

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

Prepared for the Idaho
Department of Juvenile Corrections

by

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Executive Summary

uring the past 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, and more recently a tribal JDC on the Fort Hall Indian Reservation in southeastern 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 six years (2008-2013). In 2012, the program was further expanded to the Shoshone/Bannock Tribal JDC. The principal component of the CSP is to allow clinicians to screen detained juveniles for mental health and substance abuse problems when they are admitted 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, 2010-2011, and 2011-2012 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 five 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 five 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 2007-2012 supported the funding of the CSP for another year, and in 2013 it continued in the 12 JDCs in Idaho. Moreover, in 2012 the CSP was further expanded to the Shoshone/Bannock Tribal JDC on the Fort Hall Indian Reservation. Currently, the CSP is in place in a total of 13 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 6 Assessment (Y6). Similar to the Year 1 (Y1), Year 2 (Y2), Year 3 (Y3), Year 4 (Y4), and Year 5 (Y5) 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, which were performed for the first time in Y5, were also performed in Y6.

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 1,366 juveniles were analyzed**
 - **Data on a total of 1,394 detained juveniles were submitted. Data on 28 juveniles for whom multiple data entries were submitted were excluded from this report**
 - **Over 71% of the juveniles for whom data were included in the final analyses were boys, and nearly 29% were girls**
 - **Data on detained juveniles were submitted by clinicians at all 13 JDCs. Data from the JDC in Valley County were excluded from this report because there were too few cases to guarantee anonymity (thus, the data in this assessment are from 12 JDCs). The JDCs that submitted the most data cases included those in Canyon and Kootenai (nearly 17% each), Twin Falls (nearly 13%), Nez Perce and Bonneville (over 11% each), and Bannock (10%). The Shoshone /Bannock Tribal JDC (just over 1%) submitted the fewest cases, followed by the JDCs in Lemhi (fewer than 2%), Fremont (just over 2%), Ada (fewer than 5%) and Bonner and Minidoka (fewer than 6% each) counties**
- **The most common booking charges for juveniles across all 12 JDCs were “Other crimes” not easily fitting one of the four Uniform Crime Recording (UCR) codes (many of these were probation violations), drug crimes, property crimes, crimes against persons, and sex crimes**
- **Over 56% 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 (nearly 53%)**
 - **Juveniles met the AST criteria for having a mental health problem at statistically significantly different rates across the 12 JDCs**
 - **Indications of mental health problems were highest among juveniles screened at the JDC in Ada County (over 83%), followed by the JDCs in Nez Perce (nearly 76%) and Bannock (nearly 71%) counties. Indications of mental health problems were lowest among juveniles screened at the JDCs in Minidoka (fewer than 7%), Lemhi (fewer than 9%), and Bonner (nearly 23%) counties**
- **Nearly 40% 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 12 JDCs**
 - **Indications of substance abuse problems were highest among juveniles screened at the JDCs in Fremont (over 72%), Nez Perce (nearly 69%), and Ada (nearly 64%) counties. Indications of substance abuse problems were lowest among juveniles screened at the JDCs in Minidoka (fewer than 4%), Bonner (8%), and Lemhi (over 30%) counties**
- **When the combination of AST indications of mental health and substance abuse problems were evaluated, it was found that nearly 66% 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 over 34%), followed by having both a mental health and a substance abuse problem (nearly 31%), a mental health problem only (26%), and a substance abuse problem only (just over 9%)**
 - **A statistically significant difference existed in the 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 (37% to 27%) and a substance abuse problem only (10% to 6%), girls were more likely than boys to have indications of a mental health problem only (31% to 24%) and both a mental health and substance abuse problem (35% 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 five JDCs (in Minidoka, Bonner, Lemhi, Kootenai, and Bonneville counties) was having neither a mental health nor substance abuse problem. Having a mental health problem only was the most common combination in the JDCs in Twin Falls and Canyon counties, and having both types of problems was the most common combination in the JDCs in Ada, Nez Perce, Fremont, and Bannock counties. There was a tie for the most common combination between juveniles having indications of a mental health problem only and both a mental health and substance abuse problem in the Shoshone/Bannock Tribal JDC**
 - **Whereas the least common single combination of indications for juveniles in seven JDCs (in Ada, Bannock, Canyon, Nez Perce, Bonneville, Twin Falls, and Kootenai counties) was having a substance abuse problem only, the least common combination in the JDCs in Fremont County and the Shoshone/Bannock Tribal JDC was having neither type of problem. In Lemhi County and Bonner County there was a tie for the least common combination. In Lemhi County, the least common combination was between juveniles meeting the criteria for a mental health problem only and both a mental health and substance abuse problem, and in Bonner County the least common combination was between juveniles meeting the criteria for a substance abuse problem only and both a mental health and substance abuse problem**

- **Over 73% 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 diagnosis was 1.25**
 - **A statistically significant difference in the mean number of previous diagnoses was found as a function of JDC location (data from the Shoshone/Bannock Tribal JDC and the JDCs in Bonner and Minidoka counties were excluded from this analysis because there were too few cases with a documented number of provisional diagnoses in each of these counties)**
 - **Mean numbers of previous diagnoses were highest among juveniles in the JDCs in Fremont (1.69), Bannock (1.48), and Ada (1.34) counties. Mean numbers of previous diagnoses were lowest among juveniles in the JDCs in Kootenai (1.11), Bonneville (1.12), and Lemhi (1.19) counties**
- **Nearly 55% 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 1.42**
 - **A statistically significant difference in the mean number of provisional diagnoses given was found as a function of JDC location (data from Bonner County were excluded from this analysis because too few juveniles had a documented number of provisional diagnoses in this county)**
 - **The highest mean numbers of provisional diagnoses given were to juveniles in the JDCs in Fremont County (1.69), Twin Falls County (1.61), and the Shoshone/Bannock Tribal JDC (1.58). The lowest mean numbers of provisional diagnoses were given to juveniles in the JDCs in Nez Perce (1.09), Ada (1.23), and Bannock and Kootenai (1.28 in each) counties**
- **The most common provisional diagnosis was a mood disorder, which appeared to affect approximately 40% of the provisionally diagnosed juveniles. Other common provisional diagnoses included substance abuse disorders (nearly 39% of those provisionally diagnosed), disruptive behavior disorders (nearly 20%), anxiety disorders (approximately 17%), and attention deficit disorders (nearly 10%)**
- **Recommendations for at least one service in the community were made for 1,030 juveniles. The mean number of service recommendations for juveniles who received at least one service recommendation was 1.58**
 - **Of all juveniles who received at least one service recommendation, 725 (or 70%) were given at least one provisional diagnosis and the remaining 305 (or 30%) received at least one service recommendation but were not given a provisional diagnosis. Additionally, 23 juveniles were given at least one provisional diagnosis without receiving a service recommendation**
 - **Of the 748 juveniles who received at least one provisional diagnosis, 725 (or nearly 97%) 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 (1.68) receiving more service recommendations than boys (1.54)
- There was a statistically significant difference in the mean numbers of recommendations for services as a function of JDC location
 - The highest mean numbers of recommended services were given to juveniles in the JDCs in Twin Falls County (2.25), Bannock County (2.08), and the Shoshone/Bannock Tribal JDC (1.93). The lowest mean numbers of recommended services were given to juveniles in the JDCs in Fremont (1.09), Bonneville (1.11), and Minidoka (1.14) counties
- The most commonly given recommendations for services were for individual counseling and continuation of prior treatment (just over 36% for each). Other commonly received service recommendations were for substance abuse counseling/treatment (nearly 32%) and psychological/mental evaluation (nearly 18%)
- According to information gained by clinicians during a 15-45 days post-release follow-up call, 625 juveniles, or nearly 61% of those who received at least one recommendation for a service, had accessed at least one recommended service. The mean number of accessed recommended services among juveniles who received at least one recommendation was 1.44
 - A statistically significant difference in mean numbers of recommended services accessed was found as a function of JDC location (data from Bonner County were excluded from this analysis because too few juveniles had a documented number of recommended services accessed in this county)
 - The highest mean numbers of recommended services accessed were found among juveniles released from the JDCs in Bannock County (1.91), Twin Falls County (1.74), and Kootenai County and the Shoshone/Bannock Tribal JDC (1.40 each). The lowest mean numbers of recommended services accessed were found among juveniles released from the JDCs in Fremont (1.06) and Ada and Canyon (1.13 each) counties

Wave Two: Parent Survey Data

- A total of 338 parents were contacted via telephone by callers from the Idaho Federation of Families (IFF) for Children's Mental Health. Of those, 133 parents agreed to complete the survey, for a response rate of 39% (one parent indicated that his or her child had never been detained)
- About 30% 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. Four parents (or 3% of those who provided a response) reported that they had been contacted by the JPO or someone from the Department of Health and Welfare (DHW), but not by the JDC clinician

- **Of the parents who reported being informed that their child had been identified as someone who could benefit from services, nearly 65% reported that they were given recommendations for community-based services for their child by the JDC clinician (another 8% were given recommendations either by their child's JPO or a DHW employee, but not by the JDC clinician)**
- **The services parents most often reported being recommended for their children included counseling (unspecified, mental health, and family counseling; nearly 47%) and continuation of current treatment (over 9%). Twenty-five percent of parents also reported that they could not remember what services had been recommended, and nearly 16% reported receiving recommendations for services that were not easily classifiable (e.g., trial program, court ordered, and 504 Plan)**
- **Over 90% of the parents who received at least one service recommendation for their child reported that their child had accessed at least one service**
- **All three parents who reported that their child had not accessed at least one recommended service stated why their child had not done so. One disagreed that the child needed the recommended services, one stated that the child already had service providers, and one reported that the child kept going back to detention**

Wave Three: Judge/Juvenile Probation Officer Survey

- **The response rate to the survey sent to judges/juvenile probation officers (JPOs) was 45%, as 60 of the 133 eligible judges/JPOs who received a survey returned a survey**
 - **Of the 60 respondents, 60% were JPOs, 27% were judges, and 13% were others (e.g., county administrators, directors, and supervisors)**
 - **The regions with the highest response rate were Region 1 (over 23%) and Region 5 (over 18%). Those working/having contact with juveniles in more than one region accounted for the smallest percentage, followed by Region 4**
- **Ninety-five 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 57 judges/JPOs who reported being aware of the CSP, 56 (or 98%) provided a response when asked whether they had been contacted by a clinician regarding one of the youth they were working with. Of those, nearly 77% reported having been contacted by a clinician**
 - **The level of satisfaction with the contact from the JDC clinicians was very high, as 93% of the judges/JPOs who reported having been contacted were very satisfied (nearly 56%) or satisfied (over 37%) with the contact**
 - **Respondents in Region 1 and Region 6 reported being significantly more satisfied with this contact than those in Region 3. Respondents in Region 1 also reported being significantly more satisfied than those in Region 7**

- **Of the judges/JPOs who had been contacted by a JDC clinician, all provided a response when asked whether they had been given a recommendation on treatment or decisions from this clinician. Of those, nearly 98% reported having been given a recommendation**
 - **The level of satisfaction with recommendations provided by the JDC clinicians was fairly high, as over 88% of those judges/JPOs who reported receiving at least one recommendation were very satisfied (over 38%) or satisfied (50%) with the recommendation(s)**
- **Among the judges/JPOs who reported having received recommendations from the clinicians, all provided a response when asked whether the recommendations they received had affected a decision or treatment advised for the youth. Of those, over 83% reported that the recommendation they received affected a decision or treatment advised for the youth**
- **When asked to assess how beneficial the CSP was, the most common response made by the judges/JPOs was “extremely beneficial” (over 67%), followed by “rather beneficial” (nearly 26%)**
- **When asked whether they would like to see the CSP continue, nearly 98% of the judges/JPOs reported wishing to see it continue**

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

- **Nearly 26% 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 over 33% of girls screened positive for traumatic experiences on the MAYSI-2, fewer than 23% of boys did so**
 - **A statistically significant association was found between the indication of MH problems and traumatic experiences. Whereas nearly 78% of juveniles who screened positive for traumatic experiences screened positive for a MH problem, fewer than 50% 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, regardless of gender, those juveniles who screened positive for traumatic experiences were 3.5 times more likely to screen positive for a MH problem than those who screened negative for traumatic experiences; it was found that, regardless of traumatic experience exposure, 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, 742 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 problems, and neither type of problems) and booking charges**
 - **Among juveniles who met the criteria for neither a MH nor a SA problem, the most common booking charge was drug crime (at nearly 35%), followed by property crime (over 33%) and crime against persons (nearly 26%). The least common booking charge was sex crime (just over 6%)**
 - **Among juveniles who met the criteria for a MH problem only, the most common booking charge was crime against persons (at nearly 46%), followed by property crime (nearly 34%) and drug crime (11%). The least common booking charge was sex crime (10%)**
 - **Among juveniles who met the criteria for a SA problem only, the most common booking charge was drug crime (just over 58%), followed by property crime (nearly 22%) and crime against persons (nearly 18%). The least common booking charge was sex crime (over 2%)**
 - **Among juveniles who met the criteria for both a MH and SA problem, the most common booking charge was drug crime (37%), followed closely by property crime (just over 36%) and crimes against persons (nearly 26%). The least common booking charge was sex crime (over 1%)**

Additional Analysis 3: Regional Differences in Recommended Services Accessed

- **Of the 1,030 juveniles who received at least one recommendation for services, 625 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 JDCs with the highest percentages of juveniles who accessed at least one recommended service were found in Ada (over 88%), Lemhi (nearly 86%), and Twin Falls (nearly 77%) counties. The JDCs with the lowest percentage of juveniles who accessed at least one recommended service were found in Canyon (nearly 38%), Bonneville (39%), and Nez Perce (nearly 43%) 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 JDCs with the highest percentages of juveniles who accessed at least one recommended service were found in Region 4 (over 88%) and Region 1 (nearly 75%). The JDCs with the lowest percentage of juveniles who accessed at least one recommended service were found in Region 3 (nearly 38%) and Region 2 (nearly 43%)**

Additional Analysis 4: Judges/JPOs Survey

- **Of all respondents who received a recommendation from a JDC clinician, over 83% reported that these recommendations had affected a decision or treatment they advised for the youth, whereas 17% reported that it had not**
 - **On average, respondents reporting that the recommendation had affected a decision or treatment they advised for the youth were significantly more satisfied with the contact they had with the JDC clinician ($M = 4.63$) than those reporting that it had not ($M = 3.57$)**
 - **On average, respondents reporting that the recommendation had affected a decision or treatment they advised for the youth were significantly more satisfied with recommendations made by the clinician ($M = 4.57$) than those reporting that it had not ($M = 3.14$)**
 - **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 ($M = 4.77$) than those reporting that it had not ($M = 3.71$)**

Additional Analysis 5: Clinician Interviews

- **Two of the three clinicians who were invited to complete a brief interview consisting of three questions provided their responses via email within one week of having the questions sent to them by the research team**
 - **In response to the first question asking whether they felt that there are differences in risk factors between juveniles with MH and/or SA problems and those without these problems, both clinicians agreed that juveniles with MH and/or SA problems are much more likely to have parents or other family members who also suffer from the same problems. Other factors indicated by either of the two clinicians included lack of insurance, limited resources to make scheduled appointments, lack of parental supervision, demands placed by courts and probation, poor social support systems, lack of hope and a sense of disconnectedness from the society, and lack of familial monitoring and care**
 - **In response to the second question asking whether they felt that juveniles coming into JDCs have more serious and complex problems now than they used to in the past, both clinicians expressed disagreement and suggested that the differences between juveniles then and now lie in the elevated sense of entitlement and desire for instant gratification among today's juveniles, and a general lack of accountability, remorse, respect for authority or fear of consequences. Both clinicians also expressed that some of the changes in juveniles' behaviors can be attributed to lax parental attitudes and behaviors, including lack of structure at home. Other explanations offered by either of the two clinicians included low societal expectations for juveniles, increase in exposure to violence through social media, and a change in addressing problems such as poverty, sexual abuse, substance abuse and unemployment as family problems to addressing them as social problems**

- **In response to the third and final question asking whether they observed any common patterns of aftercare or follow-up after provisionally diagnosed juveniles are released from JDCs back into their communities, both clinicians emphasized the importance of considering local circumstances and cautioned against generalizing their own experiences to other communities. In describing the patterns of aftercare and follow-up, one clinician indicated that aftercare starts with the recommendation given by the clinician at the JDC, but explained that once juveniles leave the JDC, the aftercare and follow-up are largely in the hands of the JPOs and the parents. The other clinician explained that the juveniles who meet criteria for a SA problem are referred to outpatient treatment upon receiving a GAIN assessment, and those who fail are sometimes referred to inpatient treatment. One clinician stated that high-risk juveniles who had not had success in other settings are considered for commitment to IDJC, and one clinician noted that Optum, the managers of Medicaid, present the most serious obstacle to juveniles receiving treatment due to stringent eligibility requirements**

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 (CHP) 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 four years, and reports on the continuation of the program were issued in 2010 (McDonald, Osgood, & VanNess, 2010), 2011 (McDonald & Theiler, 2011), 2012 (McDonald, Begic, & Howard, 2012), and 2013 (Begic, McDonald, & Howard). In 2012, the CSP was expanded to an additional JDC: the Shoshone/Bannock Tribal JDC located on the Fort Hall Indian Reservation in southeastern Idaho.

In the five 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, Y4, and Y5), 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. A survey was also presented to judges and JPOs (by mail in Y1-Y4 and through an online portal in Y5), asking them whether they were aware of the CSP, 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 completed in Y4. One component involved interviews with JDC administrators, clinicians, and line staff that focused on assessing the merits of the CSP 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. Several additional analyses were completed in the Y5 evaluation. Wave one data were subjected to additional analyses to explore 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 neither type of problem and those who met the AST criteria for either or both types of problems, and the differential rates at which at least one recommended service was accessed across regions/counties. Wave three data were subjected to additional analysis to explore factors that may be contributing to variations in judges'/JPOs' responses.

The five 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, 59% in Y4, and 56% in Y5) and a substance abuse problem (55% in Y1, 46% in Y2, 44% in Y3, 43% in Y4, and 40% in Y5). 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 66% in Y5), and substantial percentages were found to meet the criteria for both types of problems (41% in Y1, 30% in Y2, 31% in Y3, 29% in Y4, and 31% in Y5). Provisional diagnoses of at least one mental health or substance abuse problem were made for more than two-thirds of the juveniles in Y4 and Y5 evaluations (a comparison to provisional diagnosis for Y1-Y3 is not feasible, as problems were identified in how these were calculated in those years), with the most commonly diagnosed problems in all prior 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, Y4, and Y5 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%); approximately 32% of the parents reported receiving such information in Y5. 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%) and Y5 (53%). Of those parents who reported receiving a service recommendation, many (74% in Y2, 82% in Y3, 89% in Y5, and 96% 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 five years. Most of the respondents reported being aware of the program (66% in Y1, 80% in Y2, 79% in Y3, 91% in Y4, and 95% in Y5), having had contact with JDC clinicians (79% in Y1, 73% in Y2, 91% in Y3, and 77% in Y4 and Y5), and receiving recommendations for youth (93% in Y1,

90% in Y2, 94% in Y3, 89% in Y4, and 98% in Y5). 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, 80% in Y4, and 93% in Y5), and nearly all reported wanting to see it continue (92% in Y1, 100% in Y2, 94% in Y3, 95% in Y4, and 98% in Y5). An analysis conducted for the first time in Y5 also identified prior traumatic experiences as a significant predictor of MH problems, with juveniles screening positive for traumatic experiences being 3.5 times more likely to also screen positive for a MH problem than those screening negative for traumatic experiences.

The CSP was granted funding for a sixth year (Y6), and IDJC contracted with the same team of BSU researchers to evaluate it. The 2013 evaluation was performed on data collected at the JDCs between July 1, 2012 and June 30, 2013. The procedures for collecting data for the clinicians' and parents' portions of the 2013 evaluation were identical to those used in the 2009, 2010, 2011, and 2012 evaluations. The procedure for delivering the judges/JPOs survey was identical to that used in 2012; however it differed somewhat from those used in the 2009, 2010, and 2011 evaluations. Finally, several additional analyses utilizing data collected in waves one and three, completed for the first time in Y5, were also completed in the Y6 evaluation.

Methodology

Similar to the Y1-Y5 assessments, data were collected in several separate waves in this Y6 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 six years of evaluation (i.e., Y1-Y6). 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 six 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 essentially identical in all six evaluation years; in the Y6 evaluation, two questions were added to the survey to collect demographic data from the judges/JPOs (their profession and regions in which they work/have contact with juveniles), while all other questions remained unchanged. The methodology for delivering the survey differed by evaluation year. Several additional analyses, conducted for the first time in Y5, were also performed in this Y6 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 charges for all juveniles were entered 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 (UCR) 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 and all subsequent years of evaluation (i.e., Y1-Y6). 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-Y6 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 and Y6.

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 input the 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, 2012 and June 30, 2013. Data were submitted from all 13 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 13 JDCs (with all identifying information removed) to the BSU researchers for analysis. In total, this data set consisted of 1,413 data entries. Upon realizing that multiple entries were provided for some juveniles, the BSU team and an IDJC administrator determined that the data on 28 juveniles from four counties (21 from Minidoka, five from Twin Falls, and one each from Canyon County and the Shoshone/Bannock Tribal JDC) for whom multiple data entries were provided should be excluded from the analysis. This resulted in the exclusion of 47 data entries. Consequently, wave one data analyses included clinician data provided for 1,366 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-Y6.

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 2013, and wrote the parents' responses directly on paper copies of the survey. IFF returned the paper copies of completed surveys to IDJC in December 2013, 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 338 parents of recently released juveniles. Of these, 133 parents agreed to complete the survey, for a response rate of 39% (one parent indicated that his or her child had never been detained). This response rate is much better than the 5% achieved in Y1, somewhat lower than the 52% achieved in Y5, and considerably lower than the 66% achieved in Y5 and 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. In the Y6 evaluation, the survey was slightly modified to allow for collection of some demographic data (i.e., respondents' profession and the region in which they work/have contact with juveniles); the remaining survey items were not altered in any way. Thus, the judges/JPOs survey in Y6 consisted of 10 items (several of which had follow-up questions), asking the judges/JPOs: 1) to identify profession (judge, JPO, or other); 2) to select the region in which they work/have contact with juveniles; 3) if they were aware that the nearest JDC had a mental health clinician during the past year; 4) whether they had been contacted by the JDC clinician regarding one of the youth they were working with; 5) if they had been contacted, how satisfied they were with the contact (response options to this item ranged from "Very dissatisfied" to "Very satisfied"); 6) if they received recommendations on how to help youth with mental health issues; 7) if they had received recommendations, how satisfied they were with the recommendations (again, the response options ranged from "Very dissatisfied" to "Very satisfied"); 8) whether the recommendations they received affected any of the decisions or treatment they advised for youth; 9) 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 10) whether they would like to see the CSP continue. They were also invited to share comments or recommendations related to the program.

The method of survey delivery used in Y6 was identical to that used in Y5. This method of delivery is different from the method used in Y1-Y4, when 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 the Y6 evaluation, 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 mid-September 2013, 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 133 judges/JPOs on September 13, 2013. Respondents began to

complete the survey the same day. The IDJC program manager sent a reminder email message on September 27, 2013 encouraging potential respondents to complete the survey. The survey was closed on October 4, 2013, and at that time, a total of 60 judges/JPOs had completed it, for a response rate of 45%. This response rate is very good for an unsolicited survey, and thus the results from the judges'/JPOs' surveys are considered to be representative of the population. The response rate in Y6 was slightly lower than the 46% in Y5, slightly higher than the 44% in Y1, 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 (IJJC) 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 Y6, similar to Y5 when these analyses were conducted for the first time, the BSU research team conducted several additional analyses using the wave one and wave three data sets to address these questions. 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 accessed across regions/counties. Wave three data were utilized to explore factors that may be contributing to variations in judges'/JPOs' responses. Also, for the first time in Y6, a subset of three JDC clinicians was contacted to answer three questions related to other issues identified in previous evaluations. These questions were related to: 1) whether there were differences in risk factors (e.g., family or community factors) between juveniles with MH and/or SA problems and those without those problems; 2) whether juveniles entering JDCs currently seemed to have more serious or complex problems than juveniles entering JDCs in the past; and 3) whether there were common patterns of after-care or follow-up after provisionally diagnosed juveniles were released from JDCs back into their communities.

Results and Analyses

Analysis of JDC Data

Demographic Information

The data in this report are gleaned from the cases of 1,366 juveniles detained at one of 12 JDCs throughout Idaho. Gender codes were entered for 1,354 juveniles. Of these, 966 (or 71%) were boys and 388 (or 29%) were girls. The total number of cases was somewhat lower than in Y5 (1,481) and 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 Y6 were very similar to the averages of the first five years (denoted throughout the remainder of this report as the “five-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 13 JDCs were asked to submit data from July 1, 2012 (the period after data collection ended for the previous year’s evaluation) to June 30, 2013 (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. 12 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 JDCs in Canyon and Kootenai counties (with nearly 17% of the total cases in each), followed by the JDCs in Twin Falls County (nearly 13%). On the other hand, the smallest percentages of cases were submitted from the Shoshone/Bannock Tribal JDC (just over 1%), followed by the JDCs in Lemhi (nearly 2%) and Fremont (just over 2%) counties.

JDC Location	Number of Cases	Percentage of Total Cases
Ada County	66	4.8
Bannock County (District 6)	137	10.0
Bonner County	75	5.5
Bonneville County (3B)	155	11.3
Canyon County (Southwest Idaho)	231	16.9
Fremont County (5C)	29	<i>2.1</i>
Kootenai County (District 1)	228	16.7
Lemhi County	23	<i>1.7</i>
Nez Perce County (District 2)	156	11.4
Minidoka County	76	5.6
Shoshone/Bannock Tribal JDC	16	<i>1.2</i>
Twin Falls County (Snake River)	174	12.7

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. The three highest percentages are presented in bold, and the three lowest percentages are presented in italics.

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 1,348 of the juveniles, or 98.7% of all juveniles on whom data were collected, and two booking charges were noted for 236 (17.3%) juveniles. All booking charges were coded in accordance with the 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 (47% 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 24%) and property crimes (just over 22%), and crimes against persons (18%). Sex crimes were relatively uncommon among booking codes (accounting for just over 3% of all codes). The research team was unable to confidently classify 42 (just over 3%) 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)	633	47.0
Drug crimes	322	23.9
Property crimes	301	22.3
Crimes against persons	242	18.0
Sex crimes	44	3.3
Unable to classify (e.g., discretionary days)	42	3.1

Note. The percentages in this table are calculated out of the 1,348 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 AST was the primary instrument used for screening for mental health and substance abuse problems in the juveniles detained in the 12 JDCs. Also as discussed earlier, only data collected from the mental health and substance abuse subscales (not the traumatic brain injury subscale) were analyzed in this study and are summarized in this report.

As seen below in Table 3, over 56% 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 40% of the juveniles screened with the AST met the criteria for having a substance abuse problem. The 56% figure for the percentage of juveniles who met the AST criteria for having a mental health problem is lower than in previous years (59% in Y2, Y4, and Y5, 68% in Y1, and 62% in Y3) (the five-year average for juveniles meeting the AST criteria for having a mental health problem was 61%). The 40% figure for the percentage of juveniles who met the AST criteria for having a substance abuse problem is slightly lower than the 41% in Y5, 43% in Y4, 44% in Y3, and the 46% in Y2, and considerably lower than the 54% in Y1 (the five-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	771	56.4
Substance abuse problem	542	39.7

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 fewer than 53% 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) = 22.62, $p < .001$. 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%), Y4 (67% to 56%), and Y5 (67% to 55%). 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 39% and 42%, 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%), Y4 (44% to 40%), and Y5 (42% and 38%); 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 five of six 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	508	259	52.6	66.8
Substance abuse problem	378	162	39.1	41.8

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 12 JDCs. As seen below in Table 5, there was a rather large spread of percentages for juveniles with mental health problems as measured by the

AST, ranging from nearly 7% to over 83% 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 Ada County (over 83% of screened juveniles met the criteria for a mental health problem), Nez Perce County (nearly 76%), and Bannock County (nearly 71%). The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a mental health problem were Minidoka County (nearly 7%), Lemhi County (nearly 9%), and Bonner County (nearly 23%). 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 = 11) = 240.71, $p < .001$.

Table 5: AST Indications of Mental Health Problems by JDC Location		
JDC Location	Number of Cases	Percentage of Total Screened Cases
Ada County	55	83.3
Bannock County (District 6)	97	70.8
Bonner County	17	<i>22.7</i>
Bonneville County (3B)	73	<i>47.1</i>
Canyon County (Southwest Idaho)	159	<i>68.8</i>
Fremont County (5C)	20	<i>69.0</i>
Kootenai County (District 1)	95	<i>41.7</i>
Lemhi County	2	<i>8.7</i>
Minidoka County	5	<i>6.6</i>
Nez Perce County (District 2)	118	75.6
Shoshone/Bannock Tribal	12	<i>66.7</i>
Twin Falls County (Snake River)	118	<i>67.8</i>

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

As seen below in Table 6, there were also some noteworthy differences as a function of JDC location in the percentages of juveniles meeting the AST criteria for having a substance abuse problem. The three JDCs with the highest percentages of juveniles meeting the AST criteria for having a substance abuse problem were in Fremont (where over 72% of the screened juveniles met the criteria for a substance abuse problem), Nez Perce (nearly 69%), and Ada (nearly 64%) counties. The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a substance abuse problem were in Minidoka (nearly 4%), Bonner (8%), and Lemhi (over 30%) counties. 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 = 11) = 165.84, $p < .001$.

JDC Location	Number of Cases	Percentage of Total Screened Cases
Ada County	42	63.6
Bannock County (District 6)	62	45.3
Bonner County	6	<i>8.0</i>
Bonneville County (3B)	48	31.0
Canyon County (Southwest Idaho)	92	39.8
Fremont County (5C)	21	72.4
Kootenai County (District 1)	86	37.7
Lemhi County	7	<i>30.4</i>
Minidoka County	3	<i>3.9</i>
Nez Perce County (District 2)	107	68.6
Shoshone/Bannock Tribal	8	50.0
Twin Falls County (Snake River)	60	34.5

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 (over 34%) 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 (nearly 31%) 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 (26%). The smallest group of juveniles (just over 9%) met the criteria for a substance abuse problem only. The pattern of results regarding the most common combination was similar to Y5, but differed somewhat from the previous years. Whereas in Y6 and 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 the single least common category in all five previous evaluation years.

Condition	Number of Cases	Percentage of Total Screened Cases
Neither mental health nor substance abuse problem	469	34.3
Mental health problem only	355	26.0
Substance abuse problem only	126	9.2
Both mental health and substance abuse problem	416	30.5

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, χ^2 (df = 3) = 23.17, $p < .001$. The largest difference was in rates of meeting the diagnostic criteria for having neither type of disorder; boys (at just over 37%) were considerably more likely than girls (at nearly 27%) to fall into this category. On the other hand, girls were more likely to meet the criteria for having a mental health problem only; girls (at over 31%) were considerably more likely than boys (at nearly 24%) to fall into this category. Girls were also somewhat more likely to meet the criteria for having both types of problems (at over 35%) than boys (at nearly 29%). Lastly, boys were found to be somewhat more likely to meet the criteria for having a substance abuse problem only (at over 10%) than girls (at over 6%). 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 five previous evaluation years (i.e., Y1-Y5). 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	358	104	37.1	26.8
Mental health problem only	230	122	23.8	31.4
Substance abuse problem only	100	25	10.4	6.4
Both mental health and substance abuse problem	278	137	28.8	35.3

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 at which juveniles at the 12 JDCs fell into the four categories were found, and a chi-square test revealed that these differences were statistically significant, χ^2 (df = 33) = 397.97, $p < .001$. 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 five JDCs (in Minidoka, Bonner, Lemhi, Kootenai, and Bonneville counties), juveniles meeting the criteria for a mental health problem only were the single largest group in two JDCs (in Twin Falls and Canyon counties), and juveniles meeting the criteria for both types of problem were the single largest group in four JDCs (in Ada, Nez Perce, Fremont, and Bannock counties). In the Shoshone/Bannock Tribal JDC, 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 12 JDCs (the exceptions were the JDCs in Fremont and Minidoka counties and the Shoshone/Bannock Tribal JDC, where juveniles meeting the criteria for neither type of problem was the single smallest group, the JDC in Lemhi County, where there was a tie for single smallest group between juveniles meeting the criteria for a mental health problem only and those meeting the criteria for having both a mental health and substance abuse problem). The pattern of results concerning the single most common category was similar to Y5 and Y4, when juveniles who met the criteria for having neither a mental health nor a substance abuse problem were the single largest group in six and four of 11 JDCs, respectively. 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	13.6 (N = 9)	22.7 (N = 15)	3.0 (N = 2)	60.6 (N = 40)
Bannock County (District 6)	22.6 (N = 31)	32.1 (N = 44)	6.6 (N = 9)	38.7 (N = 53)
Bonner County	73.3 (N = 55)	18.7 (N = 14)	4.0 (N = 3)	4.0 (N = 3)
Bonneville County (3B)	43.9 (N = 68)	25.2 (N = 39)	9.0 (N = 14)	21.9 (N = 34)
Canyon County (Southwest Idaho)	24.2 (N = 56)	35.9 (N = 83)	6.9 (N = 16)	32.9 (N = 76)
Fremont County (5C)	6.9 (N = 2)	20.7 (N = 6)	24.1 (N = 7)	48.3 (N = 14)
Kootenai County (District 1)	45.2 (N = 103)	16.7 (N = 38)	13.2 (N = 30)	25.0 (N = 57)
Lemhi County	65.2 (N = 15)	4.3 (N = 1)	26.1 (N = 6)	4.3 (N = 1)
Minidoka County	90.8 (N = 69)	5.3 (N = 4)	2.6 (N = 2)	1.3 (N = 1)
Nez Perce County (District 2)	14.7 (N = 23)	16.7 (N = 26)	9.6 (N = 15)	59.0 (N = 92)
Shoshone/Bannock Tribal JDC	12.5 (N = 2)	37.5 (N = 6)	12.5 (N = 2)	37.5 (N = 6)
Twin Falls County (Snake River)	20.7 (N = 36)	45.4 (N = 79)	11.5 (N = 20)	22.4 (N = 39)

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 1,002 juveniles, or 73.4% of all juveniles on whom data were collected (this percentage is identical to the 73.4% reported in Y5, 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 12 JDCs) with at least one previous diagnosis was 1.25, with a standard deviation of .59 (the number of previous diagnoses was similar to the 1.28 in Y4 and 1.26 in Y1 and Y5, 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 (1.30) reported or were identified with slightly more previous diagnoses than boys (1.23); however, unlike in Y4 and Y3 when this difference was statistically significant, and similar to Y1, Y2, and Y5, this difference was not statistically significant in Y6, $t(df = 995) = -1.88, p > .05$. The mean number of previous diagnoses differed significantly as a function of JDC location (data from the Shoshone/Bannock Tribal JDC and the JDCs in Bonner and Minidoka counties were excluded from this analysis because fewer than ten juveniles had a documented number of previous diagnoses in each of the three counties), $F(8, 994) = 5.75, p < .001$ (this result is similar to that found in all five previous evaluation years). As seen below in Table 10, the JDCs with the highest number of mean previous diagnoses were those in Fremont (1.69), Bannock (1.48), and Ada counties (1.34). The JDCs with the lowest number of mean previous diagnoses were in Kootenai (1.11), Bonneville (1.12), and Lemhi counties (1.19).

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	64	1.34	.65
Bannock County (District 6)	106	1.48	.84
Bonneville County (3B)	143	<i>1.12</i>	..44
Canyon County (Southwest Idaho)	230	1.28	.62
Fremont County (5C)	13	1.69	.95
Kootenai County (District 1)	173	<i>1.11</i>	.31
Lemhi County	21	<i>1.19</i>	.51
Nez Perce County (District 2)	78	1.29	.63
Twin Falls County (Snake River)	175	1.22	.53

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 748 juveniles, or 54.8% of all juveniles on whom data were collected (this percentage is lower than the 73% reported in Y4 and 66.3% reported in Y5; 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). A new category, 'diagnosis deferred' that was not utilized in the prior years was introduced in Y6 (clinicians entered 'diagnosis deferred' in those cases in which they felt that a juvenile would benefit from accessing mental health or substance abuse services in the community even if the juvenile had not met criteria for a provisional diagnosis at the time of screening); a total of 81 juveniles, or 5.9% of all juveniles on whom data were collected, fell into this category. The mean number of provisional diagnoses for juveniles (of both genders and across the 12 JDCs) with at least one provisional diagnosis was 1.42, with a standard deviation of .61 (the mean number of provisional diagnoses is somewhat lower than the 1.52 in Y5 and 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] Y4 report). The range of provisional diagnoses spanned from none to four. On average, girls (1.45) received slightly more provisional diagnoses than boys (1.40); however, unlike in all prior years, when this difference was statistically significant, this difference was not statistically significant in Y6, t ($df = 740$) = -1.10, $p > .05$. As was the case in all five previous evaluation years, the mean number of provisional diagnoses significantly differed as a function of JDC location (data from Bonner County were excluded from this analysis because too few juveniles had a documented number of provisional diagnoses in this county), F (10, 758) = 5.10, $p < .001$. As seen below in Table 11, the JDCs with the highest number of mean provisional diagnoses were in Fremont (1.69) and Twin Falls (1.61) counties, and Shoshone/Bannock Tribal JDC (1.58). The JDC with the lowest number of mean provisional diagnoses was in Nez Perce County (1.09), followed by the JDCs in Ada (1.23), Bannock (1.28), and Kootenai (1.28) counties.

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	61	<i>1.23</i>	.42
Bannock County (District 6)	83	<i>1.28</i>	.57
Bonneville County (3B)	97	1.44	.56
Canyon County (Southwest Idaho)	132	1.57	.73
Fremont County (5C)	13	1.69	.75
Kootenai County (District 1)	137	<i>1.28</i>	.50
Lemhi County	13	1.46	.66
Minidoka County	25	1.32	.58
Nez Perce County (District 2)	32	<i>1.09</i>	.30
Shoshone/Bannock Tribal JDC	12	1.58	.67
Twin Falls County (Snake River)	140	1.61	.69

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. A content analysis procedure was used to classify all provisional diagnoses entered by the clinicians into conceptually consistent themes. As seen below in Table 12, the most common diagnoses given were for a mood disorder (just over 40% of the juveniles for whom a provisional diagnosis was listed were diagnosed with a mood disorder) and substance abuse disorder (nearly 39% of juveniles for whom a provisional diagnosis was listed were diagnosed with a substance abuse disorder). Two other diagnoses that were given with some frequency were disruptive behavior disorders and anxiety disorder (e.g., post-traumatic stress disorder, panic disorder). The former (which was a broad category encompassing several more specific disorders including oppositional defiant disorder and disruptive disorder) was given to nearly 20% of juveniles for whom a provisional diagnosis was listed. The latter was given to just over 17% of the juveniles for whom a provisional diagnosis was listed. One other class of disorders that was listed with some frequency was attention deficit disorders (e.g., attention deficit hyperactivity disorder), which was given to nearly 10% of juveniles. Interestingly, the five most common provisional diagnoses in Y6 were the same as in all five previous evaluation years—in exactly the same order.

Provisional Diagnosis	Number of Cases	Percentage of Total Cases
Mood disorders (e.g., depression, bipolar disorder)	300	40.1
Substance abuse disorders (e.g., marijuana or alcohol abuse)	288	38.5
Disruptive behavior disorders (e.g., oppositional defiant disorder, disruptive disorder, conduct disorder)	148	19.8
Anxiety disorders (e.g., post-traumatic stress disorder)	128	17.1
Attention deficit disorders (e.g., ADHD/ADD)	73	9.8

Note. The percentages in this table are calculated out of 748 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 1,030 juveniles. This number is higher than the total number of juveniles who received at least one provisional diagnosis (748 juveniles received at least one provisional diagnosis). Of all juveniles who received at least one service recommendation, 725 (or 70.4%) were also given at least one provisional diagnosis. The remaining 305 (or 30%) received at least one service recommendation but were not given a provisional diagnosis. Additionally, 23 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 (725) by the number of juveniles who received at least one provisional diagnosis (748). The resulting figure is 96.9%, meaning approximately 97% 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 12 JDCs) who were given at least one service recommendation was 1.58, with a standard deviation of .97 (the mean number of service recommendations was lower than the 1.92 reported in Y4 and somewhat lower than the 1.77 reported in Y5 (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] Y4 report). The range of recommended services spanned from none to six. Similar to Y1, Y3, Y4, and Y5, but different than Y2, a statistically significant difference in the number of recommended services was found between girls and boys, with girls (1.68) receiving significantly more service recommendations than boys (1.54), t ($df = 1,021$) = 2.14, $p < .05$. Also, similar to all five previous evaluation years, the mean number of recommended services was found to differ significantly as a function of JDC location, F (11, 1,018) = 19.64, $p < .001$. As seen below in Table 13, the JDC with the highest number of mean recommended services was in Twin Falls County (2.25), followed by the JDC in Bannock County (2.08) and the Shoshone/Bannock Tribal JDC (1.93). The JDC with the lowest number of mean recommended services was in Fremont County (1.09), followed by the JDCs in Bonneville (1.11) and Minidoka (1.14) counties.

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	60	1.67	.38
Bannock County (District 6)	120	2.08	1.24
Bonner County	25	1.20	.58
Bonneville County (3B)	105	<i>1.11</i>	.32
Canyon County (Southwest Idaho)	188	1.29	.54
Fremont County (5C)	23	<i>1.09</i>	.29
Kootenai County (District 1)	150	1.53	1.04
Lemhi County	21	1.67	.91
Minidoka County	21	<i>1.14</i>	.49
Nez Perce County (District 2)	134	1.51	.80
Shoshone/Bannock Tribal JDC	15	1.93	.88
Twin Falls County (Snake River)	168	2.25	1.25

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 1,030 juveniles to whom service recommendations were reportedly given. A content analysis procedure was used to classify the different types of recommended services entered in the Access database by the clinicians into conceptually consistent themes. As seen below in Table 14, the most common recommendations given were for individual counseling and/or continuation of prior treatment (over 36% of the juveniles for whom a recommended service was listed were recommended to access individual counseling and/or continue prior treatment). Recommendations for substance abuse counseling/treatment (nearly 32%) and

psychological/mental evaluations (nearly 18%) were also fairly common recommendations. Smaller numbers of recommendations were made for family counseling (just over 6%), residential treatment (nearly 4%), psychosocial rehabilitation (just over 2%), and medication evaluation (over 1%). Additionally, recommendations for other services (e.g., contact probation or courts, contact family) were given for just over 18% of juveniles for whom a recommended service was listed.

Service Recommendation	Number of Cases	Percentage of Total Cases
Individual counseling (e.g., Cognitive Behavioral Therapy)	373	36.2
Continue (unspecified) prior treatment	372	36.1
Substance abuse counseling/treatment	325	31.6
Psychological/mental evaluation	183	17.8
Family counseling	63	6.1
Residential treatment	38	3.7
Psychosocial rehabilitation	23	2.2
Medication evaluation	13	1.3

Note. The percentages in this table are calculated out of the 1,030 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 625 juveniles, or 60.7% of the 1,030 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 12 JDCs) who were given at least one service recommendation, was 1.44, with a standard deviation of .82 (the mean number of recommended services accessed was lower than the 1.81 in Y4 and slightly lower than the 1.56 in Y5; 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] Y4 report). The range of recommended services accessed spanned from one to six (39.3% of the juveniles receiving at least one service recommendation had not yet accessed a service). Unlike in Y3 and Y4, when girls accessed significantly more services than boys, but similar to Y1, Y2, and Y5, no gender differences in accessed services were found in Y6. However, the mean number of recommended services accessed differed significantly as a function of JDC location (data from Bonner County were excluded from this analysis because too few juveniles had a documented number of recommended services accessed in this county), $F(11, 634) = 7.80, p < .001$ (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 Bannock County (1.91), followed by the JDC in Twin Falls County (1.74), Kootenai County (1.40) and the

Shoshone/Bannock Tribal JDC (1.40). The JDC with the lowest number of mean recommended services accessed was in Fremont County (1.06), followed by the JDCs in Ada (1.13) and Canyon (1.13) counties.

Table 15: Number of Recommended Services Accessed by JDC Location			
JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	53	<i>1.13</i>	.34
Bannock County (District 6)	89	1.91	1.08
Bonner County	18	1.17	.51
Bonneville County (3B)	41	1.22	.42
Canyon County (Southwest Idaho)	71	<i>1.13</i>	.34
Fremont County (5C)	16	<i>1.06</i>	.25
Minidoka County	10	1.30	.67
Kootenai County (District 1)	113	1.40	.70
Lemhi County	18	1.39	.70
Nez Perce County (District 2)	57	1.21	.59
Shoshone/Bannock Tribal JDC	10	1.40	.52
Twin Falls County (Snake River)	129	1.74	.93

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 338 calls were placed by the callers from the IFF, 133 of which were successful (i.e., they resulted in a survey completion by a parent), yielding a 39% response rate. One parent indicated that his or her child had never been detained. The results described below were gleaned

from the responses from the remaining 132 parents. Parenthetically, the callers from the IFF placed additional 129 calls; however, these calls were excluded from the analysis because the number of invalid (105 cases) or these was no response (24 cases).

JDC Clinician Calls

The first question on the parent survey simply asked the respondents whether the JDC clinician had contacted them by telephone or letter to follow up on the recommendation for services made at the time their child was released from detention. All 132 parents who completed a survey answered this question. Of these parents, 40 (or 30.3%) responded “Yes” that they had been contacted by the JDC clinician, and 92 (or 69.7%) responded “No” that they had not been contacted by the JDC clinician (the percentage of those reporting having been contacted by the JDC clinician was considerably lower than the 40% in Y4 and the 47% in Y3 and slightly lower than the 32% in Y5, but is still higher than the 26% in Y2). The callers from the IFF were instructed to inform those who responded “No” to the first question that the survey was completed. Parents who responded “Yes” were asked the next question. It might be worth mentioning that of the 92 parents who responded that they had not been contacted by the JDC clinician, four (or 3% of the total sample) reported having been contacted and made aware that their child had been identified as someone who could benefit from community-based services by their child’s JPO or someone from the DHW. Also, another four parents who reported not being contacted by the JDC clinician provided additional comments. One parent reported that he or she “was told that they would be contacted, but never did,” another stated that no contact was made by the JDC clinician even though the child had “cut himself while in detention, yet another stated that the JDC clinician “only mentioned the needs during court hearing,” and one indicated that the child was “only there overnight.”

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 48 parents who completed this item, 31 (or 64.6%) reported that they had received recommendations for services from the JDC clinician (this percentage is lower than the 76% in Y2, slightly lower than the 66% in both Y3 and Y4, and considerably higher than the 53% in Y5). It might be worth noting that another four parents (or 8.3% of those who reported receiving recommendations for services) reported receiving recommendations either from their child’s JPO or a IDHW employee, but not from the JDC clinician. 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 32 parents reported at least one service recommendation. As seen below in Table 16, the most commonly reported recommendations, made for nearly half (just under 47%) of the youth for whom a recommended service was reported, were for counseling (unspecified, mental health, or family counseling) for the juveniles.

Eight parents (or 25%) reported that they could not remember what service or services had been recommended for their child. These two most common responses were the same as the top two reported in Y4, Y3 and Y2, although the percentages differed somewhat (in Y5, counseling was reported by 38% of the parents and 25% of the parents could not remember what services had been recommended for their child; in Y4, counseling was reported by 61% of the parents, and 8% of the parents could not remember what services had been recommended for their child; in Y3, counseling was reported by 67% of the parents, and in Y3 15% of the parents could not remember what services had been recommended for their child; in Y2, counseling was reported by 37% of the parents, and 18% of the parents could not remember what services had been recommended for their child).

Service Recommendation	Number of Cases	Percentage of Total Cases
Counseling (unspecified, mental health, family)	15	46.9
Can't remember	8	25.0
Other (e.g., trial program, court ordered, 504 Plan)	5	15.6
Continue previous treatment	3	9.4
Substance abuse treatment or assessment	2	6.3
Psychologist	1	3.1

Note. The percentages in this table are calculated out of the 32 parents who reported that their child received at least one service recommendation. Because up to two recommended services were entered for each individual, the total percentages in this table may exceed 100.

The fourth question asked parents whether or not their child had accessed the service(s) that had been recommended to them. Of the 31 parents who completed this item, 28 (or 90.3%) reported that their child had accessed at least one recommended service (this percentage is lower than the 96% in Y4 and is higher than the 74% in Y2, the 82% in Y3, and the 89% in Y5).

Barriers to Access

The final question on the survey asked the parents who reported that their child had not accessed at least one recommended service to report the reason why their child had not done so. Of the three parents who reported that their child had not accessed at least one recommended service, all three provided a response to this question. One disagreed that the child needed the recommended services, and one stated that the child already had service providers, and one reported that the child kept going back to detention. The number of parents reporting explanations for why their child had not accessed at least one recommended services was higher than in Y5 (1) and Y4 (2), and lower than in 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 JPOs who worked with youth detained in one of the JDCs. Because one of the goals of the CSP 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. In addition, the judges/JPOs were also asked to indicate their profession (judge, JPO, or other) and the region in which they work or have contact with juveniles. A total of 60 respondents completed this survey; their responses are discussed below.

Demographic Information

Of the 60 respondents who completed this survey, 16 (or 27%) were judges, 36 (or 60%) were JPOs, and eight (or 13%) were others (e.g., county administrators, directors, and supervisors).

As seen below in Table 17, the judges/JPOs working/having contact with juveniles in Region 1 (over 23%) accounted for the largest percentages of respondents, followed by those in Region 5 (over 18%). On the other hand, those working/having contact with juveniles in multiple regions (over 3%) accounted for the smallest percentage of respondents, followed by those in Region 4 (nearly 7%).

Table 17: Number of Respondents, by Region		
Region	Number of Respondents	Percentage of Total Respondents
Region 1 (Bonner and Kootenai counties)	14	23.3
Region 2 (Nez Perce County)	6	10.0
Region 3 (Canyon County)	7	11.7
Region 4 (Ada County)	4	<i>6.7</i>
Region 5 (Minidoka and Twin Falls counties)	5	18.3
Region 6 (Bannock County)	6	10.0
Region 7 (Bonneville, Fremont, and Lemhi counties)	10	16.7
Multiple regions	2	<i>3.3</i>

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. The two highest percentages are presented in bold, and the two lowest percentages are presented in italics.

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 60 judges/JPOs who completed this item, 57 (or 95%) reported that they were aware that the closest JDC had a clinician in it (three judges were not aware that the closest JDC had a clinician in it). This level of awareness is substantially higher than the 66% in Y1, 79% in Y3, and 80% in Y2, and slightly higher than the 91% in Y4 and the 92% in Y5. 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 56 judges/JPOs who completed this item, 43 (or nearly 77%) reported that they had been contacted by the JDC clinician about at least one of their juveniles (six judges and five JPOs reported that they had not been contacted by the JDC clinician). This percentage is identical to the 77% in Y5, somewhat higher than the 73% in Y2, somewhat lower than the 79% in Y1 and 83% in Y4, and considerably lower than the 91% in Y3. 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 the youth they were working with 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 18, 93% of the judges/JPOs who completed this item reported being very satisfied (nearly 56%) or satisfied (over 37%) with the contact with the JDC clinician. The satisfaction rate in Y6 was similar to those in previous years, which were 100% in Y4 and approximately 90% in each of the first three years (the only exception is Y5, when the satisfaction rate was 70%). Of those who did not report satisfaction with contact from the JDC clinician, two were neither satisfied nor dissatisfied, with just one being dissatisfied.

Table 18: Satisfaction with Contact with JDC Clinicians					
Item	Very Dissatisfied	Dissatisfied	Not Satisfied or Dissatisfied	Satisfied	Very Satisfied
How satisfied were you with the contact you had with the mental health clinician?	0.0% (N = 0)	2.3% (N = 1)	4.7% (N = 2)	37.2% (N = 16)	55.8% (N = 24)

Note. The percentages in this table are calculated out of the 43 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.

On average, the JPOs ($M = 4.45$, $SD = .77$) reported being somewhat more satisfied with contact with the JDC clinician than the judges ($M = 4.29$, $SD = .49$); however, this difference was not statistically significant (respondents who indicated that their profession was ‘other’ were excluded from this analysis), t ($df = 36$) = $-.54$, $p > .05$. As seen below in Table 19, Region 1 and Region 6 had the highest levels of satisfaction with this contact. The regions with the lowest levels of satisfaction were Region 3 and Region 7. Statistical analysis revealed a significant difference in the level of satisfaction with contact with the JDC clinician, as a function of region (respondents who reported working/having contact with juveniles in more than one region were excluded from this analysis), F ($6, 36$) = 4.01 , $p < .01$. On average, judges/JPOs in Region 1 and Region 6 reported being significantly more satisfied with contact with the JDC clinician than

those in Region 3. Judges/JPOs in Region 1 also reported being significantly more satisfied with this contact than those in Region 7.

Region	Mean	Standard Deviation
Region 1	4.91	.30
Region 2	4.50	.58
Region 3	<i>3.50</i>	1.00
Region 4	4.33	.58
Region 5	4.50	.76
Region 6	4.80	.41
Region 7	<i>4.00</i>	.58

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

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 43 judges/JPOs who completed this item, 42 (or nearly 98%) reported that they had received such recommendations (one judge indicated not receiving recommendation from the JDC clinician). The percentage of judges/JPOs who reported receiving recommendations was higher than in any of the previous years, which ranged from 89% in Y5 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 20, over 88% of the judges/JPOs who completed this item reported being either satisfied (over 38%) or very satisfied (50%). This satisfaction rate was higher than the 79%, 80%, and 85% in Y1, Y5, and Y2, respectively, but lower than the 90% in Y3 and the 100% in Y4. Of those who did not report satisfaction with recommendations from the JDC clinician, five (or just over 7%) were neither satisfied nor dissatisfied, with just two (or nearly 5%) being 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?	0.0% (N = 0)	4.8% (N = 2)	7.1% (N = 3)	38.1% (N = 16)	50.0% (N = 21)

Note. The percentages in this table are calculated out of the 42 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.

On average, the judges ($M = 4.50$, $SD = .55$) reported being somewhat more satisfied with recommendations received from the JDC clinician than the JPOs ($M = 4.26$, $SD = .89$); however, this difference was not statistically significant (respondents who indicated that their profession was 'other' were excluded from this analysis), $t(df = 35) = -.64$, $p > .05$. As seen below in Table

21, Region 1 and Region 6 were the regions with the highest levels of satisfaction with recommendations received from the JDC clinician. The regions with the lowest levels of satisfaction with recommendations were Region 3 and Region 7. Statistical analysis did not reveal any significant regional differences in the level of satisfaction with recommendations received from the JDC clinician (respondents who reported working/having contact with juveniles in more than one region were excluded from this analysis), $F(6, 35) = 2.01, p > .05$.

Region	Mean	Standard Deviation
Region 1	4.73	.47
Region 2	4.25	.96
Region 3	3.33	1.15
Region 4	4.33	.58
Region 5	4.38	1.06
Region 6	4.67	.52
Region 7	3.86	.69

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

The fourth item asked the judges/JPOs who reported receiving recommendations from the JDC clinicians whether these recommendations had affected any of the decisions or treatment they advised for at least one of the youth they were working with. Of the 42 judges/JPOs who completed this item, 35 (or over 83%) reported that the recommendations they received had affected a decision or treatment advised for the youth (7 JPOs indicated that the recommendations they received had not affected a decision or treatment advised for the youth). This percentage of having decisions affected by clinician recommendations is somewhat lower than the 85% in Y2, somewhat higher than the 81% in Y4, and considerably higher than the 69%, 73%, and 74% in Y5, Y3, and Y1, respectively.

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 asked 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 22, the majority (over 67%) of the judges/JPOs who completed this item reported thinking it was extremely beneficial to have a clinician in the nearest JDC, and another 26% reported it to be rather beneficial. The overall beneficial rate of 93% is identical to the 93% in Y2, somewhat lower than the 95% in Y4, and considerably higher than the 78%, 80%, and 84% in Y1, Y5, and Y3, respectively. Of those who did not report thinking that it was beneficial to have a clinician in the JDCs, two (or under 5%) reported a neutral option, with only one reporting it not being very 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?	0.0% (N = 0)	2.3% (N = 1)	4.7% (N = 2)	25.6% (N = 11)	67.4% (N = 29)

Note. The percentages in this table are calculated out of the 43 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.

On average, the judges' ($M = 4.86$ $SD = .38$) rating of how beneficial it is to have a clinician in the nearest JDC was somewhat higher than the JPOs' ($M = 4.52$, $SD = .77$); however, this difference was not statistically significant (respondents who indicated that their profession was 'other' were excluded from this analysis), t ($df = 36$) = 1.13, $p > .05$. As seen below in Table 23, the regions with the highest ratings for how beneficial it is to have a clinician in the nearest JDC were Region 1 and Region 5. The regions with the lowest ratings for how beneficial it is to have a clinician in the nearest JDC were Region 3 and Region 7. Statistical analysis did not reveal any significant regional differences in judges'/JPOs' perception of how beneficial it is to have a clinician in the nearest JDC (respondents who reported working/having contact with juveniles in more than one region were excluded from this analysis), F (6, 36) = .99, $p > .05$.

Region	Mean	Standard Deviation
Region 1	4.82	.40
Region 2	4.50	.58
Region 3	<i>4.00</i>	1.41
Region 4	4.67	.58
Region 5	4.75	.71
Region 6	4.67	.52
Region 7	<i>4.29</i>	.76

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

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 nearly 98%) of the 42 judges/JPOs who completed this item reported that they would like to see the CSP continue (one JPO indicated that he would not like to see the program housing clinicians in the JDCs continue). This approval rate was slightly lower than the 100% in Y2, but higher than the 92%, 94%, 96%, and 97% in Y1, Y3, Y5, and Y4, respectively.

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, explored for the first time in the Y5 evaluation, was explored again in the Y6 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 Y6 juveniles, an association between gender and traumatic experiences. As seen below in Table 24, whereas over 33% of girls screened positive for traumatic experiences on the MAYSI-2, fewer than 23% of boys did so. Similar to Y5, when this analysis was conducted for the first time, this difference was found to be statistically significant in Y6, χ^2 (df = 1) = 17.38, $p < .001$.

MAYSI-2 Indication	Gender			
	Number of Cases		Percentage of Total Screened Cases	
	Male	Female	Male	Female
Positive screen for traumatic experiences	217	130	22.5	33.4
Negative screen for traumatic experiences	748	259	77.5	66.6

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 25, whereas nearly 78% of juveniles who screened positive for traumatic experiences screened positive for a mental health problem, fewer than 50% of juveniles who screened negative for traumatic experiences did so. Once again, similar to Y5, when this analysis was conducted for the first time, this difference was found to be statistically significant, χ^2 (df = 1) = 83.75, $p < .001$.

Table 25: Associations between MAYSI-2 Indications of History of Traumatic Experiences and AST Indications of Mental Health Problems				
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	79	273	22.4	77.6
Negative screen for traumatic experiences	512	502	50.5	49.5

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 = 81.60, $p < .001$) emerging as a stronger predictor than gender (Wald = 16.00, $p < .001$). Odds ratios calculated within this model showed that juveniles who screened positive for traumatic experiences were 3.5 times more likely to screen positive for a mental health problem than those who screened negative for traumatic experiences (this finding is almost identical to the 3.2 odds ration found in Y5), and that girls were 1.7 times more likely to screen positive for a mental health problem than boys (this finding is identical to the odds ratio found in Y5).

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 469 juveniles who met the AST criteria for neither a mental health nor a substance abuse problem, 51% (or 240 juveniles) had at least one booking charge that could be classified as one of the four UCR categories (two booking charges were noted for 39 juveniles). Of the 897 remaining juveniles (those who met the AST criteria for a mental health problem, a substance abuse problem, or both types of problems), 56% (or 502 juveniles) had at least one booking charge that could be classified as one of the four UCR categories (two booking charges were noted for 83 juveniles). As seen below in Table 26, the majority of juveniles who met the AST criteria for neither type of problem were booked on drug crime charges (nearly 35%), whereas the majority of juveniles 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 charges (nearly 33%). Only a small percentage of juveniles in either group were booked on sex crime charges. In Y6, similar to Y5, when this analysis was conducted for the first time, the distribution of booking charges did not significantly differ 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).

Condition	Percentage (Number of Cases)			
	Drug Crime	Property Crime	Crime Against Persons	Sex Crime
Neither mental health nor substance abuse problem	34.6 (83)	33.3 (80)	25.8 (62)	<i>6.2 (15)</i>
All other diagnostic categories combined (mental health problem only, substance abuse problem only, or both)	29.3 (147)	32.9 (165)	32.7 (164)	5.2 (26)

Note. The percentages in this table are calculated out of the 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 may exceed 100. The highest row percentage is presented in bold, and the lowest row percentage is presented in italics.

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) = 90.32, $p < .001$. As seen below in Table 27, among juveniles who met the diagnostic criteria for neither a mental health problem nor a substance abuse problem, the most common booking charge was drug crime (nearly 35%), followed by property crime (over 33%) and crime against persons (nearly 26%). The least common booking charge for juveniles in this diagnostic category was sex crime (just over 6%). Among juveniles who met the diagnostic criteria for a mental health problem only, the most common booking charge was crime against persons (nearly 46%), followed by property crime (nearly 34%) and more distantly, drug crime (11%). The least common booking charge for juveniles in this diagnostic category was sex crime (10%). Among juveniles who met the diagnostic criteria for a substance abuse problem only, the most common booking charge was drug crime (just over 58%), followed distantly by property crime (nearly 22%) and crime against persons (nearly 18%). The least common booking charge for juveniles in this diagnostic category was sex crime (under 3%). Among juveniles who met the diagnostic criteria for both a mental health and a substance abuse problem, the most common booking charge was drug crime (37%), followed closely by property crime (just over 36%) and crime against persons (nearly 26%). The least common booking charge for juveniles in this diagnostic category was sex crime (approximately 1%). Thus, in terms of the diagnostic categories, in Y6, similar to Y5, when this analysis was conducted for the first time, 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 drug crime charges. Those juveniles in the other two diagnostic categories were more evenly distributed across booking charge categories.

Table 27: AST Indications of MH Problems, SA Problems, and Dual Diagnosis of Both, by Booking Charge				
Condition	Percentage (Number of Cases)			
	Drug Crime	Property Crime	Crime Against Persons	Sex Crime
Neither mental health nor substance abuse problem	34.6 (83)	33.3 (80)	25.8 (62)	6.2 (15)
Mental health problem only	11.0 (23)	33.5 (70)	45.5 (95)	<i>10.0</i> <i>(21)</i>
Substance abuse problem only	58.1 (43)	21.6 (16)	17.6 (13)	2.7 (2)
Both mental health and substance abuse problem	37.0 (81)	36.1 (79)	25.6 (56)	<i>1.4</i> <i>(3)</i>

Note. The percentages in this table are calculated out of the juveniles for whom at least one booking charge classifiable as one of the four UCR categories was noted in the IDJC database. The highest row percentage is presented in bold, and the lowest row 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; the Shoshone/Bannock Tribal JDC was classified as rural/frontier because the Fort Hall Indian Reservation has a population of less than 20,000 people (Bingham County, which surrounds the reservation, also does not have an urban area of at least 20,000). As seen below in Table 28, juveniles in rural/frontier counties (nearly 69%) accessed at least one recommended service more frequently than those in urban counties (nearly 60%). However, in Y6, similar to Y5, when this analysis was conducted for the first time, 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	553	59.8
Rural/Frontier	72	68.6

Note. The percentages in this table are calculated out of the 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 29, there was a large spread of percentages of juveniles by JDC county who accessed at least one recommended service, ranging from nearly 38% to over 88%. The three counties housing JDCs with the highest percentage of juveniles who accessed at least one recommended service were Ada (where over 88% of juveniles accessed at least one recommended service), Lemhi (nearly 86%), and Twin Falls (nearly 77%). The three counties housing JDCs with the lowest percentages of juveniles who accessed at least one recommended service were Canyon (nearly 38%), Bonneville (39%), and Nez Perce (nearly 43%). 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 = 11) = 149.94, $p < .001$.

County	Number of Cases	Percentage of Cases
Ada County	53	88.3
Bannock County	89	74.2
Bonner County	18	72.0
Bonneville County	41	39.0
Canyon County	71	37.8
Fremont County	16	69.6
Kootenai County	113	75.3
Lemhi County	18	85.7
Minidoka County	10	47.6
Nez Perce County	57	42.5
Twin Falls County	129	76.8

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 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). The data from the Shoshone/Bannock Tribal JDC were treated as a separate category. As seen below in Table 30, the two regions housing JDCs with the highest percentages of juveniles who accessed at least one recommended service were Region 4 (where over 88% of juveniles accessed at least one recommended service) and Region 1 (nearly 75%). The two regions housing JDCs with the lowest percentages of juveniles who accessed at least one recommended service were Region 3 (nearly 38%) and Region 2 (nearly 43%). In Y6, similar to Y5, when this analysis for conducted for the first time, 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 = 7) = 123.10, $p < .001$.

Table 30: At Least One Recommended Service Accessed, by Region		
Type of County	Number of Cases	Percentage of Cases
Region 1	131	74.9
Region 2	57	<i>42.5</i>
Region 3	71	<i>37.8</i>
Region 4	53	88.3
Region 5	139	<i>73.5</i>
Region 6	89	<i>74.2</i>
Region 7	75	<i>50.3</i>
Shoshone/Bannock Tribal JDC	10	<i>66.7</i>

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

In Y6, similar to Y5, several additional analyses of the judges/JPOs survey data were conducted. The results of these analyses are discussed sequentially in the following paragraphs.

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. In Y6, similar to Y5, when these analyses were conducted for the first time, a statistically significant difference on all three survey items listed above was found 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 ($M = 4.63$, $SD = .49$) than those reporting that recommendations had not affected a

decision or treatment advised ($M = 3.57$, $SD = .98$), $t(35) = 4.20$, $p < .001$. Also, respondents reporting that recommendations had affected a decision or treatment advised were also significantly more satisfied with recommendations made by the clinician ($M = 4.57$, $SD = .57$) than those reporting that recommendations received had not affected a decision or treatment advised ($M = 3.14$, $SD = .90$), $t(35) = 5.32$, $p < .001$. 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 ($M = 4.77$, $SD = .43$) than those reporting that recommendations had not affected a decision or treatment advised ($M = 3.71$, $SD = 1.11$), $t(35) = 4.15$, $p < .001$ (see Table 31).

Table 31: 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	4.63 (.49)	3.57 (.98)
Satisfaction with recommendations from JDC clinicians	4.57 (.57)	3.14 (.90)
How beneficial is it to have a clinician in the JDCs	4.77 (.43)	3.71 (1.11)

Note. The values in this table are calculated out of the 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 analysis of the three open-ended survey items was conducted. First, comments provided by the seven 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, six judges/JPOs (one responded did not provide any comments) indicated that the recommendations from clinicians did not contribute new insight (e.g., "I was already aware of what the juvenile needed," "they did not tell me anything new") or that the juvenile was already receiving services. One person expressed dissatisfaction with the communication lag, stating that "by the time we get the information from the clinician, the youth are already receiving services." One person remarked that "people do get depressed when locked up. It doesn't mean that they have mental issues."

Subsequently, comments provided by 30 judges/JPOs (or 50% of all respondents) in response to the item asking them 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-six respondents provided positive comments about the program. Some of their responses are shared in bullet points below:

- It is important for our juveniles to have contact with a clinician which may help them understand the Idaho Juvenile System cares and wants to help them
- [This program is] essential link between the community and detention center and provides communication on needs that probation may not always be aware of
- The program serves as an early and fast intervention to get kids and families help. It is a big help in getting the kids connected to the right services. It helps reduce detention time, future criminal behavior and commitments to state custody
- Not only does this program aid in our recommendations to the court but having the clinician in our detention center has helped educate and affect how detention staff interact with the youth. Great program

Several respondents expressed that they would like to see the program expand (e.g., “It would be a disservice to our probationers and individuals who enter the detention center to remove this program. If anything it would be beneficial to expand this program,” “I would like to see this position expanded to get more involved in connecting youth with services”).

Four respondents provided comments that are best described as neutral. Some of their responses are shared in bullet points below:

- The clinician program could be an asset to the facility IF the clinician did more than make recommendations. The position could be utilized in a much better way such as offering groups, crisis intervention, education with staff, etc.
- I would like to see the clinician actually spend her time working with the kids in the detention center instead of just performing an intake packet...I think there is so much more she could contribute to the position
- Often poor behavior is tied to mental health issues. Those mental health concerns need to be addressed actively if long term change is going to be achieved

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. Of the 30 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, six (or 20%) 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 six respondents who provided written recommendations, two recommended that the program be expanded (e.g., “Expand her ability to work with the kids not just interview them for an intake packet that is faxed to the JPO,” “adding to the already great services that the clinician provides”). One respondent recommended that juveniles should spend more time outside of their rooms, “not so locked up in the rooms all the time,” and another stated that he or she “would like to see the clinician interact more with the youth in the facility...not just when they are in crisis.” Of the remaining two, one expressed a desire for more funding (“More funding!!!”), and one recommended ongoing training for the clinicians (“Make sure the clinician is receiving well beyond the 20 hrs of CEUs required for their license and providing training to do so”).

Additional Analysis 5: Clinician Perceptions of Key Issues

A new addition to the Y6 evaluation included a protocol to conduct brief interviews with a subset of JDC clinicians to explore their perceptions of several issues identified as key in presentations with a variety of stakeholders. Although interviews of JDC clinicians (as well as administrators and line staff) had been part of the Y4 evaluation (McDonald et al., 2012), these had been more comprehensive and less targeted to questions raised specifically by stakeholders. The three JDC clinicians invited to participate in the Y6 brief interviews represented JDCs in North Idaho (Kootenai County-District 1), Eastern Idaho (Bonneville County-3B), and South Central Idaho (Twin Falls County-Snake River). Offered the choice of a telephone interview or answering questions via email, the clinicians chose the latter option. The three questions were sent by the research team and answered within one week by two of the three clinicians. The questions and responses to them are presented below.

Question 1: Based on your observations of working with juveniles, are there differences in risk factors (e.g., family or community factors) between juveniles with MH and/or SA problems and those without those problems?

Responses are shared below in bulleted format. All statements begin with the stem “Juveniles with MH and/or SA problems”:

- Are much more likely to have parents or family members who also suffer from the same problems (two clinicians)
- Are more often uninsured (one clinician)
- Have limited resources (e.g., transportation or gas) to make scheduled appointments (one clinician)
- Often have little or no supervision due to parent work schedules or other factors (one clinician)
- Have more demands placed on them by courts and probation (one clinician)
- Have poorer social support systems (one clinician)
- Less often have connections to society and less often believe there is hope (one clinician)
- Less often have families able to monitor and provide care for them

Question 2: Some stakeholders have suggested that juveniles coming into JDCs have more serious and complex problems than they used to. Has this been the case in your experience, and if so, what are the problems you are seeing more of today than in the past?

Both clinicians tended to disagree with the notion that the problems are more serious or complex than they used to be; what they believed to be different involved society, parenting, and expectations for children. Responses are shared below in bullet points:

- Juveniles currently do not take responsibility for their behavior; they blame others for their actions and do not feel guilty or remorseful for breaking rules. They feel entitled and seek immediate gratification. They do not seem to respect authority or fear consequences, including detention (two clinicians)
- Parental attitudes and behaviors contribute to many of the problems, as there is often no structure at home, with few expectations for juveniles to earn their own money or be

responsible or accountable. The parents do not show much respect for court themselves, and often simply make excuses for their children's behavior (two clinicians)

- Social attitudes also contribute to problems through low expectations for juveniles and a tendency to excuse or fail to hold juveniles responsible for poor behavior (one clinician)
- Social media has increased juveniles' access to violence, pornography, and other material that negatively affects their behavior (one clinician)
- There have always been serious and complex problems such as poverty, sexual abuse, substance abuse, and unemployment. Formerly these were addressed as family problems rather than social problems (one clinician)

Question 3: Can you provide any information on common patterns of after-care or follow-up after provisionally diagnosed juveniles are released from JDCs back to their communities?

Both clinicians cautioned that there may be regional differences in these factors and that they could only discuss what was true in their own experience. Responses are shared below in bullet points:

- Aftercare often starts with the recommendations given by clinicians at the JDCs, but then is largely in the hands of the JPOs and the parents. Probation often works hard to make sure that juveniles comply with recommendations or conditions for release, but parents do not provide the structure or enforce limits to keep juveniles from getting into future trouble (one clinician)
- Juveniles who meet the criteria for a SA problem receive a GAIN assessment, after which they are usually referred to individual chemical dependency treatment or Intensive Outpatient treatment (group treatment three days a week). Sometimes juveniles who have failed in outpatient treatment are referred to inpatient treatment, although this depends on a number of factors (one clinician)
- High-risk juveniles who have not been successful in any setting are considered for commitment to IDJC (one clinician)
- The more serious obstacle to juveniles receiving treatment involves Medicaid restrictions. Juveniles who are in a JDC for more than 30 days lose their Medicaid eligibility, meaning it is difficult to receive services after release. Medicaid also will not pay for GAIN assessments in the JDCs, so juveniles must wait longer to be assessed after release before they can receive treatment (one clinician) (Medicaid eligibility procedures, including the conditions under which juveniles lose eligibility for Medicaid are regulated by federal Medicaid law, which mandates that federal financial participation (FPP) be discontinued when youth are securely detained in a public institution; e.g., Bazelon Center for Mental Health Law, 2009)

Summary and Conclusions

The material in this report describes the results of the six-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 (e.g., Begic et al., 2013; 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 six 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 Y6 in very much the same way as they were in Y1. However, the researchers have noticed that the quality and completeness of data has been steadily improving over the years (with fewer missing data fields in Y6 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 13 JDCs were submitted (in addition to the 12 JDC that submitted clinical data in all prior years, data were also submitted by the Shoshone/Bannock Tribal JDC located on the Fort Hall Indian Reservation in Y6); 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. Similar to Y5, when this issue was first noticed, the BSU researchers identified a number of juveniles for whom multiple entries were provided. To ensure data quality, the data on 28 juveniles for whom multiple data entries were provided were excluded from the analysis, which resulted in the exclusion of a total of 47 data entries.

As was discussed in the Y4 report (McDonald et al., 2012), a problem with a design feature in the clinicians' 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 corrected the problem in the Y4 and Y5 datasets, anticipated and corrected for the problem in the Y6 dataset as well. It was expected that improvements would be made and the "glitch" would be removed as a result of the data collection system improvement in fall 2012; however, this problem remained unresolved in Y6.

No changes were made to the second wave data collection process between Y5 and Y6. However, although the same data collection process that was used in the four preceding evaluation years was used in Y6, the number of calls that resulted in a completed survey was

relatively low (133 completed surveys in Y6, compared to 60 in Y5 when a smaller number of parents were called, and 273, 233, and 311 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 39% in Y6 was considerably lower than in previous years (73%, 66%, 76%, and 52% in Y2, Y3, Y4, and Y5, respectively).

The methodology for data collection for the Judges'/JPOs' survey did not change between Y5 and Y6 (a mail survey method was used in Y1-Y4); however, the survey questions were slightly modified in Y6 to allow for collection of some elementary demographic data (i.e., respondents' profession and the region in which they work/have contact with juveniles). A total of 60 judges and JPOs completed a survey in Y6 (compared to 50 completed surveys in Y1, 40 in Y2, 43 in Y3, 45 in Y4, and 63 in Y5). The response rate of 45% is nearly as high as the 46% in Y5 and 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 Y6. 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. Because the MAYSI-2 data used for the first time in Y5 seemed to have enriched the understanding of factors associated with mental health problems in juvenile detainees, these data were used again in this year's evaluation. As already discussed in the Y5 report, further exploration of MAYSI-2 data may be warranted in future evaluations. Additionally, wave three data were used to explore whether there were any systematic variations in the responses of judges and JPOs as a function of several factors, including two demographic factors (profession and region in which they worked).

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-Y6 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 and the slightly lower 56% figure from Y6 leads to a five-year average of 59%. The prevalence figures for substance abuse problems vary slightly more, from 40% in Y6 to 46% in Y2, with Y3, Y4, and Y5 in between at 44%, 43%, and 41%, respectively. These figures lead to a five-year average of 43%. Thus, on the basis of AST criteria alone, averaged across five years, 59% of juveniles entering JDCs appear to suffer from a mental health problem and 43% 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 66% in Y6 to 76% in Y3, with Y2, Y4, and Y5 in between at 75%, 72%, and 69%, respectively. These figures lead to a five-year average of 72%, meaning that, averaged across five 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 28% 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-Y6 data seems appropriate. Prevalence of the dual diagnosis seems very closely clustered across the five years, with the prevalence being 30% in Y3, Y4, and Y5, with the slightly increased prevalence of 31% in Y2 and Y6. 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 (e.g., 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. As discussed in the Y5 report (Begic et al., 2013), although this finding is not surprising (research has reported a gender difference in the diagnosis of many mental health problems both in community and detention samples, for both adults and juveniles), the reason for this difference is still not well understood (e.g., Klose & Jacoby, 2004; Piccinelli & Wilkinson, 2000). 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, with a 14% difference found in Y3 and Y6, and a 17%, 11%, and 12% difference in Y2, Y4, and Y5, respectively. This yields a five-year average of 14%, meaning that the prevalence of girls meeting the criteria for a mental health problem is 14% higher than for boys. The research team replicated the analysis that examined whether differential rates of traumatic experience exposure (as measured by the MAYSI-2 Traumatic Experiences subscale) could explain the difference, conducted for the first time in Y5. Interestingly, this analysis generated results that very closely resembled those from Y5. 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) 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 and replicated in Y6, it can be concluded that 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, suggesting that close inspection of MAYSI-2 TE subscale scores prior to the clinical interview seems particularly

warranted. Moreover, 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 might 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 five-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 and Y6, with Y3 and Y4 in-between at 69% and 67%, respectively) was 70%. 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 that some juveniles entering JDCs in more recent evaluation years (e.g., Y4-Y6) were previously diagnosed by JDC clinicians in earlier evaluation years (e.g., Y1-Y3), 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. As already noted in previous evaluation reports, 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 have 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 Y6 evaluation show that, according to clinicians, nearly 97% 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 under 61%) 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 released 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 Y6 responded very positively regarding the CSP, with the vast majority being aware of the program (95%), satisfied with contact from a JDC clinician (93%), having received recommendations from the JDC clinician (98%), and being satisfied with the contact (88%). A majority also reported that recommendations affected decisions they made regarding their youth (83%). Although no statistically significant differences were found between the judges and JPOs, the JPOs tended to be somewhat more satisfied with contact from a JDC clinician than the judges, whereas the judges tended to be somewhat more satisfied with recommendations received from the clinician and rated having a clinician in the nearest JDC as somewhat more beneficial than the JPOs. The level of satisfaction with contact with the JDC clinician varied as a function of region, with judges and JPOs in Region 1 and Region 6 expressing the greatest level of satisfaction and those in Region 3 expressing the lowest level of satisfaction. In short, there is no question that judges/JPOs in Y6, as in all five 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 conducted for the first time in Y5 were replicated in Y6. 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 problem more often than those who did not screen positive for traumatic experiences. As discussed in the Y5 report (Begic et al., 2013), 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 (2013), 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.

Additional analyses of booking charges revealed that drug crime was the most frequent booking charge for juveniles who met the AST criteria for neither a mental health nor a substance abuse problem and those who met the criteria for a substance abuse problem only. In comparison, the most frequent charge for juveniles who met the AST criteria for a mental health problem only was crime against persons. This seems to suggest that juveniles with a mental health problem might be more likely to commit more serious crimes (crimes against persons) than those who have neither type of problem (these juveniles seem to be more likely to commit drug and property crimes). It is unclear why juveniles who met the criteria for a mental health problem are more likely to commit crimes against person than any other group of juveniles; however, this information, coupled with the information about the prevalence of mental health among juveniles

who enter the JDCs (including gender differences) could be used to by the JDC clinicians and other JDC staff to help inform the interaction that they have with detained juveniles on a daily basis, especially those juveniles who exhibit hostile behaviors toward others.

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 their level of satisfied 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.

A new addition to Y6 that included a brief interview of clinicians (conducted in response to several questions raised by stakeholders) yielded some interesting information. For instance, clinicians felt that compared to juveniles without mental health and/or substance abuse problems, juveniles with mental health and/or substance abuse problems are much more likely to have parents or other family members who also suffer from the same problem, are more often uninsured, have limited resources, have little or no parental supervision, and have poorer social support, among other disadvantages. Clinicians also felt that today's juveniles often fail to take responsibility for their behaviors; they believed this to be due to lack of parental involvement and supervision (including lack of structure at home), low societal expectations (including tendency to excuse or hold juveniles responsible for poor behavior), and a general lack of respect for authority among juveniles. The information obtained in these interviews, which is consistent with what is found in the research literature (e.g., Hoeve et al., 2009; Mericle, Belenko, Festinger, Fairfax-Columbo, & McCart, 2013) suggests that multiple aspects of a juvenile's life (including individual, familial, and societal) need to be carefully considered when working with juveniles with mental health and/or substance abuse problems.

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-Y6, 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 five 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 indicate 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), a concerted effort to reduce the likelihood that juveniles become involved with the justice system seems warranted. As discussed in the Y5 report (Begic et al., 2013), there is ample research in support of employing evidence-based interventions to reduce or prevent criminal behavior in children, many of which would reduce economic cost associated with juvenile detention, thus making more money available for other social programs. It is noteworthy that many of the interventions discussed by Piquero and colleagues (e.g., Piquero, Farrington, Welsh, Tremblay, & Jennings, 2009) focus on the mental health of the parents as well as the children. This approach is 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. As already noted in the previous reports, 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.

“Aftercare” has been identified as a missing piece in all evaluations conducted to date. As previously discussed, it seems very puzzling that in spite of the effectiveness 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. Considering the existing barriers to service access that exist according to the JDC administrators and clinicians (for a discussion of these barriers see McDonald et al., 2012) and the likelihood that the lack of access to community services due to barriers may lead to higher rates of recidivism among some juveniles, aftercare indeed seems inadequate. Of course, aftercare treatment, or even oversight, is not expected or within the duties of the JDC clinicians; 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 (for a detailed discussion about the importance of aftercare see Begic et al., 2013).

After six 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 (at least without substantial resource expansion). JDC clinicians are obviously in no position to provide the “pre-care” 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 literature 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, McReynolds, & Wasserman, 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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