



Idaho Department of Juvenile Corrections

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MEMORANDUM

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

From: Sharon Harrigfeld, Director

Date: June 4, 2013

Subject: Detention Clinician Project Research Findings

During the past five years Idaho's juvenile justice system has partnered to fund clinicians in the 13 juvenile detention centers for the purpose of screening detained juveniles for mental health and substance abuse issues and to make recommendations for community based services when the juvenile is released. Based upon a successful pilot project initiated by the Juvenile Justice Children's Mental Health Workgroup (JJCMH) in the Bonneville County (3-B) detention facility; the Idaho state legislature appropriated funding to the Idaho Department of Juvenile Corrections (IDJC) and the Department of Health and Welfare (DHW) to support clinicians in all 12 county detention facilities and the Shoshone-Bannock Tribal Justice Center. This partnership has proven to help juveniles and their families.

Dr. Tedd McDonald from the Boise State University Center for Health Policy analyzed the data entered by clinicians into a database, surveyed stakeholders, and completed an evaluation which is attached. In state fiscal year FY12 1,481 juveniles were screened in detention facilities and were the basis for research on the effectiveness of this program. Some highlights from the evaluation include:

- Mental health and substance abuse problems appear very common among juveniles in juvenile detention facilities with over 69% having a diagnosable mental illness, substance abuse issue or both.
- Juveniles who screened positive for traumatic experiences were 3.2 times more likely to screen positive for a MH problem than those who screened negative for traumatic experiences.
- Over 63% of the juveniles who were recommended services in the community accessed those services within 2 weeks.
- Juveniles and their families seem motivated to access community services.

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

An active partnership with communities

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

Prepared for the Idaho
Department of Juvenile Corrections

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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 approximately 70% of detained juveniles who were scored on diagnostic inventories (the mental health and substance abuse subscales of the Alaska Screening Tool, or AST) during a clinical interview with JDC clinicians, met the AST diagnostic criteria for a mental health, a substance abuse, or both types of 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 2007-2011 supported the funding of the CSP for another year, and in 2012 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 5 Assessment (Y5). Similar to the Year 1 (Y1), Year 2 (Y2), Year 3 (Y3), and Year 4 (Y4) 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. Several additional analyses of wave one and wave three data were also performed in Y5.

Key findings from each of the three waves of data collection and the additional analyses are presented below.

Wave One: JDC Clinician Data

- **Data submitted on 1,481 juveniles were analyzed**
 - **Data on a total of 1,532 detained juveniles were submitted. Data on 51 juveniles for whom multiple data entries were submitted were excluded from this report**
 - **Over 70% of the juveniles for whom data were included in the final analyses were boys, and just under 30% were girls**
 - **Data on detained juveniles were submitted by clinicians at all 12 JDCs. Data from the JDC in Valley County were 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 Kootenai (nearly 20%), Canyon (nearly 16%), Twin Falls (over 13%), Bannock (over 12%), and Ada (nearly 11%) counties. The JDCs that submitted the fewest data cases included those in Lemhi (2%), Bonner, Fremont, and Minidoka (less than 4% each) 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), drug crimes, property crimes, crimes against persons, and sex crimes**

- **Nearly 59% of all juveniles screened with the 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 (55%)**
 - **Juveniles met the AST criteria for having a mental health problem at statistically significantly different rates across the 11 JDCs**
 - **Indications of mental health problems were highest among juveniles screened at the JDCs in Nez Perce and Canyon (79%) counties, followed by the JDC in Bannock County (75%). Indications of mental health problems were lowest among juveniles screened at the JDCs in Minidoka (12%), Lemhi (17%), and Bonner (36%) counties**

- **Nearly 41% 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 Fremont (74%), Nez Perce (68%), and Ada (55%) counties. Indications of substance abuse problems were lowest among juveniles screened at the JDCs in Minidoka (0%), Bonner (15%), and Bonneville (28%) counties**

- **When the combination of AST indications of mental health and substance abuse problems were evaluated, it was found that over 69% of all screened juveniles had a mental health problem, a substance abuse problem, or both**
 - **Having indications for neither a mental health nor a substance abuse problem was the most common single combination (at 31%), followed by having both a mental health and substance abuse problem (30%), a mental health problem only (29%), and having a substance abuse problem only (11%)**
 - **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 (32% to 27%) and a substance abuse problem only (13% to 6%), girls were more likely than boys to have indications of a mental health problem only (34% to 26%) and both a mental health and substance abuse problem (32% to 29%)**
 - **A statistically significant difference also existed in combination of mental health and substance abuse indications as a function of JDC location**
 - **The most common single combination of indications for juveniles in six JDCs (in Minidoka, Bonner, Lemhi, Kootenai, Bonneville, and Ada counties) was having neither a mental health nor substance abuse problem. Having a mental health problem only was the most common combination in the JDCs in Twin Falls and Bannock counties, and having both types of problems was the most common combination in the JDCs in Nez Perce and Fremont counties. There was a tie for the most common combination between juveniles meeting the combination for a mental health problem only and both a mental health and substance abuse problem in the JDC in Canyon County**
 - **Whereas the least common single combination of indications for juveniles in seven JDCs (Bonner, Canyon, Twin Falls, Nez Perce, Bannock, Kootenai, and Bonneville) was having a substance abuse problem only, the least common combination in the JDCs in Lemhi and Ada counties was having a mental health problem only. Having neither a mental health nor a substance abuse problem was the least common combination in the JDC in Fremont County, and there was a tie for the least common combination between juveniles meeting the criteria for a substance abuse problem only and those meeting the criteria for having both a mental health and substance abuse problem in the JDC in Minidoka County**
- **Seventy-three percent of the juveniles across all JDCs were identified during a clinical interview to have been diagnosed previously with at least one mental health or substance abuse problem. The mean number of previous diagnoses for all juveniles with at least one previous diagnoses was 1.26**
 - **A statistically significant difference in mean number of previous diagnoses was found as a function of JDC location (data from the JDC in Bonner County were excluded from this analysis because there was only one case with a documented number of provisional diagnoses)**

- Mean numbers of previous diagnoses were highest among juveniles in the JDCs in Lemhi (1.55), Fremont (1.50), and Nez Perce (1.42) counties. Mean numbers of previous diagnoses were lowest among juveniles in the JDCs in Minidoka (1.00), Bonneville (1.10), and Kootenai (1.13) counties
- Sixty-six percent 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 1.52
 - A statistically significant difference in mean number of provisional diagnoses given was found between boys and girls. Girls were given more provisional diagnoses (1.62) of mental health or substance abuse problems than were boys (1.48)
 - 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 Lemhi (2.04), Ada (1.80), and Twin Falls (1.70) counties. The lowest mean numbers of provisional diagnoses were given to juveniles in the JDCs in Kootenai (1.18), Bonner (1.28), and Fremont (1.32) counties
- The most commonly given provisional diagnosis was for a mood disorder, which appeared to affect 44% of the provisionally diagnosed juveniles. Other common provisional diagnoses included substance abuse disorders (37% of those provisionally diagnosed), disruptive behavior disorders (26%), anxiety disorders (21%), and attention deficit disorders (12%)
- Recommendations for at least one service in the community were made for 1,131 juveniles. The mean number of service recommendations for juveniles who received at least one service recommendation was 1.77
 - Of all juveniles who received at least one service recommendation, 933 (or 82%) were given at least one provisional diagnosis and the remaining 198 (or 18%) received at least one service recommendation but were not given a provisional diagnosis. Additionally, 50 juveniles were given at least one provisional diagnosis without receiving a service recommendation
 - Of the 983 juveniles who received at least one provisional diagnosis, 933 (or 95%) received at least one service recommendation
 - There was a statistically significant difference in the mean numbers of recommendations for services given to boys and girls, with girls (1.92) receiving more service recommendations than boys (1.70)
 - There was a statistically significant difference in the mean numbers of recommendations for services as a function of JDC location
 - The highest mean numbers of recommended services were given to juveniles in the JDCs in Lemhi (2.93), Twin Falls (2.30), and Bannock (2.19) counties. The lowest mean numbers of recommended services were

given to juveniles in the JDCs in Bonneville (1.03), Nez Perce (1.22), and Minidoka (1.30) 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 to continue (unspecified) prior treatment (27%), for a substance abuse counseling/treatment (22%), psychological/mental evaluation (20%), and substance abuse assessment (15%)
- According to information gained by clinicians during a 15-45 days post-release follow-up call, 715 juveniles, or 63% 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 1.56
 - 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 Lemhi (2.42), Bannock (1.89), and Twin Falls (1.74) counties. The lowest mean numbers of recommended services accessed were found among juveniles released from the JDCs in Bonneville (1.00), Nez Perce (1.14), and Bonner (1.16) counties

Wave Two: Parent Survey Data

- A total of 115 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 fairly good, as 60 parents (or 52% of those contacted) agreed to complete the survey
- Nearly 32% of the parents who provided a response 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, nearly 53% reported that they were given recommendations for community-based services for their child
- The services parents most often reported being recommended for their children included individual counseling (25%) and substance abuse treatment (25%). Twenty-five percent of the parents also reported they could not remember what services had been recommended

- Close to 89% of the parents who received at least one service recommendation for their child reported that their child had accessed at least one service
- Only one parent reported barriers to accessing the services that were recommended. The respondent reported that their child had “taken off”

Wave Three: Judge/Juvenile Probation Officer Survey

- The response rate to the survey sent to judges/juvenile probation officers (JPOs) was 46%, as 63 of the 137 eligible judges/juvenile probation officers who received a survey returned a survey
- Ninety-two 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 58 judges/JPOs who were aware of the clinical services program, 57 provided a response when asked whether they had been contacted by a clinician regarding one of the youth they were working with. Of those, slightly over 77% reported having been contacted by a clinician
 - The level of satisfaction with the contact from the JDC clinicians was fairly high, as over 70% of the judges/JPOs who reported having been contacted were very satisfied (nearly 39%) or satisfied (nearly 32%) with the contact
- Of the judges/JPOs who had been contacted by a JDC clinician, 44 provided a response when asked whether they had been given a recommendation on treatment or decisions from this clinician. Of those, nearly 89% reported having been given a recommendation
 - The level of satisfaction with recommendations provided by the JDC clinicians was fairly high, as nearly 80% of those judges/JPOs who reported receiving at least one recommendation were very satisfied (over 28%) or satisfied (over 51%) with the recommendation(s)
- Among the judges/JPOs who reported having received recommendations from the clinicians, 39 provided a response when asked whether the recommendations they received had affected a decision or treatment advised for the youth. Of those, over 69% 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” (nearly 57%), followed by “rather beneficial” (nearly 23%)
- When asked whether they would like to see the CSP continue, over 95% of the judges/JPOs reported wishing to see it continue

Additional Analysis 1: Trauma and Gender Differences in the Prevalence of MH Problems

- **Nearly 28% of all juveniles who completed the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) screened positive for traumatic experiences**
 - **A statistically significant association was found between gender and traumatic experiences. Whereas nearly 36% of girls screened positive for traumatic experiences on the MAYSI-2, fewer than 25% of boys did so**
 - **A statistically significant association was found between the indication of MH problems and traumatic experiences. Whereas 77% of juveniles who screened positive for traumatic experiences screened positive for a MH problem, fewer than 52% of juveniles who screened negative for traumatic experiences did so**
- **A logistic regression analysis revealed that traumatic experiences were a stronger predictor of MH problems than gender. It was revealed that those juveniles who screened positive for traumatic experiences were 3.2 times more likely to screen positive for a MH problem than those who screened negative for traumatic experiences; it was found that girls were 1.7 times more likely than boys to screen positive for a MH problem**

Additional Analysis 2: Booking Charges

- **Of all juveniles for whom a booking charge was entered, 814 had a booking charge classifiable as one of the four UCR categories (drug crime, property crime, crime against persons, and sex crime). There was a statistically significant association between the type of problem (MH only, SA only, both types of problem, and neither type of problem) and booking charges**
 - **Among juveniles who met the criteria for neither a MH nor a SA problem, the most common booking charge was property crime (36%), followed by crime against persons and drug crime (both at 28%). The least common booking charge was sex crime (8%)**
 - **Among juveniles who met the criteria for a MH problem only, the most common booking charge was crime against persons (46%), followed by property crime (33%) and sex crime (13%). The least common booking charge was drug crime (8%)**
 - **Among juveniles who met the criteria for a SA problem only, the most common booking charge was drug crime (59%), followed by property crime (29%) and crime against persons (9%). The least common booking charge was sex crime (4%)**
 - **Among juveniles who met the criteria for both a MH and SA problem, the most common booking charge was property crime (41%), followed closely by drug crime (39%). Crimes against persons (20%) were less common, and no juveniles meeting the criteria for both a MH and SA problem was booked for a sex crime**

Additional Analysis 3: Regional Differences in Recommended Services Accessed

- **Of the 1,131 juveniles who received at least one recommendation for services, 715 had accessed at least one recommended service in the 15-45 days following their release**
 - **A statistically significant difference in the rates at which at least one recommended service was accessed was found as a function of county. The counties with the highest percentages of juveniles who accessed at least one recommended service were found in Bannock (at 85%), Fremont (80%), and Twin Falls (76%) counties. The counties with the lowest percentage of juveniles who accessed at least one recommended service were found in Minidoka (at 30%), Bonneville and Lemhi (41% each) counties.**
 - **A statistically significant difference in the rates at which at least one recommended service was accessed was also found as a function of region. The regions with the highest percentages of juveniles who accessed at least one recommended service were found in Region 6 (at 85%) and Region 5 (73%). The regions with the lowest percentage of juveniles who accessed at least one recommended service were found in Region 2 (at 45%) and Region 3 (47%)**

Additional Analysis 4: Judges/JPOs Survey

- **Of all respondents who received a recommendation from a JDC clinician, 69% reported that these recommendations had affected a decision or treatment they advised for the youth, whereas 31% reported that it had not**
 - **On average, respondents reporting that the recommendation had affected a decision or treatment they advised for the youth were statistically significantly more satisfied with the contact they had with the JDC clinician ($M = 4.33$) than those reporting that it had not ($M = 3.25$)**
 - **On average, respondents reporting that the recommendation had affected a decision or treatment they advised for the youth were statistically significantly more satisfied with recommendations made by the clinician ($M = 4.33$) than those reporting that it had not ($M = 3.17$)**
 - **On average, respondents reporting that the recommendation had affected a decision or treatment they advised for the youth rated having a mental health clinician in the detention center as significantly more beneficial ($M = 4.74$) than those reporting that it had not ($M = 3.33$)**

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 of 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 three years, and reports on the continuation of the program were issued in 2010 (McDonald, Osgood, & VanNess, 2010), 2011 (McDonald & Theiler, 2011), and 2012 (McDonald, Begic, & Howard, 2012).

In the four 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, Y3, and Y4), 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 four 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. A web-based survey focusing on juveniles’ perceptions of the CSP was presented to recently released juveniles in Y3 and Y4; specifically, juveniles were asked 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 that were not completed in any of the previous years were added to the Y4 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.

The four evaluations of the expanded CSP revealed a number of interesting findings. For example, it was found that high percentages of juveniles in all four years met the AST diagnostic criteria for a mental health problem (68% in Y1, 59% in Y2, 62% in Y3, and 59% in Y4) and a substance abuse problem (55% in Y1, 46% in Y2, 44% in Y3, and 43% in Y4). 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, 76% in Y3, and 72% in Y4), and substantial percentages were found to meet the criteria for both types of problems (41% in Y1, 30% in Y2, 31% in Y3, and 29% in Y4). Provisional diagnoses of at least one mental health or substance abuse problem were made for more than 70% of the juveniles in all four evaluations, with the most commonly diagnosed problems in all four 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, Y3, and Y4 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, this percentage was much higher in Y3 (47%) and Y4 (40%). 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 Y2 (76%) and Y3 (66%). This percentage was somewhat lower in Y4 (47%). Of those parents who reported receiving a service recommendation, many (74% in Y2, 82% in Y3, and 89% in Y4) 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, 79% in Y3, and 91% in Y4), having had contact with JDC clinicians (79% in Y1, 73% in Y2, 91% in Y3, and 77% in Y4), and receiving recommendations for youth (93% in Y1, 90% in Y2, 94% in Y3, and 89% in Y4). 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, 84% in Y3, and 80% in Y4), and nearly all reported wanting to see it continue (92% in Y1, 100% in Y2, 94% in Y3, and 95% in Y4).

The CSP was granted funding for a fifth year (Y5), and IDJC contracted with the same team of BSU researchers to evaluate it. The 2012 evaluation was performed on data collected at the JDCs between July 1, 2011 and June 30, 2012. The procedures for collecting data for the clinicians' and parents' portions of the 2012 evaluation were identical to those used in the 2009, 2010, and 2011 evaluations. Whereas the judges'/JPOs surveys were delivered by mail in the 2009, 2010, and 2011 evaluations, the judges and JPOs were asked to complete a web-based survey in the 2012 evaluation. Furthermore, several additional analyses utilizing data collected in waves one and two were conducted in Y5.

Methodology

Similar to the Y1-Y4 assessments, data were collected in several separate waves in this Y5 assessment. The first wave involved personnel at IDJC collecting data directly from clinicians at the JDCs and, after removing all personally identifying information, providing the data to the researchers at BSU. This wave of data collection was virtually identical in all five years of evaluation (i.e., Y1-Y5). 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 five years, although, as discussed below, the methodology for delivering the survey differed by evaluation year. The third wave involved surveying judges and JPOs who worked with juveniles recently released from the JDCs. The survey used was identical in all five evaluation years; however, the methodology for delivering the survey differed in the Y5 evaluation. Several additional analyses that had not been conducted in the prior years were performed in this Y5 evaluation. Each of the three waves and the additional analyses 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 AST was superior to several other available assessment inventories 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.

Although, as described above, the AST was found to be most useful for making assessments about mental health and substance abuse problems in detained juveniles, another assessment inventory known as the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) is also used in Idaho JDCs. A computer-based self-report inventory that is completed by juveniles as they are being booked into JDCs, the MAYSI-2 generates immediate results on seven subscales including Alcohol/Drug Use, Angry-Irritable, Depressed/Anxious, Somatic Complaints, Suicide Ideation, Thought Disturbance, and Traumatic Experiences (Cauffman, 2004; Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001). MAYSI-2 results were not used in any of the first four evaluation efforts (i.e., Y1-Y4), however, results from the Traumatic Experiences subscale were used for some additional analyses in Y5.

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) or from other available case notes.

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 (usually through letters given or sent to their parents) 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 five 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, 2011 and June 30, 2012. Data were submitted from all 12 JDCs; however, the data from the JDC in Valley County were not included in the final, aggregated dataset because too few cases were submitted by Valley County to guarantee juveniles anonymity. Clinician data were sent directly to personnel at IDJC, who then forwarded an Excel spreadsheet containing aggregated clinician data from all 12 JDCs (with all identifying information removed) to the BSU researchers for analysis. In total, this data set

consisted of 1,614 data entries. Upon realizing that multiple entries were provided for some juveniles, the BSU team and an IDJC administrator determined that the data on 51 juveniles from four counties (39 from Minidoka, nine from Twin Falls, two from Ada, and one from Canyon) for whom multiple data entries were provided should be excluded from the analysis. This resulted in the exclusion of 133 data entries. Consequently, wave one data analyses included clinician data provided for 1,481 juveniles for whom only one data entry was provided.

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, Y4, and Y5.

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 2012, and wrote the parents' responses directly on paper copies of the survey. IFF returned the paper copies of completed surveys to IDJC in December 2012, 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 115 parents of recently released juveniles. Of these, 60 parents agreed to complete the survey, for a fairly good response rate of 52%. This response rate

is much better than the 5% achieved in Y1, somewhat lower than the 66% achieved in Y3, and considerably lower than the 76% achieved in Y2 and Y4.

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.

Though the survey used in Y5 was identical to the survey used in the prior evaluation years, the method of delivery was altered. In the previous years, an IDJC program administrator identified the judges/JPOs for the BSU researchers to send survey packets to and provided the BSU researchers with the names and postal addresses for these judges/JPOs. The researchers at BSU then 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. In Y5, the BSU research team created an internet-based survey utilizing the Qualtrics Online Survey Software package for which BSU has a site license. The judges/JPOs survey was programmed into Qualtrics by early December 2012, and the survey link was sent to an IDJC administrator along with an initial invitation message describing the survey and a one-week reminder statement. Recruitment of the judges/JPOs was conducted directly by the IDJC administrator, who sent an initial invitation and link to the Qualtrics survey hosted on the BSU server to 137 judges/JPOs on December 10, 2012. Respondents began to complete the survey the same day. The IDJC program manager sent a reminder email message on December 17, 2012 encouraging potential respondents to complete the survey. The survey was closed on January 4, 2013, and at that time, a total of 63 judges/JPOs had completed it, for a response rate of 46%. This response rate is very 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 in Y5 was slightly higher than the 44% in Y1 (44%), and considerably higher than the 31% in Y2 and the 33% in Y3 and Y4.

Additional Analyses

When the results of the Year 4 evaluation were presented at a meeting of the Idaho Criminal Justice Commission (ICJC) in 2012, questions were raised about gender differences in the prevalence of MH problems and the association between MH problems and traumatic experiences. Several additional questions were raised when the preliminary results of the Year 5 evaluations were presented at a meeting of the Idaho Juvenile Justice Commission (IJJ) in March 2013. These questions asked whether there existed differences in booking charges between juveniles who met the AST criteria for either type of problem and those who met the AST criteria for neither, whether rates at which at least one recommended service was accessed differed across regions/counties, and what factors may be contributing to variations in judges/JPOs responses. In an effort to address these questions, the BSU research team conducted several additional analyses using the wave one and wave three data sets. Specifically, wave one data were utilized to address questions about gender differences in the prevalence of MH problems, the association between MH problems and trauma experiences, differences in booking charges between juveniles who met the AST criteria for either type of problem and those who met the AST criteria for neither, and differential rates at which at least one recommended service was accesses across regions/counties. Wave three data were utilized to explore factors that may be contributing to variations in judges'/JPOs' responses.

Results and Analyses

Analysis of JDC Data

Demographic Information

The data in this report are gleaned from the cases of 1,481 cases of juveniles detained at one of 11 JDCs throughout Idaho. Gender codes were entered for 1,466 juveniles. Of these, 1,030 or 70.3% were boys and 436 or 29.7% were girls. The total number of cases was somewhat lower than in Y3 (1,669), and considerably lower than in Y2 (1,941), Y1 (2,060), and Y4 (2,066). The percentages of boys and girls in Y5 were very similar to the averages of the first three years (denoted throughout the remainder of this report as the “four-year average”) of CSP evaluations, which were 72% for boys and 28% 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, 2011 (the period after data collection ended for the previous year’s evaluation) to June 30, 2012 (the end of the fiscal year). One JDC that submitted data for the study, which is in Valley County, was not included in the report because there were too few cases to guarantee anonymity. The remaining 11 JDCs that submitted data are included below in Table 1.

As seen below in Table 1, the largest percentage of cases submitted was from the JDC in Kootenai County (with nearly 20% of the total cases), followed by the JDCs in Canyon (nearly 16%), and Twin Falls (over 13%) counties. On the other hand, the smallest percentages of cases were submitted from the JDCs in Lemhi (2%), Bonner and Fremont (less than 4%) counties.

JDC Location	Number of Cases	Percentage of Total Cases
Ada County	161	10.9
Bannock County (District 6)	184	12.4
Bonner County	53	3.6
Bonneville County (3B)	90	6.1
Canyon County (Southwest Idaho)	236	15.9
Fremont County (5C)	54	3.6
Kootenai County (District 1)	289	19.5
Lemhi County	29	2.0
Nez Perce County (District 2)	131	8.8
Minidoka County	57	3.8
Twin Falls County (Snake River)	197	13.3

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 1,449 of the juveniles, or 97.8% of all juveniles on whom data were collected, and two booking charges were noted for

335 (22.6%) juveniles. All booking charges were coded in accordance with the Uniform Crime Reporting (UCR) categories. As seen in Table 2, the most common class of booking charge was for “other” crimes that did not easily fit a UCR category (nearly 52% of the booking charges fit most appropriately in this “Other” category); 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 drug crimes (nearly 25%) and property crimes (just over 23%), and crimes against persons (slightly over 18%). Sex crimes were relatively uncommon among booking codes (accounting for less than 1% of all codes). The research team was unable to confidently classify 25 (less than 1%) of the listed booking codes.

Booking Charge	Number of Cases	Percentage of Total Cases
“Other” crimes not easily fitting a category (e.g., probation violation, runaway, incorrigible, disturbing the peace)	746	51.5
Drug crimes	355	24.5
Property crimes	336	23.2
Crimes against persons	262	18.1
Sex crimes	60	0.4
Unable to classify (e.g., discretionary days)	25	0.2

Note. The percentages in this table are calculated out of the 1,449 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 41% 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 and Y4, but is lower than the 68% in Y1 and the 62% in Y3 (the four-year average for juveniles meeting the AST criteria for having a mental health problem was 61%). The 41% figure for the percentage of juveniles who met the AST criteria for having a substance abuse problem is slightly lower than the 43% in Y4, 44% in Y3, and the 46% in Y2, and considerably lower than the 54% in Y1 (the four-year average for juveniles meeting the AST criteria for a substance abuse problem was 46%).

Condition	Number of Cases	Percentage of Total Screened Cases
Mental health problem	867	58.5
Substance abuse problem	601	40.6

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

To better understand whether boys and girls appeared to have mental health or substance abuse problems at a similar rate, we analyzed the distribution of diagnoses separately by juvenile gender. We will discuss each type of problem sequentially, beginning with mental health. 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 55% 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) = 16.58, $p < .001$. The pattern revealing girls significantly more often meeting the AST criteria for having a mental health problem than boys was also found in Y1 (76% to 65%), Y2 (71% to 54%), Y3 (73% to 59%), and Y4 (67% to 56%). 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 42% and 38%, 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%), Y3 (45% and 44%), and Y4 (44% to 40%); 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 four of five 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	567	290	55.0	66.5
Substance abuse problem	431	167	41.8	38.3

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

Percentages of juveniles meeting the criteria for suffering from mental health and substance abuse disorders were also separated by JDC location, to determine whether the juveniles met the diagnostic criteria at similar rates across the 11 JDCs. As seen below in Table 5, there was a rather large spread of percentages for mental health problems as measured by the AST, ranging from over 12% to over 79% of the juveniles in an individual JDC. The three JDCs with the highest percentages of juveniles meeting the AST criteria for having a mental health problem

were Nez Perce County (where over 79% of screened juveniles met the criteria for a mental health problem), Canyon County (nearly 79%), and Bannock County (75%). The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a mental health problem were Minidoka County (over 12%), Lemhi County (over 17%), and Bonner County (nearly 36%). 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) = 230.06, $p < .001$.

JDC Location	Number of Cases	Percentage of Total Screened Cases
Ada County	71	44.1
Bannock County (District 6)	138	75.0
Bonner County	19	35.8
Bonneville County (3B)	42	46.7
Canyon County (Southwest Idaho)	186	78.8
Fremont County (5C)	38	70.4
Kootenai County (District 1)	121	41.9
Lemhi County	5	<i>17.2</i>
Minidoka County	7	<i>12.3</i>
Nez Perce County (District 2)	104	79.4
Twin Falls County (Snake River)	136	69.0

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

As seen below in Table 6, there were also some noteworthy differences as a function of JDC location in the percentages of juveniles meeting the AST criteria for having a substance abuse problem. The three JDCs with the highest percentages of juveniles meeting the AST criteria for having a substance abuse problem were Fremont County (where over 74% of the screened juveniles met the criteria for a substance abuse problem), Nez Perce County (nearly 68%), and Ada County (nearly 55%). The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a substance abuse problem were Minidoka County (0%), Bonner County (just over 15%), and Bonneville County (nearly 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) = 161.44, $p < .001$.

JDC Location	Number of Cases	Percentage of Total Screened Cases
Ada County	88	54.7
Bannock County (District 6)	77	41.8
Bonner County	8	<i>15.1</i>
Bonneville County (3B)	25	<i>27.8</i>
Canyon County (Southwest Idaho)	109	46.2
Fremont County (5C)	40	74.1
Kootenai County (District 1)	95	32.9
Lemhi County	14	48.3
Minidoka County	0	<i>0.0</i>
Nez Perce County (District 2)	89	67.9
Twin Falls County (Snake River)	56	28.4

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

To gain a better understanding of the extent to which juveniles in detention in Idaho suffer from mental health problems and substance abuse problems separately and together (i.e., a dual diagnosis), we combined the information on mental health and substance abuse problems for each juvenile. In this way, juveniles were coded as having: 1) neither a mental health nor 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 31%) who were screened with the AST met the diagnostic criteria for neither a mental health nor a substance abuse problem. The next largest group of juveniles (just under 30%) met the AST criteria for both a mental health problem and a substance abuse problem, followed by juveniles who met the criteria for a mental health problem only (nearly 29%). The smallest group of juveniles (just over 11%) met the criteria for a substance abuse problem only. The pattern of results regarding the most common combination differed somewhat from the previous years. Whereas in Y5 the single most common category was meeting the criteria for neither a mental health nor a substance abuse problem, in Y3 and Y4, meeting the criteria for a mental health problem only was the single most common category, and in 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 four previous evaluation years.

Condition	Number of Cases	Percentage of Total Screened Cases
Neither mental health nor substance abuse problem	456	30.8
Mental health problem only	424	28.6
Substance abuse problem only	158	10.7
Both mental health and substance abuse problem	443	29.9

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, $\chi^2 (df = 3) = 23.13, p < .001$. The largest difference was in rates of meeting the diagnostic criteria for having a mental health problem only; girls (at over 34%) were considerably more likely than boys (nearly 26%) to fall into this category. Girls were also somewhat more likely to meet the criteria for having both types of problems (at just over 32%) than boys (slightly over 29%). On the other hand, boys were found to be more likely to meet the criteria for having a substance abuse problem only (nearly 13%) than girls (slightly over 6%), and boys (over 32%) were also somewhat more likely to meet the criteria for having neither type of disorder than girls (over 27%). 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 four previous evaluation years (i.e., Y1-Y4). 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	333	119	32.3	27.3
Mental health problem only	266	150	25.8	34.4
Substance abuse problem only	130	27	12.6	6.2
Both mental health and substance abuse problem	301	140	29.2	32.1

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) = 424.56, $p < .001$. These differences may most easily be seen in visual analysis of the most and least common diagnostic categories that emerged for each JDC. The most common diagnostic category often differed by JDC location. Juveniles meeting the diagnostic criteria for neither a mental health problem nor a substance abuse problem were the single largest group in six JDCs (in Ada, Bonner, Bonneville, Kootenai, Lemhi, and Minidoka counties), juveniles meeting the criteria for a mental health problem only were the single largest group in two JDCs (in Bannock and Twin Falls counties), and juveniles meeting the criteria for both types of problem were the single largest group in two JDCs (in Fremont and Nez Perce counties). In Canyon County, there was a tie for single largest group between those juveniles meeting the criteria for a mental health problem only and those meeting the criteria for both a mental health and substance abuse problem. 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 Ada and Lemhi counties, where juveniles meeting the criteria for a mental health problem only was the single smallest group, the JDC in Fremont County, where juveniles meeting the criteria for neither type of problem was the least common group, and the JDC in Minidoka County, where there was a tie for single smallest group between juveniles meeting the criteria for a substance abuse 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 Y4, when juveniles who met the criteria for having neither a mental health nor a substance abuse problem were the single largest group in four of 11 JDCs, and identical to Y3, when this group was the single largest group in six of 11 JDCs. The pattern 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 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	31.1 (N = 50)	<i>14.3</i> (N = 23)	24.8 (N = 40)	29.8 (N = 48)
Bannock County (District 6)	16.3 (N = 30)	41.8 (N = 77)	8.7 (N = 16)	33.2 (N = 61)
Bonner County	62.3 (N = 33)	22.6 (N = 12)	<i>1.9</i> (N = 1)	13.2 (N = 7)
Bonneville County (3B)	43.3 (N = 39)	28.9 (N = 26)	<i>10.0</i> (N = 9)	17.8 (N = 16)
Canyon County (Southwest Idaho)	14.4 (N = 34)	39.4 (N = 93)	6.8 (N = 16)	39.4 (N = 93)
Fremont County (5C)	<i>7.4</i> (N = 4)	18.5 (N = 10)	22.2 (N = 12)	51.9 (N = 28)
Kootenai County (District 1)	48.1 (N = 139)	19.0 (N = 55)	<i>10.0</i> (N = 29)	22.8 (N = 66)
Lemhi County	48.3 (N = 14)	<i>3.4</i> (N = 1)	34.5 (N = 10)	13.8 (N = 4)
Minidoka County	87.7 (N = 50)	12.3 (N = 7)	<i>0.0</i> (N = 0)	<i>0.0</i> (N = 0)
Nez Perce County (District 2)	13.0 (N = 17)	19.1 (N = 25)	7.6 (N = 10)	60.3 (N = 79)
Twin Falls County (Snake River)	23.4 (N = 46)	48.2 (N = 95)	7.6 (N = 15)	20.8 (N = 41)

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 1,087 juveniles, or 73.4% of all juveniles on whom data was collected (this percentage is somewhat higher than the 67% reported in Y4, 69% in Y3, and 68% 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 1.26, with a standard deviation of .58 (the number of previous diagnoses was similar to the 1.28 in Y4, identical to the 1.26 in Y1, and slightly higher than the 1.22 in Y2 and 1.17 in Y3). The range of previous diagnoses spanned from none to five. On average, girls (1.28) reported or were identified with slightly more previous diagnoses than boys (1.24); however, unlike in Y4 and Y3, when this difference was statistically significant, and similar to Y1 and Y2, this difference was not statistically significant in Y5, $t(df = 1072) = -.881, p > .05$. The mean number of previous diagnoses also differed significantly as a function of JDC location (Bonner County was excluded from this analysis because only one juvenile had a documented number of previous diagnoses), $F(9, 1,076) = 5.26, p < .001$ (this result is similar to that found in all four previous evaluation years). As seen below in Table 10, the JDCs with the highest number of mean previous diagnoses were those in Lemhi, Fremont, and Nez Perce counties. The JDCs with the lowest number of mean previous diagnoses were in Minidoka, Bonneville, and Ada counties.

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	155	1.15	.39
Bannock County (District 6)	155	1.36	.65
Bonneville County (3B)	83	<i>1.10</i>	.30
Canyon County (Southwest Idaho)	231	1.34	.76
Fremont County (5C)	24	1.50	.78
Kootenai County (District 1)	196	<i>1.13</i>	.40
Lemhi County	29	1.55	.63
Minidoka County	3	<i>1.00</i>	.00
Nez Perce County (District 2)	24	1.42	.65
Twin Falls County (Snake River)	186	1.26	.56

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest means 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 983 juveniles, or 66.3% of all juveniles on whom data was collected (this percentage is somewhat lower than the 73% reported in Y4; a comparison to provisional diagnoses for Y1-Y3 is not feasible, as problems were identified in how these were calculated in those years; this issue is discussed in detail in McDonald et al.'s [2012] Y4 report). The mean number of provisional

diagnoses for juveniles (of both genders and across the 11 JDCs) with at least one provisional diagnosis was 1.52, with a standard deviation of .71 (the mean number of provisional diagnoses is almost identical to the 1.51 in Y4; a comparison to means for years Y1-Y3 is not feasible due to problems with how these were calculated in those years; this issue is also discussed in detail in McDonald et al.'s [2012] report). The range of provisional diagnoses spanned from none to four. As was the case in all four previous evaluation years, a statistically significant difference in mean number of provisional diagnoses was found to exist between boys (1.48) and girls (1.62), with girls receiving significantly more provisional diagnoses than boys, $t(972) = -2.92, p < .01$. As was the case in all four previous evaluation years, the mean number of provisional diagnoses significantly differed as a function of JDC location, $F(10, 972) = 10.16, p < .001$. Also seen below in Table 11, the JDCs with the highest number of mean provisional diagnoses were in Lemhi and Ada counties, followed by the JDC in Twin Falls County. The JDC with the lowest number of mean provisional diagnoses was in Kootenai County, followed by the JDCs in Bonneville and Fremont counties.

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	127	1.80	.85
Bannock County (District 6)	144	1.40	.64
Bonner County	20	1.40	.50
Bonneville County (3B)	61	<i>1.28</i>	.45
Canyon County (Southwest Idaho)	189	1.52	.69
Fremont County (5C)	28	<i>1.32</i>	.61
Kootenai County (District 1)	141	<i>1.18</i>	.41
Lemhi County	28	2.04	.92
Minidoka County	13	1.38	.65
Nez Perce County (District 2)	60	1.62	.64
Twin Falls County (Snake River)	172	1.70	.79

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest means 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. At least one provisional diagnosis was indicated in every appropriate case, except one. 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 44% 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 just over 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 over 21% of juveniles and attention deficit disorders (e.g., attention deficit hyperactivity disorder), which was given to nearly 12% of juveniles. Interestingly, the five most common provisional diagnoses in Y5 were the same as in all four previous evaluation years—in exactly the same order.

Provisional Diagnosis	Number of Cases	Percentage of Total Cases
Mood disorders (e.g., depression, bipolar disorder)	427	43.5
Substance abuse disorders (e.g., marijuana or alcohol abuse)	364	37.1
Disruptive behavior disorders (e.g., oppositional defiant disorder, disruptive disorder, conduct disorder)	255	26.0
Anxiety disorders (e.g., post-traumatic stress disorder)	209	21.2
Attention deficit disorders (e.g., ADHD/ADD)	117	11.9

Note. The percentages in this table are calculated out of 982 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 1,131 juveniles. This number is higher than the total number of juveniles who received at least one provisional diagnosis (983 juveniles received at least one provisional diagnosis). Of all juveniles who received at least one service recommendation, 933 (or 82%) were also given at least one provisional diagnosis. The remaining 198 (or 18%) received at least one service recommendation but were not given a provisional diagnosis. Additionally, 50 juveniles were given at least one provisional diagnosis without receiving a service recommendation. Perhaps the best measure of the success of clinicians in making recommendations to those who were supposed to receive them is through dividing the number of provisionally diagnosed juveniles who also received at least one service recommendation (933) by the number of juveniles who received at least one provisional diagnosis. The resulting figure is 94.9%, meaning just under 95% of the juveniles who should have received a service recommendation did in fact receive at least one. 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 1.77, with a standard deviation of 1.14. The mean number of service recommendations was slightly lower than the 1.92 reported in Y4 (the mean number of recommended services was slightly lower than the 1.92 in Y4; the mean number of service recommendations cannot be compared to Y1-Y3 due to problems with how these were calculated; this issue is discussed in detail in McDonald et al.'s [2012] report). The range of recommended services spanned from none to 12. Similar to Y1, Y3, and Y4, but different than Y2, a statistically significant difference in the number of recommended services was found between boys and girls, with girls (1.92) receiving significantly more service recommendations than boys (1.70), $t(df = 1,125) = -3.13, p < .01$. Also, similar to all four previous evaluation years, the mean number of recommended services was found to differ significantly as a function of JDC location, $F(10, 1,128) = 19.81, p < .001$. As seen below in Table 13, the JDC with the

highest number of mean recommended services was in Lemhi County, followed by the JDCs in Twin Falls and Bannock counties. The JDC with the lowest number of mean recommended services was in Bonneville County, followed by the JDCs in Nez Perce and Minidoka counties.

Table 13: Number of Recommended Services by JDC Location			
JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	131	1.76	.88
Bannock County (District 6)	176	2.19	1.55
Bonner County	29	1.34	.55
Bonneville County (3B)	61	<i>1.03</i>	.18
Canyon County (Southwest Idaho)	189	1.65	.83
Fremont County (5C)	45	1.44	.59
Kootenai County (District 1)	168	1.47	.73
Lemhi County	29	2.93	1.65
Minidoka County	10	<i>1.30</i>	.67
Nez Perce County (District 2)	109	<i>1.22</i>	.55
Twin Falls County (Snake River)	192	2.30	1.40

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest means are presented in bold, and the three lowest means 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. Clinicians indicated what the recommended service was (or recommended services were, if multiple recommendations were given) for all 1,131 juveniles to whom service recommendations were reportedly given. Although a number of categories were provided in drop-down menus in the clinicians' Access databases, clinicians were also 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; nearly 53% of the juveniles for whom a recommended service was listed were recommended to access individual counseling. Continuation of prior treatment (over 27%) comprised the second-most common category. Recommendations for substance abuse counseling/treatment (nearly 22%), psychological/mental evaluations (nearly 20%), and substance abuse assessment (over 15%) were also fairly common recommendations. Smaller numbers of recommendations were made for family counseling (11%), medication evaluation (over 6%), and residential treatment (over 5%). These eight most common service recommendation categories were also the eight most common in Y4 and Y3.

Service Recommendation	Number of Cases	Percentage of Total Cases
Individual counseling (e.g., Cognitive Behavioral Therapy)	560	52.7
Continue (unspecified) prior treatment	289	27.2
Substance abuse counseling/treatment	232	21.8
Psychological/mental evaluation	212	19.9
Substance abuse assessment	162	15.2
Family counseling	117	11.0
Medication evaluation	68	6.4
Residential treatment	57	5.4

Note. The percentages in this table are calculated out of the 1,131 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 715 juveniles, or 63.2% of the 1,131 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 1.56, with a standard deviation of 1.02 (the mean number of recommended services accessed was slightly lower than the 1.81 in Y4; the mean number of recommended services accessed cannot be compared to Y1-Y3 due to problems with how these were calculated; this issue is discussed in detail in McDonald et al.'s [2012] report). The range of recommended services accessed spanned from none (36.8% of the juveniles receiving at least one service recommendation had not yet accessed a service) to 12. Unlike in Y3 and Y4, when girls accessed significant more services than boys, but similar to Y1 and Y2, no gender differences in accessed services were found in Y5. However, the mean number of recommended services accessed differed significantly as a function of JDC location, $F(10, 706) = 6.40, p < .001$ (as it also did in all four prior evaluation years). As seen below in Table 15, the JDC with the highest number of mean recommended services accessed was in Lemhi County, followed by the JDCs in Bannock and Twin Falls counties. The JDC with the lowest number of mean recommended services accessed was in Bonneville County, followed by the JDCs in Nez Perce and Bonner counties.

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	68	1.24	.50
Bannock County (District 6)	150	1.89	1.45
Bonner County	19	<i>1.16</i>	.37
Bonneville County (3B)	25	<i>1.00</i>	.00
Canyon County (Southwest Idaho)	88	1.60	.74
Fremont County (5C)	36	1.33	.53
Minidoka County	3	1.33	.58
Kootenai County (District 1)	122	1.40	.66
Lemhi County	12	2.42	1.44
Nez Perce County (District 2)	49	<i>1.14</i>	.41
Twin Falls County (Snake River)	145	1.74	1.21

Note. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values. The three highest means are presented in bold, and the three lowest means 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 115 calls were placed by the callers from the Idaho Federation of Families (IFF), 60 of which were successful (i.e., they resulted in a survey completion by a parent). The results described below were gleaned from the responses from these parents.

JDC Clinician Calls

The first question on the parent survey simply asked the respondents whether the JDC clinician had made them aware that their child had been identified as someone who could benefit from

community-based mental health or substance abuse treatment. All 60 parents who completed a survey answered this question. Of these parents, 19 (31.7%) responded “Yes” that they had been made aware of this, and 41 (68.3%) responded “No” that they had not been made aware (the percentage of those reporting having been made aware was considerably lower than the 40% in Y4 and the 47% in Y3, but is still 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 19 parents who completed this item, 10 (or 52.6%) reported that they had received recommendations for services (this percentage is much lower than the 76% in Y2 and the 66% in both Y3 and Y4). 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 8 parents reported at least one service recommendation. As seen below in Table 16, the most commonly reported recommendations, made for one-quarter of the youth for whom a recommended service was reported, were for individual counseling for the juveniles, and substance abuse treatment. Two parents (also 25.0%) 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 Y4, Y3 and Y2, although the percentages differed somewhat (in Y4, counseling and substance abuse treatment were reported by 61% and 11% of the parents, respectively, and 8% of the parents could not remember what services had been recommended for their child; 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).

Service Recommendation	Number of Cases	Percentage of Total Cases
Individual counseling	2	25.0
Substance abuse treatment	2	25.0
Can't remember	2	25.0
Continue previous treatment	1	12.5
Mental health counseling	1	12.5

Note. The percentages in this table are calculated out of the 8 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 nine parents who completed this item, eight (or 88.9%) reported that their children had accessed at least one recommended service (this percentage is lower than the 95.9% of parents in Y4 who reported their children accessing at least one recommended service and is higher than the 74% of parents in Y2 and the 82% of parents in Y3 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. One respondent completed this item, stating his or her child had “taken off”. The number of parents reporting barriers was lower than in Y4 (2), Y3 (5), and Y2 (13).

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 63 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 63 judges/JPOs who completed this item, 58 (or 92.1%) 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 first three years (66% in Y1, 79% in Y3, and 80% in Y2) and slightly higher than the 91% in Y4. 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 57 judges/JPOs who completed this item, 44 (or 77.2%) reported that they had been contacted by the JDC clinician about at least one of their juveniles (this percentage is considerably lower than the 91% in Y3, somewhat lower than the 83% in Y4 and 79% in Y1, and higher than the 73% in Y2). A statement on the survey informed those who responded “No” to this second question that they were not required to complete the remaining items, and to simply return the survey as it was. Judges/JPOs who responded “Yes” were asked to complete the remaining items.

Those judges/JPOs who reported having been contacted by the JDC clinician about at least one of their youth were asked to indicate how satisfied they were with this contact. They were asked 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, just over 70% of the judges/JPOs who completed this item reported being very satisfied (nearly 39%) or satisfied (nearly 32%) with the contact with the JDC clinician. The satisfaction rate in Y5 is considerably lower than those in previous years, which were 100% in Y4 and approximately 90% in each of the first three years. Of those who did not report satisfaction with contact from the JDC clinician, most (over 18%) were neither satisfied nor dissatisfied, with just over 11% being dissatisfied or very dissatisfied.

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?	4.5% (N = 2)	6.8% (N = 3)	18.2% (N = 8)	31.8% (N = 14)	38.6% (N = 17)

Note. The percentages in this table are calculated out of the 44 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 44 judges/JPOs who completed this item, 39 (or 88.6%) reported that they had received such recommendations (the percentage of judges/JPOs who reported receiving recommendations was lower than in any of the previous years, which ranged from 90% in Y2 to 97% in Y4). All judges/JPOs who reported having received recommendations were asked to indicate on a five-point Likert-type scale how satisfied they were with the recommendations made. As seen below in Table 18, nearly 80% of the judges/JPOs who completed this item reported being either satisfied (over 51%) or very satisfied (over 28%). This satisfaction rate was slightly higher than the 79% in Y1, but lower than the 85%, 90%, and 100% in Y2, Y3, and Y4, respectively. Of those who did not report satisfaction with recommendations from the JDC clinician, most (nearly 13%) were neither satisfied nor dissatisfied, with just under 8% being dissatisfied or very dissatisfied.

Item	Very Dissatisfied	Dissatisfied	Not Satisfied or Dissatisfied	Satisfied	Very Satisfied
How satisfied were you with the recommendations made by the mental health clinician?	2.6% (N = 1)	5.1% (N = 2)	12.8% (N = 5)	51.3% (N = 20)	28.2% (N = 11)

Note. The percentages in this table are calculated out of the 39 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 39 judges/JPOs who completed this item, 27 (or 69.2%) reported that the recommendations they received had affected a decision or treatment advised for the youth. This percentage of having decisions affected by clinician recommendations is the lowest of any of the previous four years of evaluation, which ranged from 73% in Y3 to 85% in Y2.

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, the majority—nearly 57%—of the judges/JPOs who completed this item reported thinking it was very beneficial to have a clinician in the nearest JDC, and another 23% reported it to be rather beneficial. The overall beneficial rate of nearly 80% is slightly higher than the 78% in Y1, but lower than the 84%, 93%, and 95% found in Y3, Y2, and Y4, respectively. Of those who did not report thinking that it was beneficial to have a clinician in the JDCs, most (over 11%) reported a neutral option, with 9% reporting that it is not very beneficial or not at all beneficial.

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?	4.5% (N = 2)	4.5% (N = 2)	11.4% (N = 5)	22.7% (N = 10)	56.8% (N = 25)

Note. The percentages in this table are calculated out of the 44 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. Forty-one (or 95.3%) of the 43 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 and 97% in Y4, but slightly higher than the 92% in Y1 and 94% in Y3.

Additional Analysis 1: Trauma and Gender Differences in the Prevalence of MH Problems

As noted in this and other reports (e.g., McDonald et al., 2012), it has been found in each year of CSP evaluations that a greater percentage of girls meet the AST diagnostic criteria for having a mental health problem than boys. When the results of the Y4 evaluation were presented at a meeting of the Idaho Criminal Justice Commission (ICJC), questions were raised about why the prevalence of mental health problems seemed higher in girls than in boys. One possible explanation was explored in the Y5 evaluation: Differential trauma experiences.

In order to measure whether (and if so, how) traumatic experiences are related to gender and mental health problems, the researchers chose to use scores from the MAYSI-2 inventory that juveniles complete as they are processed into a JDC. One of the seven subscales on the MAYSI-

2 is the Traumatic Experiences or TE subscale, which documents juveniles' exposure to a host of traumatic events over a period of time. Information from the MAYSI-2, including whether juveniles 'screened positive' for traumatic events, is included in the clinicians' Access databases that are provided to IDJC. Analysis of possible associations among gender, traumatic experiences, and mental health problems therefore involved determining whether boys and girls differed in their experiences of trauma, and also whether traumatic experiences varied systematically with the presence of mental health problems.

The first set of analyses revealed that there was, within the Y5 juveniles, an association between gender and traumatic experiences. As seen below in Table 20, whereas nearly 36% of girls screened positive for traumatic experiences on the MAYSI-2, fewer than 25% of boys did so. This difference was found to be statistically significant, χ^2 (df = 1) = 19.89, $p < .001$.

MAYSI-2 Indication	Gender			
	Number of Cases		Percentage of Total Screened Cases	
	Male	Female	Male	Female
Positive screen for traumatic experiences	251	156	24.4	35.8
Negative screen for traumatic experiences	779	280	75.6	64.2

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

The second set of analyses revealed that there was also an association between the indication of mental health problems and traumatic experiences. As seen below in Table 21, whereas 77% of juveniles who screened positive for traumatic experiences screened positive for a mental health problem, fewer than 52% of juveniles who screened negative for traumatic experiences did so. This difference was also found to be statistically significant, χ^2 (df = 1) = 79.47, $p < .001$.

MAYSI-2 Indication	AST Indication			
	Number of Cases		Percentage of Total Screened Cases	
	No MH Problem	MH Problem	No MH Problem	MH Problem
Positive screen for traumatic experiences	94	315	23.0	77.0
Negative screen for traumatic experiences	520	552	48.5	51.5

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

To determine the relative strength of traumatic experiences and gender in predicting mental health status, a logistic regression model was developed and tested. The results of this test showed that both variables emerged as independent predictors of mental health status, with

traumatic experiences (Wald = 69.29, $p < .001$) emerging as a stronger predictor than gender (Wald = 9.96, $p < .01$). Odds ratios calculated within this model showed that juveniles who screened positive for traumatic experiences were 3.2 times more likely to screen positive for a mental health problem than those who screened negative for traumatic experiences, and that girls were 1.7 times more likely to screen positive for a mental health problem than boys.

Additional Analysis 2: Booking Charges

To examine whether there were any systematic differences in booking charges between juveniles who met the AST criteria for a mental health problem, a substance abuse problem, or both types of problems and those juveniles who met the AST criteria for neither a mental health nor a substance abuse problem, a set of additional analyses was performed. Only those booking charges that could be classified as one of the four UCR categories were included in these analyses (the remaining booking charges that could not be classified as one of the four UCR categories were removed). Of 456 juveniles who met the AST criteria for neither a mental health nor a substance abuse problem, 56.8 % (or 259 juveniles) had at least one booking charge that could be classified as one of the four UCR categories (two booking charges were noted for 49 juveniles). Of the 1,026 remaining juveniles (those who met the AST criteria for a mental health problem, a substance abuse problem, or both types of problems), 54.1% (or 555 juveniles) had at least one booking charge that could be classified as one of the four UCR categories (two booking charges were noted for 150 juveniles). As seen below in Table 22, the majority of juveniles in both groups (juveniles who met the AST criteria for neither type of problem and those who met the AST criteria for a mental health problem, a substance abuse problem, or both types of problems combined) were booked on property crime, crime against persons, and drug crime charges. Only a small percentage of juveniles in either group were booked on sex crime charges. No statistically significant differences in how booking charges were distributed between juveniles who met the AST criteria for neither type of problem and all other juveniles combined (those who met the AST criteria for a mental health, a substance abuse, or both types of problems) were found.

Condition	Number of Cases (Percentage)			
	Drug Crime	Property Crime	Crime Against Persons	Sex Crime
Neither mental health nor substance abuse problem	73 (28.2)	93 (35.9)	73 (28.2)	20 (7.7)
All other diagnostic categories combined (mental health problem only, substance abuse problem only, or both)	156 (28.1)	198 (35.7)	165 (29.2)	36 (6.9)

Note. The percentages in this table are calculated out of the 814 juveniles for whom at least one booking charge that could be classifiable as one of the four UCR categories was noted in the IDJC database. Because up to two booking charges were coded for each individual, the total percentages in this table may exceed 100.

However, when we analyzed how booking charges were distributed across all four diagnostic categories (this analysis was limited to the first booking charge only), a chi-square test revealed statistically significant differences, χ^2 (df = 9) = 149.15, $p < .001$. As seen below in Table 23, among juveniles who met the diagnostic criteria for neither a mental health problem nor a substance abuse problem, the most common booking charge was property crime (36%), followed by crime against persons and drug crime (both at 28%). The least common booking charge for juveniles in this diagnostic category was sex crime (8%). Among juveniles who met the diagnostic criteria for a mental health problem only, the most common booking charge was crime against persons (46%), followed by property crime (33%) and more distantly, sex crime (13%). The least common booking charge for juveniles in this diagnostic category was drug crime (8%). Among juveniles who met the diagnostic criteria for a substance abuse problem only, the most common booking charge was drug charge (59%), followed distantly by property crime (29%) and crime against persons (9%). The least common booking charge for juveniles in this diagnostic category was sex crime (4%). Among juveniles who met the diagnostic criteria for both a mental health and a substance abuse problem, the most common booking charge was property crime (41%), followed closely by drug crime (39%). Crime against persons was a far less common booking code (20%), and no juveniles in this diagnostic category had a booking charge for a sex crime. Thus, in terms of the diagnostic categories, those juveniles with a mental health problem only were the most likely to be booked on charges of crimes against persons, and those with a substance abuse problem only were the most likely to be booked on charges of drug crimes. Those juveniles in the other two diagnostic categories were more evenly distributed across booking charge categories.

Condition	Number of Cases (Percentage)			
	Drug Crime	Property Crime	Crime Against Persons	Sex Crime
Neither mental health nor substance abuse problem	73 (28.2)	93 (35.9)	73 (28.2)	20 (7.7)
Mental health problem only	19 (7.7)	82 (33.3)	112 (45.5)	33 (13.4)
Substance abuse problem only	47 (58.8)	23 (28.8)	7 (8.8)	3 (3.8)
Both mental health and substance abuse problem	90 (39.3)	93 (40.6)	46 (20.1)	0 (0.0)

Note. The percentages in this table are calculated out of the 814 juveniles for whom at least one booking charge classifiable as one of the four UCR categories was noted in the IDJC database. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. The highest row percentage is presented in bold, and the lowest percentage is presented in italics.

Additional Analysis 3: Regional Differences in Recommended Services Accessed

To determine whether there were any differences in the rates at which at least one recommended service was accessed by the time the 15-45 day follow-up call had been placed, three additional sets of analyses were conducted. First, we analyzed whether at least one recommended service was accessed at different rates by juveniles released from JDCs in urban and rural/frontier counties. The 11 counties housing JDCs from which data were analyzed in this report were classified as either urban or rural/frontier using the definition provided by the state of Idaho (Idaho Division of Financial Management, 2005). According to this definition, counties with an urban area of at least 20,000 people are classified as urban, and all other counties are classified as rural/frontier. Of the 11 counties housing JDCs included in this report, seven (Ada, Bannock, Bonneville, Canyon, Kootenai, Nez Perce, and Twin Falls) were classified as urban, and the remaining five (Bonner, Fremont, Lemhi, Minidoka, and Valley) were classified as rural/frontier. As seen below in Table 24, the rates at which at least one recommended service was accessed by juveniles who received at least one recommendation for services did not significantly differ between urban and rural/frontier counties.

Type of County	Number of Cases	Percentage of Cases
Urban	645	62.9
Rural/Frontier	70	61.9

Note. The percentages in this table are calculated out of 715 juveniles who accessed at least one recommended service.

Next, we analyzed whether there were any differences in the rates at which at least one recommended service was accessed across juveniles released from JDCs in individual counties. As seen below in Table 25, there was a large spread of percentages of juveniles by JDC county who accessed at least one recommended service, ranging from 30% to over 85%. The three counties housing JDCs with the highest percentage of juveniles who accessed at least one recommended service were Bannock (where over 85% of juveniles accessed at least one recommended service), Fremont (80%), and Twin Falls (nearly 76%) counties. The three counties housing JDCs with the lowest percentages of juveniles who accessed at least one recommended service were Minidoka (30%), Bonneville (41%), and Lemhi (over 41%) counties. A chi-square test revealed that the differential rate at which at least one recommended service was accessed as a function of JDC county was statistically significant, χ^2 (df = 10) = 127.88, $p < .001$.

County	Number of Cases	Percentage of Cases
Ada County	68	51.9
Bannock County	150	85.2
Bonner County	19	65.5
Bonneville County	25	<i>41.0</i>
Canyon County	88	46.6
Fremont County	36	80.0
Kootenai County	120	71.4
Lemhi County	12	<i>41.4</i>
Minidoka County	3	<i>30.0</i>
Nez Perce County	49	45.0
Twin Falls County	145	75.5

Note. The percentages in this table are calculated out of the juveniles who accessed at least one recommended services. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

Finally, an analysis of regional differences in rates at which at least one recommended service was accessed was conducted. For the purposes of this analysis, the 11 counties housing JDCs from which data were analyzed in this report were categorized into one of the following seven regions defined by the Idaho Department of Health and Welfare: Region 1 (Bonner and Kootenai counties); Region 2 (Nez Perce County), Region 3 (Canyon County), Region 4 (Ada County), Region 5 (Minidoka and Twin Falls counties), Region 6 (Bannock County), and Region 7 (Bonneville, Fremont, and Lemhi counties). As seen below in Table 26, the two regions housing JDCs with the highest percentages of juveniles who accessed at least one recommended service were Region 6 (where over 85% of juveniles accessed at least one recommended service) and Region 5 (over 73%). The two regions housing JDCs with the lowest percentages of juveniles who accessed at least one recommended service were Region 2 (45%) and Region 3 (nearly 47%). A chi-square test revealed that the differential rate at which at least one recommended service was accessed as a function of region was statistically significant, χ^2 (df = 6) = 99.66, $p < .001$.

Type of County	Number of Cases	Percentage of Cases
Region 1	139	70.6
Region 2	49	<i>45.0</i>
Region 3	88	<i>46.6</i>
Region 4	68	51.9
Region 5	148	73.3
Region 6	150	85.2
Region 7	73	54.1

Note. The percentages in this table are calculated out of the juveniles who accessed at least one recommended services. The two highest percentages are presented in bold, and the two lowest percentages are presented in italics.

Additional Analysis 4: Judges/JPOs Survey

The initial analysis of responses to the judges/JPOs survey revealed some interesting findings. For example, whereas almost all respondents (95%) reported that they would like to see the program housing a mental health clinician in detention center continue, the percentage of those who reported this program to be very beneficial (57%) or beneficial (23%) was somewhat lower (nearly 80%). Likewise, of those respondents who reported receiving recommendations on how to help youth with mental health issues, nearly 80% reported being very satisfied (over 28%) or satisfied (over 51%) with these recommendations. However, the percentage of those who reported that the recommendations they received had affected a decision or treatment they advised for the youth was somewhat lower (over 69%). To gain a better understanding of what, if any, factors may be contributing to these variations, additional analyses were performed.

First, we examined whether 1) the respondents' level of satisfaction with the contact they had had with the JDC clinician, 2) their level of satisfaction with recommendations made by the clinicians, and 3) the degree to which they thought it beneficial to have a mental health clinician in detention center differed between respondents who reported that recommendations made by the clinicians had affected their decisions or treatments advised for the youth and those who reported that it had not. In other words, we were interested in knowing whether judges and JPOs whose decisions or treatments were affected by the JDC clinicians' recommendations were differentially satisfied with the contact with or the recommendations from the clinicians, and/or felt differently about the benefit of the CSP, compared to judges and JPOs whose decisions or treatments were not affected by the clinicians' recommendations. These analyses revealed a statistically significant difference on all three survey items listed above between judges/JPOs who reported that recommendations made by the clinicians had affected their decisions or treatments advised and those who reported that it had not. Respondents reporting that recommendations had affected a decision or treatment advised for the youth were significantly more satisfied with the contact they had with the JDC clinician ($M = 4.33$, $SD = .88$) than those reporting that recommendations had not affected a decision or treatment advised ($M = 3.25$, $SD = 1.29$), $t(37) = 3.07$, $p < .01$. Also, respondents reporting that recommendations had affected a decision or treatment advised were also significantly more satisfied with recommendations made by the clinician ($M = 4.33$, $SD = .55$) than those reporting that recommendations received had not affected a decision or treatment advised ($M = 3.17$, $SD = 1.11$), $t(37) = 4.39$, $p < .001$. Finally, judges/JPOs reporting that recommendations had affected a decision or treatment advised rated having a mental health clinician in the detention center as significantly more beneficial ($M = 4.74$, $SD = .53$) than those reporting that recommendations had not affected a decision or treatment advised ($M = 3.33$, $SD = 1.44$), $t(37) = 4.52$, $p < .01$ (see Table 27).

Table 27: Judges/JPOs Ratings of Contact with JDC Clinicians, Clinicians' Recommendations, and Program's Value, by whether Recommendations Affected Decisions or Recommendations Advised for Youth		
Perception of Program Element	Recommendations Affected Decisions or Recommendations Advised for Youth	
	Yes	No
Satisfaction with contact	4.33 (.88)	3.25 (1.29)
Satisfaction with recommendations from JDC clinicians	4.33 (.55)	3.17 (1.11)
How beneficial is it to have a clinician in the JDCs	4.74 (.55)	3.33 (1.44)

Note. The values in this table are calculated out of the 39 judges/JPOs who reported having received recommendations from a JDC clinician on how to help youth with mental health issues. All three items were rated on a five point Likert scale (1 = Very dissatisfied/Not at all beneficial to 5 = Very satisfied/Extremely beneficial). Standard deviations, provided in parentheses below the means, reflect the spread of values, with larger standard deviations indicating a wider spread of values.

Next, content analyses of the three open-ended survey items were conducted. First, comments provided by the 12 respondents who indicated that the recommendations from JDC clinicians had not affected any of the decisions or treatments they advised for the youth were analyzed. When asked why these recommendations did not affect their decisions or treatment advised, all 12 judges/JPOs indicated that the recommendations from clinicians contributed no new insight (e.g., “The recommendations had already been included in the youth’s treatment plan,” “the recommendations did not shed any light on anything that was not already being done. The recommendations were very general – i.e., Individual Counseling,” “recommendations coincided with the direction I was already going with the case”). Three respondents also suggested that “checking a box” was not very useful and expressed that some kind of counseling in detention would be beneficial (e.g., “A check off box with a recommendation for continued counseling or a mental health evaluation doesn’t give me any details on the areas of concern that need to be addressed with the juvenile... it is a useless process to have someone tell us the juvenile is in need of these services... and the clinician is not capable or willing to provide any services even when juveniles are incarcerated for a long period of time,” “I would prefer to have her provide some form or fashion of counseling to my youth when incarcerated rather than just check a box on a form and fax it to me,” “in recent events it has been questionable as to the purpose of the clinician and how often she is even available to assist in matters”).

Subsequently, comments provided by 29 judges/JPOs (or over 45% of all respondents) in response to the item asking survey takers to provide explanations as to why or why not they would like to see the program housing a mental health clinician in detention center continue were subjected to content analysis. Twenty-two respondents provided positive comments about the program (e.g., “The insights and recommendations have been very helpful and beneficial,” “it helps determine if the child is getting appropriate services,” “it is helpful with my probationers and their families. It especially helps convince parents that their child needs additional

help/counseling,” “provides a safety net to those juveniles in detention that may be struggling with mental health issues...The clinician provides invaluable training to line staff”). Five respondents provided comments that are best described as neutral (e.g., “I am neutral – I am certain that there is some benefit to have a juvenile screened, particularly for juveniles who we have little or no history with in juveniles justice. For those juveniles who we have had a history with we are not learning much that is new,” “having a mental health clinician in the detention facility is very important; however, I do not believe that the clinician at the detention facility we send juveniles to understands what her role is. Juveniles that are sent to detention for an extended period of time that need mental health counseling should be able to access this while being held in detention”), and two comment were rather negative in tone (“It is not beneficial to us or our juveniles,” “perhaps if the clinician ran groups in detention it may be a little more beneficial”).

Finally, a content analysis was conducted on the written recommendations entered in response to the closing survey item asking the respondents to provide recommendations that could help improve the mental health services in detention centers was conducted. Of the 29 judges/JPOs who provided explanations as to why or why not they would like to see the program housing a mental health clinician in detention center continue, eight (or nearly 28%) also provided recommendations for improving mental health services in detention centers (interestingly, none of the respondents who failed to provide explanations as to why or why not they would like the program to continue provided recommendations on the closing survey item). Of the eight respondents who provided written recommendations, four recommended that groups or other services be provided to juveniles in detention (e.g., “Run groups in detention,” “I believe providing direct services, counseling, or groups to deal with their mental health issues would be more beneficial, especially for those juveniles who are incarcerated for long periods of time,” “it would be nice if some type of on-going group could be run by the clinician in detention”). One respondent recommended that more “in-house family” activities should occur (“Face-to-face family contact with the families and juveniles to let them know about the identified areas of need and possible services available”), and another suggested that the clinician should “actually...have contact with the probation department to have a discussion about the treatment needs or recommendations.” Of the remaining two, one expressed a desire for more funding (“More of a wish...more dollars to enhance the program”), and one summarized the activities currently undertaken (“We are working on taking the program to the next level where service providers come to detention at the behest of the detention workers and take the planning and treatment to the next level before the juveniles is released”).

Summary and Conclusions

The material in this report describes the results of the five-year, multimodal evaluation of the CSP. In this report, the evaluation methodology and results generated through the three waves of data collection and several additional analyses 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; McDonald et al., 2012), a benefit of conducting programmatic research over multiple years is that improvements can be made when difficulties are identified in previous evaluations. Over the five 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 Y5 in very much the same way as they were in Y1. However, it is clear that clinicians in Y5 submitted more complete and better data than in previous years. There were fewer missing data fields in Y5 (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 Valley County JDC were excluded from the analysis because too few cases were submitted by this JDC to be able to ensure juveniles' anonymity. Also, upon removing data from the Valley County JDC, the BSU researchers noticed that multiple entries were provided for some juveniles. To ensure data quality, the BSU team and the lead administrator from IDJC determined that the data on 51 juveniles for whom multiple data entries were provided should be excluded from the analysis. This resulted in the exclusion of 133 data entries.

As was discussed in the Y4 report (McDonald et al., 2012) a problem with a design feature in the clinician's Access database led to an initial inflation of provisional diagnoses and service recommendations. This problem involved auto-population of the "Number of Provisional Diagnosis" and "Number of Recommended Services" columns with a "1" whenever a clinician typed in a word such as "None" (thus, the "None" was being inadvertently converted to a "One"). The BSU researchers, having identified and corrected the problem in the Y4 dataset, anticipated and corrected for the problem in the Y5 dataset as well. Improvements made in the data collection system, initiated in fall 2012 after extraction problems with the clinicians' Access databases, include a correction of this "glitch" so it should not continue to be problematic in future years of evaluation. Other improvements made in the data collection system in fall 2012 include more comprehensive drop-down menus for types of provisional diagnoses and service recommendations, which should lead not only to greater ease for clinicians in entering information into their Access databases, but also better quality data in future years.

No changes were made to the second wave data collection process between Y4 and Y5. To reduce the likelihood that parents who should not be called would not be called, the lead administrator was conservative in identifying parents for the IFF callers to contact. For this reason, a smaller number of parents were called in Y5 compared to previous years and this led to a smaller number of completed calls (60 in Y5 compared to 273, 233, and 311 completed in Y2, Y3, and Y4, respectively; a telephone survey method was not used in Y1). For reasons that cannot be fully explained, the response rate of 52% in Y5 was considerably lower than in previous years (73%, 66%, and 76% in Y2, Y3, and Y4, respectively).

The same Judges'/JPOs' survey used in Y1-Y4 was also used in the Y5 evaluation; however, the methodology for data collection was altered in Y5. This methodological change involved moving from a mail survey to a web-based survey of judges/JPOs. The web-based survey strategy has been a clear improvement; whereas 63 judges/JPOs completed a web-based survey in Y5, the number of returned mail surveys was lower in all of the prior evaluation years, with 50 returned surveys in Y1, 40 in Y2, 43 in Y3, and 45 in Y4 (furthermore, the response rate of 46% in Y5 was considerably higher than the 31% in Y2 and the 33% in Y3 and Y4, and somewhat higher than the 44% in Y1).

Several additional analyses utilizing already existing data were conducted in Y5. Specifically, wave one data were used to address questions about gender differences in the prevalence of mental health problems, the association between mental health problems and trauma experiences, differences in booking charges between juveniles who met the AST criteria for either type of problem and those who met the AST criteria for neither, and differential rates at which at least one recommended service was accessed across regions/counties. As discussed in the Methodology section of this report, the use of MAYSI-2 data was a unique feature of the Y5 evaluation. These data seemed to enrich the understanding of factors associated with mental health problems in juvenile detainees, and it seems warranted that further exploration of MAYSI-2 data be considered in future evaluations. Additionally, wave three data were used to identify factors that may be contributing to variations in judges/ JPOs responses.

Mental Health and Substance Abuse Issues

As has been discussed in previous reports on the CSP, a striking finding of all evaluations of this program is the high prevalence of both mental health and substance abuse problems among juveniles detained in the JDCs across Idaho. As noted in the Y4 report (McDonald et al., 2012), it is probably wise to exclude the percentages of mental health and substance abuse problems from Y1 in any aggregate analysis, because those percentages were so much higher than in other years; the higher percentages from that year were likely due to the newness of the program and the fact that many clinicians were still becoming accustomed to working in a juvenile justice environment. Focusing instead only on prevalence figures from Y2-Y5 shows that these figures cluster closely—particularly for mental health problems. For example, in three of the four years (i.e., Y2, Y4, and Y5), 59% of juveniles detained met the AST criteria for mental health problem. Averaging in the slightly higher 63% figure from Y3 leads to a four-year average of 60%. The prevalence figures for substance abuse problems vary slightly more, from 41% in Y5 to 46% in Y2, with Y3 and Y4 in between at 44% and 43%, respectively. These figures lead to a four-year average of 44%. Thus, on the basis of AST criteria alone, averaged across four years, 60% of juveniles entering JDCs appear to suffer from a mental health problem, and 44% appear

to suffer from a substance abuse problem. The percentage of juveniles who appear to suffer from either a mental health problem, a substance abuse problem, or both types of problems, also seem to cluster fairly closely, from 69% in Y5 to 76% in Y3, with Y2 and Y4 in between at 75% and 72%, respectively. These figures lead to a four-year average of 73%, meaning that, averaged across four years, nearly three-quarters of juveniles entering JDCs appear to suffer from a mental health and/or a substance abuse problem (or conversely, that only around 27% appear to suffer from neither).

The data gathered across the years of CSP evaluations also raise concerns about the prevalence of dual diagnoses (sometimes called co-occurring disorders), or meeting the diagnostic criteria for having both a mental health and a substance abuse problem. Because Y1 prevalence figures were again outlying in the high direction (at 41%), an aggregate assessment of only Y2-Y5 data seems appropriate. Prevalence of the dual diagnosis seems very closely clustered across the four years, with the prevalence being 30% in Y3, Y4, and Y5, with the slightly increased prevalence of 31% in Y2. These figures lead to a four-year average of 30%, meaning nearly one-third of the juveniles entering JDCs in a given year are likely to be suffering both a mental health and a substance abuse problem. As noted in the Y4 report (McDonald et al., 2012), co-occurring mental health and substance abuse problems tend to be highly complex, and are both time- and resource-intensive in terms of treatment (Horsfall, Cleary, Hunt, & Walter, 2009). Some level of preparation to address these, both in the juvenile justice system and in the communities that absorb recently released juveniles, will surely be necessary to remediate these problems.

It has been noted in each CSP evaluation report that girls entering Idaho's JDCs more often meet the diagnostic criteria for a mental health problem than boys. This is not an unusual finding by any means, as research has reported a gender difference in the diagnosis of many (though not all) mental health problems both in community and detention samples, for both adults and juveniles (e.g., Cauffman, 2004; Cauffman, Lexcen, Goldweber, Shulman, & Grisso, 2007; Klose & Jacoby, 2004; Teplin, Abram, McClelland, Dulcan & Mericle, 2002). Still, the reason for this difference is not well understood (Klose & Jacoby, 2004; Piccinelli & Wilkinson, 2000), and in any case, the finding that detained girls in Idaho meet the criteria for mental health disorders more often than boys is important to consider. The magnitude of the difference has not been the same for each evaluation year, but it has been similar (a 17%, 14%, 11%, and 12% difference in Y2, Y3, Y4, and Y5, respectively), with a four-year average of 14% (i.e., the prevalence of girls meeting the criteria for a mental health problem is 14% higher than for boys). Largely for this reason, and because it was identified as a concern at the 2012 presentation of Y4 results to the Idaho Criminal Justice Commission, the issue was explored more deeply in Y5—with a particular focus on whether differential rates of traumatic experience exposure (as measured by the MAYSI-2 Traumatic Experiences subscale) could explain the difference. As discussed in this report, girls entering detention in Idaho indeed reported more traumatic experience exposure than boys, however, this did not completely explain the gender difference in diagnosis of mental health problems; although traumatic experience exposure emerged as a stronger predictor of mental health problems than gender, gender itself (i.e., independent of traumatic experiences) itself was a predictor of mental health problems, with girls more likely to meet the diagnostic criteria for mental health problems than boys regardless of whether they had been exposed to traumatic experiences. On the basis of the in-depth analyses conducted for the first time in Y5, two conclusions can be defensibly reached. First, traumatic experience exposure is extremely

important in terms of its ability to identify juveniles (both boys and girls) as persons likely in need of mental health assistance. In this respect, close inspection of MAYSI-2 Traumatic Experiences subscale scores prior to the clinical interview seems particularly warranted. Second, girls seem to be at greater risk of having mental health problems than boys, regardless of whether or not they have been exposed to traumatic experiences. Thus, clinicians should be mindful that girls entering detention may be particularly in need of mental health assistance, both in the JDC and upon their release to the community.

Another noteworthy finding throughout the years of the CSP evaluations is that most of the juveniles screened in any given reporting year are documented to have previous diagnoses of mental health and/or substance abuse problems. Again excluding the anomalous Y1 (when only 59% of juveniles were reported to have had previous mental health and/or substance abuse diagnosis—perhaps due to the newness of the CSP), the four-year average of juveniles who had been previously diagnosed with a mental health and/or substance abuse problem (closely clustered, with a range from 68% in Y2 and 73% in Y5, with Y3 and Y4 in-between at 69% and 67%, respectively) was 69%. As noted in several recent CSP evaluation reports, it is clearly problematic that such a high percentage of juveniles entering JDCs have been previously identified as having a mental health problem, substance abuse problem, or both. Of course, it seems likely than some juveniles entering JDCs in more recent evaluation years (e.g., Y4 or Y5) were previously diagnosed by JDC clinicians in earlier evaluation years (e.g., Y1 or Y2), however, it is also quite clear that many, if not most, of these juveniles were previously diagnosed by others, such as family physicians or school counselors. In any case, it seems reasonable to conclude that better early identification and treatment of mental health and substance abuse problems by professionals in the juveniles' communities would likely help a number of these juveniles avoid future involvement in the juvenile justice system.

Service Recommendations and Access

As has been noted in earlier evaluation reports, it seems clear that CSP clinicians become quite successful in attempting to assist juveniles who are recently released from JDCs access mental health and substance abuse services, when appropriate. Results from the Y5 evaluation show that, according to clinicians, nearly 95% of those juveniles who are given a provisional diagnosis of a mental health or substance abuse problem receive at least one community-based service recommendation upon their release. Results from this evaluation also show that, again according to clinicians, a majority of them (just over 63%) appear to have accessed at least one recommended service by the 15-45 day follow-up call to the juveniles' parents. The juveniles' parents, according to parent survey results, suggest that a much smaller percentage note the receipt of service recommendations. The discrepancy between what JDC clinicians and juveniles' parents report with respect to whether service recommendations are made (and sometimes accessed) remains a problem; the fact that clinicians much more often report making recommendations than parents report receiving, for example, raises questions about the extent to which clinicians and parents are experiencing the same reality.

Stakeholder Perceptions

The primary stakeholder group in the CSP evaluations has been the judges/JPOs. Unlike the parents of recently received juveniles, whose response rates have been generally poor and whose responses (as noted above) often contradict what is reported by clinicians, response rates from judges/JPOs have been consistent and reasonable, and the perceptions reported by these respondents have been consistently positive. Similar to previous years, the judges/JPOs who completed surveys in Y5 responded very positively regarding the CSP, with the vast majority being aware of the program (92%), satisfied with contact from a JDC clinician (77%), having received recommendations from the JDC clinician (89%), and being satisfied with the contact (70%). A majority also reported that recommendations affected decisions they made regarding their youth (69%). Interestingly, whereas nearly all (95%) reported wanting to see the CSP program continue, fewer than 80% believed it to be beneficial; the reason for this discrepancy is not clear at present. In short, there is no question that judges/JPOs in Y5, 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. However, although the perceptions of judges and JPOs remained largely positive in this year's evaluation, some variations existed that would be valuable to explore in the future.

Additional Analyses

As already noted, several additional analyses that were not included in any of the prior evaluations were conducted in the Y5 evaluation. These analyses yielded some important findings. For instance, there was a clear tendency for girls to screen positive for traumatic experiences on the MAYSI-2 more often than boys. It was also found that juveniles who screened positive for traumatic experiences on the MAYSI-2 met the criteria for a mental health or a substance abuse problem more often than those who did not screen positive for traumatic experiences. These findings have important implications, especially in light of some recent research on both short- and long-term effect of adverse childhood experiences or "ACEs" (including trauma). According to the Center for Disease Control and Prevention (CDC) website, childhood exposure to traumatic events is associated with increased risk of developing a range of health problems later in life (including alcohol abuse, depression, illicit drug use, and suicide attempts). Additionally, whereas men on average report a greater number of instances of childhood physical abuse and neglect than women, women report greater numbers of instances of sexual abuse and emotional abuse and neglect than men. In any case, the results of these additional analyses may be useful in terms of identifying members of populations that, if left undiagnosed and/or untreated, are candidates to end up in detention.

Some additional analyses of booking charges revealed that the most frequent booking charge for juveniles who met the AST criteria for neither a mental health nor a substance abuse problem was property crime. In comparison, the most frequent charge for juveniles who met the AST criteria for a mental health problem only was crime against persons, whereas the most frequent charge for those who met the AST criteria for a substance abuse only was drug crime. This seems to suggest that juveniles with a mental health or a substance abuse problem are more likely to commit more serious crimes (crimes against persons and drug crimes) than those who have neither type of problem (these juveniles seem to be more likely to commit property crimes than any other type of crime). This finding seems to support anecdotal accounts of the JDC staff

and IDJC administrators suggesting that the youth they encounter in the juvenile justice system in the present time are very different from youth who were in the system just a few decades ago. According to these anecdotal accounts, juveniles now enter the system with problems that are so great in severity and complexity that the JDCs are often described as the “dumping ground” for youth with mental health and substance abuse problems.

Additional analyses of the judges/JPOs’ responses revealed that whether judges/JPOs felt that recommendations made by the clinicians had affected their decisions or treatments advised for the youth was highly predictive of the degree to which they thought it beneficial to have a clinician in detention center and how satisfied they felt with the contact with and recommendations made by JDC clinicians. This finding suggests that changes may be needed in the information exchange processes that are presently occurring between JDC clinicians and judges/JPOs. Additionally, based on comments provided by judges/JPOs in response to the three open-ended survey items, it appears that in addition to maintaining ongoing communication between JDC clinicians and judges/JPOs, some comprehensible specifications of JDC clinicians’ duties and responsibilities and judges’/JPOs’ expectations in terms of what type of information is most useful to them in making decisions and providing recommendations for youth may be warranted.

Concluding Comments

As the research team has reported in years past (e.g., McDonald et al., 2012), it is clear that mental health and substance abuse problems are very common among juveniles entering Idaho’s JDCs. Most juveniles meet the criteria for a mental health problem, and close to half meet the criteria for a substance abuse problem—with close to one-third meeting the criteria for both. The prevalence numbers have stayed remarkably consistent between Y2-Y5, and seem comparable with (or slightly higher than) those reported in other samples of detained juveniles (e.g., Cauffman et al., 2007; Fazel, Doll, & Langstrom, 2008; Wasserman et al., 2003). The lack of substantial variation in four years of rates of mental health and substance abuse among Idaho juvenile detainees suggests that what is being observed represents a “steady state” that may continue to characterize populations of juveniles detained in the coming years. As disturbing as these results are, they do not seem to place Idaho in a category of its own. In fact, the results of many studies support that mental health and substance abuse disorders are highly prevalent in detained juveniles. As stated by Anthony and her colleagues (Anthony et al., 2010), “There is a general consensus in the literature that youth with mental health disorders in need of treatment make up the majority of youth in correctional settings” (p. 1275). Thus, the situation in Idaho seems part of a broader trend: Juveniles being detained in the current time are more likely than not to have mental health or substance abuse problems in need of treatment.

To avoid well-documented social and economic costs associated with juvenile crime (for a discussion of these costs, see McDonald et al., 2012), it seems a concerted effort to reduce the likelihood that juveniles become involved with the justice system is warranted. Researchers Farrington and Welsh, authors of the often-cited book *Saving Children from a Life of Crime* (2007) and a host of scholarly journal articles on the prevention of juvenile crime (e.g., Farrington & Welsh, 2003; Welsh & Farrington, 2011), report that there are many evidence-based interventions that prove efficacious in reducing or preventing criminal behavior in

children, many of which save society great amounts of money that would be otherwise spent on incarceration, unemployment, or welfare. Some of these programs focus on parent training either in home or community settings, and others involve family or systems-based interventions in preschools, schools, and other settings. It is noteworthy that many of the interventions discussed by Farrington, Welsh, and their colleagues (e.g., Piquero, Farrington, Welsh, Tremblay, & Jennings, 2009) focus on the mental health of the parents as well as the children—perhaps a very important consideration in Idaho given the anecdotal reports of JDC clinicians and staff, as well as IDJC administrators, that the parents of many detained juveniles have more serious mental health and substance abuse problems than their children, which affects these parents' ability to monitor their children's behavior and comply with post-release treatment. In any case, it seems that if the goal is *prevention* of juvenile crime, early intervention with at-risk families is the key. For those juveniles who have already been detained, it seems the goal shifts to preventing them from becoming more deeply involved in the correctional systems—both at the juvenile and adult levels.

One of the more striking revelations for the research team, after five years of CSP evaluations, is that despite the success of the CSP in identifying mental health and substance abuse problems in detained juveniles, and attempting to connect diagnosed, recently released juveniles with appropriate services in their communities, many of these juveniles do not seem to receive the services (or level of these services) they need. In short, the “aftercare” piece seems to be missing. Evidence of this comes from two sources. First, in the Y4 evaluation (McDonald et al., 2012), both JDC administrators and clinicians were asked whether they perceived there to be barriers to juveniles accessing community-based services that were recommended for them, and many such barriers were listed. The most common among these included lack of parental compliance, initiative, or motivation, economic concerns such as cost and lack of resources, lack of available services in the community, and a need for JPOs to follow-up with families to ensure that recommended services are being accessed. Second, although recidivism of individual cases has not been tracked in any prior CSP evaluation, a fairly high level of recidivism is evidenced both by anecdotal reports from JDC administrators and clinicians and by the presence of common Juvenile ID numbers in clinicians' databases, both across and even within evaluation years. Because barriers to service access exist and because juveniles who should have received community-based services likely recidivated due at least in part to lack of service access, aftercare indeed seems wanting. Of course, aftercare treatment, or even oversight, is not expected or within the duties of the JDC clinicians. Thus, it is technically not even an expected activity of the CSP. Still, to the extent that the CSP is intended to reduce mental health and substance abuse problems in juveniles who have been detained, and to reduce the likelihood that previously detained juveniles have further contact with the juvenile justice system, some discussion of the importance of aftercare seems necessary. Simply put, if juveniles diagnosed with a mental health and/or substance abuse problem are not appropriately treated upon release, it seems highly likely that they will return to detention.

Aftercare, then, seems absolutely necessary if juveniles are to be reintegrated to their communities in a way that reduces the likelihood that they recidivate. As stated by Anthony and her colleagues (2010), “Re-entry and rehabilitation need to be goals from the moment youth enter the juvenile justice system” (p. 1275). However, as noted above, the aftercare needed for successful re-entry and rehabilitation seems missing in Idaho (and probably most other states).

Also as noted above, we understand some of what the necessary aftercare is in Idaho from JDC administrators' and clinicians' reports in the Y4 evaluation (McDonald et al., 2012); this aftercare would aim to ensure that juveniles receive services even when their parents are initially non-compliant or unmotivated to help their children receive services, and would involve JPOs or other designated persons working diligently with families to make sure the services are being accessed as recommended or mandated. Some authors, including Voisin, Tan, Tack, Wade, and DiClemente (2012) have postulated that increased parental monitoring can reduce recidivism, however, if parents are functionally incapacitated by their own mental health and/or substance abuse problems (as JDC personnel interviews suggest they are), encouraging better parental monitoring may be a limited strategy. Actually getting the juveniles into the services recommended for them seems a more beneficial alternative (Hoeve, McReynolds, & Wasserman, 2013). In addition to mental health and/or substance abuse treatment, re-entry programming that focuses on educational and vocational opportunities also seem related to reduced recidivism (Abrams, Terry, & Franke, 2011).

After five years of evaluation, the researchers can confidently make several conclusions. First, JDC clinicians have become increasingly refined in their ability to identify and provisionally diagnose mental health and substance abuse problems in detained youth. Second, most of the youth identified and diagnosed with mental health and substance abuse problems were known (or at least suspected) to have these problems prior to detention. Third, most of the juveniles detained appear to suffer from a mental health problem, a substance abuse problem, or both types of problem. Fourth, clinicians appear, largely by their own reports, to recommend juveniles to appropriate community-based services when they are warranted. Fifth, the extent to which juveniles in need of mental health and/or substance abuse problems actually receive those services, at least to a meaningful degree, is highly questionable.

On the basis of these five conclusions, several final statements seem justified. The first of these is that the evidence suggests that the CSP is highly effective in accomplishing what it is intended to do. Clinicians are clearly identifying detained juveniles who are struggling with mental health and/or substance abuse problems, which, although they may have been diagnosed previously, were likely untreated or undertreated. They are also making recommendations for post-release treatment services as necessary. However, the CSP cannot achieve more than it was intended to achieve. JDC clinicians are obviously in no position to provide the "precare" that could keep previously diagnosed juveniles who have not yet had contact with the juvenile justice system, out of detention. They are also in no way empowered to ensure that recently released juveniles receive any recommended treatment at all, much less the level of treatment they might need. Thus, some mechanism for encouraging early identification and treatment of youth at-risk for mental health and/or substance abuse problems, before they encounter contact with the juvenile justice system, seems necessary—at least if there is a genuine interest in promoting community safety and reducing the costs associated with arrest, detention, and their aftereffects. Furthermore, some mechanism for successfully treating or otherwise remediating mental health and/or substance abuse problems in juveniles, especially after their first detention episode, seems highly desirable. The literatures on family and child mental health offer many viable alternatives, ranging from early childhood home visitation programs (Welsh & Farrington, 2011) to proximal post-release treatment, that can address mental health and substance abuse problems before they mire people in lifelong criminal justice system involvement (Hoeve et al., 2013). Therefore, to

progress the success of the CSP to the next logical step (that is, from identification of problems and service recommendations) to avoiding or arresting juvenile justice system involvement, investments in systemic family, community, and health services interventions seem warranted.

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