

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

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by

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Executive Summary

During the past several years, a program known as the clinical services program (CSP) has housed a mental health clinician in each of the 12 juvenile detention centers (JDCs) in Idaho. During 2007, the CSP was conducted as a pilot program 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 five years (2008-2012). 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, 2009-2010, and 2010-2011 by researchers at the Center for Health Policy (CHP) at Boise State University (BSU), all strongly indicated a need for continued clinical services for detained juveniles. For example, all four evaluations indicated that over 70% 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, met the AST diagnostic criteria for a mental health or substance abuse disorder. All four 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 2007-2010 supported the funding of the CSP for another year, and in 2011 it continued in the 12 JDCs in Idaho. The CSP retained its collaborative nature as a partnership among the Idaho Department of Juvenile Corrections (IDJC), the Juvenile Justice Children's Mental Health Workgroup (JJCMH), and the Idaho Department of Health and Welfare (IDHW). IDJC, which continued to be responsible for oversight of the project, again contracted with researchers from the CHP to conduct the Year 4 Assessment (Y4). Similar to the Year 1 (Y1), Year 2 (Y2), and Year 3 (Y3) 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. The fourth wave of evaluation, which was used in Y3 but was not part of the evaluation protocol in prior years (i.e., pilot study, Y1, and Y2), involved an internet-based survey of recently released

juveniles who had received at least one recommendation for community-based services from a JDC clinician. Two additional data collection waves were included in the Y4 evaluation protocol. The fifth wave of data collection, which has not been used in any of the prior years, involved information gathered in interviews with JDC clinicians, administrators, and line staff; the purpose of these interviews was to determine whether having a clinician was associated with any changes in Idaho's JDCs. The sixth and final wave of evaluation, which was also new to the Y4 evaluation protocol, involved the transfer of incident data for each JDC for calendar years 2005-2010 from IDJC to the researchers at BSU; these incident data consisted of use of restraints and suicide attempts.

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

Wave One: JDC Clinician Data:

- **Data were submitted on a total of 2,066 juveniles**
 - **Close to 73% of the juveniles on whom data were collected were boys, and approximately 27% were girls**
 - **Data on detained juveniles were submitted by clinicians at all 12 JDCs. Data from the JDC in Lemhi County was excluded from the report because there were too few cases to guarantee anonymity (thus, the data in this assessment are from 11 JDCs)**
 - **The JDCs that submitted the most data cases included those in Twin Falls (slightly over 16%), Canyon (more than 14%), Minidoka (14%), and Kootenai (nearly 14%) counties. The JDCs that submitted the fewest data cases included those in Valley (less than 1%), Bonner (less than 3%), and Fremont (less than 4%) 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**
- **Nearly 59% 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 67%) were statistically significantly more likely to meet the AST criteria for a mental health problem than were boys (nearly 56%)**
 - **Juveniles met the AST criteria for having a mental health problem at statistically significantly different rates across the 11 JDCs**
 - **Indications of mental health problems were highest among juveniles screened at the JDCs in Fremont (76%), Canyon (75%), and Nez Perce (68%) counties. Indications of mental health problems were lowest among juveniles screened at the JDCs in Valley (38%), Bonner (43%), and Ada (47%) counties**

- **Nearly 43% 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 (63%), Kootenai (62%), and Fremont (60%) counties. Indications of substance abuse problems were lowest among juveniles screened at the JDCs in Minidoka (23%), Bonneville (26%), and Bonner (28%) counties**

- **When the combination of AST indications of mental health and substance abuse problems were evaluated, it was found that 72% 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 30%), followed by having both a mental health and substance abuse problem (29%), having neither a mental health nor a substance abuse problem (28%), 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 (29% to 24%) and a substance abuse problem only (15% to 9%), girls were more likely than boys to have indications of a mental health problem only (36% to 27%) and both a mental health and substance abuse problem (31% to 29%)**
 - **A statistically significant difference also existed in combination of mental health and substance abuse indications as a function of JDC location**
 - **The most common single combination of indications for juveniles in four JDCs (in Ada, Bonner, Kootenai, and Bonneville 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, Minidoka, and Twin Falls counties), and having both types of problems was the most common combination in three JDCs (in Canyon, Fremont, and Nez Perce counties). There was a tie for the most common combination between juveniles meeting the combination for a substance abuse problem only and neither a mental health nor a substance abuse problem in the JDC in Valley County**
 - **Whereas the least common single combination of indications for juveniles in seven JDCs was having a substance abuse problem only, the least common combination in the JDCs in Bannock and Nez Perce counties was having neither a mental health nor a substance abuse problem, and there was a tie for the least common combination between juveniles meeting the criteria for a mental health problem only and those meeting the criteria for having both a mental health and substance abuse problem in the JDC in Valley County**

- **Sixty-seven 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 1.28**
 - **A statistically significant difference in mean number of previous diagnoses was found between boys and girls, with girls reporting more previous diagnoses (1.34) than boys (1.26)**
 - **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 Nez Perce (1.71), Fremont (1.61), and Bonner (1.50) counties. Mean numbers of previous diagnoses were lowest among juveniles in the JDCs in Kootenai (1.04), Bonneville (1.09), and Ada (1.15) counties**
- **Fully 73% 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 problem. The mean number of provisional diagnoses for all juveniles with at least one provisional diagnosis was 1.51**
 - **A statistically significant difference in mean number of provisional diagnoses given was found between boys and girls. Girls were given more provisional diagnoses (1.59) of mental health or substance abuse problems than were boys (1.47)**
 - **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 Twin Falls and Valley (both 1.75) counties, followed by the JDC in Ada County (1.65). The lowest mean numbers of provisional diagnoses were given to juveniles in the JDCs in Kootenai (1.06), Bonner (1.23), and Bonneville (1.29) counties**
- **The most commonly given provisional diagnosis was for a mood disorder, which appeared to affect 49% of the provisionally diagnosed juveniles. Other common provisional diagnoses included substance abuse disorders (37% of those provisionally diagnosed), disruptive behavior disorders (26%), anxiety disorders (20%), and attention deficit disorders (10%)**
- **Recommendations for at least one service in the community were made for 1,443 juveniles—nearly 96% of juveniles who received a provisional diagnosis. The mean number of service recommendations for juveniles who received at least one service recommendation was 1.92**
 - **There was a statistically significant difference in the mean numbers of recommendations for services given to boys and girls, with girls (2.09) receiving more service recommendations than boys (1.86)**
 - **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 Bannock (3.19), Twin Falls (2.78), and Valley (1.87) counties. The lowest mean numbers of recommended services were given to juveniles in the JDCs in Nez Perce (10.7), Minidoka (1.10), and Bonneville (1.17) counties**
- **The most commonly given recommendation for services was a recommendation for individual counseling (53% of juveniles who were given at least one service recommendation received a recommendation for individual counseling). Other commonly received service recommendations were for a substance abuse assessment (28%), to continue (unspecified) prior treatment (19%), psychological/mental evaluation (18%), and family counseling (15%)**
- **According to information gained by clinicians during a 15-day post-release follow-up call, 885 juveniles, or over 61% 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 1.81**
 - **A statistically significant difference was found in the mean number of recommended services accessed, with girls (1.96) accessing more services than boys (1.74)**
 - **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 (2.80), Twin Falls (2.07), and Canyon (1.45) counties. The lowest mean numbers of recommended services accessed were found among juveniles released from the JDCs in Fremont (.00), Valley (1.00), and Bonneville (1.12) counties**

Wave Two: Parent Survey Data:

- **A total of 410 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 311 parents (or nearly % of those contacted) agreed to complete the survey**
- **Slightly more than 40% 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 (62%) and substance abuse treatment (11%). Eight percent of the parents reported they could not remember what services had been recommended, which is the same percentage of parents who reported that their children were recommended continuation of current treatment
- Close to 96% of the parents who received at least one service recommendation for their child reported that their child had accessed at least one service
- Two parents reported barriers to their children accessing the services they were recommended. One parent reported that he or she could not afford the recommended service, and the other parent reported that his or her child refused to access the recommended service

Wave Three: Judge/Juvenile Probation Officer Survey

- The response rate to the survey sent to judges/juvenile probation officers (JPOs) was just over 31%, as 45 of the 136 eligible judges/juvenile probation officers who received a survey returned a survey
- Ninety-one percent of the judges/JPOs who completed a survey reported that they were aware that the JDC nearest to them had a mental health clinician working in it
- Of the judges/JPOs who were aware of the clinical services program, nearly 93% reported having been contacted by a clinician regarding one of the youth they were working with
 - The level of satisfaction with the contact from the JDC clinicians was outstanding, as 100% of those judges/JPOs who reported having been contacted were very satisfied (nearly 61%) or satisfied (over 39%) with the contact
- Of the judges/JPOs who had been contacted by a JDC clinician, over 97% reported having been given a recommendation on treatment or decisions from this clinician
 - The level of satisfaction with recommendations provided by the JDC clinicians was outstanding, as 100% of those judges/JPOs who reported receiving at least one recommendation were very satisfied (nearly 52%) or satisfied (nearly 49%) with the recommendation(s)
- Among the judges/JPOs who reported having received recommendations from the clinicians, over 81% 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” (75%), followed by “rather beneficial” (nearly 22%). One judge/JPO (3%) reported it to be “not very beneficial”

- When asked whether they would like to see the CSP continue, nearly 97% of the judges/JPOs reported wishing to see it continue

Wave Four: Juvenile Survey

- The response rate to the juvenile survey could not be determined because it was not known how many information sheets were actually distributed to juveniles and their parents by those JPOs to whom packets containing information sheets were mailed by the BSU researchers. Of the unknown number of juveniles who received an invitation to complete the survey, 27 actually completed it
 - Due to the small number of completed surveys and the unknown response rate, caution should be used when generalizing the responses of the juveniles who completed the survey to all recently released juveniles who received recommendations for community-based services
- Of the 27 juveniles who completed the survey, nearly 67% reported that they had met with a counselor when they were in detention in the JDC
- Of those juveniles who reported that they had met with a counselor when they were in detention in the JDC, slightly over 22% reported that the counselor informed them that they may have a mental health or a substance abuse disorder

Wave Five: JDC Staff Interviews

- Seven of 11 JDC administrators who were sent requests to complete interviews with their staff granted interviews (no interviews were planned or conducted in the Lemhi County JDC because no data were analyzed from that JDC). The interviews lasted between 15 and 60 minutes and were completed with eight clinicians, eight administrators, and 18 line staff
- The first question on whether there had been any changes in the JDCs since clinicians were hired was asked to and completed by all administrators and line staff
 - The most common theme among the administrators was a general positive commentary on the impact of the program (100%), followed by perceptions that clinicians promote knowledge transfer and information exchange that lead to positive outcomes (88%) and that clinicians improve communication among all parties (75%). Less common themes reflected perceptions that juveniles feel more comfortable talking with clinicians than other staff and that the presence of a clinician reduces liability for the JDC (38% each)
 - The most common response provided by the 18 line staff was the perception that clinicians promote knowledge transfer and information exchange that lead to positive outcomes (56%), followed by the perceptions that clinicians are able to deescalate situations more effectively than other JDC staff (44%). Four (22%) of the line staff reported a perception that there has been no real difference since before the CSP began

- **The second question on how, if at all, the CSP had affected juveniles' behaviors in the JDCs was asked to and completed by all participants**
 - **The most common theme among the administrators reflected a perception that juveniles feel more comfortable talking about problems since the clinicians were hired (75%), followed by perceptions that training provided by clinicians helped staff better understand juvenile's mental health and substance abuse problems, that clinicians helped better prepare staff to "deal with" juveniles with such problems, and that there were fewer incidents in the JDCs requiring restrains (63% each). Less common themes reflected perceptions that there were fewer incidents in the JDCs requiring restraints, that there was a positive change in juveniles' behavior, and that the level of stress and anxiety in the JDCs was reduced (38% each)**
 - **The most common themes among the clinicians were that there were fewer incidents and a positive change in juveniles' behavior and that the JDCs were now safer as a result of the program (75% each), followed by the perception that juveniles feel more comfortable talking about problems since the clinicians were hired (63%)**
 - **The most common response provided by the line staff was that juveniles feel more comfortable talking about problems since the clinicians were hired (61%), followed by perceptions that there were fewer incidents and a positive change in juveniles' behavior (56%) and that the JDCs were now safer as a result of the program (50%)**

- **The third question about the extent to which the mental health and substance abuse screening procedures were effective at identifying problems, and what, if anything, could be done to improve screening or assessment of these problem was asked to and completed by all clinicians**
 - **The only common theme that emerged across interviews was that the AST and MAYSI-2 are good initial screening inventories (75%)**

- **The fourth question about the perceived gaps or barriers to juveniles who had been identified as possibly having mental health and/or substance abuse problems accessing community-based services that clinicians had recommended for them was asked to and completed by all administrators and clinicians**
 - **The three themes that emerged as common among the administrators were economic concerns such as cost and lack of resources to access recommended services (63%), perceived lack of parental compliance, initiative or motivation to help their children access recommended services (50%), and a perception that JPOs need to do a better job of following up with families to ensure that juveniles access recommended services (50%)**
 - **The major theme that emerged in the interviews with clinicians was lack of parental compliance, initiative, or motivation (63%), followed by economic concerns such as cost and lack of resources which was tied with lack of available services in the community (50% each)**

- **The fifth question about how juveniles' family members were involved in the CSP and what could be done to improve family involvement was asked to and completed by all administrators and clinicians**
 - **The major theme that emerged across interviews with both administrators and clinicians was that family members of juveniles who are provisionally diagnosed with a mental health or substance abuse problem are presented with a letter from clinicians that documents recommendations for community-based services (and in some cases, provides contact information for such services)(63% and 50% respectively)**

- **The sixth question on whether they had received training about mental health and substance abuse issues in detained juveniles, how any training received affected how they interact with juveniles in the JDCs, and whether they were interested in receiving further training was asked to and completed by all line staff**
 - **The major theme identified in the responses of the line staff was that more training would be helpful (56%), followed by the perceptions that training had lead to a better understanding of juveniles' behaviors and needs (44%), that training had been very helpful (33%), and that training has led to a better understanding of behaviors to watch for (28%). Four of the line staff (22%) reported that training they received from clinicians had not been very effective or helpful**

- **The seventh and final question about whether they had any final thoughts about the value of the CSP was asked to and completed by all interviewees**
 - **The most common response among the administrators was that the program should continue (100%), followed by the perceptions that the program is valuable or essential (75%), that it is beneficial for everyone involved in it (63%), and that it leads to better communication throughout the juvenile justice system (50%)**
 - **All clinicians (100%) believed that the CSP should continue, with 50% expressing the belief that the program is very valuable and 38% stating that clinicians serve as a resource to others in the juvenile justice system**
 - **Two themes that emerged as most common among the line staff were that the program is valuable or essential (61%) and that the program is beneficial to everyone involved in it (56%)**

Wave Six: Incident Data

- **Incident data were submitted for calendar years 2005-2010**

- **There were 28,017 bookings in the three years (2005-2007) prior to the implementation of the CSP compared to 24,9011 bookings in the three years (2008-2010) following the implementation of the CSP**

- **The average use of restraints per 1,000 bookings decreased from 16.17 in the 2005-2007 “pre-clinician period” to 14.05 in the 2008-2010 “clinician period,” a 13% decline**
- **The average suicide attempts per 1,000 bookings decreased from 1.53 in the 2005-2007 “pre-clinician period” to 1.04 in the 2008-2010 “clinician period,” a 32% decline**

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 JDC 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 two years, and reports on the continuation of the program were issued in 2010 (McDonald, Osgood, & VanNess, 2010) and 2011 (McDonald & Theiler, 2011).

In the three 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 with 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 and Y3), asking them whether 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 all three 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 three evaluations of the expanded CSP revealed a number of interesting findings. For example, it was found that high percentages of juveniles in all three years met the AST diagnostic criteria for a mental health problem (68% in Y1, 59% in Y2, and 62% in Y3) and a substance abuse problem (55% in Y1, 46% in Y2, and 44% in Y3). Very high percentages of juveniles were found to meet the AST criteria for at least one type of problem (82% in Y1, 75% in Y2 and 76% in Y3), and substantial percentages were found to meet the criteria for both types of problems (41% in Y1, 30% in Y2, and 31% Y3). Provisional diagnoses of at least one mental health or substance abuse problem were made for more than 70% of the juveniles in all three evaluations, with the most commonly diagnosed problems in all three years being mood disorders, substance abuse disorders, and disruptive behavior disorders. 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 surveys used in Y2 and Y3 yielded valuable results. For example, whereas in Y2 only 26% of the parents reported that they had received information from clinicians about their child's mental health and substance abuse problems, in Y3 this percentage was considerably higher (47%). Also, two-thirds or more of the parents who reported receiving information about their child's mental health and substance abuse problems reported that their children had received at least one recommendation for a community-based service in both Y2 (76%) and Y3 (66%). Of those parents who reported receiving a service recommendation, many (74% in Y2 and 82% in Y3) reported that their child had accessed at least one recommended service. Responses to the judges'/JPOs' survey indicated positive perceptions of the CSP in all three years. Most of the respondents reported being aware of the program (66% in Y1, 80% in Y2, and 79% in Y3), having had contact with JDC clinicians (79% in Y1, 73% in Y2, and 91% in Y3), and receiving recommendations for youth (93% in Y1, 90% in Y2, and 94% in Y3). A very high percentage of judges and JPOs who were aware of the program believed it to be beneficial (78% in Y1, 93% in Y2, and 84% in Y3), and nearly all reported wanting to see it continue (92% in Y1, 100% in Y2 and 94% in Y3).

The CSP was granted funding for a fourth year, and IDJC contracted with the same team of BSU researchers to evaluate it. The 2011 evaluation was performed on data collected at the JDCs between July 1, 2010 and June 30, 2011. The procedures for collecting data for the clinicians', parents', and judges'/JPOs' portions of the 2011 evaluation were identical to those used in the 2009 and 2010 evaluations. A web-based survey of recently released juveniles, which was added to the 2010 evaluation, was also included in the 2011 evaluation; 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). Two additional components were added to the 2011 evaluation. One component involved interviews with JDC administrators, clinicians and line staff that focused on assessing the merits of the clinical services program from the perspective of the members of these three populations. The other component involved an analysis of the JDC incident data for calendar years 2005-2010 that was made available to the BSU researchers by IDJC; these incident data consisted of use of restraints and suicide attempts.

Methodology

Similar to the Y1, Y2, and Y3 assessments, data were collected in several separate waves in this Y4 assessment; however, whereas data were collected in three waves in Y1 and Y2, and in four waves in Y3, there were six waves of data collection in Y4. 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 four years of evaluation (i.e., Y1, Y2, Y3, and Y4). 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 four 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 JPOs who worked with juveniles recently released from the JDCs; this wave of data collection was identical in all four evaluation years. The fourth wave of data collection, which was part of Y3, but not Y1 and Y2 evaluations (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. Although the survey itself was virtually identical in Y3 and Y4, the method of delivery differed somewhat between Y3 and Y4. The fifth wave of data collection was unique to Y4. This wave of data collection involved conducting qualitative interviews with JDC staff (clinicians, administrators, and line staff). The sixth and final wave of data collection, which was also unique to Y4, involved analysis of incident data provided by IDJC to the researchers at BSU. 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, etc.), 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 which corresponded to Uniform Crime Reporting categories (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 (notably the MAYSI-2), and the AST was ultimately used in the pilot study, Y1, Y2, Y3, and Y4. 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-Y4 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. In some cases, even if the juveniles report they have not been previously diagnosed with a mental health problem, clinicians can detect the presence of a previous diagnosis through the use of information about prescription medicines taken by the juveniles (e.g., if a juvenile is taking an anti-depressant medication, he or she has clearly at some point been diagnosed with a mental health problem).

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 four 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 15-45 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, 2010 and June 30, 2011. Data were submitted from all 12 JDCs, however, the data from the JDC in Lemhi County were not included in the final, aggregated dataset because too few cases were submitted by Lemhi County to guarantee juveniles anonymity. 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 2,066 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 and Y4.

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 2011, and wrote the parents' responses directly on paper copies of the survey. IFF returned the paper copies of completed surveys to IDJC in November 2011, 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 410 parents of recently released juveniles. Of these, 311 parents agreed to complete the survey, for a very good response rate of 76%. This response rate is identical to the 76% achieved in Y2, better than the 66% achieved in Y3, and much better than the 5% achieved in Y1.

Wave Three: Judges/Juvenile Probation Officers Survey Data

The third wave of data collected for this project involved information gathered through a survey of judges and JPOs who worked with youth released from the county JDCs. As discussed in the Y1 report (McDonald et al., 2009), a strategy for surveying judges and JPOs was developed by

Brian Mecham and used in the pilot study in 2007, and a slightly modified version of his original survey was used in each evaluation year. 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 CSP continue. They were also invited to share comments or recommendations related to the program.

Personnel at IDJC identified 139 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 45 completed surveys were returned by judges/JPOs prior the end of the data collection period, for a response rate of 33.1% (the denominator for the response rate calculation was 136, as one survey was returned due to a “bad” address, and two judges/JPOs contacted the researcher and reported not working with any juveniles in the past year). This response rate is fairly good for an unsolicited survey, and thus the results from the judges’/JPOs’ survey are considered to be representative of the population. The response rate was lower than in Y1 (44%), but higher than in Y2 (31%) and identical to Y3 (33%).

Wave Four: Juvenile Survey Data

The fourth wave of data collection involved 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. This wave of data collection was also included in the Y3 evaluation protocol, but it resulted in an extremely low response rate.

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 in Y4 was similar to the procedure utilized in Y3 in some respects, but it differed in others. In both Y3 and Y4, this procedure 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 by JPOs, described the study, discussed the voluntary and anonymous nature of participation and included a web link to the survey. A separate information sheet was created and provided to the juveniles' parents, in the recognition that they would also want to know about the study in which their children were being invited to participate. Juveniles were informed that they could only complete the survey with their parents' permission. However, whereas in Y3 the survey was hosted by a contractor (Peak Systems, Inc., a Washington-based web development and hosting company), which required the juveniles to enter a password to access the survey, in Y4 the survey was hosted on Boise State University's server (utilizing Qualtrics, a survey development program). This eliminated the need for a password. The absence of a password reduced some problems encountered in the Y3 evaluation because some of the unique passwords provided by Peak Systems, Inc. in Y3 did not allow access to the website, which may have prevented some juveniles from completing the survey. Additionally, the Uniform Resource Locator (URL) link to the survey in Y3 was very long, which may have discouraged some juveniles from completing the survey; the URL was much shorter in Y4. Finally, in Y4 an effort was made to provide more detailed information about the purpose and significance of the survey in an e-mail message sent to each JPO prior to mailing the information sheets for distribution to juveniles and their parents to them. It is possible that some JPOs were not fully convinced of the significance of the survey in the previous year because it seemed that some failed to distribute the information sheets to the juveniles in their charge in Y3.

Unfortunately, much like in Y3, Y4's wave four data collection efforts were largely unsuccessful. A total of 420 information sheets for distribution to juveniles and their parents were delivered to 42 JPOs (packets were sent to 44 JPOs, but two packets containing 10 information sheets each were returned to the sender). Prior to the end of the data collection period, 37 juveniles accessed the survey, and only 27 of those who accessed the survey actually completed it. The number of completed surveys in Y4 was considerably higher than in Y3 (when the surveys was partially completed by only two juveniles), but it was not sufficiently large to be considered representative of all recently released juveniles. It is impossible to determine why more juveniles did not complete the survey, but once again, for reasons not fully understood, it appears that some JPOs may not have distributed the information sheets to the juveniles in their charge or even opened the materials sent to them despite the effort of the researchers to provide a comprehensive explanation of the purpose and meaning of the survey in a detailed e-mail message sent to all JPOs prior to the actual mailing of the survey packets to them.

Wave Five: JDC Staff Interviews

The fifth wave of data collection involved interviewing of JDC staff, including administrators, clinicians, and line staff who worked in JDCs long enough to be able to assess the effects of the CSP. Because the implementation of the CSP in most JDCs started in 2008, only those JDC staff who were employed by the JDC for at least one year prior to the CSP implementation were eligible for participation in this segment of the evaluation. This wave of data collection, which aimed to assess the effects of the CSP on juveniles' behavior and staff safety in the JDCs, staff perception of value of the CSP, and how (if at all) the CSP could be improved, was unique to the Y4 evaluation protocol (i.e., it was not conducted in any of the prior evaluations). In the previous years of the CSP evaluation, information was solicited about juveniles' mental health and substance abuse diagnoses, and from parents, judges, and JPOs, but never from the actual personnel working with juveniles in the JDCs. It seemed important to capture the perceptions of these personnel, as they represent a way to evaluate the success of the CSP.

The same interview protocol was utilized with all staff at all seven participating JDCs, but the questions asked varied across the three target groups (i.e., administrators, clinicians, and line staff). There were a total of seven questions, some of which were asked of all interviewees and others of which were asked of members of some target groups but not others. These questions asked the JDC staff: 1) what if anything they thought was different now compared to the time before mental health and substance abuse screening in detention centers in Idaho became part of the intake process (administrators and line staff); 2) how, if at all, they thought the CSP affected juveniles' behaviors in the JDCs (all JDC staff); 3) how effective they thought the screening procedures for identifying mental health and substance abuse problems were and what, if anything, could be done to improve screening or assessment of these problems (clinicians); 4) what gaps or barriers they perceived in juveniles accessing recommended services (administrators and clinicians); 5) how family members were involved in the current CSP and what, if anything, could the program do to improve family involvement (administrators and clinicians); 6) whether they had received training about mental health and substance abuse issues in detained juveniles, how (if at all) this training had helped them work with juveniles with mental health and substance abuse problems, and whether there was additional training or

support they would like to receive from clinicians (line staff); and 7) whether they had any final thoughts about the value of the CSP (all JDC staff).

Personnel at IDJC provided the BSU researchers with the names and e-mail addresses of the administrators of 11 JDCs in Idaho covered in this evaluation. The researchers at BSU sent a request to complete interviews, along with an explanation of the purpose of the interviews including information about the voluntary and anonymous nature of the participation, to each of the 11 JDC administrators in October 2011. Seven of the 11 administrators responded to the e-mail invitation, and all seven of those who responded granted interviews. Interviews with JDC staff were conducted in person at three sites (JDCs in Bonneville, Canyon, and Kootenai counties) to allow the researchers to meet some of the JDC staff and become familiar with JDC facilities. The remaining four of the seven JDCs that granted interviews were given an option to choose whether they wished to complete the interviews via telephone or by e-mail. Telephone interviews were conducted with JDC staff from three sites (JDCs in Bannock, Bonner, and Twin Falls counties). The staff at the JDC in Fremont County chose to complete the interview via e-mail (the interview questions were e-mailed to the staff, and they returned the responses to the BSU researchers via e-mail).

A total of 34 interviews (eight clinicians, eight administrators, and 18 line staff) were completed with JDC staff from seven JDCs (Bannock, Bonner, Bonneville, Canyon, Fremont, Kootenai, and Twin Falls counties) in November and December 2011. Responses were not received from the administrators at four JDCs (Ada, Minidoka, Nez Perce, and Valley counties). Interviews with staff from the Lemhi County JDC were not planned or conducted because no data from this county were analyzed in the Y4 evaluation. As previously mentioned, some interviews were conducted in person, some on telephone, and some via e-mail. All interviews lasted between 15 and 60 minutes, the administrators and clinicians interviews generally lasting longer (between 30 and 60 minutes) than the line staff interviews (between 15 and 30 minutes).

Wave Six: Incident Data

The sixth wave of data collection involved the transfer of incident data from the IDJC to the BSU research team. The incident data consisted of the numbers of bookings, restrains, and suicide attempts for each of the 12 JDCs in Idaho for six calendar years, 2005-2010. Because in most JDCs the implementation of the CSP started in 2008, the data on the numbers of bookings, restrains, and suicide attempts were collapsed into two three-year time periods for analysis purposes: the period before (2005-2007) JDCs began implementing the CSP and the period after (2008-2010) the implementation of the CSP began. Also, because the numbers of bookings varied greatly across the six calendar years, the numbers of restrains and suicide attempts were converted to numbers per 1,000 bookings for analysis purposes to control for a possible bias that might have resulted from reporting raw numbers of restrains and suicide attempts.

Results and Analyses

Analysis of JDC Data

Demographic Information

The data in this report are gleaned from the cases of 2,066 cases of juveniles detained at one of 11 JDCs throughout Idaho. Gender codes were entered for 2,063 juveniles. Of these, 1,504 or 72.8% were boys and 559 or 27.1% were girls. The total number of cases was higher than in Y3 (1,669), Y2 (1,941), and Y1 (2,060). The percentages of boys and girls in Y4 were very similar to the averages of the first three years (denoted throughout the remainder of this report as the “three-year average”) of CSP evaluations, which were 71% for boys and 29% for girls.

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, 2010 (the period after data collection ended for the previous year’s evaluation) to June 30, 2011 (the end of the fiscal year). One JDC that submitted data for the study, which is in Lemhi County, was not included in the report because there were too few cases to guarantee anonymity (the inability to use data from the Lemhi County JDC for this reason was also the case in Y2). 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 Twin Falls County (with over 16% of the total cases), followed by the JDCs in Canyon (over 14%), and Minidoka (14%) counties. On the other hand, the smallest percentages of cases were submitted from the JDCs in Valley (less than 1%), Bonner (less than 3%), and Fremont (nearly 4%) counties.

JDC Location	Number of Cases	Percentage of Total Cases
Ada County	209	10.1
Bannock County (District 6)	171	8.3
Bonner County	54	2.6
Bonneville County (3B)	195	9.4
Canyon County (Southwest Idaho)	296	14.3
Fremont County (5C)	80	3.9
Kootenai County (District 1)	287	13.9
Nez Perce County (District 2)	133	6.4
Minidoka County	290	14.0
Twin Falls County (Snake River)	335	16.2
Valley County	16	< 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 1,981 of the juveniles,

or 95.9% of all juveniles on whom data were collected, and two booking charges were noted for 310 (15.0%) 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 (over 52% 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 and drug crimes (both just under 19%), and crimes against persons (slightly over 17%). Sex crimes were relatively uncommon among booking codes (accounting for close to 2% of all codes). The research team was unable to confidently classify 39 (just under 2%) of the listed booking codes.

Table 2: Most Common Booking Charges		
Booking Charge	Number of Cases	Percentage of Total Cases
“Other” crimes not easily fitting a category (e.g., probation violation, runaway, incorrigible, disturbing the peace)	1077	52.2
Property crimes	391	18.9
Drug crimes	390	18.8
Crimes against persons	354	17.2
Sex crimes	40	1.9
Unable to classify (e.g., discretionary days)	39	1.9

Note. The percentages in this table are calculated out of the 1,981 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, nearly 59% of the juveniles who were screened using the AST met the criteria for having a mental health problem. Also as seen in Table 3, nearly 43% of the juveniles screened with the AST met the criteria for having a substance abuse problem. The 59% figure for the percentage of juveniles who met the AST criteria for having a mental health problem is identical to that in Y2, but is lower than the 68% in Y1 and the 62% in Y3 (the three-year average for juveniles meeting the AST criteria for having a mental health problem was 63%). The 43% figure for the percentage of juveniles who met the AST criteria for having a substance abuse problem is slightly lower than the 44% in Y3 and the 46% in Y2, and considerably lower than the 54% in Y1 (the three-year average for juveniles meeting the AST criteria for a substance abuse problem was 48%).

Condition	Number of Cases	Percentage of Total Screened Cases
Mental health problem	1,032	58.5
Substance abuse problem	750	42.5

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 67% of the girls who were screened using the AST met the criteria for having a mental health problem, whereas nearly 56% of the boys appeared to have a mental health problem. A chi-square test revealed that the difference in mental health problems was statistically significant, χ^2 (df = 1) = 18.93, $p < .001$. 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%), Y2 (71% to 54%), and Y3 (73% to 59%). Thus, the gender difference in meeting AST mental health criteria continues to seem 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 quite similar at 44% and 40%, respectively, and there was no statistically significant difference in meeting these criteria as a function of gender. The lack of a statistically significant difference between boys and girls in rates of meeting AST substance abuse criteria was also found in Y1 (with boys at 55% and girls at 53%) and Y3 (45% and 44%); the exception was in Y2, when boys (at 48%) met the AST criteria for having a substance abuse problem significantly more often than girls (41%). That boys and girls met the substance abuse criteria at similar rates in three of four evaluation years suggests that the actual prevalence of substance abuse problems in these populations is indeed similar.

Condition	Number of Cases		Percentage of Total Screened Cases	
	Male	Female	Male	Female
Mental health problem	711	320	55.5	66.9
Substance abuse problem	559	189	43.6	39.5

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 nearly 38% to over 76% of the juveniles in an individual JDC. The three JDCs with the highest percentages of juveniles meeting the AST criteria for having a mental health problem

were Fremont County (where over 76% of screened juveniles met the criteria for a mental health problem), Canyon County (nearly 75%), and Nez Perce County (over 68%). The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a mental health problem were Valley County (nearly 38%), Bonner County (nearly 43%), and Ada County (over 47%). 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) = 84.66, $p < .001$.

JDC Location	Number of Cases	Percentage of Total Screened Cases
Ada County	99	<i>47.4</i>
Bannock County (District 6)	107	62.6
Bonner County	23	<i>42.6</i>
Bonneville County (3B)	96	49.2
Canyon County (Southwest Idaho)	221	74.7
Fremont County (5C)	61	76.3
Kootenai County (District 1)	101	49.5
Minidoka County	34	48.6
Nez Perce County (District 2)	34	68.4
Twin Falls County (Snake River)	193	57.6
Valley County	6	<i>37.5</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 63% of the screened juveniles met the criteria for a substance abuse problem), Kootenai County (over 62%), and Fremont County (60%). The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a substance abuse problem were Minidoka County (nearly 23%), Bonneville County (just over 26%), and Bonner County (just under 28%). 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) = 94.94, $p < .001$.

JDC Location	Number of Cases	Percentage of Total Screened Cases
Ada County	84	40.2
Bannock County (District 6)	92	53.8
Bonner County	15	27.8
Bonneville County (3B)	51	26.2
Canyon County (Southwest Idaho)	151	51.0
Fremont County (5C)	48	60.0
Kootenai County (District 1)	127	62.3
Minidoka County	16	22.9
Nez Perce County (District 2)	84	63.2
Twin Falls County (Snake River)	124	37.0
Valley County	8	50.0

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

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 a 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 only (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 (slightly under 30%) who were screened with the AST met the diagnostic criteria for a mental health problem only. The next largest group of juveniles (just over 29%) met the AST criteria for both a mental health problem and a substance abuse problem, followed by juveniles who met the criteria for neither a mental health nor a substance abuse problem (28%). The smallest group of juveniles (just over 13%) met the criteria for a substance abuse problem only. The pattern of results regarding the most common combination was similar to Y3, when meeting the criteria for a mental health problem only was also the single most common category (in both Y1 and Y2, meeting the criteria for both a mental health and substance abuse problem was the single most common category). Meeting the criteria for a substance abuse problem only was also the single least common category in all three previous evaluation years.

Condition	Number of Cases	Percentage of Total Screened Cases
Neither mental health nor substance abuse problem	493	28.0
Mental health problem only	522	29.6
Substance abuse problem only	234	13.3
Both mental health and substance abuse problem	514	29.2

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, $\chi^2 (df = 3) = 23.04, p < .001$. The largest difference was in rates of meeting the diagnostic criteria for having a substance abuse problem only; boys (at just under 15%) were considerably more likely than girls (nearly 9%) to fall into this category. Boys (at over 29%) were also somewhat more likely to meet the criteria for having neither type of disorder than girls (slightly over 24%). On the other hand, girls were found to meet the criteria for having a mental health problem only (just over 36%) than boys (slightly over 27%), and girls were also somewhat more likely to meet the criteria for having both types of problems (close to 31%) than boys (nearly 29%). 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 found in all three previous evaluation years (i.e., Y1-Y3). Clearly, these seem to be robust patterns in classification and categorization.

Condition	Number of Cases		Percentage of Total Screened Cases	
	Male	Female	Male	Female
Neither mental health nor substance abuse problem	376	116	29.3	24.3
Mental health problem only	349	173	27.2	36.2
Substance abuse problem only	191	42	14.9	8.8
Both mental health and substance abuse problem	366	147	28.5	30.8

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) = 190.96, $p < .001$. 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 four JDCs (in Ada, Bonner, Bonneville, and Kootenai counties), juveniles meeting the criteria for a mental health problem only were the single largest group in three JDCs (in Bannock, Minidoka, and Twin Falls counties), and juveniles meeting the criteria for both types of problem were the single largest group in three JDCs (in Canyon, Fremont, and Nez Perce counties). In Valley County, there was a tie for single largest group between those juveniles meeting the criteria for neither a mental health nor a substance abuse problem and those meeting the criteria for a substance abuse problem only. 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 seven of the 11 JDCs (the exceptions were the JDCs in Bannock and Nez Perce counties, where juveniles meeting the criteria for neither type of problem was the single smallest group, and the JDC in Valley County, where there was a tie for single smallest group between juveniles meeting the criteria for a mental health problem only and those meeting the criteria for having both a mental health and substance abuse problem). The pattern of results concerning the single most common category was similar to Y3, when juveniles who met the criteria for having neither a mental health nor a substance abuse problem were the single largest group in six of 11 JDCs, but differed from Y2, when meeting the criteria for a mental health problem only and neither type of problem were tied as the single largest groups in four JDCs each, and also differed 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	34.9 (N = 73)	25.4 (N = 53)	17.2 (N = 36)	22.5 (N = 47)
Bannock County (District 6)	17.5 (N = 30)	28.1 (N = 48)	20.5 (N = 35)	22.5 (N = 47)
Bonner County	42.6 (N = 23)	31.5 (N = 17)	13.0 (N = 7)	13.0 (N = 7)
Bonneville County (3B)	46.7 (N = 91)	27.2 (N = 53)	4.1 (N = 8)	21.5 (N = 43)
Canyon County (Southwest Idaho)	16.2 (N = 48)	33.1 (N = 98)	8.8 (N = 26)	41.9 (N = 124)
Fremont County (5C)	13.8 (N = 11)	26.3 (N = 21)	10.0 (N = 8)	50.0 (N = 40)
Kootenai County (District 1)	36.3 (N = 74)	26.0 (N = 53)	14.2 (N = 29)	23.5 (N = 48)
Minidoka County	36.4 (N = 24)	39.4 (N = 26)	12.1 (N = 8)	12.1 (N = 8)
Nez Perce County (District 2)	10.5 (N = 14)	26.3 (N = 35)	21.1 (N = 28)	42.1 (N = 56)
Twin Falls County (Snake River)	28.7 (N = 96)	34.3 (N = 115)	13.1 (N = 44)	23.9 (N = 80)
Valley County	31.3 (N = 5)	18.8 (N = 3)	31.3 (N = 5)	18.8 (N = 3)

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 (along with, as noted in the Methodology section, information about any psychotropic medications a juvenile might be taking) 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 1,380 juveniles, or 66.8% of all juveniles on whom data was collected (this percentage is slightly lower than the 69% reported in Y3 and 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 10 JDCs) with at least one previous diagnosis was 1.28, with a standard deviation of .61 (the number of previous diagnoses was slightly higher than the 1.26 in Y1, 1.22 in Y2, and 1.17 in Y3). The range of previous diagnoses spanned from none to five. Similar to Y3 (but unlike in Y1 and Y2), in Y4 girls (1.34) reported or were identified with significantly more previous diagnoses than boys (1.26), $t(df = 1376) = -2.24, p < .05$. The mean number of previous diagnoses also differed significantly as a function of JDC location, $F(10, 1,369) = 11.71, p < .001$ (this result is similar to that found in all three previous evaluation years). As seen below in Table 10, the JDCs with the highest number of mean previous diagnoses were those in Nez Perce, Fremont and Bonner counties. The JDCs with the lowest number of mean previous diagnoses were in Kootenai, Bonneville, and Ada counties.

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	206	<i>1.15</i>	<i>.37</i>
Bannock County (District 6)	166	1.49	.81
Bonner County	6	1.50	.84
Bonneville County (3B)	153	<i>1.09</i>	<i>.33</i>
Canyon County (Southwest Idaho)	292	1.32	.69
Fremont County (5C)	33	1.61	.86
Kootenai County (District 1)	204	<i>1.04</i>	<i>.19</i>
Minidoka County	19	1.47	.96
Nez Perce County (District 2)	7	1.71	.49
Twin Falls County (Snake River)	278	1.42	.76
Valley County	16	1.19	.40

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 1,505 juveniles, or 72.8% of all juveniles on whom data was collected (a comparison to provisional diagnoses for previous years is not feasible, as problems were identified in how these were calculated; this issue is discussed in detail in the Summary and Conclusions section of this report). The mean number of provisional diagnoses for juveniles (of both genders and across the 11 JDCs) with at least one provisional diagnosis was 1.51, with a standard deviation of .70 (the mean number of provisional diagnoses also cannot be compared to previous years due to

problems with how these were calculated; this issue is also discussed in detail in the Summary and Conclusions section of the report). The range of provisional diagnoses spanned from none to five. As was the case in all three previous evaluation years, a statistically significant difference in mean number of provisional diagnoses was found to exist between boys (1.47) and girls (1.59), with girls receiving significantly more provisional diagnoses than boys, $t(1,502) = -3.00, p < .01$. As was the case in all three previous evaluation years, the mean number of provisional diagnoses significantly differed as a function of JDC location, $F(10, 1,494) = 18.21, p < .001$. Also seen below in Table 11, the JDCs with the highest number of mean provisional diagnoses were in Twin Falls and Valley counties, followed by the JDC in Ada County. The JDC with the lowest number of mean provisional diagnoses was in Kootenai County, followed by the JDCs in Bonner and Bonneville counties.

Table 10: Number of Provisional Diagnoses by JDC Location			
JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	155	1.65	.78
Bannock County (District 6)	139	1.64	.90
Bonner County	17	<i>1.24</i>	.56
Bonneville County (3B)	119	<i>1.29</i>	.49
Canyon County (Southwest Idaho)	270	1.57	.70
Fremont County (5C)	32	1.34	.55
Kootenai County (District 1)	200	<i>1.06</i>	.23
Minidoka County	159	1.35	.56
Nez Perce County (District 2)	95	1.64	.56
Twin Falls County (Snake River)	331	1.75	.76
Valley County	8	1.75	.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, 1,505 juveniles were reportedly given at least one provisional diagnosis, in only 1,423 of these cases did clinicians indicate what the diagnosis was (or diagnoses were, if multiple diagnoses were made). Although some basic categories were provided in drop-down menus in the clinicians' Access databases, they were allowed to type in the provisional diagnoses given, and often chose to do so. A content analysis procedure was used to classify all typed answers into conceptually consistent themes. As seen below in Table 12, by far the most common diagnosis given was for a mood disorder; nearly 49% 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 37% 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 26% 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 nearly 20%

of juveniles and attention deficit disorders (e.g., attention deficit hyperactivity disorder), which was given to 10% of juveniles. Interestingly, the five most common provisional diagnoses in Y4 were the same as in all three previous evaluation years—in exactly the same order.

Table 12: Most Common Provisional Diagnoses		
Provisional Diagnosis	Number of Cases	Percentage of Total Cases
Mood disorders (e.g., depression, bipolar disorder)	688	48.6
Substance abuse disorders (e.g., marijuana or alcohol abuse)	526	37.0
Disruptive behavior disorders (e.g., oppositional defiant disorder, disruptive disorder, conduct disorder)	365	25.7
Anxiety disorders (e.g., post-traumatic stress disorder)	278	19.5
Attention deficit disorders (e.g., ADHD/ADD)	143	10.0

Note. The percentages in this table are calculated out of 1,423 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 1,443 juveniles, or 95.9% of the 1,505 juveniles who reportedly received at least one provisional diagnosis (a comparison to service recommendations for previous years is not feasible, as problems were identified in how these were calculated; this issue is discussed in detail in the Summary and Conclusions section of this report). 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 1.92, with a standard deviation of 1.55 (the mean number of service recommendations also cannot be compared to previous years due to problems with how these were calculated; this issue is also discussed in detail in the Summary and Conclusions section of the report). The range of recommended services spanned from none to 17. Similar to Y1 and Y3, but different than Y2, a statistically significant difference in the number of recommended services was found between boys and girls, with girls (2.09) receiving significantly more service recommendations than boys (1.86), $t(df = 1,439) = -2.61, p < .01$. However, similar to all three evaluation years, the mean number of recommended services was found to differ significantly as a function of JDC location, $F(10, 1,432) = 45.47, p < .001$. As seen below in Table 13, the JDC with the highest number of mean recommended services was in Bannock County (interestingly, eight juveniles were reported to have received 10 or more service recommendations from this JDC, whereas no juvenile was reported to be given as many as 10 service recommendations from any of the other JDCs), followed by the JDCs in Twin Falls and Valley counties. The JDC with the lowest number of mean recommended services was in Nez Perce County, followed by the JDCs in Minidoka and Bonneville counties.

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	168	1.75	.80
Bannock County (District 6)	169	3.19	2.85
Bonner County	42	1.50	.63
Bonneville County (3B)	124	<i>1.17</i>	.44
Canyon County (Southwest Idaho)	236	1.56	.74
Fremont County (5C)	14	1.79	.80
Kootenai County (District 1)	143	1.29	.54
Minidoka County	93	<i>1.10</i>	.33
Nez Perce County (District 2)	114	<i>1.07</i>	.29
Twin Falls County (Snake River)	325	2.78	1.66
Valley County	15	1.87	1.13

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, 1,443 juveniles were reportedly given at least one recommendation for a service, in only 1,369 (94.9%) 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 53% of the juveniles for whom a recommended service was listed were recommended to access individual counseling. Recommendations for substance abuse assessments (28%) comprised the second-most common category. Continuation of prior treatment (nearly 19%), psychological/mental evaluations (nearly 18%), and family counseling (nearly 15%) were also fairly common recommendations. Smaller numbers of recommendations were made for substance abuse counseling/treatment (nearly 11%), residential treatment (over 8%), and a medication evaluation (nearly 8%). These eight most common service recommendation categories were also the eight most common in Y3.

Service Recommendation	Number of Cases	Percentage of Total Cases
Individual counseling (e.g., Cognitive Behavioral Therapy)	727	53.1
Substance abuse assessment	385	28.1
Continue (unspecified) prior treatment	256	18.7
Psychological/mental evaluation	241	17.6
Family counseling	205	15.0
Substance abuse counseling/treatment	148	10.8
Residential treatment	114	8.3
Medication evaluation	102	7.5

Note. The percentages in this table are calculated out of the 1,369 juveniles who were assigned at least one service recommendation in the IDJC database. Because up to four 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 15-45 days after release, whether or not the recommended service(s) had been accessed. The clinicians reported that 885 juveniles, or 61.3% of the 1,443 juveniles for whom at least one service had been recommended, had accessed at least one service. 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 1.81, with a standard deviation of 1.46 (the mean number of recommended services accessed cannot be compared to previous years due to problems with how these were calculated; this issue is discussed in detail in the Summary and Conclusions section of the report). The range of recommended services accessed spanned from none (38.7% of the juveniles receiving at least one service recommendation had not yet accessed a service) to 17. Unlike in Y1 and Y2, when no gender differences in accessed services were found, but similar to Y3, a significant difference emerged in Y4 showing that girls accessed more mean services (1.96, with a standard deviation of 1.50) than boys (1.74, with a standard deviation of 1.43), $t(882) = -2.13$, $p < .05$. The mean number of recommended services accessed also differed significantly as a function of JDC location, $F(9, 875) = 18.54$, $p < .001$ (as it also did in all three prior evaluation years). As seen below in Table 15, the JDC with the highest number of mean recommended services accessed was in Bannock County (interestingly, six juveniles were reported to have accessed at least 10 recommended services from this JDC, whereas no juvenile was reported to have accessed as many recommended services from any of the other JDCs), followed by the JDCs in Twin Falls and Canyon counties. The JDC with the lowest number of mean recommended services accessed was in Fremont County, followed by the JDCs in Valley and Bonneville counties.

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	87	1.44	.62
Bannock County (District 6)	161	2.80	2.53
Bonner County	33	1.42	.56
Bonneville County (3B)	91	<i>1.12</i>	.42
Canyon County (Southwest Idaho)	86	1.45	.70
Fremont County (5C)	0	<i>.00</i>	.00
Minidoka County	19	1.16	.37
Kootenai County (District 1)	98	1.32	.58
Nez Perce County (District 2)	42	1.17	.44
Twin Falls County (Snake River)	262	2.07	1.25
Valley County	6	<i>1.00</i>	.00

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 15-45 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 15-45 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 311 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. Of the 311 parents who completed a survey, 309 answered this question. Of these parents, 124 (40.1%) responded "Yes" that they

had been made aware of this, and 185 (59.9%) responded “No” that they had not been made aware (the percentage of those reporting having been made aware was considerably lower than the 47.2% in Y3, but is still 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 126 parents who completed this item, 83 (or 65.9%) reported that they had received recommendations for services (this percentage is nearly identical to the 65.5% in Y3). 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 85 parents reported at least one service recommendation. As seen below in Table 16, the most commonly reported recommendation, made for 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 nearly 11% of the parents who completed this item. Seven parents (or just over 8% of those 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 Y3 and Y2, although the percentages differed somewhat (in Y3, counseling and substance abuse treatment were reported by 67% and 21% of the parents, respectively, and in Y3 15% of the parents could not remember what services had been recommended for their child; 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). Additionally, in Y4, the continuation of current treatment being received by the child was reported by seven parents, which was the same number (and percentage—8%) of parents who reported that they could not remember what services had been recommended for their child.

Service Recommendation	Number of Cases	Percentage of Total Cases
Individual counseling	52	61.2
Substance abuse treatment	9	10.6
Can't remember	7	8.2
Continue previous treatment	7	8.2

Note. The percentages in this table are calculated out of the 85 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 74 parents who completed this item, 71 (or 95.9%) reported that their children had accessed at least one recommended service (this percentage is considerably higher than the 82% of parents in Y3 who reported their children accessing at least one recommended service, and is much higher than the 74% of parents in Y2 who reported their children accessing 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. Two respondents completed this item. One parent reported that his or her child refused to access the recommended service. The other parent reported that they could not afford the recommended service. The number of parents reporting barriers was lower than in Y3 (5) and Y2 (13), even though the number of parents completing a survey was higher in Y4 than in Y3 (233) and Y2 (273) (thus, a lower percentage parents seem to perceive barriers to accessing services in Y4 than in previous years).

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 45 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 45 judges/JPOs who completed this item, 41 (or 91.1%) reported that they were aware that the closest JDC had a clinician in it. This level of awareness is substantially higher than any of the previous years (66% in Y1, 80% in Y2, and 79% in Y3, respectively). 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 41 judges/JPOs who completed this item, 34 (or 82.9%) reported that they had been contacted by the JDC clinician about at least one of their juveniles (this percentage is noticeably lower than the 91% reported by judges/JPOs in Y3, but higher than the 79% reported in Y1 and the 73% reported 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, every one of those judges/JPOs who completed this item reported being very satisfied (over 60%) or satisfied (nearly 40%) with the contact with the JDC clinician. The satisfaction rate of 100% is clearly the highest of the four years of evaluation (satisfaction rates in Y1-Y3 were all approximately 90%).

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)	0.0% (N = 0)	39.4% (N = 13)	60.6% (N = 20)

Note. The percentages in this table are calculated out of the 33 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 or substance abuse problems. Of the 34 judges/JPOs who completed this item, 33 (or 97.1%) reported that they had received such recommendations (the percentage of judges/JPOs who reported receiving recommendations was the higher than the 94% in Y3, 93% in Y1, and 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, every one of the judges/JPOs who completed this item reported being either very satisfied (nearly 52%) or satisfied (nearly 49%); the 100% satisfaction rate was clearly higher than the 90% in Y3, 85% in Y2, and 79% in Y1.

Item	Very Dissatisfied	Dissatisfied	Not Satisfied or Dissatisfied	Satisfied	Very Satisfied
How satisfied were you with the recommendations made by the mental health clinician?	0.0% (N = 0)	0.0% (N = 0)	0.0% (N = 0)	48.5% (N = 16)	51.5% (N = 17)

Note. The percentages in this table are calculated out of the 33 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 32 judges/JPOs who completed this item, 26 (or 81.3%) 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 clearly higher than that of the 73% and 74% of judges/JPOs in Y3 and Y1, respectively, but slightly lower than the 85% of judges/JPOs 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. Six judges/JPOs wrote at least one comment in the blank. Two common themes emerged in the comments. The first, reported by four judges/JPOs, was that they were already aware of the target juvenile’s mental health or substance abuse problem, and the second, reported by two judges/JPOs, was that the recommendations reinforced existing decisions or advised treatment.

The fifth item on the survey asked the judges/JPOs how beneficial they thought it was to have a clinician in the nearest JDC. The judges/JPOs were allowed to indicate how beneficial they thought it was to have clinicians in the JDCs on a five-point Likert-type scale with values ranging from 1 = Not at all beneficial to 5 = Extremely beneficial. As seen below in Table 19, fully 75% of the judges/JPOs who completed this item reported thinking it was very beneficial to have a clinician in the nearest JDC, and another 22% reported it to be beneficial (for an overall beneficial rate of nearly 95%). 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 Y4 was higher than all of the other years (78% in Y1, 93% in Y2, and 84% in Y3, respectively).

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)	3.1% (N = 1)	0.0% (N = 0)	21.9% (N = 7)	75.0% (N = 24)

Note. The percentages in this table are calculated out of the 32 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. Thirty-one (96.9%) of the 32 judges/JPOs who completed this item reported that they would like to see the clinical services program continue; this approval rate was slightly lower than the 100% in Y2, but slightly higher than the 94% in Y3 and the 92% in Y1. All judges/juvenile probation officers were then asked to explain why they would or would not like to see the program continue, and 14 comments were offered. Eleven of these comments were positive in tone (e.g., “I believe it is an absolute necessity,” “One of the best ways to help kids”) two were negative in tone (“Detention and probation staff are not trained to deal with mental issues,” “They need to offer programming in the detention center”), and one was fairly neutral in nature (“A very high percentage of kids who wind up in detention are MH or dual diagnosis”).

Juvenile Survey

As discussed earlier in this report, the fourth wave 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. As noted in the Methodology section of this report, it is not known how many juveniles were invited by their JPOs to complete the survey, but only 37 juveniles accessed the survey, and only 27 completed the first question.

The first item on the survey asked whether the juveniles met with a counselor (the title that juveniles generally use for what are otherwise known as "clinicians") while at the detention center. Of the 27 juveniles who responded, 18 (or 66.7%) reported that they had met with a counselor while in detention. The nine individuals who reported that they had not met with a counselor at the detention center were 'skipped' by the survey software to the end of the survey, as the other questions were predicated on juveniles having met with a counselor.

The second item on the survey asked juveniles who reported having met with a counselor whether they were informed that they might have a mental health or substance abuse problem. Four (22.2%) of the 18 juveniles who completed this item reported having been informed of such. The third item on the survey asked if the juveniles already had services in place such as counseling, or if their JPO, judge, or parents scheduled an appointment for services prior to meeting with the counselor in the JDC. Of the four individuals who completed this item, all four (or 100%) reported that an appointment for services had been scheduled prior to them meeting with the counselor while in detention.

The fourth item asked if the counselor in the JDC recommended any mental health or substance abuse services in the community that might have been helpful when they were released, such as a call to Business Psychology Associates (a statewide contractor for coordinating substance abuse treatment for juvenile offenders), medication management, or counseling. A total of three of the four juveniles (or 75%) who answered this question reported that the counselor had recommended at least one community-based service for them to contact upon their release. In a follow-up question, the juveniles were asked to indicate what types of services the counselor recommended. The three juveniles who completed this question reported different services. The first reported an alcohol support group, the second reported drug, alcohol, counseling and Moral Reconciliation Therapy (MRT), and the third reported MRT, psychosocial rehabilitation, and counseling.

The next item on the survey asked if the juveniles were currently receiving any service (such as counseling) recommended by the counselor in the JDC. Of the three juveniles who responded to this question, one (33.3%) reported currently receiving a recommended service. The two juveniles who responded "No" to this item were asked if their parent/guardian had made an appointment to access the recommended service, and of one the two reported that his or her parent/guardian having made an appointment to access the recommended service. The next question asked if the service(s) was helpful with any problems the juvenile had. All three juveniles who responded to this question reported that the service(s) was helpful. The next question probed for why the juveniles had not accessed the recommended services. One juvenile reported not accessing the recommended service because he or she did not agree that the recommended service was necessary.

The final items on the survey asked the juveniles if they were still using any service recommended to them, and if they were not, why they stopped. Of the three juveniles who completed this item, two (66.7%) reported that they were still using the service(s) recommended to them. The one juvenile who reported no longer using the recommended service reported not doing so because “I don’t think it was helping me.”

JDC Staff Interviews

The fifth wave of data collection, one of two that were new to the Y4 evaluation, involved conducting interviews of JDC staff, including administrators, clinicians, and other correctional staff (usually line staff, but in several cases teachers). In October 2011 requests to perform interviews were sent via email to JDC administrators at all 11 JDCs covered in this evaluation (because no data were analyzed from the Lemhi County JDC, no interviews were planned or conducted with staff from that JDC). Responses, all of which granted interviews, were received from administrators at seven of the 11 JDCs (no responses were received from the administrators at the JDCs in Ada, Minidoka, Nez Perce, and Valley counties). To have an opportunity to meet some JDC staff and become familiar with facilities in the three major regions of the state (North, Southeast, and Southwest Idaho), several members of the research team visited the JDCs in Bonneville, Canyon, and Kootenai counties and interviewed staff there. Telephone interviews were conducted with staff from the JDCs in Bannock, Bonner, and Twin Falls counties. Email “interviews” (the interview questions were sent via email to staff, and responses were returned via email) were conducted with staff at the JDC in Fremont County.

The interview protocol was the same with all staff, however not all questions were asked of all of the staff in the three target groups (i.e., administrators, clinicians, and line staff). Each interview question is listed below in Table 20; it is also noted in this table which staff members were asked each question. The administrator and clinician interviews generally lasted between 30 and 60 minutes each. The line staff interviews generally lasted between 15 and 30 minutes each.

Question Number	Question	Target Group
1.	In 2008, use of a clinician to perform mental health and substance abuse screening in detention centers in Idaho became a standard practice. What, if anything, is different now compared to the time before screening became part of the intake process?	A, LS
2.	How, if at all, has the Clinical Services Program (e.g., screening, interventions, safety plans, training, and treatment) affected juveniles' behaviors in the JDCs? For example, have there been any changes in problem behaviors or in the level of safety for juveniles or correctional staff?	A, C, LS
3.	How effective are screening procedures for identifying mental health and substance abuse problems? What, if anything, could be done to improve screening or assessment of these problems?	C
4.	Part of the Clinical Services Program protocol involves clinicians making recommendations for community-based services for juveniles who are assessed to have mental health and/or substance abuse problems. Past evaluations show that not all juveniles who receive recommendations access the community-based services. What gaps or barriers do you perceive in juveniles accessing recommended services?	A, C
5.	How are family members involved in the current Clinical Services Program? What could the program do to improve family involvement?	A, C
6.	Have you received training about mental health and substance abuse issues in detained juveniles? How, if at all, has this training helped you work with juveniles with mental health or substance abuse problems? What, if anything, do you do differently since receiving this training? Is there additional training or support you would like to receive from clinicians?	LS
7.	Do you have any final thoughts about the value of the Clinical Services Program?	A, C, LS

Note. A = Administrators; C = Clinicians; LS = Line Staff.

In the following paragraphs, coverage of the responses to each of the seven questions presented to the JDC staff will be provided.

The first question on the survey was asked to both administrators and line staff, and it focused on whether the respondents felt there had been any changes in the JDCs since clinicians were hired to perform mental health and substance abuse screenings in the JDCs. All eight administrators from the seven participating JDCs (two administrators from the JDC in Kootenai County completed interviews) responded to this question. Using a content analysis procedure, the administrators' responses were organized into conceptually similar themes. As seen below in Table 21, the most common theme was a general positive commentary on the impact of the program (noted in the responses of all eight administrators), followed by perceptions that clinicians promote knowledge transfer and information exchange that leads to positive outcomes, that routine screening at intake leads to more informed decision making, that clinicians serve as an information broker or mediator among key parties in the juveniles' lives and care, that

communication is better with IDHW, and that referral processes are improved. Less common themes reflected perceptions that juveniles feel more comfortable talking with clinicians than other staff, and that the presence of a clinician reduces liability for the JDC.

Table 21: Changes in JDCs After Hiring of Clinicians: Administrators	
Question	
In 2008, use of a clinician to perform mental health and substance abuse screening in detention centers in Idaho became a standard practice. What, if anything, is different now compared to the time before screening became part of the intake process?	
Most Common Responses	Number (%)
Program has positive impact; led to beneficial change	8 (100.0)
Clinician promotes knowledge transfer and information exchange that lead to better decision making and understanding of juveniles and/or their problems/behaviors	7 (87.5)
Clinician improves communication among all interested/involved parties (e.g., staff, parents, justice system, treatment providers)	6 (75.0)
Routine screening at intake leads to more informed decision making (e.g., regarding suicide watch levels)	5 (62.5)
Clinician serves as broker/mediator among staff, parents, juveniles, and justice system	5 (62.5)
Better communication with and less need to contact IDHW	4 (50.0)
Improved referral processes (i.e., juveniles are referred to appropriate community-based services and resources)	4 (50.0)
Juveniles feel comfortable talking with clinician; juveniles feel they have someone who cares specifically about them	3 (37.5)
Reduced liability for JDC	3 (37.5)

Note. The percentages in this table are calculated out of the eight administrators who responded to this question. Because multiple response themes were coded for each individual, the total percentages in this table may exceed 100.

The most common response to the first question by the 18 line staff who completed an interview was also one of the most common for administrators: That clinicians promote knowledge transfer and information exchange that leads to positive outcomes. As seen below in Table 22, other common responses by line staff included perceptions that juveniles feel more comfortable talking with clinicians than other staff, that clinicians promote knowledge transfer and information exchange that lead to positive outcomes, and that clinicians are able to deescalate situations more effectively than other JDC staff. In one of the few response themes that did not comment favorably on the CSP, slightly over one-fifth of the line staff reported a perception that there has been no real difference since before the CSP began.

Table 22: Changes in JDCs After Hiring of Clinicians: Line Staff	
Question	
In 2008, use of a clinician to perform mental health and substance abuse screening in detention centers in Idaho became a standard practice. What, if anything, is different now compared to the time before screening became part of the intake process?	
Most Common Responses	Number (%)
Clinician promotes knowledge transfer and information exchange that lead to better decision making and understanding of juveniles and/or their problems/behaviors	10 (55.6)
Juveniles feel comfortable talking with clinician; juveniles feel they have someone who cares specifically about them	8 (44.4)
Clinician improves communication among all interested/involved parties (e.g., staff, parents, justice system, treatment providers)	5 (27.8)
Clinicians are able to more effectively deescalate situations than other staff	4 (22.2)
No major difference from before to after start of program	4 (22.2)

Note. The percentages in this table are calculated out of the 18 line staff who responded to this question. Because multiple response themes were coded for each individual, the total percentages in this table may exceed 100.

The second question on the survey was asked to all three target groups (i.e., administrators, clinicians, and line staff), and it focused on how, if at all, the respondents felt the CSP had affected juveniles' behaviors in the JDCs. All eight administrators from the seven participating JDCs responded to this question, and four major themes emerged in their responses. As seen below in Table 23, the most common theme reflected a perception that juveniles feel more comfortable talking about problems since the clinicians were hired, followed by perceptions that training provided by clinicians helped staff better understand juveniles' mental health and substance abuse problems, that clinicians helped better prepare staff to "deal with" juveniles with mental health and substance abuse problems, and that the JDCs were now safer as a result of the program. Less common themes reflected perceptions that there were fewer incidents in the JDCs requiring restraints, that there was a positive change in juveniles' behavior, and that the level of stress and anxiety in the JDCs was reduced.

Table 23: Effect of CSP on Juveniles' Behavior: Administrators	
Question	
How, if at all, has the Clinical Services Program (e.g., screening, interventions, safety plans, training, and treatment) affected juveniles' behaviors in the JDCs? For example, have there been any changes in problem behaviors or in the level of safety for juveniles or correctional staff?	
Most Common Responses	Number (%)
Juveniles feel comfortable talking with clinician; juveniles feel they have someone who cares specifically about them	6 (75.0)
Improved training led to enhanced understanding of juveniles' mental health and substance abuse issues	5 (62.5)
Staff better equipped to deal with juveniles with problems	5 (62.5)
Increased safety in JDCs	5 (62.5)
Fewer incidents/decreased use of restraints	3 (37.5)
Positive change in juveniles' behavior	3 (37.5)
Level of stress/anxiety reduced	3 (37.5)

Note. The percentages in this table are calculated out of the eight administrators who responded to this question. Because multiple response themes were coded for each individual, the total percentages in this table may exceed 100.

Clinicians' perceptions of how the CSP affected juveniles' behaviors in the JDCs were similar in many respects to those of the administrators. As seen below in Table 24, the most common themes, reported by six of the eight clinicians who completed interviews (two clinicians from the JDCs in Bannock County completed interviews) were that there were fewer incidents and a positive change in juveniles' behavior (these were two separate themes in the administrators' responses, but tended to occur as an integrated theme in the clinicians' responses), and that the JDCs were now safer as a result of the program. Other common themes (several of which were also identified by administrators) included perceptions that juveniles feel more comfortable talking about problems since the clinicians were hired, that clinicians help juveniles better understand why they are in the JDC, that clinicians can serve as a mediator and resource for those involved in the juveniles' care, that staff have someone to talk to about juveniles with mental health or substance abuse problems, that clinician-led training has helped staff develop a better understanding of juveniles with mental health or substance abuse problems, and that clinicians are able to deescalate situations more effectively than other JDC staff.

Table 24: Effect of CSP on Juveniles' Behavior: Clinicians	
Question	
How, if at all, has the Clinical Services Program (e.g., screening, interventions, safety plans, training, and treatment) affected juveniles' behaviors in the JDCs? For example, have there been any changes in problem behaviors or in the level of safety for juveniles or correctional staff?	
Most Common Responses	Number (%)
Fewer incidents; positive change in juveniles' behavior	6 (75.0)
Increased safety in JDCs	6 (75.0)
Juveniles feel comfortable talking with clinician; juveniles feel they have someone who cares specifically about them	5 (62.5)
Juveniles develop a better understanding of why they are in the JDC	4 (50%)
Clinician serves as a mediator and a resource	4 (50%)
Staff have someone to talk to or ask questions of regarding juveniles who may have mental health or substance abuse problems	4 (50%)
Improved training led to enhanced understanding of juveniles' mental health and substance abuse issues	4 (50%)
Clinicians are able to more effectively deescalate situations than other staff	4 (50%)

Note. The percentages in this table are calculated out of the eight clinicians who responded to this question. Because multiple response themes were coded for each individual, the total percentages in this table may exceed 100.

Many of the line staff perceptions regarding how the CSP has affected juveniles' behaviors in the JDCs were similar to themes identified in the responses of administrators and clinicians. As seen below in Table 25, the most common theme was that juveniles feel more comfortable talking about problems since the clinicians were hired. Other common themes reflected perceptions that there were fewer incidents and a positive change in juveniles' behavior (as was the case with the clinicians, the constructs "fewer incidents" and "positive behavior change" seemed integrated into one unified theme), that the JDCs were now safer as a result of the program, and that clinicians help identify potentially problematic behavior in juveniles so that staff know better what to watch for.

Table 25: Effect of CSP on Juveniles' Behavior: Line Staff	
Question	
How, if at all, has the Clinical Services Program (e.g., screening, interventions, safety plans, training, and treatment) affected juveniles' behaviors in the JDCs? For example, have there been any changes in problem behaviors or in the level of safety for juveniles or correctional staff?	
Most Common Responses	Number (%)
Juveniles feel comfortable talking with clinician; juveniles feel they have someone who cares specifically about them	11 (61.1)
Fewer incidents; positive change in juveniles' behavior	10 (55.6)
Increased safety in JDCs	9 (50.0)
Clinicians help staff understand which behaviors may be problematic; know better "what to watch for"	6 (33.3)

Note. The percentages in this table are calculated out of the 18 line staff who responded to this question. Because multiple response themes were coded for each individual, the total percentages in this table may exceed 100.

The third question was asked to clinicians only, and asked them specifically about the extent to which the mental health and substance abuse screening procedures were effective at identifying problems, and what, if anything, could be done to improve screening or assessment of these problems. Only one response theme emerged as common, and was identified in the responses of six of the eight (or 75.0%) clinicians who completed interviews. This was that the AST and MAYSI-2 are good initial screening inventories. The only other themes that were common in more than one clinician's responses were that follow-up interviews were helpful to supplement the initial screening tools (this theme was identified in the responses of three of the eight clinicians, or 37.5%), and that the AST is superior to the MAYSI-2 (2; 25.0%).

The fourth question was asked to both administrators and clinicians, and asked them about gaps or barriers they perceived to juveniles who had been identified as possibly having mental health and/or substance abuse problems accessing community-based services that clinicians had recommended for them. As seen below in Table 26, three themes emerged as common among the responses provided by administrators. The most common theme identified economic concerns such as cost and lack of resources to access recommended services. The other two themes, both reported by half of the responding administrators, were a perceived lack of parental compliance, initiative, or motivation to help their children access recommended services, and a perception that JPOs need to do a better job of following up with families to ensure that juveniles access recommended services. The only other theme that emerged in more than one administrator's responses was a lack of available services in the community, which was identified in the responses of two (25.0%) administrators.

Table 26: Barriers to Accessing Community-Based Services: Administrators	
Question	
Part of the Clinical Services Program protocol involves clinicians making recommendations for community-based services for juveniles who are assessed to have mental health and/or substance abuse problems. Past evaluations show that not all juveniles who receive recommendations access the community-based services. What gaps or barriers do you perceive in juveniles accessing recommended services?	
Most Common Responses	Number (%)
Economic concerns (e.g., cost, lack of resources)	5 (62.5)
Lack of parental compliance, initiative, or motivation	4 (50.0)
Need for JPO follow-up with families	4 (50.0)

Note. The percentages in this table are calculated out of the eight administrators who responded to this question. Because multiple response themes were coded for each individual, the total percentages in this table may exceed 100.

Several of the common themes identified in the responses from the eight clinicians were similar to those identified by the administrators. As seen below in Table 27, a lack of parental compliance, initiative, or motivation was the most common theme among clinicians' responses, and economic concerns such as cost and lack of resources was tied with lack of available services in the community for the second-most common theme. The only other themes that emerged in more than one clinician's responses were a perception that many of the parents themselves had mental health or substance abuse problems that needed to be addressed and that there is a lack of funding to provide services to juveniles who need them.

Table 27: Barriers to Accessing Community-Based Services: Clinicians	
Question	
Part of the Clinical Services Program protocol involves clinicians making recommendations for community-based services for juveniles who are assessed to have mental health and/or substance abuse problems. Past evaluations show that not all juveniles who receive recommendations access the community-based services. What gaps or barriers do you perceive in juveniles accessing recommended services?	
Most Common Responses	Number (%)
Lack of parental compliance, initiative, or motivation	5 (62.5)
Economic concerns (e.g., cost, lack of resources)	4 (50.0)
Lack of available or accessible services in the community	4 (50.0)
Many parents have their own problems with mental health or substance abuse	3 (37.5)
Lack of funding for service provision	3 (37.5)

Note. The percentages in this table are calculated out of the eight clinicians who responded to this question. Because multiple response themes were coded for each individual, the total percentages in this table may exceed 100.

The fifth question was asked of administrators and clinicians, and asked about how juveniles' family members were involved in the CSP, and what could be done to improve family involvement. The only common theme identified among the administrators' responses was that family members of juveniles who are provisionally diagnosed with a mental health or substance abuse problem are presented with a letter from clinicians that documents recommendations for community-based services (and in some cases, provides contact information for such services); this theme was identified in the responses of five (62.5%) administrators. The only other theme that emerged in more than one administrator's responses was that their JDC clinician is available to meet with families during visitation hours, which was identified in the responses of two (25.0%) administrators.

The theme that family members of juveniles who are provisionally diagnosed with a mental health or substance abuse problem are presented with a letter from clinicians that documents recommendations for community-based services was also common among clinicians; this theme was identified in half (i.e., four) of the clinicians' responses. Three (37.5) of the clinicians also reported that they met with parents on an "as needed" basis. The only other themes that emerged in more than one clinician's responses were a perception that JPOs need to engage parents more, and a perception that parents should be better educated on what they can do at home to help their children, and on the type of community-based services available. Both of these themes were identified in the responses of two (25.0%) clinicians' responses.

The sixth question was asked only of line staff, and asked about whether they had received training about mental health and substance abuse issues in detained juveniles, and how any training received affected how they interact with juveniles in the JDCs. It also asked whether they were interested in receiving further training. As seen below in Table 28, the most common theme identified in the line staff's responses was that more training, on topics such as the effects of psychotropic medications or how to work with juveniles with specific types of needs or problems, would be helpful. Other common responses included perceptions that training had led to a better understanding of juveniles' behaviors and needs, that training had been very helpful, and that training has led to a better understanding of behaviors to watch for. In another rare instance of a commentary that did not reflect positively on the CSP, one-third of the line staff reported that training they received from clinicians had not been very effective or helpful.

Table 28: Training from Clinicians: Line Staff	
Question	
Have you received training about mental health and substance abuse issues in detained juveniles? How, if at all, has this training helped you work with juveniles with mental health or substance abuse problems? What, if anything, do you do differently since receiving this training? Is there additional training or support you would like to like to receive from clinicians?	
Most Common Responses	Number (%)
More training would be helpful (e.g., on topics such as effects of different psychotropic medications, how to work with juveniles with special needs, different types of mental health and substance abuse conditions)	10 (55.6)
Better understanding of juveniles' behaviors and needs	8 (44.4)
Training has not been very effective/helpful	6 (33.3)
Training has been very helpful	5 (27.8)
Training has led to better understanding of behaviors to "watch for"	4 (22.2)

Note. The percentages in this table are calculated out of the 18 line staff who responded to this question. Because multiple response themes were coded for each individual, the total percentages in this table may exceed 100.

The final question was asked of members of all three target groups, and asked whether the interviewees had any final thoughts about the value of the CSP. As seen below in Table 29, the most common response theme voiced by administrators (all eight) was that the program should continue. Other common themes included that the program is valuable or essential, that it is beneficial for everyone involved with it, and that it leads to better communication throughout the juvenile justice system.

Table 29: Final Thoughts on Value of the CSP: Administrators	
Question	
Do you have any final thoughts about the value of the Clinical Services Program?	
Most Common Responses	Number (%)
Program should continue	8 (100)
Program is valuable/essential	6 (75.0)
Program is beneficial for everyone involved	5 (62.5)
Program leads to better communication among different components of the juvenile justice system	4 (50.0)

Note. The percentages in this table are calculated out of the eight administrators who responded to this question. Because multiple response themes were coded for each individual, the total percentages in this table may exceed 100.

Similar to the administrators, every clinician (i.e., all eight) that responded to this item reported a belief that the CSP should continue. The only other common theme was that the program is very valuable; this theme was identified in the responses of half (i.e., four) of the clinicians' responses. Three (37.5%) of the clinicians also stated that clinicians serve as a resource to others in the juvenile justice system, noting that judges and JPOs often contact them for advice on juveniles' cases or treatment.

Two themes emerged as quite common among the final thoughts of the line staff. As seen below in Table 30, the first common theme was that the program is valuable or essential, and the second was that the program is beneficial for everyone involved with it. A less common theme reflected a perception that the CSP is an amazing, excellent program.

Table 30: Final Thoughts on Value of the CSP: Line Staff	
Question	
Do you have any final thoughts about the value of the Clinical Services Program?	
Most Common Responses	Number (%)
Program is valuable/essential	11 (61.1)
Program is beneficial for everyone involved	10 (55.6)
Amazing/excellent program	4 (22.2)

Note. The percentages in this table are calculated out of the 18 line staff who responded to this question. Because multiple response themes were coded for each individual, the total percentages in this table may exceed 100.

Incident Data

The sixth wave of data collection, which like the fifth wave was also new to the Y4 evaluation, involved the transfer of incident data from IDJC to the researchers at BSU. As discussed earlier in this report, the incident data consisted of the number of two types of incidents—use of restraints and suicide attempts—for each JDC for each of six years, calendar years 2005-2010. Because most JDCs began implementing the CSP in 2008, the primary analysis involved assessing for possible differences in the number of times restraints were used and the number of suicide attempts in the three years prior to (i.e., 2005-2007) and after (i.e., 2008-2010) the implementation of the CSP.

As seen below in Table 31, the number of incidents of use of restraints and suicide attempts (in the third and fourth columns) differed markedly across the six years. However, because the number of bookings also varied considerably across the six years (see the second column), a comparison of raw incident data (i.e., the number of use of restraints and suicide attempts alone) would be biased; therefore, the number of bookings was controlled for by converting the number of use of restraints and suicide attempts to a number per 1,000 bookings. As seen in the fifth and sixth columns of Table 31, the weighted number (i.e., controlled for differences in number of bookings) of use of restraints and suicide attempts also varied from year to year. Some random fluctuation is to be expected, of course, so the key calculation involves the aggregation of incident numbers per 1,000 bookings across the three years prior to and after the implementation of the CSP. As seen in Table 31, average use of restraints per 1,000 bookings decreased from 16.17 in the “pre-clinician period” 2005-2007 to 14.05 in the “clinician period” 2008-2010. This represents a 13% decline. Also as seen in Table 31, average suicide attempts per 1,000 bookings decreased from 1.53 in the pre-clinician period 2005-2007 to 1.04 in the clinician period 2008-2010. This represents a 32% decline.

Year	Bookings	Use of Restraints	Suicide Attempts	Use of Restraints per 1,000 Bookings	Suicide Attempts per 1,000 Bookings
2005	9,595	161	15	16.78	1.56
2006	9,027	159	18	17.61	1.99
2007	9,395	133	10	14.16	1.06
<i>2005-2007</i>	<i>28,017</i> <i>(total)</i>	<i>453</i> <i>(total)</i>	<i>43</i> <i>(total)</i>	<i>16.17</i> <i>(average)</i>	<i>1.53</i> <i>(average)</i>
2008	9,038	139	12	15.38	1.33
2009	8,381	140	3	16.71	.36
2010	7,492	72	11	9.61	1.47
<i>2008-2010</i>	<i>24,911</i> <i>(total)</i>	<i>351</i> <i>(total)</i>	<i>26</i> <i>(total)</i>	<i>14.05</i> <i>(average)</i>	<i>1.04</i> <i>(average)</i>

Note. The “pre-clinician period” years 2005-2007 are in unshaded cells; the “clinician period” years 2008-2010 are in shaded cells. Totals and/or averages for both periods are shown in italics.

Summary and Conclusions

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

Methodology

As noted in earlier reports on the CSP (McDonald et al., 2010; McDonald & Theiler, 2011), a benefit of conducting programmatic research over multiple years is that improvements can be made when difficulties are identified in previous evaluations. Over the four 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 Y4 in very much the same way as they were in Y1. However, it is clear that clinicians in Y4 submitted more complete and better data than in previous years. There were fewer missing data fields in Y4 (e.g., fields in which AST scores, provisional diagnoses, or recommended services were not entered) than in any of the previous years, suggesting that clinicians are becoming increasingly comfortable with the information submission process and that the evaluators are getting more accurate information from the clinicians. Data from all 12 JDCs were submitted; however, data from the Lemhi County JDC were excluded from the analysis because too few cases were submitted by this JDC to be able to ensure juveniles' anonymity.

During the evaluation of the First Wave data, a disturbing finding was made that cast doubt on a handful of findings reported in previous years of the CSP evaluation. This finding was that rates of provisional diagnoses and service recommendations may have been artificially inflated due to a design feature in the clinicians' Access database. In the case of provisional diagnoses, clinicians have four fields in which they are able to type in any provisional diagnoses made for a given juvenile. A column in the database tallies the number of provisional diagnoses made for each juvenile. In past presentations and reports (McDonald et al., 2009; McDonald et al., 2010; McDonald & Theiler, 2011), the research team has reported the number of juveniles for whom at least one provisional diagnosis was made. The problem that was identified during the Y4 analysis was that if clinicians selected or typed a "None" response (indicating that no provisional diagnosis was made), the column tallying the number of provisional diagnoses was "auto-populated" with a "1"; in other words, clinicians trying to indicate that a juvenile had *not* been given a provisional diagnosis were inadvertently signaling to the Access database that a provisional diagnosis *had* been made. This inflated the number of juveniles who appeared to have at least one provisional diagnosis. For example, before this problem was detected it appeared that 89% of the juveniles in Y4 had at least one provisional diagnosis made. After the problem was detected and the research team manually removed the "Nones"—which in turn "de-

populated” the number of provisional diagnoses column and changed the “1” to a “0”—the percentage of juveniles with at least one provisional diagnosis dropped to 73%. Thus, the problem was identified and corrected in the Y4 analysis, but was not in the previous years of analysis. As a result, the percentages of juveniles provisionally diagnosed with at least one mental health or substance abuse problem were likely higher than they should have been. For this reason, we did not compare the percentage of provisionally diagnosed juveniles from Y4 to those in previous years (i.e., Y1-Y3) in this report.

The situation was nearly identical regarding the number of service recommendations. Four fields existed in the clinicians’ Access database for them to note what, if any, community-based services they recommended to juveniles who had been provisionally diagnosed with a mental health or substance abuse problem. If the clinicians entered “None,” this response auto-populated with a “1” a later column that tallied the number of recommended services. This served to inflate the percentage of juveniles who appeared to have been recommended at least one community-based service. Manually removing the “Nones” de-populated each inappropriate “1” from the number of recommended services and replaced each with a “0.” In this way, the problem was identified and corrected in the Y4 analysis, but not in previous years of analysis. It is very likely that the percentages of juveniles who were reported in previous years to have received at least one service recommendation were artificially inflated, and for this reason we did not compare the percentage of juveniles receiving service recommendations from Y4 to those in previous years (i.e., Y1-Y3) in this report.

The final problem caused by the inappropriate auto-population of columns involves the calculation of the percentage of juveniles who received at least one service recommendation who accessed at least one recommended service. This calculation, if the “Nones” were counted as “1s,” is bound to be artificially deflated, as people who were not actually recommended any services obviously would not have accessed any services. Thus, the percentage of people who actually were recommended services and accessed at least one service would be larger (and more accurate) if the “Nones” were removed and each “1” in the number of services accessed column changed to a “0.” We made this correction in the Y4 analysis, but could not for the previous three years of analyses. For this reason, we did not compare the percentage of juveniles accessing at least one recommended service from Y4 to those in previous years (i.e., Y1-Y3) in this report.

No changes were made to the Second Wave data collection process between Y3 and Y4. The major methodological change from Y1 to Y2 involved moving from a mail survey to a telephone survey of parents, and very few changes (minor wording modifications on survey items to increase clarity) were made between Y2 and Y3. The telephone survey strategy, which was retained in Y3 and utilized again in Y4, has been a clear improvement; whereas only 48 parents completed the mail survey in Y1, 273, 233, and 311 completed a telephone survey in Y2, Y3, and Y4, respectively (furthermore, the response rate improved from less than 6% in Y1 to 73%, 66%, and 76% in Y2, Y3, and Y4, respectively). The minor changes in survey item wording also led to more complete survey responses in Y3 and Y4 compared to Y2. No real changes of any type have been made to the Third Wave data collection process between Y1 and Y4 as the judges’/JPOs’ survey strategy 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 very successful. This is the third consecutive year that IDJC staff and the BSU research team have attempted to capture juveniles' perceptions on issues related to the CSP—particularly the extent to which they have accessed recommended community-based services. Due to procedural delays (see McDonald et al., 2010 for a more detailed discussion), the plan to conduct a juvenile survey in Y2 was not put into action. As reported in last year's evaluation report (McDonald & Theiler, 2011), although all critical aspects of the data collection plan were in place prior to the beginning of the Y3 evaluation, only two juveniles actually accessed and provided responses (both incomplete) to the survey. In an attempt to address some possible procedural pitfalls, the Wave Four data collection process was modified between Y3 and Y4. Whereas in Y3, the survey was hosted on a professional website that required juveniles to enter a password to access the survey (it appears that some passwords provided by the website developer did not allow access to the website), the survey was hosted on BSU's server in Y4, which eliminated the need for a password. Second, the lengthy and complex URL address that was provided by the website developer in Y3 (which might have deterred some juveniles from completing the survey) was substantially shortened and simplified in Y4. Finally, it appears that, despite the personal contact made by IDJC administrators in Y3 and extensive information about the purpose and significance of the survey provided to the JPOs by the BSU researchers in an e-mail message sent to them prior to mailing of the actual packets in Y4, some JPOs may not have fully understood the reasons for or importance of the survey, and hence may have failed to distribute the information sheets to eligible juveniles and their parents. Such a failure to provide an opportunity to participate systematically prevented eligible juveniles from being able to provide meaningful responses in both Y3 and Y4. In short, although a considerably greater number of juveniles completed the survey in Y4 compared to Y3 (27 and 2, respectively), Wave Four data collection in Y4 appears to have failed largely due to a lack of JPOs' understanding about the survey and possibly, though unlikely, technological challenges some juveniles may have had in accessing the web-based survey. If a juvenile survey is to be used in any future evaluations of the CSP, a mail survey may be a better option given the largely unsuccessful attempts to collect information from the juveniles via web-based surveys in the past three years. One way to do this would be to ask JPOs to provide paper surveys with a self-addressed, postage-paid envelope directly to the eligible juveniles and their families. Of course, for this strategy to be successful, JPOs would still need to better understand and support the data collection efforts. It appears that a greater effort to 'advertise' the juvenile survey by persons with organizational credibility (e.g., administrators or clinicians working at the JDCs) is still necessary to help the JPOs develop an understanding of the goals and importance of the juvenile survey effort.

Two additional waves of data collection were introduced in Y4. The Wave Five data collection procedure involved requesting and completing interviews with JDC staff (administrators, clinicians, and line staff) to capture the perceptions of effectiveness of the CSP from the perspective of the JDC personnel. The Wave Five data collection methodology (discussed in the Methodology section) was largely successful, as the administrators of seven of the 11 JDCs covered in this report granted interviews; this resulted in 34 completed interviews (eight administrators, eight clinicians, and 18 line staff). The Wave Six data collection procedure consisted of the transfer of incident data, comprised of the number of bookings, restraints, and suicide attempts, from IDJC to the BSU researchers. The incident data for six calendar years, 2005-2010, were delivered by all 12 JDCs and appeared to be complete.

Mental Health and Substance Abuse Issues

From the standpoint of the research team, one of the most—probably *the* most—important findings of the four years of evaluation of the CSP is the striking prevalence of mental health and substance abuse problems in juveniles detained in Idaho’s JDCs. In every evaluation year (i.e., Y1-Y4), the majority of juveniles have met the AST criteria for having at least one mental health problem. Even if one removed the percentage obtained in Y1, which was something of an outlier at 68% (compared to 59% in Y2 and Y4, and 63% in Y3), the average annual percentage of juveniles meeting the AST criteria for a mental health problem is 60%. In every evaluation year, a sizable percentage of juveniles have also met the AST criteria for a substance abuse problem. Even if one removed the percentage obtained in Y1, which again was something of an outlier at 54% (compared to the 46% in Y2, 44% in Y3, and 43% in Y4), the average annual percentage of juveniles meeting the AST criteria for a substance abuse problem is 44%. Furthermore, based on AST criteria, a large majority of juveniles detained in one of Idaho’s JDCs appear to have a mental health problem, a substance abuse problem, or both. Even if one removed the percentage obtained in Y1, which once again seemed something of an outlier at 82% (compared to the 75% in Y2, 76% in Y3, and 72% in Y4), the average annual percentage of juveniles meeting the AST criteria for having a mental health problem, a substance abuse problem, or both types of problems is 74%, or nearly three-quarters of juveniles detained in JDCs. Thus, without question, most juveniles entering JDCs in any given year appear to have some type of mental health or substance abuse problem.

Another very important finding from the four years of evaluation is the high percentage of juveniles who meet the AST criteria for both a mental health and a substance abuse problem. The scientific literature is rife with articles documenting the serious consequences of having a “dual diagnosis” (Morojele, Saban, & Seedat, 2012) and with articles detailing the intensive treatment needs of dually diagnosed persons (Horsfall, Cleary, Hunt, & Walter, 2009). In every evaluation year, a sizable minority of the juveniles detained in Idaho JDCs met AST criteria for both a mental health and a substance abuse problem. Even if one removed the percentage obtained in Y1, which was something of an outlier at 41% (compared to the 31% in Y2 and 30% in both Y3 and Y4), the average annual percentage of juveniles meeting the criteria for both types of problems is 30%, or nearly one-third of all juveniles entering JDCs in a given year. The commonness of dually diagnosed juveniles, especially when coupled with what is known about the seriousness of co-occurring disorders and their intensive treatment needs, has some very important implications for Idaho’s juvenile justice system, which will be discussed later in this final section of the report.

Yet another important result from four years of evaluation is the clearly established tendency for girls to meet the AST criteria for having a mental health problem more often than boys. In each evaluation year, the difference in percentages of girls and boys meeting the AST criteria for a mental health problem was statistically significant; the percentage difference was 11% in Y1 (girls = 76%, boys = 65%), 17% in Y2 (girls = 71%, boys = 54%), 14% in Y3 (girls = 73%, boys = 59%), and 11% in Y4 (girls = 67%, boys = 56%). The average annual percentages of boys and girls meeting the AST criteria for meeting a mental health problem are 72% for girls and 59% for boys, a difference of 13 percentage points. There is a relatively large literature (e.g., Klose &

Jacoby, 2004; Teplin, Abram, McClelland, Dulcan & Mericle, 2002) showing that girls and women have a higher prevalence of certain mental health problems—most notably major depression, but also anxiety and somatoform disorders—than boys and men (it is also noteworthy, however, that boys and men are often reported to have a greater prevalence of other mental health problems, including antisocial disorders; Klose & Jacoby, 2004). A number of explanations have been postulated for these differences, including that girls often have more adverse childhood experiences such as sexual abuse, that girls have greater role limitations and stricter role expectations, and that girls may have greater fluctuations in hormone or neurotransmitter activity (Piccinelli & Wilkinson, 2000). Interestingly, some recent research (e.g., Essau, Lewinsohn, Seeley, & Sasagawa, 2010) has shown that the gender difference in major depression arises around puberty, and rises dramatically by the mid-teens (the age of many juveniles detained in JDCs). In short, the onset of certain types of mental health problems may begin earlier for girls than boys, which would at least partially explain the greater prevalence of apparent mental health problems in girls than boys in Idaho's JDCs. The tendency for detained girls to more often meet the diagnostic criteria for mental health problems than boys is certainly not unique to Idaho, either. Elizabeth Cauffman (e.g., Cauffman, 2004; Cauffman et al., 2007) has reported similar results, drawing samples of juveniles detained in states as diverse as California, Florida, Pennsylvania, and Virginia. In her work, Cauffman has not only reported that girls more often meet the diagnostic criteria for mental health problems than boys (81% to 70%, aggregated across four states; Cauffman et al., 2007), but also that the gender difference is more pronounced in detained juveniles than in matched community samples. Furthermore, she reported that detained juveniles are three times more likely to suffer mental health problems than those in the community, raising questions about the extent to which JDCs are something of a magnet for juveniles with mental health problems. Whatever the reason for the gender difference in the prevalence of mental health problems, it seems wise for JDC administrators and clinicians to be aware of the tendency of girls to more often experience problems such as depression and anxiety as girls are processed into the JDCs. The validated diagnostic tests and treatment protocols are not different for girls or women and boys or men, but the presentation of symptoms and risk of self-harm are sometimes different (Bhatia & Bhatia, 1999) and an awareness and preparation for this may help clinicians in their work.

Similar to previous years, a major finding in the Y4 evaluation is that a large percentage of the juveniles entering Idaho JDCs during the reporting year had been previously diagnosed with at least one mental health or substance abuse problem. Even if one removed the percentage obtained in Y1, which was something of an outlier at 59% (compared to the 68% in Y2, 69% in Y3, and 67% in Y4), the average annual percentage of juveniles having previously been diagnosed with a mental health or substance abuse problem is 68%, or more than two-thirds. This result, combined with Cauffman et al.'s (2007) findings reported above, call into question whether Idaho's JDCs have collectively become a magnet for the state's juveniles with mental health and substance abuse problems. Clearly, prior to their most recent detention (i.e., the one captured in the Y4 evaluation), there were professionals aware that more than two-thirds of the detained juveniles were suffering from mental health or substance abuse problems. Of course, it is likely that some of the 'repeat offenders' (i.e., juveniles who had been in a JDC in a previous reporting or evaluation year) were first diagnosed by a JDC clinician, however, many were likely diagnosed in the community prior to detention by school counselors, licensed mental health professionals, family physicians, and the like. As the research team has commented on in

previous reports (most fully in McDonald & Theiler, 2011), the fact that Idaho juveniles with mental health and substance abuse problems end up in detention is highly undesirable, with real and quantifiable consequences to the state. Idaho's JDCs, like most juvenile (and adult) correctional facilities across the country (Erickson, Rosenheck, Trestman, Ford, & Desai, 2008; Rogers, Zima, Powell, & Pumariega, 2001; Sullivan, Veysey, Hamilton, & Grillo, 2007), are not well equipped to provide the types of intensive mental health and or substance abuse treatment clinically diagnosable juveniles need. That level of treatment can only be accessed in the community. It seems that one of the real sources of value of the CSP is linking juveniles with identified mental health and substance abuse problems with community-based services, but that linkage is made *after* detention—in other words, after a crime has been committed (causing harm to the community) and after the costs of detention have been incurred by counties or the state. Prevention in the community (most likely through treatment of juveniles known to have mental health or substance abuse problems) is likely the only way to reduce or avoid the costly detention of juveniles suffering from mental health and substance abuse problems (Foster, Qaseem, & Connor, 2004).

Service Recommendations and Access

In the Y3 evaluation report (McDonald & Theiler, 2011), the research team noted that it appeared that the JDC clinicians had become increasingly adept at making community-based service recommendations for juveniles provisionally diagnosed with mental health and substance abuse problems. Sadly, one reason for that conclusion was the artificially inflated number of juveniles who appeared to have been given recommendations in Y3. This is due to the problem reported earlier in this section; many clinicians typed "None" into the first field for recommendations, and this auto-populated another column that tallied the number of recommendations. This problem in the database was corrected in Y4, and it was found that there are still some very encouraging indicators regarding the clinicians' ability to make community-based service recommendations. As noted earlier in this report, the clinicians made at least one service recommendation for 96% of the juveniles who were given a provisional diagnosis for a mental health or substance abuse problem—which is exactly what they are supposed to do according to the CSP protocol. Also, more than 61% of these juveniles were reported to have accessed at least one recommended service by the time of the 15-45 day clinician follow-up call. Furthermore, in response to the parent survey issued well after the clinician follow-up call, 96% 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 that clinicians are very effectively providing community-based service recommendations to those juveniles who (by receiving a provisional diagnosis for at least one mental health or substance abuse problem) need them, and that a clear majority of those juveniles are accessing the services recommended to them.

Stakeholder Perceptions

Throughout the four 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 Y4 (with comparisons to Y1, Y2, and, Y3, as appropriate) are discussed below. An additional group of stakeholders whose perceptions were assessed for the first time in

Y4 were JDC staff, including administrators, clinicians, and line staff. Their perceptions are also discussed below.

The parent survey does not seek, unlike the other stakeholder assessment methods, to assess parents' perceptions of the value of the CSP; in fact, the primary utility of the parent survey is to understand whether the CSP is 'working' by making parents aware of when their child has been identified as likely having a mental health or substance abuse problem, and then facilitating community-based service access through clinician recommendations. In past reports, the research team has commented primarily on parents' reports of whether they were informed by clinicians that their child had been identified as likely having a mental health or substance abuse problem, and their reports about whether their child accessed the recommended service. In Y4, 40% of the parents who completed a survey reported that they had been contacted by a clinician and informed that their child may have a mental health or substance abuse problem. This percentage is higher than the 26% in the Y2 evaluation, but lower than the 47% in the Y3 evaluation. This result is not positive. As noted in the Y3 evaluation report, there seems to be a tremendous disconnect between what clinicians report (that they make service recommendations to nearly 96% of juveniles provisionally diagnosed with a mental health or substance abuse problem) and what parents report (that only 40% of them were even contacted by clinicians and informed that their child may have a mental health or substance abuse problem). The reasons for this disconnect have been difficult to ascertain; in past evaluation reports (e.g., McDonald et al., 2010; McDonald & Theiler, 2011), the research team has postulated on one hand that parents might not consider the letter they receive from clinicians (which notes identified problems and gives service recommendations) as 'contact' from the clinician, and on the other that the relatively long time that had passed since the parents were contacted by clinicians (from several months to just over a year) may have caused parents to forget being contacted by clinicians. Both of these possible explanations may have merit, and could explain at least part of the disconnect between what clinicians and parents report. One other possibility emerged during a presentation of the findings to some of the JDC clinicians in February 2012. Several clinicians reported that the list of parents sent to the IFF callers may have included juveniles who actually were *not* provisionally diagnosed with a mental health or substance abuse problem, and who therefore were not contacted by clinicians about any identified mental health or substance abuse problem (and therefore also did not receive any recommendations for community-based services). If this is true, it is at variance with the expectations of the researchers (and with IDJC); only parents of juveniles who *were* provisionally diagnosed with a mental health or substance abuse problem should be surveyed by IFF callers. If some parents of juveniles who did not receive a provisional diagnosis and service recommendations were called, they would correctly answer that they were not contacted by clinicians and informed of a provisional diagnosis and given a service recommendation. This would artificially deflate the percentage of parents of juveniles who were given a provisional diagnosis and service recommendation and who were contacted by clinicians. In short, if indeed IFF callers have been surveying parents who should not be surveyed, the research team is not capturing an accurate assessment of whether parents who should be contacted by clinicians are actually being contacted by clinicians. If there are future years of evaluation, the research team strongly recommends that it is ensured that only parents whose child was provisionally diagnosed with a mental health or substance abuse problem be included in the IFF survey lists.

The perceptions of judges and JPOs were overwhelmingly positive in the first three years of the CSP, and Y4 was no different. Large majorities of the judges/JPOs who returned surveys in Y4 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. Nearly all (97%) judges/JPOs reported believing the CSP to be beneficial, and the same percentage reported wanting to see the program continue. In short, there is no question that judges/JPOs in Y4, as in all three previous years, are convinced of the value of the CSP and the effect it has on juveniles processed in the JDCs.

The perceptions of the JDC staff (clinicians, administrators, and line staff) regarding the effectiveness of the CSP, assessed for the first time in Y4, were overall very positive. For instance, the clear majority of JDC administrators and line staff expressed that the impact of the CSP program has been largely positive (they felt that the clinicians promote knowledge transfer and information exchange, improve communication among all parties, and deescalate situations more effectively than other JDC staff). At the same time, although close to half of line staff believed training provided by the clinicians has been helpful in better understanding juveniles' behaviors and needs, more than half of line staff also expressed a desire for additional training. Overall, the CSP seemed to be well-received by the JDC staff, with all administrators and clinicians expressing a belief that the program should continue, and close to two-thirds of line staff stating that they believed the program to be valuable or essential.

Concluding Comments

As documented throughout this report, rates of mental health and substance abuse problems, averaged across four years of evaluations, are very high among Idaho's detained juveniles. That 62% of these juveniles meet the diagnostic criteria for a mental health problem and 47% 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 76% of Idaho's detained juveniles (averaged across the four years of evaluation) who met the AST screening criteria for a mental health problem, a substance abuse problem, or both. The percentage of Idaho's detained juveniles with mental health or substance abuse problems also seems higher than those reported in many other studies (e.g., Arroyo, Buzogany, & Hansen, 2001; Fazel, Doll, & Langstrom, 2008), though it is quite similar to those reported in several others (e.g., Cauffman et al., 2007). Thus, the need is great in Idaho for a comprehensive strategy to work with juveniles with mental health and substance abuse problems.

As the research team noted in the Y3 evaluation report, the lack of a comprehensive strategy to address mental health and substance abuse problems in Idaho's juvenile population will likely lead to a number of future problems. There is a well-developed literature (e.g., Baillargeon,

Binswanger, Penn, Williams, & Murray, 2009; Behnken, Arredondo, & Packman, 2009; Cottle, Lee, & Heilbrun, 2001; Fazel et al., 2008; Foster et al., 2004) documenting that when persons with mental health or substance abuse problems are released from detention, but are either untreated or undertreated in the community, they are likely to recidivate and be incarcerated once again. The costs of continued criminal activity to the community, and of future incarceration to counties and the state, are likely to be high. As the research team noted in the Y3 evaluation report (McDonald & Theiler, 2011), recent research by Cohen and Piquero (2009) highlights the potential cost savings of keeping high-risk juveniles (many of whom suffer from untreated and often undiagnosed mental health and substance abuse problems, are huge. In their article, Cohen and Piquero (2009) estimated, using a sophisticated cost estimation model, that “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). As the research team also noted in the Y3 evaluation report, 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 to be 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 CSP has evolved considerably over the four years it has been in place. The researchers noted, when conducting staff interviews with JDC personnel, that clinicians clearly feel more efficient and comfortable in their roles as time passes, and both administrators and line staff continue to recognize clinicians’ value in serving juveniles with mental health and/or substance abuse problems. The evaluation of the CSP has evolved over time as well, with the Year 4 evaluation incorporating a number of new elements, including capturing JDC staff perceptions of the program, incident data strongly suggesting that the CSP has reduced the use of restraints and suicide attempts, and a somewhat more successful juvenile survey. The incorporation of new methods has not changed the basic conclusion of prior years’ evaluations—that the CSP is performing a valuable and necessary function. If anything, the new methodology in Y4 provided information further supporting the value and necessity of the program. There is certainly room for improvement in any future evaluations, however. Some of this improvement could occur in the previously used methodology (for example, ensuring that only parents of juveniles provisionally diagnosed with mental health or substance abuse problems are contacted by IFF callers, and increasing the number of juveniles completing surveys on their experiences accessing recommended community-based services), and some could involve new methodologies. For example, the research team for several years has expressed an interest in comparing recidivism rates of juveniles prior to and after the implementation of the CSP; discussions with IDJC administrators suggest that the capacity to do this may exist. The research team has also expressed (most notably in the Y3 evaluation report by McDonald & Theiler, 2011) an interest in determining the extent to which the mental health and substance abuse services accessed by recently released juveniles meet the guidelines for evidence-based best practices (a discussion of these practices in Idaho is provided by Mueller, Giacomazzi, Greenleaf, May, & Towell, 2008). Discussions with IDJC administrators suggest that this may also be possible. Inclusion of these new elements could lead to an increasingly powerful assessment of the value of the CSP, and the ability of the counties and the state to reduce

problems associated with juvenile offenders with mental health or substance abuse problems, in future years.

In conclusion, through four years of evaluation, there is considerable evidence to suggest that the CSP is making a substantial contribution not only to the JDCs and the juveniles detained there, but also to the counties and state that bear the cost of caring for these juveniles. Over the four years since the statewide inception of the CSP, thousands of juveniles have been screened and identified with likely mental health and substance abuse problems, and the vast majority of these juveniles have received recommendations for community-based services that may not only improve the quality of their lives, but also (according to the scientific literature) reduce the likelihood that they return to a correctional setting and incur further costs to the counties and State of Idaho. Prior to the inception of the CSP, screening, diagnosis, and the facilitation of community-based services were performed on an ad-hoc, non-systematic basis, if at all. Future investment in the CSP, and any supplementary programming such as aftercare (e.g., follow-up to ensure the use and quality of service provision), seem desirable and warranted.

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