (N = 0)	6.7% (N = 2)	46.7% (N = 14)	43.3% (N = 13)

Note. The percentages in this table are calculated out of the 30 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 30 judges/JPOs who completed this item, 22 (or 73.3%) 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 similar to that of the 74% of judges/JPOs in Y1, but markedly lower than the 85% in Y2. 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. Nine judges/JPOs wrote a comment in response in the blank. The only comment written by multiple judges/JPOs (four, or 44.4%) was that the juvenile for whom the recommendation was made was already receiving the recommended service.

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, over 61% 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 nearly 84%). Four judges/JPOs, representing nearly 13% of the total sample, reported a neutral response. One judge/JPO (3%) reported believing that it was not very beneficial to have a clinician in the nearest JDC. The total beneficial rate in Y3 was higher than the 78% in Y1, but lower than the 93% in Y2.

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)	3.2% (N = 1)	12.9% (N = 4)	22.6% (N = 7)	61.3% (N = 19)

Note. The percentages in this table are calculated out of the 31 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. Twenty-nine (93.5%) of the 31 judges/JPOs who completed this item reported that they would like to see the clinical services program continue (this approval rate was very similar to the 92% in Y1, and lower than the 100% in Y2). All judges/juvenile probation officers were then asked to explain why they would or would not like to see the program continue, and 22 comments were offered. Eighteen of these comments were positive in tone, and four were negative in nature.

Juvenile Survey

As discussed earlier in this report, the fourth phase of data collection involved a web-based survey of juveniles recently released from detention. This survey included items almost identical to those on the parents’ survey, and were intended to understand issues related to clinician

contact and community-based services recommended by clinicians, as well as issues related to whether the juveniles had accessed the services recommended for them. Unfortunately, and as discussed earlier, only two juveniles accessed and submitted a survey. Both of these were incomplete, with the juveniles answering only the first item. This item asked about whether the juveniles had met with a clinician while in the JDC. One juvenile responded “Yes” to this question, and the other answered “No.”

Summary and Conclusions

The material in this report describes the results of the third-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 (only two valid responses have been gathered to date from Wave Four, no results from this wave 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

As noted in an earlier report on the CSP (McDonald et al., 2010), a benefit of conducting programmatic research over multiple years is that improvements can be made when difficulties are identified in previous evaluations. Over the three years of evaluations of the CSP, methodological improvements have been made, and they seem to be leading to desired outcomes. As mentioned in the Methodology section of this report, no substantive changes have been made to the First Wave data collection process; data from clinicians were collected in Y3 in very much the same way as they were in Y1. However, it is clear that clinicians in Y3 submitted more complete and better data than in previous years. There were fewer missing data fields in Y3 (e.g., fields in which AST scores, provisional diagnoses, or recommended services were not entered) than in either previous year, suggesting that clinicians are becoming increasingly comfortable with the information submission process and that the evaluators are getting more accurate information from the clinicians. The only shortcoming in the Y3 Wave One data collection effort involved the inability to utilize data from the JDC in Minidoka County, which, as discussed earlier in the report, was due to corruptions of the Excel files sent by the clinician at that facility. File corruptions certainly occur periodically in research, and there is little that can be done to control for this, however, the loss of the Minidoka JDC data was unfortunate, as an average of 184 juvenile cases (representing an average 9.3% of the total population) had been submitted from that JDC in the previous two evaluations. The lack of data from Minidoka County make it difficult to generalize the results of the Y3 evaluation to the areas served by the Minidoka County JDC.

Very few changes (minor wording modifications on survey items to increase clarity) were made to the Second Wave data collection process between Y2 and Y3; the major methodological change from Y1 to Y2 involved moving from a mail survey to a telephone survey of parents, and in Y3 the telephone survey strategy was retained. The telephone survey strategy has been a clear improvement; whereas only 48 parents completed the mail survey in Y1, 273 and 233 completed a telephone survey in Y2 and Y3, respectively (furthermore, the response rate improved from less than 6% in Y1 to 73% and 66% in Y2 and Y3, respectively). The minor changes in survey item wording also led to more complete survey responses in Y3 compared to Y2. No real

changes of any type have been made to the judges'/JPOs' survey strategy between Y1 and Y3. This wave of data collection has worked efficiently in each year of the evaluation.

As noted earlier, the Wave Four efforts to utilize a web-based survey of juveniles were not successful. This is the second consecutive year that IDJC staff and the BSU research team have attempted to gain juveniles' responses on issues related to the CSP—particularly the extent to which they have accessed recommended community-based surveys. As discussed in an earlier evaluation report (McDonald et al., 2010), due to procedural delays the plan to conduct a juvenile survey in Y2 was not put into action. In Y3, critical aspects of the data collection plan were in place prior to the beginning of the evaluation; a professional website was developed, information sheets and web passwords were distributed to JPOs in a timely fashion, and IDJC administrators made personal contact with JPOs to lend organizational credibility to the data collection effort and to encourage participation. It seemed the important components for successful data collection were operational, however, as noted earlier, only two juveniles actually accessed and provided responses (both incomplete) to the survey. As noted in the Methodology section of this report, in retrospect it appears that some of the passwords provided by the website developer did not allow access to the website; thus, it is probable that some juveniles who could have provided meaningful responses were systematically prevented from doing so. Second (and also as noted in the Methodology section), it appears that, despite the personal contact made by IDJC administrators, some JPOs may not have understood the reasons for or importance of the survey, and did not distribute the information sheets and passwords to eligible juveniles and their parents. Such a failure to provide an opportunity to participate also systematically prevented eligible juveniles from being able to provide meaningful responses. In short, Wave Four data collections appear to have failed largely due to a technological flaw in website access and a lack of JPO understanding about the survey.

If a juvenile survey is to be used in any future evaluations of the CSP, it seems an overhaul of the proposed methodology is in order. The decision to use a web-based survey was originally made to allow for a high level of confidentiality in responding (e.g., no juveniles' handwriting could be linked to the data, no postmarks would exist on returned envelopes) and also to reduce cost (e.g., no photocopying of materials or postage would be required). In hindsight, the benefits of a web-based survey may be outweighed by the costs. Use of a web-based survey requires juveniles to access a computer, type in a URL address (the length and complexity of the URL provided by the website developer was sadly prohibitively long and complex), and navigate through a software program. For juveniles with home computers, some patience, and a bit of computer experience this might not be difficult, however many juveniles may lack one, several, or all three of these resources. Simply put, a web-based survey perhaps creates more barriers to participation than it removes. A mail survey may be a better option—especially if prepared surveys with a self-addressed, postage-paid envelope were provided directly by JPOs to the eligible juveniles and their families. Of course, for this modified strategy to be successful, JPOs would still need to better understand and support data collection efforts. A greater effort to 'advertise' the juvenile survey by persons with organizational credibility is likely necessary to help the JPOs feel comfortable with the goals and importance of the juvenile survey effort.

Mental Health and Substance Abuse Issues

Longitudinal (or multi-year) evaluations have a number of benefits, not the least of which is the ability to establish patterns. When a single year evaluation is conducted, observers may always wonder if what was reported for that year was an anomaly (e.g., whether what was found that year would not be true of most years). When a second-year evaluation is conducted, any observed discrepancies between the two years may lead observers to wonder which year was more representative of the true state of affairs. A third year of evaluation provides the ability to better account for anomalies (if two years are similar, and one is different, it is likely the different year that truly represents an anomaly) and to allow for an investigation of changes in important variables over time. These advantages of a longitudinal evaluation certainly exist in the assessment of the CSP. In this section, an overall assessment—from a three-year perspective—of mental health and substance abuse problems in Idaho’s detained juveniles will be presented.

There seems little question that the prevalence of mental health problems in detained juveniles is disturbingly high. Comparisons for the three years of evaluations show that the percentage of juveniles meeting the AST diagnostic criteria for a mental health problem range from 59% in Y2 to 68% in Y1, with the three-year average of 63% being nearly identical to the Y3 percentage. In plain language, the conclusion that must be reached is that close to two-thirds of juveniles detained in Idaho in a given year meet the clinical criteria for diagnosis with a mental health problem. Comparisons of the three years of evaluations show the percentage of detained juveniles meeting the AST diagnostic criteria for a substance abuse problem range from 44% in Y3 to 54% in Y1, with a three-year average of 48% (close to the 46% reported in Y2). Again in plain language, the conclusion that must be reached is that close to half of juveniles detained in Idaho in a given year meet the clinical criteria for diagnosis with a substance abuse problem. Based only on AST screening outcomes, we can conclude that in a given year more than three-fourths of juveniles detained in Idaho meet the clinical criteria for diagnosis with either a mental health or substance abuse problem (based on annual percentages of 82%, 75%, and 76% for Y1, Y2 and Y3, respectively). Also based only on AST screening outcomes, we can conclude that in a given year approximately one-third of juveniles detained in Idaho meet the clinical criteria for diagnosis with both a mental health problem and a substance abuse problem (based on the annual percentages of 41%, 31%, and 30% for Y1, Y2, and Y3 respectively) in a given year.

A more sensitive index than AST scores of the actual prevalence of mental health and substance abuse problems are the provisional diagnoses made by JDC clinicians. This is true because the JDC clinicians make provisional diagnoses based on AST scores *and* their brief clinical interviews of detained juveniles (i.e., not simply AST scores alone). Based on the provisional diagnoses, it can be concluded that over four-fifths of juveniles detained in Idaho suffer from either a mental health or substance abuse problem (based on annual percentages of 84, 86, and 83 for Y1, Y2, and Y3, respectively). Because they were reported to be the three most commonly provisionally diagnosed problems in each year’s evaluation (and in the same order), we can conclude that the specific problems affecting detained juveniles are likely to include depression, substance abuse, and disruptive behavior disorders.

It is not only clear that a large percentage of Idaho juveniles entering detention suffer from mental health and substance abuse problems, but also that many of these juveniles were known to have these problems prior to detention. Based on juveniles' reports on whether or not they have been previously diagnosed with a mental health or substance abuse problem (59%, 68%, and 69% in Y1, Y2, and Y3, respectively), it can be concluded that nearly two-thirds of juveniles detained in Idaho in a given year have been previously diagnosed with such a problem prior to their most recent detention. As noted in the Y2 report (McDonald et al., 2010), this finding has important implications regarding the identification and treatment of juveniles who suffer from mental health and substance abuse problems. It is well known that untreated or undertreated mental health and substance abuse problems steer both juveniles (Rogers, Zima, Powell, & Pumariega, 2001; Sullivan, Veysey, Hamilton, & Grillo, 2007) and adults (Erickson, Rosenheck, Trestman, Ford, & Desai, 2008) into the corrections system. It is also well understood that the correctional environment is not the ideal setting to deliver mental health and substance abuse treatment; often many detainees who are in need of treatment do not receive it while incarcerated (Teplin, Abram, McClelland, Washburn, & Pikus, 2005). Finally, it is well documented that once juveniles and adults—especially those with mental health and substance abuse problems—become involved in the correctional system they tend to cycle back through it for years to come (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009). Given that the costs of incarceration in Idaho and around the nation are painfully high (Schmitt, Warner, & Gupta, 2010), it seems wise to reduce the rates of initial incarceration and recidivism (Cohen & Piquero, 2009). Reducing the rates of initial incarceration seem beyond the ability of the CSP; those juveniles coming into the system with a previous diagnosis of a mental health or substance abuse problem may have avoided eventual detention had their problem been treated in an efficacious fashion, however the fact is that they were detained. Ideally, similar to what has been reported by others (e.g., Burraston, Cherrington, & Bahr, 2010; Foster, Qaseem, & Connor, 2004), the CSP can help reduce recidivism and future social costs through helping detained juveniles avoid subsequent contact with the correctional system by linking them with necessary community-based services upon their release.

Service Recommendations and Access

As noted in earlier reports (McDonald et al., 2009; McDonald et al., 2010), the identification of mental health and substance abuse problems is only one key component of the CSP; the other involves the successful linkage of diagnosed juveniles to community-based services upon their release. Simply knowing that a high percentage of juveniles suffer from mental health problems, substance abuse problems, or both obviously will not facilitate their recovery or reduce the likelihood that they return to the correctional system; the knowledge only becomes powerful through its ability to facilitate treatment. As noted in earlier evaluation reports (McDonald et al., 2009; McDonald et al., 2010), the success of clinicians in facilitating mental health and/or substance abuse treatment for provisionally diagnosed juveniles can be measured in several ways. 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. Using the first metric, it can be surmised that the clinicians have been doing a better job each year recommending services to provisionally diagnosed juveniles. In Y1, 88% of provisionally diagnosed juveniles were given at least one

recommendation for a community-based service; in Y2, 94% were. In Y3, more juveniles were given recommendations for community-based services than were provisionally diagnosed, suggesting that all or nearly all provisionally diagnosed youth were given recommendations, as were a number of juveniles who did not meet the criteria for a provisional diagnosis. In short, clinicians were much more active in making service recommendations in Y3 than in either of the previous years. Using the second metric, it seems that the clinicians have become increasingly successful in facilitating juveniles' access to the services they recommend. In Y1, only about 43% of the juveniles reported having accessed a recommended service by the time of the clinicians' follow-up calls at 15 days post-release. In Y2, that percentage increased to 53%. In Y3, 57% of the juveniles reported having accessed at least one recommended service—a 33% increase over Y1 (the actual percentage of juveniles accessing recommended services may actually be higher than the 57% who had done so by the time of the 15-day follow-up call; in response to the parent survey issued well after 15 days post-release, 82% of the parents who reported their child receiving a service recommendation reported that their child had accessed at least one recommended service). Thus, it seems to be that clinicians are not only recommending services to more juveniles than they were earlier, but also that more juveniles are accessing the services recommended to them.

Stakeholder Perceptions

Throughout the three years of CSP evaluations, the two key groups of stakeholders whose perceptions have been consistently assessed have been parents and judges/JPOs. The perceptions of these two groups in Y3 (with comparisons to Y1 and Y2, as appropriate) are discussed below.

One of the major findings in the Y3 parent survey is that a much higher percentage of Y3 parents (over 47%) reported that their child had been identified as someone who could benefit from community-based mental health or substance abuse services than in Y2 (26%). It is possible that this higher percentage is due to subtle wording changes in the Y3 survey (which reflected that clinicians could make parents aware through a letter or telephone contact, whereas the Y2 language may have inadvertently inferred that the awareness was made by telephone only), or it could be that clinicians are doing a better job of raising awareness of the need for services than in previous years. In any case, the increased parent awareness is clearly a positive development; if parents are not aware of service recommendations, it is unlikely that they will facilitate service access or ensure that their child complies with the recommendations. Still, the fact that 53% of the parents reported that they had not been made aware that their child was identified as someone who could benefit from community-based services is a cause for concern. In presentations and debriefing sessions with clinicians from around the state, the research team noted that clinicians are quite adamant that they always or almost always inform parents of services they recommend for their children; why a majority of parents report otherwise is unknown. One possibility is that the telephone survey of parents was often conducted well after (in some cases, by more than one year) the services were recommended, the parents simply forgot about the information provided by clinicians. In any case, the dynamics behind this disconnect seem they deserve further exploration.

The perceptions of judges and JPOs were overwhelmingly positive in both of the first two years of the CSP, and Y3 was no different. Large majorities of the judges/JPOs who returned surveys

in Y3 reported being aware of the CSP, having been contacted by a JDC clinician, receiving recommendations from the JDC clinician, and being satisfied with the contact. A clear majority also reported that recommendations affected decisions they made regarding their youth. Eighty-four percent of the judges/JPOs reported believing the CSP to be beneficial, and 94% reported wanting to see the program continue. In short, there is no question that judges/JPOs in Y3, as in Y1 and Y2, are convinced of the value of the CSP and the effect it has on youth processed in the JDCs.

Concluding Comments

As documented throughout this report, rates of mental health and substance abuse problems, averaged across three years of evaluations, are very high among Idaho's detained juveniles. That 63% of these juveniles meet the diagnostic criteria for a mental health problem and 48% meet the criteria for a substance abuse problem alone suggest that Idaho's juvenile justice community faces a serious challenge in providing services to detained youth. Although it is always difficult to make direct comparisons to other states (often due to different diagnostic or reporting strategies), it appears Idaho's challenge with respect to treating detained juveniles with mental health and or substance abuse problems is as great or greater than in other areas. For example, Wasserman and her colleagues (2003), summarizing numerous scientific studies, reported that "as many as 65% of youths in the juvenile justice system have diagnosable disorders" (p. 752); this percentage is clearly lower than the 78% of Idaho's detained juveniles (averaged across the three years of evaluation) who met the AST screening criteria for either a mental health or a substance abuse problem, as well as the 84% of Idaho's detained juveniles (again averaged across the three years of evaluation) who were given a provisional diagnosis of a mental health or substance abuse problem after AST screening and a clinical interview. The percentage of Idaho's detained juveniles with mental health or substance abuse problems also seems higher than those reported in other studies (e.g., Arroyo, Buzogany, & Hansen, 2001; Fazel, Doll, & Langstrom, 2008). Thus, the need is great in Idaho for a comprehensive strategy to work with juveniles with mental health and substance abuse problems.

The consequences for not having a comprehensive strategy to treat these problems are likely to be serious. Untreated and undertreated mental health and substance abuse problems are both widely reported to be risk factors for recidivism (e.g., Baillargeon, Binswanger, Penn, Williams, & Murray, 2009; Behnken, Arredondo, & Packman, 2009; Cottle, Lee, & Heilbrun, 2001; Fazel et al., 2008; Foster, Qaseem, & Connor, 2004). It is well understood that high levels of recidivism have enormous social and personal costs. For example, in their recent article on the economic costs of crime, Cohen and Piquero (2009) noted that a relatively small subset of individuals who begin committing crimes as juveniles and continue offending as they age, cost society a tremendous amount of money over their criminal careers. They estimate "the present value of saving a 14-year-old high risk juvenile from a life of crime to range from \$2.6 to \$5.3 million" (p. 25). Evidence-based, scientifically sound mental health and substance abuse screening and facilitation of linkages to community-based services are both recognized best practices in effective treatment and reducing recidivism (e.g., Luchansky, He, Longhi, Krupski, & Stark, 2006; Wasserman et al., 2003), and these are two cornerstones of the CSP. Thus, the CSP appears one important element of a comprehensive strategy to identify and treat mental

health and substance abuse problems in detained Idaho juveniles in order to reduce recidivism and the social and personal costs of crime.

The results of the three evaluations of the CSP strongly suggest that this program is successful in identifying mental health and substance abuse problems in detained juveniles in Idaho, and it appears the program is also increasingly successful in linking these juveniles, upon their release, to community-based services. Still, as noted in the Y2 report (McDonald et al., 2010), there is no way of knowing the extent to which the identification of problems and linkages to community-based services are reducing recidivism and the social and personal costs of untreated mental health and substance abuse problems. In terms of future directions for research, outcome tracking may be a desirable and appropriate strategy to make judgments about the effectiveness of the CSP in achieving these goals. The simplest measure of “success” in terms of the reduction of recidivism would be to assess whether juveniles who have been detained after the statewide implementation of the CSP recidivate at lower levels than juveniles who were detained prior to the program’s implementation (methodologically, this might be relatively easy to accomplish as existing data collected at the JDCs could be used). A more in-depth strategy would involve assessing the community-based services accessed to determine their effectiveness; ultimately, the CSP will only be as effective as the community-based services it facilitates access to. In terms of making judgments about effectiveness, researchers could use the best practices identified by Mueller and his colleagues (Mueller, Giacomazzi, Greenleaf, May, & Towell, 2008) in their report to the Idaho Criminal Justice Commission. In this report, Mueller et al. (2008) discussed a number of evidence-based practices for treating juvenile offenders with mental health and substance abuse problems, including Functional Family Therapy, Multisystemic Therapy, Family Empowerment Intervention, Systems of Care, and Wraparound programs. One measure of the effectiveness of the community-based services JDC clinicians refer detained youth to would be whether the recommended service providers utilize one or more of the best practices identified by Mueller et al. (2008). Individual or focus group interviews with service providers could help clarify the answer to this question.

In conclusion, it is clear that the CSP is demonstrating its effectiveness in identifying mental health and substance abuse problems in detained juveniles, and in facilitating access to community-based services for juveniles when they are released from the JDCs. The extent to which these program successes lead to reduced recidivism and the social and personal costs associated with continued criminal behavior are not clear, however, and future research to understand this better seem both desirable and warranted.

References

- Arroyo, W., Buzogany, W., & Hansen, G. (2001). *American Academy of Child and Adolescent Psychiatry (AACAP) Task Force on Juvenile Justice Reforms: Recommendations for juvenile justice reform*. Washington, DC: AACAP.
- Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. Psychiatric disorders and repeat incarcerations: The revolving prison door. *American Journal of Psychiatry*, *166*, 103-109.
- Behnken, M. P., Arredondo, D. E., & Packman, W. L. (2009). Reduction in recidivism in a juvenile mental health court: A pre- and post-treatment outcome study. *Juvenile and Family Court Journal*, *60*, 23-44.
- Burraston, B. O., Cherrington, D. J., & Bahr, S. J. (2010). Reducing juvenile recidivism with cognitive training and a cell phone follow-up: An evaluation of the RealVictory program. *International Journal of Offender Therapy and Comparative Criminology*. DOI: 10.1177/0306624X10388635
- Cohen, M. A., & Piquero, A. R. (2009). New evidence on the monetary value of saving a high risk youth. *Journal of Quantitative Criminology*, *25*, 25-49.
- Cottle, C., Lee, R., & Heilbrun, K. (2001). The prediction of criminal recidivism in juveniles: A meta-analysis. *Criminal Justice and Behavior*, *28*, 367-394.
- Erickson, S. K., Rosenheck, R. A., Trestman, R. L., Ford, J. D., & Desai, R. A. (2008). Risk of incarceration between cohorts of veterans with and without mental illness discharged from inpatient units. *Psychiatric Services*, *59*, 178-183.
- Fazel, S., Doll, H., & Langstrom, N. (2008). Mental disorders among adolescents in juvenile detention and correctional facilities: A systematic review and metaregression analysis of 25 surveys. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*, 1010-1019.
- Foster, E. M., Qaseem, A., & Connor, T. (2004). Can better mental health services reduce the risk of juvenile justice system involvement? *American Journal of Public Health*, *94*, 859-865.
- Luchansky, B., He, L., Longhi, D., Krupski, A., & Stark, K. D. (2006). Treatment readmissions and criminal recidivism in youth following participation in chemical dependency treatment. *Journal of Addictive Diseases*, *25*, 87-94.
- McDonald, T. W., Williams, M. N., Osgood, L. S., & VanNess, E. M. (2009). *A statewide and multimodal assessment of the Idaho Department of Juvenile Corrections' Clinical Services Program*. Boise, ID: Center for Health Policy, Boise State University.

McDonald, T. W., Osgood, L. S., & VanNess, E. M. (2009). *Year two assessment of the Idaho Department of Juvenile Corrections' Clinical Services Program*. Boise, ID: Center for Health Policy, Boise State University.

Mueller, D., Giacomazzi, A., Greenleaf, D., May, D., & Towell, A. (2008). *Best practices/gap analysis regarding the handling of juvenile offenders with substance abuse, mental illness, and co-occurring disorders: A white paper to the Idaho Criminal Justice Commission*. Boise, ID: Department of Criminal Justice, Boise State University.

Rogers, K. M., Zima, B., Powell, E., & Pumariega, A. J. (2001). Who is referred to mental health services in the juvenile justice system? *Journal of Child and Family Studies, 10*, 485-494.

Schmitt, J. Warner, K., & Gupta, S. (2010). *The high budgetary cost of incarceration*. Washington, D.C.: Center for Economic and Policy Research.

Sullivan, C. J., Veysey, B. M., Hamilton, Z. K., & Grillo, M. (2007). Reducing out-of-community placement and recidivism: Diversion of delinquent youth with mental health and substance abuse problems from the justice system. *International Journal of Offender Therapy and Comparative Criminology, 51*, 555-577.

Teplin, L. A., Abram, K. M., McClelland, G. M., Washburn, J. J., & Pikus, A. K. (2005). Detecting mental disorder in juvenile detainees: Who receives services. *American Journal of Public Health, 95*, 1773-1780.

Wasserman, G. A., Jensen, P. S., Ko, S. J., Cocozza, J., Trupin, E., Angold, et al. (2003). Mental health assessments in juvenile justice: Report on the consensus conference. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*, 752-761.