

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

Prepared for the Idaho
Department of Juvenile Corrections

by

Sandina Begic
Theodore W. McDonald
Loren L. Toussaint

Center for Health Policy
Boise State University

March 2015

Executive Summary

During 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 seven years (2008-2014). 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 2007-2008, 2008-2009, 2009-2010, 2010-2011, 2011-2012, and 2012-2013 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 six 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, substance abuse, or both types of disorder. All six evaluations also indicated that the program is well received and supported by the judges and Chief JPOs (CJPOs) contacted by the JDC clinicians.

The favorable evaluations from 2007-2013 supported the funding of the CSP for another year, and in 2013 it continued in the 13 JDCs in Idaho (the 12 JDCs that have been a part of this evaluation since Y1 and the Shoshone/Bannock Tribal JDC on the Fort Hall Indian Reservation that was added in 2012). 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 7 Assessment (Y7). Similar to the Year 1 (Y1) – Year 6 (Y6) 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 CJPOs, which asked questions about contact by JDC clinicians, the value of recommendations made and information provided, and the value of the program as a whole. Several additional analyses of wave one and wave three data were conducted in Y7; these analyses were also performed in Y5 and Y6 but were not completed in any of the other evaluation years.

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 1,336 juveniles were analyzed**
 - **Data on a total of 1,398 detained juveniles were submitted. Data on 30 juveniles for whom multiple data entries were submitted were excluded from this report**
 - **Nearly 73% of the juveniles for whom data were included in the final analyses were boys, and over 27% 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 Kootenai (just over 18%), Twin Falls (nearly 13%), Canyon (just under 12%), Ada (just over 11%), and Bonneville (nearly 10%). The JDC in Lemhi County and the Shoshone/Bannock Tribal JDC (approximately 1% each) submitted the fewest cases, followed by the JDCs in Fremont (just over 3%), Bonner (just over 6%), Minidoka (7%), Nez Perce (just over 8%), and Bannock (nearly 9%) 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), followed by property crimes, drug crimes, crimes against persons, and sex crimes**
- **Over 59% of all juveniles screened with the AST mental health and substance abuse subscales met the diagnostic criteria for having a mental health problem**
 - **Girls (at over 71%) were statistically significantly more likely to meet the AST criteria for a mental health problem than were boys (nearly 54%)**
 - **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 Canyon County (78%), followed by the JDCs in Nez Perce (just over 77%) and Twin Falls (over 74%) counties. Indications of mental health problems were lowest among juveniles screened at the JDCs in Lemhi (0%), Minidoka (fewer than 7%), and Bonner (just over 30%) counties**

- **Nearly 38% 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 Shoshone/Bannock Tribal JDC (over 63%), followed by the JDCs in Nez Perce and Bannock (55% each) counties. Indications of substance abuse problems were lowest among juveniles screened at the JDCs in Minidoka (just over 1%), Lemhi (just over 11%), and Bonner (12%) counties**
- **When the combination of AST indications of mental health and substance abuse problems were evaluated, it was found that over 67% 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 nearly 33%), followed by having a mental health problem only (nearly 30%), both a mental health and a substance abuse problem (over 29%), and a substance abuse problem only (just over 8%)**
 - **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 (36% to 28%) and a substance abuse problem only (10% to 4%), girls were more likely than boys to have indications of both a mental health and substance abuse problem (36% to 26%) and a mental health problem only (35% to 28%)**
 - **A statistically significant difference also existed in combination of mental health and substance abuse indications as a function of JDC location**
 - **The most common combination of indications for juveniles in five JDCs (in Minidoka, Lemhi, Bonner, Kootenai, and Bonneville counties) was having neither a mental health nor substance abuse problem. Having both a mental health and a substance abuse problem was the most common combination in three JDCs (in Bannock, Nez Perce, and Ada counties), and having a mental health problem only was most common in the JDCs in Twin Falls and Canyon counties. There was a tie for the most common combination between juveniles having indications of a substance abuse problem only and both a mental health and a substance abuse problem in the Shoshone/Bannock Tribal JDC**
 - **Having a substance abuse problem only was least common in 10 JDCs (Minidoka, Bonner, Canyon, Bonneville, Kootenai, Bannock, Twin Falls, Nez Perce, Ada, and Fremont counties). The only exceptions were the JDC in Lemhi County, where there was a tie for the least common combination between juveniles having a mental health problem only and both a mental health and a substance abuse problem, and the Shoshone/Bannock Tribal JDC, where having a mental health problem only was least common**

- **Over 74% 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 1.29**
 - **A statistically significant difference in mean number of previous diagnoses was found between boys and girls, with girls reporting more previous diagnoses (1.40) than boys (1.24)**
 - **A statistically significant difference in the mean number of previous diagnoses was found as a function of JDC location (data from the JDC in Minidoka County were excluded from this analysis because there were too few cases with a documented number of provisional diagnoses in this county)**
 - **Mean numbers of previous diagnoses were highest among juveniles in the JDCs in Fremont (1.48), Nez Perce (1.42), and Canyon (1.40) counties. Mean numbers of previous diagnoses were lowest among juveniles in the JDCs in Lemhi (1.06), Bonneville (1.10), and Bonner (1.12) counties**
- **Nearly 59% 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 1.44. Diagnosis was deferred for another 3.4% of juveniles**
 - **A statistically significant difference in mean number of provisional diagnoses given was found between boys and girls. Girls were given more provisional diagnoses (1.59) of mental health or substance abuse problems than were boys (1.36)**
 - **A statistically significant difference in the mean number of provisional diagnoses given was found as a function of JDC location**
 - **The highest mean numbers of provisional diagnoses given were to juveniles in the JDCs in Canyon (1.78), Fremont (1.71), and Twin Falls (1.58) counties. The lowest mean numbers of provisional diagnoses were given to juveniles in the JDCs in Nez Perce (1.06), Minidoka (1.10), and Lemhi (1.11) counties**
- **The most common provisional diagnosis was a mood disorder, which appeared to affect approximately 39% of the provisionally diagnosed juveniles. Other common provisional diagnoses included substance abuse disorders (nearly 33% of those provisionally diagnosed), disruptive behavior disorders (over 25%), anxiety disorders (over 16%), and attention deficit disorders (nearly 11%)**
- **Recommendations for at least one service in the community were made for 1,141 juveniles. The mean number of service recommendations for juveniles who received at least one service recommendation was 1.52**
 - **Of all juveniles who received at least one service recommendation, 744 (or 65%) were given at least one provisional diagnosis and the remaining 397 (or 35%) received at least one service recommendation but were not given a provisional**

diagnosis. Additionally, 53 juveniles were given at least one provisional diagnosis without receiving a service recommendation

- Of the 797 juveniles who received at least one provisional diagnosis, 744 (or over 94%) received at least one service recommendation
- There was a statistically significant difference in the mean numbers of recommendations for services as a function of JDC location
 - The highest mean numbers of recommended services were given to juveniles in the JDCs in Twin Falls (2.32), Bannock (2.25), and Nez Perce (1.49) counties. The lowest mean numbers of recommended services were given to juveniles in the JDC in Bonneville County (1.09), followed by the JDCs in Minidoka and Fremont (1.16) counties
- The most commonly given recommendations for services were continuation of prior treatment (over 36%) and for individual counseling (nearly 30%). Other commonly received service recommendations were for substance abuse counseling/treatment (nearly 25%) and psychological/mental evaluation (nearly 19%)
- According to information gained by clinicians during a 15-45 day post-release follow-up call, 725 juveniles, or nearly 64% 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 1.45
 - 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 JDCs in Twin Falls (1.90), Bannock (1.84), and Canyon (1.34) counties. The lowest mean numbers of recommended services accessed were found among juveniles released from the JDC in Lemhi County and the Shoshone/Bannock Tribal JDC (1.13 each), followed by the JDC in Ada County (1.14)

Wave Two: Parent Survey Data

- A total of 333 parents were contacted via telephone by callers from the Idaho Federation of Families (IFF) for Children's Mental Health. Of those, 111 parents agreed to complete the survey, for a response rate of 33%
- About 36% of the parents who provided a response reported that they had been contacted by the JDC clinician and informed that their child had been identified as a person who could benefit from community-based mental health and/or substance abuse services.

- Of the parents who reported being informed that their child had been identified as someone who could benefit from services, 59% reported that they were given recommendations for community-based services for their child by the JDC clinician
- The services parents most often reported being recommended for their children included counseling (unspecified, mental health, and family counseling; over 46%) and continuation of current treatment (nearly 12%). Fifteen percent of parents also reported that they could not remember what services had been recommended, and another 15% reported receiving recommendations for services that were not easily classifiable (e.g., trial program, court ordered, and 504 Plan). Approximately 8% reported receiving a recommendation for a substance abuse treatment or assessment, and another 8% reported receiving a recommendation for a mental health evaluation
- Nearly 91% of the parents who received at least one service recommendation for their child reported that their child had accessed at least one service
- The two parents who reported that their child had not accessed at least one recommended service stated why their child had not done so. One indicated that the child refused to access or use the recommended service and the other stated that the child had already received the recommended service

Wave Three: Judge/Juvenile Probation Officer Survey

- A total of 94 judges, CJPOs and others working with juveniles completed a survey (the response rate could not be calculated because an unspecified number of invitations were unexpectedly extended to individuals other than judges and CJPOs)
 - Of the 94 respondents, 25.5% were judges and the remaining 75.5% were CJPOs and others working with juveniles (e.g., JPOs, POs, directors, and supervisors)
 - The regions with the highest percentage of respondents were Region 1 (nearly 27%), Region 4 (over 20%), and Region 3 (nearly 14%). The regions with the lowest percentage of respondents were Region 2 (over 6%), Region 7 (nearly 9%), and Region 6 (nearly 12%)
- Nearly 96% of the judges, CJPOs, and other working with juveniles 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 90 judges, CJPOs, and others working with juveniles who reported being aware of the CSP, all provided a response when asked whether they had been contacted by a clinician regarding one of the youth they were working with. Of those, just over 81% reported having been contacted by a clinician
 - The level of satisfaction with the contact from the JDC clinicians was very high, as nearly 95% of the judges, CJPOs, and others who reported having

been contacted were very satisfied (just under 59%) or satisfied (nearly 36%) with the contact

- Respondents in Region 1, Region 4, Region 5, and Region 6 reported being significantly more satisfied with this contact than those in Region 2. Respondents in Region 1 also reported being significantly more satisfied than those in Region 3
- Of the judges, CJPOs, and others working with juveniles 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 95% reported having been given a recommendation
 - The level of satisfaction with recommendations provided by the JDC clinicians was fairly high, as over 91% of those judges, CJPOs, and others who reported receiving at least one recommendation were very satisfied (just over 52%) or satisfied (just over 39%) with the recommendation(s)
 - Respondents in Region 1 and Region 5 reported being significantly more satisfied with the recommendation they received than those in Region 3. Respondents in Region 1 also reported being significantly more satisfied than those in Region 2
- Among the judges, CJPOs, and others working with juveniles 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/CJPOs was “extremely beneficial” (nearly 72%), followed by “rather beneficial” (just over 21%)
- When asked whether they would like to see the CSP continue, nearly 99% of the judges/CJPOs reported wishing to see it continue

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

- Nearly 27% 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 34% of girls screened positive for traumatic experiences on the MAYSI-2, fewer than 25% of boys did so
 - A statistically significant association was found between the indication of MH problems and traumatic experiences. Whereas just over 78% of juveniles who screened positive for traumatic experiences also screened positive for a MH problem, nearly 53% 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 3.2 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 2.0 times more likely than boys to screen positive for a MH problem

Additional Analysis 2: Booking Charges

- Of all juveniles for whom one of the four AST classifications was documented and for whom a booking charge was entered, 793 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 (neither type of problem and a MH problem only, a SA problem only, or both types of problems) and the type of booking charge
 - Those juveniles who met the criteria for a mental health problem, a substance abuse problem, or both types of problems were more likely to be booked for crimes against persons (just over 33%) than those who met the criteria for neither a mental health nor a substance abuse problem (just over 23%). Juveniles who met the criteria for neither types of problems were more likely to be booked for drug crimes (over 33%), crimes against property (over 36%), and sex crimes (over 7%) than those who met the criteria for one, the other, or both types of problems (31%, nearly 32%, and nearly 6%, respectively)
 - Juveniles who were booked on drug crime charges were most likely to meet the AST criteria for both a mental health and a substance abuse problem (nearly 38%) and least likely to meet the criteria for a mental health problem (over 10%)
 - Juveniles who were booked on property crime charges were most likely to meet the AST criteria for neither a substance abuse nor a mental health problem (nearly 36%) and least likely to meet the criteria for substance abuse problem (just over 7%)
 - Juveniles who were booked on crimes against persons and sex crimes were most likely to meet the AST criteria for a mental health problem (approximately 50% each) and least likely to meet the criteria for a substance abuse problem (just over 3% and over 4%, respectively)

Additional Analysis 3: Regional Differences in Recommended Services Accessed

- Of the 1,141 juveniles who received at least one recommendation for services, 725 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 type of county (urban vs. rural/frontier), county, and region
 - Juveniles released from JDCs in urban counties (nearly 61%) were more likely to access at least one recommended service than those released from JDCs in rural or frontier counties (28%)
 - The JDCs with the highest percentages of juveniles who accessed at least one recommended service were found in Bannock (nearly 90%), Ada (nearly 85%), and Lemhi (over 83%) counties. The JDCs with the lowest percentage of juveniles who accessed at least one recommended service were found in Minidoka (nearly 88%), Bonneville (nearly 18%), and Bonner (nearly 29%) counties
 - The JDCs with the highest percentages of juveniles who accessed at least one recommended service were found in Region 6 (nearly 90%), Region 4 (nearly 85%), and Region 3 (nearly 68%). The JDCs with the lowest percentage of juveniles who accessed at least one recommended service were found in Region 7 (29%), Region 2 (nearly 39%), and Region 1 (just over 41%)

Additional Analysis 4: Judges/CJPOs Survey

- Of all respondents who received a recommendation from a JDC clinician, nearly 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 ($M = 4.61$) than those reporting that it had not ($M = 4.17$)
 - 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 ($M = 4.56$) than those reporting that it had not ($M = 3.83$)
- Of the 12 judges, CJPOs, and others working with juveniles who indicated that recommendations they received from JDC clinicians had not affected any of the decisions or treatments they advised for the juveniles, a total of 10 provided a comment in response to the item asking them to explain why these recommendations had not affected any of the decisions or treatments they advised for the juveniles
 - Most indicated that the recommendations received from JDC clinicians did not offer new insight or that youth were already receiving those services recommended by JDC clinicians. Several respondents remarked that receiving a validation from a mental health professional was important even if new insight was not gained
- Two-thirds of those judges, CJPOs, and others working with juveniles who indicated that they were aware that the nearby detention center had a mental health clinician provided a comment when asked why or why not they would like to see the program housing a mental health clinician in the detention center continue

- Nearly 88% of respondents provided a positive comment about the program. The most prominent topics discussed by the respondents included provision of training to line staff, provision of firsthand information about youth to judges and probation officers, provision of information about resources and services available to youth and their families, completion of mental health assessments, identification of mental health problems and recommendation of appropriate treatments and services, as well as availability to the youth to discuss problems they may be experiencing
- Of the 73 judges, CJPOs, and others working with juveniles who indicated that they had been contacted by a mental health clinician, nearly 37% provided a comment when asked whether they had any recommendations that would improve the mental health services in juvenile detention centers
 - Ten respondents reiterated the importance of the program and commended the work JDC clinicians are doing. Another 10 respondents recommended program expansion and an increase in funding to allow clinicians to spend more time with youth and start providing treatment services to youth while in detention. Five respondents commented on the importance of having all parts of the system work collaboratively with JDC clinicians to ensure the best possible outcomes for high need youth

Additional Analysis 5:

- The MAYSI-2 subscale indications do not predict AST diagnoses particularly well. The MAYSI-2 yields a large number of “false negatives,” meaning that many juveniles who were found by JDC clinicians to have mental health or substance abuse problem during the AST-driven clinical interview scored negative for mental health or substance abuse problems on the self-administered MAYSI-2
 - MAYSI-2 subscale indications likely underestimate the prevalence of mental health and substance abuse problems in juveniles
 - The AST diagnoses are likely much better indicators of mental health and substance abuse problems in juveniles than MAYSI-2 subscale scores

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 justice 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. A report on the expanded program (McDonald, Williams, Osgood, & VanNess, 2009) was issued in January 2009. The expanded program continued for five 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), 2013 (Begic, McDonald, & Howard, 2013), and 2014 (Begic, McDonald, Gazieva, & Lindsay, 2014). 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 six years of the expanded CSP, clinicians working in the 13 JDCs (the CSP was expanded to the Shoshone/Bannock Tribal JDC in 2012, and the data from this JDC were used for the first time in the Y6 evaluation) 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 chief juvenile probation officers (CJPOs) who work with the youth. A survey was presented to parents (by mail in Y1 and by telephone in Y2-Y6), asking them whether they had been contacted by clinicians and informed that their child 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 CJPOs (by mail in Y1-Y4 and through an online portal in Y5 and Y6), 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 and Y6 evaluations. 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 also subjected to additional analysis to explore factors that may be contributing to variations in judges'/CJPOs' responses.

The six evaluations of the expanded CSP revealed a number of interesting findings (Y1 percentages of MH and SA problems were excluded from the aggregate analyses because those percentages were much higher than in other evaluation years). For example, it was found that high percentages of juveniles in all five years (Y2-Y6) met the AST diagnostic criteria for a mental health problem (the five-year average for juveniles meeting the AST criteria for having a mental health problem was 59%, ranging from a low of 59% in Y2, Y4 and Y5 to a high of 62% in Y3) and a substance abuse problem (the five-year average for juveniles meeting the AST criteria for a substance abuse problem was 43%, ranging from a low of 40% in Y6 to a high of 46% in Y2). Very high percentages of juveniles were found to meet the AST criteria for at least one type of problem (the five-year average for juveniles meeting the AST criteria for at least one type of problem was 72%, ranging from a low of 66% in Y6 to a high of 76% in Y3), and substantial percentages were found to meet the criteria for both types of problems (the five-year average for juveniles meeting the AST criteria for both types of problems was 30%, ranging from a low of 29% in Y4 to a high of 31% in Y3 and Y6). Provisional diagnoses of at least one mental health or substance abuse problem were made for a majority of the juveniles in the last three evaluation years (Y4-Y6; a comparison to provisional diagnoses for Y1-Y3 is not feasible because problems were identified in how these were calculated in those years) (the three-year average for juveniles being diagnosed with at least one mental health or substance abuse problem was 65%, ranging from a low of 55% in Y6 to a high of 73% in Y4), 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-Y6 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 the following years (the four-year average [Y3-Y6] was 37%, ranging from a low

of 30% in Y6 to a high of 47% in Y3. Also, high percentages 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 all five years (the five-year average was 61%, ranging from a low of 47% in Y4 to a high of 76% in Y2). Of those parents who reported receiving a service recommendation, many reported that their child had accessed at least one recommended service (the five-year average was 86%, ranging from a low of 74% in Y2 to a high of 96% in Y4). Responses to the judges'/CJPOs' survey indicated positive perceptions of the CSP in all five years (Y2-Y6). Most of the respondents reported being aware of the program (the five-year average was 87%, ranging from a low of 79% in Y3 to a high of 95% in Y6), having had contact with JDC clinicians (the five-year average was 80%, ranging from a low of 73% in Y2 to a high of 91% in Y3), and receiving recommendations for youth (the five-year average was 94%, ranging from a low of 89% in Y5 to a high of 98% in Y6). A very high percentage of judges and CJPOs who were aware of the program believed it to be beneficial (the five-year average was 89%, ranging from a low of 80% in Y5 to a high of 93% in Y2 and Y6), and nearly all reported wanting to see it continue (the five-year average was 97%, ranging from a low of 94% in Y3 to a high of 100% in Y2). An analysis conducted for the first time in Y5, and replicated in Y6, also identified prior traumatic experiences as a significant predictor of MH problems, with juveniles screening positive for traumatic experiences being over three times more likely to also screen positive for a MH problem than those screening negative for traumatic experiences in both Y5 and Y6.

The CSP was granted funding for a seventh year (Y7), and IDJC contracted with the same team of BSU researchers to evaluate it. The 2014 evaluation was performed on data collected at the JDCs between July 1, 2013 and June 30, 2014. The procedures for collecting data for the clinicians' and parents' portions of the 2013 evaluation were identical to those used in the 2008-2013 evaluations. The procedure for delivering the judges/CJPOs survey was identical to that used in 2012 and 2013; however it differed somewhat from those used in the 2008-2011 evaluations. Finally, several additional analyses utilizing data collected in waves one and three, completed for the first time in Y5 and replicated in Y6, were also completed in the Y7 evaluation.

Methodology

Similar to the Y1-Y6 assessments, data were collected in several separate waves in this Y7 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 seven years of evaluation (i.e., Y1-Y7). 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 seven years, although, as discussed below, the methodology for delivering the survey differed by evaluation year. The third wave involved surveying judges and CJPOs who worked with juveniles recently released from the JDCs. The survey used was essentially identical in all seven evaluation years; in the Y7 assessment, similar to Y6, two questions were added to the survey to collect demographic data from the judges/CJPOs (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 and replicated in Y6, were also performed in the Y7 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 was repeated 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-Y7). 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-Y7 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 the Y5, Y6, and Y7 evaluations.

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 items 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, 2013 and June 30, 2014. 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 1,398 data entries. Upon realizing that multiple entries were provided for some juveniles, the BSU team and an IDJC administrator determined that the data on 30 juveniles from two counties (29 from Minidoka County and one from Canyon County) for whom multiple data entries were provided should be excluded from the analysis. This resulted in the exclusion of 62 data entries. Consequently, wave one data analyses included clinician data provided for 1,336 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-Y7.

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 2014 and wrote the parents' responses directly on paper copies of the survey. IFF returned the paper copies of completed surveys to IDJC in December 2014, 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 333 parents of recently released juveniles (the callers from IFF placed additional 90 calls; however, these calls were excluded from the analysis because there either was no response or the number was invalid). Of these, 111 parents agreed to complete the survey, for a response rate of 33%. This response rate is much better than the 5% achieved in Y1, but lower than the average of the other five years (Y2-Y6), which was 62% (ranging from a low of 39% in Y6 to a high of 76% in Y2 and Y4).

Wave Three: Judges/Chief Juvenile Probation Officers Survey Data

The third wave of data collected for this project involved information gathered through a survey of judges and CJPOs 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 CJPOs 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 further modified to allow for collection of some demographic data (i.e., respondents' profession and the region in which they work/have contact with juveniles), and this version of the survey was used again in the Y7 evaluation. Thus, the judges/CJPOs survey in Y7 consisted of 10 items (several of which had follow-up questions), asking the judges/CJPOs: 1) to identify profession (judge, CCJPO, 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 1 = "Very dissatisfied" to 5 = "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 Y7 was identical to that used in Y6 and Y5. This method of delivery is different from the method used in Y1-Y4, when an IDJC program administrator identified the judges/CJPOs for the BSU researchers to send survey packets to and provided the BSU researchers with the names and postal addresses for these judges/CJPOs. 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/CJPOs to return the surveys directly to the researchers at BSU. In the Y7 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/CJPOs survey was programmed into Qualtrics by mid-November 2014, and the survey link was sent to an IDJC administrator along with an initial invitation message describing the survey and a two-week reminder statement. Recruitment of the judges/CJPOs was conducted directly by the IDJC administrator, who sent an initial invitation and link to the Qualtrics survey hosted on the BSU server to 140 judges/CJPOs (97 judges and 43 CJPOs) on December 2, 2014.

Respondents began to complete the survey the same day. The IDJC program manager sent a reminder email message on December 15, 2014 encouraging potential respondents to complete the survey. The survey was closed on December 19, 2014, and at that time, a total of 94 judges, CJPOs and others working with juveniles had completed it (the response rate could not be calculated because the invitation to complete the survey was unexpectedly forwarded to an unspecified number of individuals who were neither judges nor CJPOs).

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/CJPOs responses. In Y7, similar to Y5 and Y6 when these analyses were also completed, 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 accesses across regions/counties. Wave three data were utilized to explore factors that may be contributing to variations in judges'/CJPOs' responses. Also, for the first time in Y7, a set of analyses were conducted to test whether indications on the MAYSI-2's subscales other than Traumatic Experience were significantly associated with AST mental health indications.

Results and Analyses

Analysis of JDC Data

Demographic Information

The data in this report are gleaned from the cases of 1,336 juveniles detained at one of 12 JDCs throughout Idaho. Gender codes were entered for 1,282 juveniles. Of these, 932 (or 73%) were boys and 350 (or 27%) were girls. The total number of cases was somewhat lower than the average of the first six years (denoted throughout the remainder of this report as the “six-year average”) of CSP evaluations, which was 1,764 juveniles (ranging from a low of 1,366 in Y6 to a high of 2,066 in Y4). The percentages of boys and girls in Y7 were very similar to the six-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, 2013 (the period after data collection ended for the previous year’s evaluation) to June 30, 2014 (the end of the fiscal year). The JDC in Valley County submitted the data for the study but 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 Kootenai County (with just over 18% of the total cases), followed by the JDCs in Twin Falls County (nearly 13%) and Canyon County (nearly 12%). On the other hand, the smallest percentages of cases were submitted from Lemhi County and the Shoshone/Bannock Tribal JDC (just over 1%), followed by the JDCs in Fremont County (over 3%).

JDC Location	Number of Cases	Percentage of Total Cases
Ada County	150	11.2
Bannock County (District 6)	117	8.8
Bonner County	83	6.2
Bonneville County (3B)	131	9.8
Canyon County (Southwest Idaho)	159	11.9
Fremont County (5C)	44	3.3
Kootenai County (District 1)	242	18.1
Lemhi County	18	<i>1.3</i>
Minidoka County	93	7.0
Nez Perce County (District 2)	109	8.2
Shoshone/Bannock Tribal JDC	19	<i>1.4</i>
Twin Falls County (Snake River)	171	12.8

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 1,316 of the juveniles, or 98.5% of all juveniles on whom data were collected, and two booking charges were noted for 244 (18.3%) 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 (40% of the booking charges fit most appropriately in this “Other” category); a large number of these were explicitly noted to be probation violations. Also as seen in Table 2, substantial numbers of juveniles were booked for property crimes (nearly 20%), drug crimes (just over 19%), and crimes against persons (over 15%). Sex crimes were relatively uncommon among booking codes (accounting for 3% of all codes). The research team was unable to confidently classify 32 (just over 2%) 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)	639	40.1
Property crimes	304	19.5
Drug crimes	300	19.2
Crimes against persons	238	15.3
Sex crimes	47	3.0
Unable to classify (e.g., discretionary days)	32	2.1

Note. The percentages in this table are calculated out of the 1,316 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 59% of the juveniles who were screened using the AST met the criteria for having a mental health problem. Also as seen in Table 3, nearly 38% of the juveniles screened with the AST met the criteria for having a substance abuse problem. The 59% figure for the percentage of juveniles who met the AST criteria for having a mental health problem is identical to the five-year average (Y2-Y6; Y1 percentages of mental health and substance abuse problems are excluded from the aggregate analyses because these percentages were much higher than the other years), which was 59% (ranging from a low of 56% in Y6 to a high of 62% in Y3). The 38% figure for the percentage of juveniles who met the AST criteria for having a substance abuse problem is lower than in the previous years (the five-year average was 43%, ranging from a low of 40% in Y6 to a high of 46% in Y2).

Condition	Number of Cases	Percentage of Total Screened Cases
Mental health problem	789	59.1
Substance abuse problem	502	37.6

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

To better understand whether boys and girls appeared to have mental health or substance abuse problems at a similar rate, we analyzed the distribution of diagnoses separately by juvenile gender. We will discuss each type of problem sequentially, beginning with mental health. As seen below in Table 4, over 71% of the girls who were screened using the AST met the criteria for having a mental health problem, whereas nearly 54% 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) = 32.75, $p < .001$. The pattern revealing girls significantly more often meeting the AST criteria for having a mental health problem than boys was also found in all prior years. 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 36% and 40%, respectively, and there was no statistically significant difference in meeting these criteria as a function of gender. The lack of a statistically significant difference between boys and girls in rates of meeting AST substance abuse criteria was also found in all prior years except for 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 six of seven 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	501	250	53.8	71.4
Substance abuse problem	335	140	35.9	40.0

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

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 0% to 78% 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 in Canyon (78% of screened juveniles met the criteria for a mental health problem), Nez Perce (just over 77%), and Twin Falls (over 74%) counties. The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a mental health problem were in Lemhi (0%), Minidoka (nearly 7%), and Bonner (just over 30%) counties. 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) = 233.04, $p < .001$.

JDC Location	Number of Cases	Percentage of Total Screened Cases
Ada County	103	68.7
Bannock County (District 6)	81	69.2
Bonner County	25	<i>30.1</i>
Bonneville County (3B)	74	56.5
Canyon County (Southwest Idaho)	124	78.0
Fremont County (5C)	29	65.9
Kootenai County (District 1)	127	52.5
Lemhi County	0	<i>0.0</i>
Minidoka County	6	<i>6.5</i>
Nez Perce County (District 2)	84	77.1
Shoshone/Bannock Tribal	9	47.4
Twin Falls County (Snake River)	127	74.3

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 JDC with the highest percentages of juveniles meeting the AST criteria for having a substance abuse problem was the Shoshone/Bannock Tribal JDC (where over 63% of the screened juveniles met the criteria for a substance abuse problem), followed by the JDCs in Nez Perce and Bannock (approximately 55% in each) counties. The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a substance abuse problem were in Minidoka (just over 1%), Lemhi (just over 11%), and Bonner (12%) 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) = 142.51, $p < .001$.

Table 6: AST Indications of Substance Abuse Problems by JDC Location		
JDC Location	Number of Cases	Percentage of Total Screened Cases
Ada County	81	54.0
Bannock County (District 6)	64	54.7
Bonner County	10	<i>12.0</i>
Bonneville County (3B)	39	29.8
Canyon County (Southwest Idaho)	63	39.6
Fremont County (5C)	23	52.3
Kootenai County (District 1)	92	38.0
Lemhi County	2	<i>11.1</i>
Minidoka County	1	<i>1.1</i>
Nez Perce County (District 2)	60	55.0
Shoshone/Bannock Tribal	12	63.2
Twin Falls County (Snake River)	55	32.2

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 (nearly 33%) 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 30%) met the AST criteria for a mental health problem only, followed by those who met the criteria for both a mental health problem and a substance abuse problem (over 29%). The smallest group of juveniles (just over 8%) met the criteria for a substance abuse problem only.

Table 7: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both		
Condition	Number of Cases	Percentage of Total Screened Cases
Neither mental health nor substance abuse problem	438	32.8
Mental health problem only	396	29.6
Substance abuse problem only	109	8.2
Both mental health and substance abuse problem	393	29.4

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 at 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) = 35.13, $p < .001$. The largest difference was in rates of meeting the diagnostic criteria for having neither type of problem; boys (at over 36%) were considerably more likely than girls (at nearly 28%) to fall into this category. On the other hand, girls were more likely to meet the criteria for having a mental health problem only with girls (at over 35%) being considerably more likely than boys (at nearly 28%) to fall into this category. Girls were also somewhat more likely to meet the criteria for having both types of problems (at 36%) than boys (at just over 26%). Lastly, boys were found to be somewhat more likely to meet the criteria for having a substance abuse problem only (at nearly 10%) than girls (at 4%). 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 six previous evaluation years. 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	339	86	36.4	27.7
Mental health problem only	258	124	27.7	35.4
Substance abuse problem only	92	14	9.9	4.0
Both mental health and substance abuse problem	243	126	26.1	36.0

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) = 392.04, $p < .001$. 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, Lemhi, Bonner, 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 Bannock, Nez Perce, Ada, and Fremont counties). In the Shoshone/Bannock Tribal JDC, there was a tie for single largest group between those juveniles meeting the criteria for a substance abuse 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 10 of the 12 JDCs (the exceptions were the Shoshone/Bannock Tribal JDC, where juveniles meeting the criteria for a mental health problem was the single smallest group, and 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).

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	18.7 (N = 28)	27.3 (N = 41)	12.7 (N = 19)	41.3 (N = 62)
Bannock County (District 6)	21.4 (N = 25)	23.9 (N = 28)	9.4 (N = 11)	45.3 (N = 53)
Bonner County	67.5 (N = 55)	20.5 (N = 17)	2.4 (N = 2)	9.6 (N = 8)
Bonneville County (3B)	36.6 (N = 48)	33.6 (N = 44)	6.9 (N = 9)	22.9 (N = 30)
Canyon County (Southwest Idaho)	18.2 (N = 29)	42.1 (N = 67)	3.8 (N = 6)	35.8 (N = 57)
Fremont County (5C)	18.2 (N = 8)	29.5 (N = 13)	15.9 (N = 7)	36.4 (N = 16)
Kootenai County (District 1)	39.3 (N = 95)	22.7 (N = 55)	8.3 (N = 20)	29.8 (N = 72)
Lemhi County	88.9 (N = 16)	0.0 (N = 0)	11.1 (N = 2)	0.0 (N = 0)
Minidoka County	93.5 (N = 87)	5.4 (N = 5)	0.0 (N = 0)	1.1 (N = 1)
Nez Perce County (District 2)	12.8 (N = 14)	32.1 (N = 35)	10.1 (N = 11)	45.0 (N = 49)
Shoshone/Bannock Tribal JDC	21.1 (N = 4)	15.8 (N = 3)	31.6 (N = 6)	31.6 (N = 6)
Twin Falls County (Snake River)	16.4 (N = 28)	51.5 (N = 88)	9.4 (N = 16)	22.8 (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 992 juveniles, or 74.3% of all juveniles on whom data were collected (this percentage is higher than in any of the previous years, which ranged from a low of 59% in Y1 to a high of 73% in Y6). The mean number of previous diagnoses for juveniles (of both genders and across the 12 JDCs) with at least one previous diagnosis was 1.29, with a standard deviation of .63 (the number of previous diagnoses was similar to the six-year average, which was 1.24 (ranging from a low of 1.17 in Y3 to a high of the 1.28 in Y4). The range of previous diagnoses for those juveniles for whom at least one previous diagnosis was noted spanned from one to six. In Y7, similar to Y3 and Y4 (but unlike in Y1, Y2, Y5, and Y6), girls (1.40) reported or were identified with significantly more previous diagnoses than boys (1.24), $t(df = 950) = -3.69, p < .001$. The mean number of previous diagnoses differed significantly as a function of JDC location (data from the JDC in Minidoka County were excluded from this analysis because fewer than five juveniles had a documented number of previous diagnoses in each of the three counties), $F(10, 980) = 3.79, p < .001$ (this result is similar to that found in all six previous evaluation years). As seen below in Table 10, the JDCs with the highest number of mean previous diagnoses were those in Fremont (1.48), Nez Perce (1.42), and Canyon (1.40) counties. The JDCs with the lowest number of mean previous diagnoses were in Lemhi (1.06), Bonneville (1.10), and Bonner (1.12) counties.

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	129	1.38	.68
Bannock County (District 6)	98	1.32	.62
Bonner County	6	<i>1.12</i>	.41
Bonneville County (3B)	130	<i>1.10</i>	.29
Canyon County (Southwest Idaho)	158	1.40	.80
Fremont County (5C)	29	1.48	1.02
Kootenai County (District 1)	186	1.15	.46
Lemhi County	18	<i>1.06</i>	.24
Nez Perce County (District 2)	69	1.42	.69
Shoshone/Bannock Tribal JDC	6	1.17	.41
Twin Falls County (Snake River)	162	1.33	.65

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 831 juveniles, or 62.2% of all juveniles on whom data were collected. A new category, ‘diagnosis deferred,’ that was first introduced in Y6, was utilized again in Y7 (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 45 juveniles, or 3.4% 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 (excluding ‘diagnosis deferred’) was 1.44, with a standard deviation of .65. The range of provisional diagnoses for those juveniles for whom at least one provisional diagnosis was noted spanned from one to six. As was the case in all prior years except for Y6, a statistically significant difference in mean number of provisional diagnoses was found to exist between girls (1.59) and boys (1.36), with girls receiving significantly more provisional diagnoses than boys, $t(df = 758) = -4.31, p < .001$. As was the case in all six previous evaluation years, the mean number of provisional diagnoses significantly differed as a function of JDC location, $F(11, 792) = 6.49, p < .001$. As seen below in Table 11, the JDCs with the highest number of mean provisional diagnoses were in Canyon (1.78), Fremont (1.71), and Twin Falls (1.58) counties. The JDCs with the lowest number of mean provisional diagnoses were in Nez Perce (1.06), Minidoka (1.10), and Lemhi (1.11) counties.

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	141	1.41	.67
Bannock County (District 6)	71	1.25	.60
Bonner County	26	1.38	.75
Bonneville County (3B)	107	1.34	.47
Canyon County (Southwest Idaho)	115	1.78	.76
Fremont County (5C)	21	1.71	1.23
Kootenai County (District 1)	150	1.34	.53
Lemhi County	9	<i>1.11</i>	.33
Minidoka County	21	<i>1.10</i>	.30
Nez Perce County (District 2)	16	<i>1.06</i>	.25
Shoshone/Bannock Tribal JDC	9	1.33	.50
Twin Falls County (Snake River)	118	1.58	.63

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 39% of the juveniles for whom a provisional diagnosis was listed were diagnosed with a mood disorder) and a substance abuse disorder (nearly 33% 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 for disruptive behavior disorders and anxiety disorders (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 over 25% of juveniles for whom a provisional diagnosis was listed. The latter was given to over 16% 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 11% of juveniles. Interestingly, the five most common provisional diagnoses in Y7 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)	311	39.1
Substance abuse disorders (e.g., marijuana or alcohol abuse)	262	32.9
Disruptive behavior disorders (e.g., oppositional defiant disorder, disruptive disorder, conduct disorder)	202	25.3
Anxiety disorders (e.g., post-traumatic stress disorder)	130	16.3
Attention deficit disorders (e.g., ADHD/ADD)	87	10.9

Note. The percentages in this table are calculated out of 797 juveniles for whom at least one provisional diagnosis (excluding ‘diagnosis deferred’) 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 1,141 juveniles. This number is higher than the total number of juveniles who received at least one provisional diagnosis (797 juveniles received at least one provisional diagnosis). Of all juveniles who received at least one service recommendation, 744 (or over 65%) were also given at least one provisional diagnosis. The remaining 397 (or nearly 35%) received at least one service recommendation but were not given a provisional diagnosis. Additionally, 53 juveniles (or less than 7% of all juveniles who received a provisional diagnosis) 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 (751) by the number of juveniles who received at least one provisional diagnosis (797). The resulting figure is 94.2%, meaning approximately 94% 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 1.52, with a standard deviation of .92. The range of recommended services for those juveniles for whom at least one recommended service was noted spanned from one to 11. Unlike in Y1 and Y3-Y6, but similar to Y2, no statistically significant difference in the number of recommended services was found between girls and boys (the mean number of recommended services was 1.55 for girls and 1.53 for boys). However, similar to all six previous evaluation years, the mean number of recommended services was found to differ significantly as a function of JDC location, $F(11, 1,129) = 33.47, p < .001$. As seen below in Table 13, the JDC with the highest number of mean recommended services was in Bannock County (2.25), followed by the JDCs in Twin Falls (2.32) and Nez Perce (1.49) counties. The JDC with the lowest number of mean recommended services was in Bonneville County (1.09), followed by the JDCs in Minidoka and Fremont (1.16 in each) counties.

Table 13: Number of Recommended Services by JDC Location			
JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	149	1.20	.42
Bannock County (District 6)	111	2.25	1.49
Bonner County	34	1.32	.47
Bonneville County (3B)	128	<i>1.09</i>	.29
Canyon County (Southwest Idaho)	159	1.38	.54
Fremont County (5C)	43	<i>1.16</i>	.37
Kootenai County (District 1)	186	1.23	.55
Lemhi County	17	1.29	.69
Minidoka County	19	<i>1.16</i>	.50
Nez Perce County (District 2)	108	1.49	.70
Shoshone/Bannock Tribal JDC	17	1.35	.61
Twin Falls County (Snake River)	170	2.32	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 1,141 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 recommendation given was for continuation of prior treatment (over 36% of juveniles for whom a recommended service was listed were either already in treatment or recommended to continue prior treatment), followed by recommendations for individual counseling (nearly 30%), substance abuse counseling/treatment (nearly 25%), and psychological/mental evaluation (nearly 19%). Smaller numbers of recommendations were made for residential treatment (6%), family counseling (nearly 5%), psychosocial rehabilitation, medication evaluation, and DJC commitment (approximately 1% for each). Additionally, recommendations for other services (e.g., contact probation or courts, contact family) were given for over 18% of juveniles for whom a recommended service was listed.

Service Recommendation	Number of Cases	Percentage of Total Cases
Continue (unspecified) prior treatment/Already in treatment	414	36.3
Individual counseling (e.g., Cognitive Behavioral Therapy)	337	29.5
Substance abuse counseling/treatment	284	24.9
Psychological/mental evaluation	212	18.6
Residential treatment	68	6.0
Family counseling	55	4.8
Psychosocial rehabilitation	13	1.1
Medication evaluation	11	1.0
DJC commitment	10	0.9

Note. The percentages in this table are calculated out of the 1,141 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 had been accessed. The clinicians reported that 725 juveniles, or nearly 64% of the 1,141 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 and accessed at least one recommendation, was 1.45, with a standard deviation of .81. The range of recommended services accessed for those juveniles for whom at least one recommended service accessed was noted spanned from one to nine (approximately 37% of the juveniles receiving at least one service recommendation had not yet accessed a service). However, similar to all six previous evaluation years, the mean number of recommended services accessed differed significantly as a function of JDC location, $F(11, 634) = 11.01, p < .001$. As seen below in Table 15, the JDC with the highest number of mean recommended services accessed was in Twin Falls County (1.90), followed by the JDCs in Bannock (1.84) and Canyon (1.34) counties. The JDCs with the lowest number of mean recommended services accessed were the JDC in Lemhi County and the Shoshone/Bannock Tribal JDC (1.13 in each), followed by the JDC in Ada County (1.14).

JDC Location	Number of Cases	Mean	Standard Deviation
Ada County	127	<i>1.14</i>	.35
Bannock County (District 6)	105	1.84	1.19
Bonner County	24	1.29	.46
Bonneville County (3B)	23	1.30	.47
Canyon County (Southwest Idaho)	108	1.34	.51
Fremont County (5C)	18	1.22	.43
Kootenai County (District 1)	110	1.21	.49
Lemhi County	15	<i>1.13</i>	.35
Minidoka County	7	1.29	.76
Nez Perce County (District 2)	42	1.29	.46
Shoshone/Bannock Tribal JDC	8	<i>1.13</i>	.35
Twin Falls County (Snake River)	138	1.90	1.08

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 333 calls were placed by the callers from the IFF, 111 of which were successful (i.e., they resulted in a survey completion by a parent), yielding a 33% response rate. Parenthetically, the callers from the IFF placed additional 90 calls; however, these calls were excluded from the analysis because there either was no response (23 cases) or the number was invalid (67 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 111 parents who completed a survey answered this question. Of these parents, 40 (or just over 36%) responded “Yes” that they had been contacted by the JDC clinician. 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.

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 39 parents who completed this item, 23 (or 59%) reported that they had received recommendations for services 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 26 parents reported at least one service recommendation. As seen below in Table 16, the most commonly reported recommendations, made for nearly half (or over 46%) of the youth for whom a recommended service was reported, were for counseling (unspecified, mental health, or family counseling) for the juveniles. Four parents (or 15%) reported that they could not remember what service or services had been recommended for their child, and another four (or 15%) reported receiving a recommendation for a service that was not easily classifiable (e.g., court order, YMCA, etc.).

Table 16: Most Commonly Received Service Recommendations		
Service Recommendation	Number of Cases	Percentage of Total Cases
Counseling (unspecified, mental health, family)	12	46.2
Can't remember	4	15.4
Other (e.g., trial program, court ordered, YMCA)	4	15.4
Continue previous treatment	3	11.5
Substance abuse treatment or assessment	2	7.7
Mental health evaluation	2	7.7

Note. The percentages in this table are calculated out of the 26 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 21 parents who completed this item, 19 (or nearly 91%) reported that their child had accessed at least one recommended service.

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. Both parents who reported that their child had not accessed at least one recommended service provided a response to this question, neither of which included barriers to access. One indicated that the child refused to access or use the recommended service, and the other stated that the child had already received the recommended service (i.e., mental health evaluation).

Judges and Probation Officers Survey

As discussed earlier in this report, the third phase of data collection involved a survey of judges and CJPOs 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 CJPOs were considered very important. The judges'/CJPOs' 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/CJPOs were also asked to indicate the region in which they work or have contact with juveniles and their profession (judge, CJPO, or other). A total of 94 respondents completed this survey (a response rate could not be calculated because an unspecified number of invitations were unexpectedly extended to individuals other than judges or CJPOs); their responses are discussed below.

Demographic Information

Of the 94 respondents who completed this survey, 23 (or 25.5%) identified themselves as judges and 71 (or 75.5%) identified themselves as either a CJPO or other (because invitation to complete a survey was unexpectedly extended to some individuals who were neither a judge nor a CJPO, the responses to this year's judges/CJPOs survey are grouped into two categories, those provided by 'judges' and those provided by 'CJPOs and others working with juveniles').

As seen below in Table 17, judges, CJPOs, and others working with juveniles in Region 1 (nearly 27%) accounted for the largest percentages of respondents, followed by those in Region 4 (over 20%) and Region 3 (nearly 14%). On the other hand, judges, CJPOs, and those working with juveniles in Region 2 (over 6%) accounted for the smallest percentage of respondents, followed by those in Region 7 (nearly 9%) and Region 6 (nearly 12%).

Region	Number of Respondents	Percentage of Total Respondents
Region 1 (Bonner and Kootenai counties)	25	26.6
Region 2 (Nez Perce County)	6	<i>6.4</i>
Region 3 (Canyon County)	13	13.8
Region 4 (Ada County)	19	20.2
Region 5 (Minidoka and Twin Falls counties)	12	12.8
Region 6 (Bannock County)	11	<i>11.7</i>
Region 7 (Bonneville, Fremont, and Lemhi counties)	8	8.5

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.

Program Awareness

The first item on the survey simply asked the judges, CJPOs, and others working with juveniles whether or not they were aware that the closest JDC had a mental health clinician in the past year. Of the 94 respondents who completed this item, 90 (or nearly 96%) reported that they were aware that the closest JDC had a clinician in it. A statement on the survey informed those who responded “No” to this first question that they were not required to complete the remaining items, and to simply return the survey as it was. Judges, CJPOs, and other working with juveniles who responded “Yes” were asked to complete the next item.

Satisfaction with Contact

The second item on the survey asked the judges, CJPOs, and others working with juveniles whether they had been contacted by the JDC clinician regarding one of the juveniles they worked with. Of the 90 respondents who completed this item, 73 (or just over 81%) reported that they had been contacted by the JDC clinician about at least one of their juveniles. 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. Those who responded “Yes” were asked to complete the remaining items.

Those judges, CJPOs, and others working with juveniles who reported having been contacted by the JDC clinician about at least one of the youth they were working with were asked to indicate how satisfied they were with this contact. They were asked to indicate their satisfaction on a five-point Likert-type scale with values ranging from 1 = Very Dissatisfied to 5 = Very Satisfied. As seen below in Table 18, nearly 95% of the respondents who completed this item reported being very satisfied (nearly 59%) or satisfied (nearly 36%) with the contact with the JDC clinician. Of those who did not report satisfaction with contact from the JDC clinician, three were neither satisfied nor dissatisfied, with just one being dissatisfied.

Item	Very Dissatisfied	Dissatisfied	Not Satisfied or Dissatisfied	Satisfied	Very Satisfied
How satisfied were you with the contact you had with the mental health clinician?	0.0% (N = 0)	1.4% (N = 1)	4.1% (N = 3)	35.6% (N = 26)	58.9% (N = 43)

Note. The percentages in this table are calculated out of the 73 judges/others working with juveniles 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.

Similar to Y6, when the difference between judges and CJPOs was systematically examined for the first time, no statistically significant differences in the level of satisfaction with contact with JDC clinician were found between judges and CJPOs and others working with juveniles. However, and also similar to Y6, a statistically significant differences were found as a function of region, $F(6, 66) = 4.90, p < .001$. On average, judges, CJPOs, and others working with juveniles in Region 1, Region 4, Region 5, and Region 6 reported being significantly more satisfied with contact with the JDC clinician than those in Region 2. Judges, CJPOs, and others working with juveniles in Region 1 also reported being significantly more satisfied with this contact than those in Region 3. As seen in Table 19 below, Region 1 was the region with the highest levels of satisfaction with this contact (4.86), followed by Region 5 (4.70) and Region 6 (4.60). The region with the lowest levels of satisfaction was Region 2 (3.50), followed by Region 3 (4.00) and Region 7 (4.17).

Region	Mean	Standard Deviation
Region 1	4.86	.48
Region 2	<i>3.50</i>	1.29
Region 3	<i>4.00</i>	.63
Region 4	4.50	.52
Region 5	4.70	.48
Region 6	4.60	.52
Region 7	<i>4.17</i>	.41

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.

The third item asked the judges, CJPOs, and others working with juveniles whether they received recommendations from the JDC clinicians to help youth with mental health or substance abuse problems. Of the 73 respondents who completed this item, 69 (or nearly 95%) reported that they had received such recommendations. All respondents 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 91% of the judges, CJPOs, and others working with juveniles who completed this item reported being either satisfied (just over 39%) or very satisfied (just over 52%). Of those who did not report

satisfaction with recommendations from the JDC clinician, six (or nearly 9%) were neither satisfied nor dissatisfied and none reported 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)	0.0% (N = 0)	8.7% (N = 6)	39.1% (N = 27)	52.2% (N = 36)

Note. The percentages in this table are calculated out of the 69 judges, CJPOs, and others working with juveniles 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.

Again, similar to Y6, no statistically significant differences in the level of satisfaction with recommendations received from the JDC clinician were found between judges and CJPOs and others working with juveniles. However, and also similar to Y6, statistically significant differences were found as a function of region, $F(6, 62) = 4.86, p < .001$. On average, judges, CJPOs, and others working with juveniles in Region 1 and Region 5 reported being significantly more satisfied with recommendations received from the JDC clinician than those in Region 3. Judges, CJPOs, and others working with juveniles in Region 1 also reported being significantly more satisfied with these recommendations than those in Region 2. As seen in Table 21 below, Region 1 was the region with the highest levels of satisfaction with this contact (4.81), followed by Region 5 (4.60) and Region 6 (4.50). The region with the lowest levels of satisfaction was Region 3 (3.60), followed by Region 2 (3.75) and Region 7 (4.17).

Region	Mean	Standard Deviation
Region 1	4.81	..51
Region 2	3.75	.96
Region 3	<i>3.60</i>	.55
Region 4	4.31	.48
Region 5	4.60	.52
Region 6	4.50	.53
Region 7	<i>4.17</i>	.75

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.

The fourth item asked the judges, CJPOs, and others working with juveniles 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 69 respondents who completed this item, 57 (or nearly 83%) reported that the recommendations they received had affected a decision or treatment advised for the youth.

No statistically significant differences in whether recommendations received from the JDC clinicians affected any of the decisions or treatment they advised for the youth were found between judges and CJPOs and others working with juveniles, χ^2 (df = 1) = 3.37, $p = .07$. However, as seen in Table 22 below, whereas all judges indicated that the recommendations received from the JDC clinicians affected the decisions or treatment they advised for the youth, less than 79% of CJPOs and others working with juveniles agrees that these recommendations affected the decisions or treatment they advised for the youth.

Recommendation from JDC Clinician Affected Decision or Treatment Advised for the Youth	Profession			
	Number of Cases		Percentage of Total Screened Cases	
	Judge	Other	Judge	Other
Yes	13	44	100.0	78.6
No	0	12	0.0	21.4

Note. The percentages in this table are calculated out of the judges, CJPOs, and others working with juveniles who indicated whether recommendations received from the JDC clinician affected the decisions or treatment they advised for the youth.

The fifth item on the survey asked the judges, CJPOs, and others working with juveniles how beneficial they thought it was to have a clinician in the nearest JDC. They 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 in Table 23 below, the majority (nearly 72%) of the judges, CJPOs, and others working with juveniles who completed this item reported thinking it was extremely beneficial to have a clinician in the nearest JDC, and another 21% reported it to be rather beneficial, yielding the overall rate of 93%. Of those who did not report thinking that it was beneficial to have a clinician in the JDCs, five (or 7%) reported a neutral option and none 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)	0.0% (N = 0)	7.0% (N = 2)	21.1% (N = 15)	71.8% (N = 51)

Note. The percentages in this table are calculated out of the 43 judges, CJPOs, and others working with juveniles 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.

Once again, similar to Y6, no statistically significant difference in how beneficial they felt it was to have a clinician in the nearest JDC was found between judges and CJPOs and others working with juveniles. However, and also similar to Y6, a statistically significant differences were found as a function of region, $F(6, 64) = 7.00$, $p < .001$. On average, judges, CJPOs, and others working with juveniles in Region 1, Region 4, and Region 5 reported being significantly more

satisfied with recommendations received from the JDC clinician than those in Region 2 and Region 3. Judges, CJPOs, and others working with juveniles in Region 1 also reported being significantly more satisfied with these recommendations than those in Region 6. As seen in Table 24 below, Region 1 was the region with the highest levels of satisfaction with this contact (5.00), followed by Region 5 (4.80) and Region 4 (4.73). The region with the lowest levels of satisfaction was Region 2 (3.75), followed by Region 3 (3.80) and Region 6 (4.40).

Region	Mean	Standard Deviation
Region 1	5.00	.00
Region 2	<i>3.75</i>	.96
Region 3	<i>3.80</i>	.84
Region 4	4.73	.46
Region 5	4.80	.42
Region 6	<i>4.40</i>	.70
Region 7	<i>4.67</i>	.52

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.

The final item on the survey asked the judges, CJPOs, and others working with juveniles whether they would like to see the program housing clinicians in the JDCs continue. Sixty-nine (or nearly 99%) of the 70 respondents who completed this item reported that they would like to see the CSP continue. This approval rate was higher than in any of the previous years, which ranged from 92% in Y1 to 97% in Y4 (the only exception is Y2, when the approval rate was 100%).

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 and Y7 evaluations: 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 indications 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 Y7 juveniles, an association between gender and traumatic experiences. As seen below in Table 25, whereas over 34% of girls screened positive for traumatic experiences on the MAYSI-2, fewer than 25% of boys did so. Similar to Y5 and Y6, this difference was found to be statistically significant in Y7, χ^2 (df = 1) = 12.19, $p < .001$.

MAYSI-2 Indication	Gender			
	Number of Cases		Percentage of Total Screened Cases	
	Male	Female	Male	Female
Positive screen for traumatic experiences	229	121	24.5	34.2
Negative screen for traumatic experiences	706	233	75.5	65.8

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 26, whereas over 78% of juveniles who screened positive for traumatic experiences screened positive for a mental health problem, fewer than 53% of juveniles who screened negative for traumatic experiences did so. Once again, similar to Y5 and Y6, this difference was found to be statistically significant, χ^2 (df = 1) = 77.03, $p < .001$.

MAYSI-2 Indication	AST Indication			
	Number of Cases		Percentage of Total Screened Cases	
	No MH Problem	MH Problem	No MH Problem	MH Problem
Positive screen for traumatic experiences	78	278	21.9	78.1
Negative screen for traumatic experiences	467	520	47.3	52.7

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 = 63.99, $p < .001$) emerging as a stronger predictor than gender (Wald = 24.37, $p < .001$). Odds ratios calculated within this model showed that juveniles who screened positive for traumatic experiences were 3.2 times more likely to screen positive for a

mental health problem than those who screened negative for traumatic experiences (this finding is identical to the 3.2 odds ratio found in Y5, and similar to the 3.5 odds ratio found in Y6), and that girls were 2.0 times more likely to screen positive for a mental health problem than boys (this finding is similar to the 1.7 odds ratios found in Y5 and Y6).

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 438 juveniles who met the AST criteria for neither a mental health nor a substance abuse problem, 59% (or 257 juveniles) had at least one booking charge that could be classified as one of the four UCR categories (two booking charges were noted for only five or just over 1% of juveniles who met the AST criteria for neither a mental health nor a substance abuse problem). Of the 898 remaining juveniles (those who met the AST criteria for a mental health problem, a substance abuse problem, or both types of problems), 60% (or 536 juveniles) had at least one booking charge that could be classified as one of the four UCR categories (two booking charges were noted for 24 or less than 3% of juveniles who met the AST criteria for a mental health problem, a substance abuse problem, or both types of problems). As seen in Table 27 below, the majority of juveniles who met the AST criteria for neither type of problem were booked on property crime charges (nearly 41%), 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 drug crime charges (nearly 23%). Only a small percentage of juveniles in either group were booked on sex crime charges.

Condition	Booking Charge			
	Drug Crime	Property Crime	Crime Against Persons	Sex Crime
Neither MH nor SA problem	37.4 (96)	40.5 (104)	23.7 (61)	7.0 (18)
All other diagnostic categories combined (MH problem only, SA problem only, or both)	22.7 (204)	22.3 (200)	19.7 (177)	3.2 (29)

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 actual numbers of juveniles are presented in parentheses. The highest row percentage is presented in bold, and the lowest row percentage is presented in italics.

Unlike in Y6 and Y5, when no statistically significant association was found between the type of booking charge and the type of the AST diagnosis, a chi-square test revealed a statistically

significant association between these two variables in Y7, χ^2 (df = 3) = 8.05, $p < .05$ (this analysis was limited to the first booking charge only). As seen in Table 28 below, juveniles who met the AST diagnostic criteria for a mental health problem, a substance abuse problem, or both types of problems were more likely to be booked for crimes against persons (just over 33%) than those who met the AST criteria for neither a mental health nor a substance abuse problem (just over 23%). Conversely, those juveniles who met the AST diagnostic criteria for neither types of problems were more likely to be booked for drug crimes (over 33%), crimes against property (over 36%), and sex crimes (over 7%) than those who met the AST criteria for one, the other, or both types of problems (31%, nearly 32%, and nearly 6%, respectively).

Condition	Booking Charge			
	Drug Crime	Property Crime	Crime Against Persons	Sex Crime
Neither MH nor SA problem	33.3 (82)	36.2 (89)	23.2 (57)	7.3 (18)
All other diagnostic categories combined (MH problem only, SA problem only, or both)	31.0 (234)	31.5 (160)	33.1 (168)	5.5 (28)

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 actual numbers of juveniles are presented in parentheses.

When we analyzed how booking charges were distributed across all four diagnostic categories (this analysis was also limited to the first booking charge only), a chi-square test revealed a statistically significant association between the type of booking charge and the AST diagnostic category, χ^2 (df = 9) = 116.14, $p < .001$. As seen in Table 29 below, juveniles who were booked on drug crime charges were most likely to meet the AST criteria for a substance abuse problem (nearly 38%) and least likely to meet the criteria for a mental health problem (over 10%). Those who were booked on property crime charges were most likely to meet the AST criteria for neither a substance abuse nor a mental health problem (nearly 36%) and least likely to meet the criteria for a substance abuse problem (just over 7%). Juveniles who were booked on crimes against persons and sex crimes were most likely to meet the AST criteria for a mental health problem (approximately 50% each) and least likely to meet the criteria for a substance abuse problem (just over 3% and over 4%, respectively).

Booking Charge	AST Diagnostic Category			
	Neither Problem	MH Problem	SA Problem	Both Problems
Drug crime	35.0 (82)	<i>10.3</i> (24)	17.1 (40)	37.6 (88)
Property crime	35.7 (89)	29.3 (73)	7.2 (18)	27.7 (69)
Crime against person	25.3 (57)	49.8 (112)	3.1 (7)	21.8 (49)
Sex crime	39.1 (18)	50.0 (23)	4.3 (2)	6.5 (3)

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 four (Bonner, Fremont, Lemhi, and Minidoka) 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). Unlike in Y6 and Y5, when no statistically significant association was found between the type of county and the rate at which at least one recommended service was accessed by juveniles, a chi-square test revealed a statistically significant association between these two variables in Y7, χ^2 (df = 1) = 88.36, $p < .001$. As seen in Table 30 below, juveniles released from JDCs in urban counties (nearly 61% of juveniles residing in an urban county accessed at least one recommended service) were statistically significantly more likely to access at least one recommended service than those released from JDCs in rural or frontier counties (28%).

Type of County	Recommended Services Accessed	
	Number of Cases	Percentage of Cases
Urban	653	60.5
Rural/Frontier	72	28.0

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

Next, we analyzed whether the rate at which at least one recommended service was accessed varied across counties. As seen in Table 31 below, there was a large spread of percentages of juveniles by county who accessed at least one recommended service, ranging from less than 8% to nearly 90%. The three counties housing JDCs with the highest percentage of juveniles who accessed at least one recommended service were Bannock (where nearly 90% of juveniles accessed at least one recommended service), Ada (nearly 85%), and Lemhi (over 83%). The three counties housing JDCs with the lowest percentages of juveniles who accessed at least one recommended service were Minidoka (less than 8%), Bonneville (nearly 18%), and Bonner (nearly 29%). In Y7, similar to Y6 and Y5, 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) = 378.65, $p < .001$.

County	At Least One Recommended Service Accessed	
	Number of Cases	Percentage of Cases
Ada County	127	84.7
Bannock County	105	89.7
Bonner County	24	<i>28.9</i>
Bonneville County	23	<i>17.6</i>
Canyon County	108	67.9
Fremont County	118	40.9
Kootenai County	110	45.5
Lemhi County	15	83.3
Minidoka County	7	<i>7.5</i>
Nez Perce County	42	38.5
Shoshone/Bannock Tribal JDC	8	42.1
Twin Falls County	138	80.7

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

Finally, an analysis of regional variations 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 in Table 32 below, the three regions housing JDCs with the highest percentages of juveniles who accessed at least one recommended service were Region 6 (where nearly 90% of juveniles accessed at least one recommended service), Region 4 (nearly 85%), and Region 3 (nearly 68%). The three regions housing JDCs with the lowest percentages of juveniles who accessed at least one recommended service were Region 7 (29%), Region 2 (nearly 39%), and Region 1 (just over 41%). In Y7, similar to Y6 and Y5, 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) = 211.03, $p < .001$.

Table 32: At Least One Recommended Service Accessed, by Region		
Type of County	At Least One Recommended Service Accessed	
	Number of Cases	Percentage of Cases
Region 1	134	<i>41.2</i>
Region 2	42	<i>38.5</i>
Region 3	108	67.9
Region 4	127	84.7
Region 5	145	<i>54.9</i>
Region 6	105	89.7
Region 7	56	<i>29.0</i>
Shoshone/Bannock Tribal JDC	8	<i>42.1</i>

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

Additional Analysis 4: Judges/CJPOs Survey

In Y7, similar to Y6 and Y5, several additional analyses of the judges/CJPOs 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 Y7, similar to Y6 and Y5, statistically significant differences on the first two items listed above were found between judges, CJPOs, and others working with juveniles who reported that recommendations made by the clinicians had affected their decisions or treatments advised and those who reported that it had not. As seen in Table 33 below, 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 ($M = 4.61$, $SD = .56$) than those reporting that recommendations had not affected a decision or

treatment advised ($M = 4.17$, $SD = .94$), $t(67) = 3.51$, $p < .05$. As also seen in Table 33 below, respondents reporting that recommendations had affected a decision or treatment advised were significantly more satisfied with recommendations made by the clinician ($M = 4.56$, $SD = .57$) than those reporting that recommendations received had not affected a decision or treatment advised ($M = 3.83$, $SD = .72$), $t(67) = 3.85$, $p < .001$. However, unlike in Y6 and Y5, when a statistically significant difference in the degree to which they thought it beneficial to have a mental health clinician in the detention centers was found between these two groups, no statistically significant difference was found in Y7.

Table 33: Judges/CJPOs Ratings of Contact with JDC Clinicians, Clinicians' Recommendations, and Program's Value, by whether Recommendations Affected Decisions or Recommendation Advised for Youth		
Perception of Program Element	Recommendations Affected Decisions or Recommendations Advised for Youth	
	Yes	No
Satisfaction with contact	4.61 (.56)	4.17 (.94)
Satisfaction with recommendations from JDC clinicians	4.56 (.57)	3.83 (.72)
How beneficial is it to have a clinician in the JDCs	4.70 (.57)	4.36 (.81)

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

Next, content analyses of the three open-ended survey items were conducted. First, comments provided by the 12 respondents who indicated that the recommendations from JDC clinicians had not affected any of the decisions or treatments they advised for the youth were analyzed. When asked why these recommendations did not affect their decisions or treatment advised, 10 CJPOs and others working with juveniles (none of the judges indicated that the recommendation from JDC clinicians had not affected their decisions or treatments they advised for the youth) provided a comment. Most respondents indicated that the recommendations received from clinicians did not contribute new insight (e.g., "They were consistent with what we were planning and doing, and were more of a validation of our strategy," and "They didn't offer any new information, they just confirmed what we already knew") or that youth were already receiving the recommended services. However, several respondents expressed that having a clinician make the same type of recommendations was validating even if the recommendations received from clinicians did not yield any new insights. One respondent indicated that he or she and the clinician were working together and making all decisions about the youth jointly, suggesting that that the JDC clinician and the CJPO are always "on the same page." One respondent remarked that most of the time they were already working on mental health issues in the treatment plan, but that there were some occasions when the clinician "recommends

something outside of what we are doing such as a complete psych eval, but for the most part we are already doing the things recommended in the case plan.”

Subsequently, comments provided by 58 judges, CJPOs, and others working with juveniles (or approximately two-thirds of those who indicated that they were aware that the nearby detention center had mental health clinician) in response to the item asking 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. The vast majority of respondents (nearly 88%) provided positive comments about the program, many stating that having a mental health clinician was extremely beneficial or even indispensable. Some of their responses are shared in bullet points below:

- It is a great resource to have a mental health professional right in detention so the kids can speak to someone promptly as needed. [The clinician] provides good resources and is good at collaboration
- Having a clinical in detention is helpful because they are able to identify and find treatment for juveniles with mental health disorders and either shorten their stay in detention or prevent future chances of incarceration
- [The clinician] is absolutely instrumental in assisting with connecting juvenile clients and their parents to mental health, community and chemical dependency services. She has firsthand contact through interviews with the juvenile and her knowledge and experience is absolutely indispensable
- Often it is the first time youth get a chance to meet with a counselor and they then can see its benefits
- They have knowledge and experience that us probation officers do not have and it is vital to the treatment/supervision of our youth. They offer a level of skills that we need to do our jobs and they get a lot of firsthand experience with our youth and youth tend to share a lot of valuable information with them
- The clinician services at the juvenile detention center allow the probation officers to recommend appropriate service to the judge. Our clinician recommendations are invaluable to our rural community with limited services
- The assessment is an invaluable tool in helping us to identify areas that need to be addressed in our work with juveniles. Our mental health clinician has a good knowledge of community based, regional and some state resources and is definitely an essential part of the team that works to help to create a plan to help young people be successful
- Provides valuable insight that direct line staff may miss in regards to risk to offender and staff. Provides hands on clinical intervention and recommendations. Training provided monthly in various mental health issues including how to work with offenders families with mental health needs
- On the spot, real time information about the juvenile, usually in a moment/time of crisis. Gives me a good picture of what is going on with the juvenile when they have deteriorated to a point of placement into detention.
- We judges are not equipped to handle juveniles with mental health issues without this very valuable resource

As seen from the comments provided above, judges, CJPOs, and other working with juveniles believed that the services clinicians provide are invaluable in several areas such as:

- Training the line staff and providing them with information they need to interact with youth with high need in the best and safest ways
- Being available to the youth to talk about the feelings and problems they may be experiencing
- Providing firsthand information about youth to probation officers and judges
- Providing information about resources and services available to youth and their families
- Completing a mental health assessment with youth, identifying mental health problems, and recommending appropriate treatments and services

Several respondents emphasized the importance of having a mental health clinician in juvenile detention centers considering the high prevalence of mental health problems among youth in detention, some even remarking how “each year there seems to be more and more youth with mental health issues.” Acknowledging the high need of youth in detention centers, several respondents highlighted this service as a “great tool” particularly because “detention staff do not have the training or education to deal with the trauma and drama these youth bring with them.”

Six respondents (or approximately 10%) provided comments that are best described as neutral, with most respondents commenting that it would be beneficial for a clinician to offer actual treatment services to youth while in detention. Some of their responses are shared in bullet points below:

- I would like to see our mental health clinician work more with the kids to offer treatment for them while they are in detention. It seems they do an assessment, then discontinue there meetings.
- I feel the clinician is a very valuable resource. However, I do not feel we are using the position to the fullest. We could be partnering up and possibly run or do more in depth mental health assessments.
- Having a mental health professional in our detention center is amazing. However, it would seem more effective to have that person conduct treatment (drug/alcohol groups, anger management groups) while the kids are in detention rather than just checking a couple treatment recommendation boxes and submitting it to the JPO when the juvenile is released.
- It would be helpful if full diagnosis were done for youth participating in the clinician project and then collaboration with Children's Mental Health was done to seek services to match the need. Currently recommendations are passed on to probation to follow up with obtaining those resources and services.

One respondent had a rather negative perception of the CSP program, remarking that in his or her view too much money is being paid “to contract with a clinician who only comes in and sees a juvenile for a very short amount of time, like 5-10 minutes, within 24 hours of the juvenile being brought in,” and adding, “There is no real program. The juvenile is given a MAYSI by way of computer, from detention staff and then if they are suicidal detention staff follows appropriate protocol, prior to the clinician seeing the juvenile. There are usually no other services provided from the clinician, other than a self-generated, generic letter to parents recommending either mental health assessments or substance abuse assessments.”

Finally, content analysis was conducted on the written comments 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 73 respondents who indicated that they had been contacted by a mental health clinician, 27 (or nearly 37%) provided a comment when asked whether they had any recommendations that would help improve the mental health services in detention centers. Of the 27 respondents who provided written comments, 10 reiterated the importance of the having a mental health specialist in a detention center and commended the work that the clinician in their respective country is doing. Of the remaining 17 respondents, 10 recommended program expansion and an increase in funding to allow clinician to spend more hours working with youth (e.g., “Additional hours so that they would be available more to provide information to the POs and parents,” “Funding levels for all juvenile detention center to be able to employ at least one fulltime clinician, and “Having a clinician available (physically present) on weekends!”) and start providing treatment services to youth while in detention (e.g., “More money to fund treatment providers to allow treatment and evaluation to take place within the detention center” and “Provide mental health classes (stress reduction, coping skills, etc.) to educate the juveniles that their mental health is just as important as their physical health). Five respondents emphasized the importance of having different parts of the system (e.g., Health and Welfare and Children’s Mental Health) work collaboratively with JDC clinicians to ensure the best possible outcomes for high need youth (e.g., “There needs to be a process to bring H&W into the detention center to have children hospitalized rather than leaving them in detention due to their mental health problems,” “Suicidal youth are referred to Children's Mental Health for risk assessment, it might speed things up regarding putting safety plans in place if detention clinicians could perform these suicide risk assessments,” and “Collaboration with H&W so that when the home environment is in part or whole the issue, there can be wraparound services. If all parties are communicating well this service can be done more efficiently.” Of the remaining two respondents who provided recommendations, one suggested that more guidance should be attached to dollars being spent on the program in an effort to standardize the services clinicians provide across detention centers and the other noted that “Clinicians need to know more about the legal process in the juvenile justice world” and added that clinicians could benefit from “getting some background on juveniles before making a recommendation” from other sources rather than basing the recommendation solely on the information they obtain from the juveniles themselves.

Additional Analysis 5: Exploration of MAYSI-2 Subscale Indications as Predictors of AST Mental Health and Substance Abuse Diagnoses

A new addition to the Y7 evaluation included a set of analyses designed to test whether indications on the MAYSI-2’s subscales other than Traumatic Experiences were significantly associated with AST mental health and substance abuse diagnoses. As discussed earlier in this report, Traumatic Experience subscale indications have already been tested, in Y5-Y7, for association with AST mental health diagnoses. The extent to which MAYSI-2 subscale indications are associated with AST diagnoses seems important, as the MAYSI-2 (as described earlier in the Methodology section of this report) is a self-administered instrument completed at intake by detained juveniles, whereas the AST (though it was created for self-report) is ordinarily completed by JDC clinicians as part of a semi-structured clinical interview with the juveniles in the days following intake. If it was found that the MAYSI-2 subscale indications could strongly

predict AST provisional diagnoses, it might be perceived that the administration of the AST was redundant or superfluous (i.e., if the MAYSI-2 indications strongly predicted AST diagnoses, it might make sense to rely on MAYSI-2 indications alone). Contrarily, if it was found that MAYSI-2 subscale indications were not strong predictors of AST diagnoses, the added benefit of the AST administration would be supported.

A detailed analysis, included as Appendix A, was conducted to determine the extent to which MAYSI-2 indications (i.e., whether juveniles met the scoring criteria for the presence of issues on the seven subscales, for example angry/irritable, depression anxiety, or somatic complaints) were associated with AST provisional diagnoses. Generally, it was found that MAYSI-2 indications included a large number of ‘false negatives’ relative to AST mental health diagnoses; in other words, the MAYSI-2 subscale indications often failed to detect mental health problems later identified by clinicians using the AST as part of a clinical interview (this was particularly true for the MAYSI-2 Thought Disturbance, Depression/Anxiety, and Somatic Complaint subscales). In fact, it was found that the clinician-administered AST generally identified two to three times as many mental health problems as the MAYSI-2. The MAYSI-2 Alcohol/Drug Problem subscale also failed to detect many substance abuse problems later identified by clinicians using the AST as part of a clinical interview. These results seem to validate the importance of clinicians using the AST as part of clinical interviews with juveniles detained in Idaho’s JDCs. If the self-administered MAYSI-2 was used alone to screen for mental health and substance abuse problems, a large number of juveniles who have these problems would go unidentified and the prevalence of these problems would be underreported.

Summary and Conclusions

The material in this report describes the results of the seven-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., 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 seven years of evaluations of the CSP, methodological improvements have been made that 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 Y7 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 Y7 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; 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 Y6 and 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 30 juveniles for whom multiple data entries were provided were excluded from the analysis, which resulted in the exclusion of a total of 62 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, Y5, and Y6 datasets, anticipated and corrected for the problem in the Y7 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 Y7.

No changes were made to the second wave data collection process between Y6 and Y7. However, although the same data collection process that was used in the five preceding evaluation years (Y2-Y6) was used in Y7, the number of calls that resulted in a completed survey was relatively low in this year (111 completed surveys in Y7, compared to the five-year

average of 202 completed surveys, ranging from a low of 60 in Y5, when a smaller number of parents were called, to 311 in Y4; a telephone survey method was not used in Y1).

The methodology for data collection for the Judges'/CJPOs' survey did not change between Y6 and Y7 (a mail survey method was used in Y1-Y4 and the survey questions were slightly modified in Y6 to allow for collection of some elementary demographic data, including respondents' profession and the region in which they work/have contact with juveniles). A total of 94 judges, CJPOs, and others working with juveniles completed a survey in Y7 (a comparison to the previous years is not feasible because the judges/CJPOs survey was completed by a number of individuals working with juveniles who were neither a judge nor a CJPO). The response rate for Y7 could not be calculated either because invitation to complete survey was unexpectedly forwarded to a number of persons other than judges and CJPOs.

Several additional analyses utilizing already existing data were conducted in Y7. 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 in Y5 and Y6 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. Wave three data were also used to explore whether there were any systematic variations in the responses of judges and CJPOs as a function of several factors, including two demographic factors (profession and region in which they worked). A set of new analyses added to the Y7 evaluation explored whether significant associations existed between indications on the MAYSI-2's subscales other than Traumatic Experiences and AST mental health indications.

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-Y7 shows that these figures cluster closely—particularly for mental health problems. For example, in four of the six years (i.e., Y2, Y4, Y5, and Y7), 59% of juveniles detained met the AST criteria for a mental health problem. Averaging in the slightly higher 63% figure from Y3 and the slightly lower 56% figure from Y6 leads to a six-year average of 59%. The prevalence figures for substance abuse problems vary slightly more, from 38% in Y7 to 46% in Y2, with Y3, Y4, Y5, and Y6 in between at 44%, 43%, 41%, and 40%, respectively. These figures lead to a six-year average of 42%. Thus, on the basis of AST criteria alone, averaged across six years, 59% of juveniles entering JDCs appear to suffer from a mental health problem and 42% appear to suffer from a substance abuse problem. Interestingly, whereas the prevalence figures for mental health

problems have been mostly steady, the prevalence figures for substance abuse problems have been steadily declining over the six evaluation years, from 44% in Y2 to 38% in Y7, a small but steady decrease. 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 across the six years, with the six-year average of 71% (ranging from a low of 66% in Y6 to a high of 76% in Y3). This means that, averaged across six years, nearly three-fourths of juveniles entering JDCs appear to suffer from a mental health and/or a substance abuse problem (or conversely, that only around 29% 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-Y7 data seems appropriate. Prevalence of the dual diagnosis seems very closely clustered across the six years, with the six-year average of 30% (ranging from a low of 29% in Y7 to a high of 31% in Y2 and Y6), 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, yielding a six-year average of 14% (ranging from a low of 11% in Y4 to a high of 17% in Y7 and Y2), meaning that the prevalence of girls meeting the criteria for a mental health problem is 14% higher than for boys. An analysis that examined whether differential rates of traumatic experience exposure (as measured by the MAYSI-2 Traumatic Experiences subscale) could explain the difference in the prevalence of mental health problems among girls and boys, completed for the first time in Y5 and replicated in Y6, was also conducted in Y7. Interestingly, this analysis generated results that very closely resembled those from Y5 and Y6. 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 and Y7, 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 six-year average of juveniles who had been previously diagnosed with a mental health and/or a substance abuse problem was 70% (ranging from a low of 67% in Y4 to a high of 74% in Y7). 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, considering the increase in the percentage of juveniles entering detention who have been reported to have had a previous diagnosis, it seems likely that some juveniles entering JDCs in more recent evaluation years (e.g., Y4-Y7) 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 Y7 evaluation show that, according to clinicians, approximately 94% 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 (nearly 64%) 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/CJPOs. 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/CJPOs have been consistent and reasonable, and the perceptions reported by these respondents have been consistently positive. Similar to previous years, the judges, CJPOs, and others who completed surveys in Y7 (as previously discussed, a number of individuals who work with juveniles other than judges and CJPOs completed the survey in Y7) responded very positively regarding the CSP, with the vast majority being aware of the program (96%), being satisfied with contact from a JDC clinician (95%), having received recommendations from the JDC clinician (95%), and being satisfied with the recommendation received from the clinician (91%). A majority also reported that recommendations received from the JDC clinician affected decisions they made regarding their youth (83%) and felt that the CSP program was beneficial (93%), and nearly all wanted to see it continue (99%). Although no statistically significant differences were found between the judges and others (CJPOs and others working with juveniles), the judges tended to be somewhat more satisfied than the CJPOs and others working with juveniles with both contact from the JDC clinician and recommendations received from the clinician. They also rated having a clinician in the nearest JDC as somewhat more beneficial than the CJPOs and other working with juveniles. The level of satisfaction with contact with the JDC clinician and the recommendations received from the clinician varied as a function of region, with judges, CJPOs, and others working with juveniles in Region 1 and Region 5 expressing the greatest level of satisfaction and those in Region 2 and Region 3 expressing the lowest level of satisfaction. In short, even though slight variations were found, there is no question that judges, CJPOs, and others working with juveniles in Y7, as in all six previous years, are convinced of the value of the CSP and the effect it has on juveniles processed in the JDCs.

Additional Analyses

As already noted, several additional analyses that were conducted for the first time in Y5 and replicated in Y6 were also completed in Y7. Similar to the previous two years, these analyses yielded some important findings in Y7. 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 property crime was the most frequent booking charge for juveniles who met the AST criteria for neither a mental health nor a substance abuse problem, whereas drug crime was the most common crime for all other AST diagnostic categories combined (a mental health only, a substance abuse only, and both types of problems). Unlike in the previous two years, a significant association was found between the type of the AST diagnosis (neither and all other diagnostic categories combined) and type of booking charge, such that juveniles who met the AST criteria for a mental health problem, a substance abuse problem, or both types of problems were more likely to be booked for crimes against persons than those who met the AST criteria for neither type of problem. Conversely, those juveniles who met the AST criteria for neither type of problem were more likely to be booked for drug crimes, crimes against persons, and sex crimes than those who met the AST criteria for one, the other, or both types of problems. When all four AST diagnostic categories were analyzed separately, it was found that juveniles who were booked on drug crime charges were most likely to meet the AST criteria for both types of problems, and those who were booked on property crime charges were most likely to meet the AST criteria for neither type of problem. Interestingly, juveniles who were booked for crimes against persons and sex crimes were most likely to meet the AST criteria for a mental health problem. This finding seems to suggest that juveniles with a mental health problem might be more likely to commit more serious crimes that involve other individuals (crimes against persons and sex crimes) whereas those who have neither type of problem or both types of problem are more likely to commit property crimes and drug crimes, respectively. It is unclear why juveniles who met the criteria for a mental health problem are more likely to commit more serious crimes (crimes against persons and sex crimes) 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.

Unlike in the two previous years, when no differences in the rates at which juveniles accessed at least one recommended service within 15-45 days of release from detention was found as a function of region, additional analysis completed in Y7 revealed that juveniles released from JDCs in urban counties were more likely to access at least one recommended service within 15-45 days of release than those released from JDCs in rural counties. It is not entirely clear why juveniles in urban counties are accessing recommended services at a higher rate than those in rural counties. One possible explanation could be that the lack of availability of services in rural counties in addition to other possible barriers (e.g., transportation, travel distance, etc.) may lead juveniles being released from JDCs in rural counties to access recommended services at a lower rate than those being released from JDCs in urban counties where community services may be more readily available and more easily accessible.

Additional analyses of the responses provided by judges, CJPOs, and others working with juveniles revealed that whether they felt that recommendations made by the clinicians had affected their decisions or treatments advised for the youth was highly predictive of their level of satisfaction 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/CJPOs. Additionally, based on comments provided

by judges, CJPOs, and others working with juveniles in response to the three open-ended survey items, it appears that in addition to maintaining ongoing communication between JDC clinicians and judges, CJPOs, and others working with juveniles some comprehensible specifications of the duties and responsibilities of JDC clinicians and expectations of judges, CJPOs, and others working with juveniles in terms of what type of information is most useful to them in making decisions and providing recommendations for youth may be warranted. This may particularly apply to the communication between JDC clinicians and individuals working with juveniles other than judges as one of the findings of this Y7 evaluation revealed that whereas all judges agreed that the recommendations received from the JDC clinicians had affected the decisions or treatment they advised for youth, over 20% of CJPOs and others working with juveniles indicated that it had not.

Content analysis of comments provided by judges, CJPOs, and others working with juveniles revealed that most judges, CJPOs, and others working with juveniles had positive view of the CSP program. They expressed that the services JDC clinicians provide to juveniles in detention are invaluable in terms of providing training to line staff about how to interact with high need juveniles in best and safest ways, being available to youth to talk about their feelings and problems they may be experiencing, providing firsthand information about youth to judges and probation offices, providing information about resources available to youth and their families, and completing a mental health assessment with youth, identifying mental health problems they may be experiencing and recommending appropriate treatments and services in the community. Several judges, CJPOs, and others working with juveniles provided recommendations for how the CSP program could be improved in the future. They recommended program expansion and increase in funding to enable clinicians to spend more time working with youth, some even suggesting having clinicians be present in JDCs on weekends, having JDC clinicians start to provide treatment services to youth while in detention, better collaboration information sharing among different parts of the system (JDC clinicians, DHW, etc.), and standardization of the services that JDC clinicians provide across detention centers.

The additional analyses of the associations between MAYSI-2 subscale indications and AST diagnoses reveal that the AST seems a more sensitive index of whether detained juveniles experience mental health and/or substance abuse problems than the MAYSI-2. This finding is consistent with the perceptions of clinician Brian Mecham from the Bonneville County (3B) JDC, who in his pilot project reported that he favored using AST scores over MAYSI-2 scores because juveniles seemed to underreport (or sometimes overreport) symptoms to hide the actual extent to which they were experiencing certain types of problems. There seems to be no reason to recommend that the MAYSI-2 no longer be used at intake, as it can help guide housing decisions and observation patterns (e.g., for “suicide watch”) and inform clinicians of potential issues prior to their clinical interviews. However, the use of the AST seems more critical, as it enables clinicians much more readily to identify mental health and/or substance abuse problems in the juveniles they work with.

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-Y7, 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 six 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 IDJC administrators as well as JDC clinicians and staff (McDonald et al., 2012), 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 are present 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 seven years of evaluation, the researchers continue to be confident about making 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.

References

- Anthony, E. K., Samples, M. D., de Kervor, D. N., Ituarte, C. L., & Austin, M. J. (2010). Coming back home: The reintegration of formerly incarcerated youth with service implications. *Children and Youth Services Review, 32*, 1271-1277.
- Bazelon Center for Mental Health Law (2009). *The effects of incarceration on Medicaid benefits for people with mental illnesses*. Retrieved from http://www.bazelon.org/LinkClick.aspx?fileticket=_Ns68MefCJY%3D&tabid=441
- Begic, S., McDonald, T. W., & Howard, E. K. M. (2013). *Year five assessment of the Idaho Department of Juvenile Corrections' Clinical Services Program*. Boise, ID: Center for Health Policy, Boise State University.
- Cauffman, E. (2004). A statewide screening of mental health symptoms among juvenile offenders in detention. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 4, 430-9.
- Cauffman, E., Lexcen, F., Goldweber, A., Shulman, E., & Grisso, T. (2007). Gender differences in mental health symptoms among delinquent and community youth. *Youth Violence and Juvenile Justice, 5*, 3, 287-307.
- Centers for Disease Control and Prevention (2013). *Adverse Childhood Experiences (ACE) study*. Retrieved from <http://www.cdc.gov/ace/index.htm>
- Farrington, D. P., & Welsh, B. C. (2003). Family-based prevention of offending: A meta-analysis. *Australian and New Zealand Journal of Criminology, 36*, 127-151. doi: 10.1375/acri.36.2.127
- Farrington, D. P., & Welsh, B. C. (2007). *Saving children from a life of crime: Early risk factors and effective interventions*. New York, NY: Oxford University Press.
- Fazel, S., Doll, H., & Langstrom, N. (2008). Mental disorders among adolescents in juvenile detention and correctional facilities: A systematic review and metaregression analysis of 25 surveys. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*, 1010-1019.
- Grisso, T., Barnum, R., Fletcher, K. E., Cauffman, E., & Peuschold, D. (2001). Massachusetts Youth Screening Instrument for mental health needs of juvenile justice youths. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 430-9.
- Hoeve, M., Dubas, J. S., Eichelshein, V. I., van der Laan, P. H., Smeenk, W., Gerris, J. R. M. (2013). The relationship between parenting and delinquency: A meta-analysis. *Journal of Abnormal Child Psychology, 37*, 749-775. doi:10.1007/s10802-009-9310-8

- Hoeve, M. McReynolds, L. S., & Wasserman, G. A. (2013). Service referral for juvenile justice youths: Associations with psychiatric disorder and recidivism. *Administration and Policy in Mental Health and Mental Health Services Research*, 1-11. doi: 10.1007/s10488-013-0472-x
- Horsfall, J., Cleary, M., Hunt, G. E., & Walter, G. (2009). Psychosocial treatments for people with co-occurring severe mental illnesses and substance use disorders (dual diagnosis): A review of empirical literature. *Harvard Review of Psychiatry*, 17, 24-34.
- Idaho Division of Financial Management (2005). *Idaho outlook: News of Idaho's economy and budget*. Retrieved from <http://lmi.idaho.gov/Portals/13/PDF/population/The%20two%20Idahos%20press%20release.pdf>
- Klose, M., & Jacobi, F. (2004). Can gender differences in the prevalence of mental disorders be explained by sociodemographic factors? *Archives of Women's Mental Health*. DOI: 10.1007/s00737-004-0047-7
- McDonald, T. W., Williams, M. N., Osgood, L. S., & VanNess, E. M. (2009). *A statewide and multimodal assessment of the Idaho Department of Juvenile Corrections' Clinical Services Program*. Boise, ID: Center for Health Policy, Boise State University.
- McDonald, T. W., Osgood, L. S., & VanNess, E. M. (2010). *Year two assessment of the Idaho Department of Juvenile Corrections' Clinical Services Program*. Boise, ID: Center for Health Policy, Boise State University.
- McDonald, T. W., & Theiler, A. A. (2011). *Year three assessment of the Idaho Department of Juvenile Corrections' Clinical Services Program*. Boise, ID: Center for Health Policy, Boise State University.
- McDonald, T. W., Begic, S., & Howard, E. K. M. (2012). *Year four assessment of the Idaho Department of Juvenile Corrections' Clinical Services Program*. Boise, ID: Center for Health Policy, Boise State University.
- Mericle, A. A., Belenko, S., Festinger, D., Fairfax-Columbo, J., & McCart, M. R. (2009). Staff perspectives on juvenile drug court operations: A multi-site qualitative study. *Criminal Justice Policy Review*, 1-23. doi:10.1177/0887403413486342
- Piccinelli, M., & Wilkinson, G. (2000). Gender differences in depression: Critical review. *British Journal of Psychiatry*, 177, 486-492.
- Piquero, A. R., Farrington, D. P., Welsh, B. C., Tremblay, R., & Jennings, W. G. (2009). Effects of early family/parent training programs on antisocial behavior and delinquency. *Journal of Experimental Criminology*, 5, 83-120. doi: 10.1007/s11292-009-9072-x
- Wasserman, G. A., Jensen, P. S., Ko, S. J., Cocozza, J., Trupin, E., Angold, et al. (2003). Mental health assessments in juvenile justice: Report on the consensus conference. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 752-761.

Welsh, B. C., & Farrington, D. P. (2011). The benefits and costs of early prevention compared with imprisonment: Toward evidence-based policy. *The Prison Journal*, *91*, 120S-137S. doi: 10.1177/0032885511415236

Appendix A:
Detailed Analysis of the Association Between MAYSI-2 and AST Indications
By Loren L. Toussaint, Ph.D., Luther College

Considering the AST as the comparison measure of mental health problems in a juvenile population, the MAYSI-2 can be examined for its sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV). Examining these four indices along with the 2X2 tables reveals the validity of the MAYSI-2 as compared to the AST.

Sensitivity is the proportion of cases identified with mental health problems by the MAYSI-2 out of the total number of cases identified with mental health problems by the AST. Specificity is the proportion of cases identified as not having mental health problems by the MAYSI-2 out of the total number of cases identified as not having mental health problems by the AST. Positive predictive value (PPV) is the proportion of cases identified with mental health problems by the AST out of the total number of case identified with mental health problems by the MAYSI-2. Negative predictive value (NPV) is the proportion of cases identified as not having mental health problems by the AST out of the total number of cases identified as not having mental health problems by the MAYSI-2. See Table 1.

Sensitivity, specificity, positive predictive value and negative predictive value for the MAYSI-2 is provided in Table 2, considering the AST as the measure against which the MAYSI-2 should be compared. The MAYSI-2 shows sensitivity levels in the .15 - .40 range, which is unacceptable. MAYSI-2 specificity levels are in the .86 - .97 range, which is much more acceptable. MAYSI-2 positive predictive values are .78 - .88 and more acceptable. Negative predictive values are .44 - .69 and unacceptable.

Examining the 2X2 contingency tables reveal that, across all the mental health subscales of the MAYSI-2, the MAYSI-2 shows high levels of false negatives (contributing to lower negative predictive value and lower sensitivity). This is also evidenced in examining the total number of cases identified with mental health problems by both the AST and MAYSI-2. The AST generally identifies 2-3 times as many cases with mental health problems as the MAYSI-2.

In conclusion, the MAYSI-2 is specific in not detecting mental health problems, but is not sensitive. The MAYSI-2 possesses higher positive predictive value, but lower negative predictive value, due in most part to the MAYSI-2's higher rate of false negatives and apparent higher threshold for identifying a case with mental health problems. Clinicians and corrections professionals should be aware that the MAYSI-2 identifies lower numbers of cases with mental health problems than the AST. Juveniles with mental health problems are less likely to be identified using the MAYSI-2 than the AST, but unfortunately a large number of juveniles with abnormal mental health will also be falsely identified as not having problems. This may not facilitate effective and efficient diagnosis and treatment.

Table 1: Conceptual Understanding of Sensitivity, Specificity, Positive Predictive Value (PPV), and Negative Predictive Value (NPV)				
MAYSI-2	AST			
	Positive Case	Negative Case	Total	
Positive Case	a (true positive)	b (false positive)	a+b	PPV = $a/(a+b)$
Negative Case	c (false negative)	d (true negative)	c+d	NPV = $d/(c+d)$
Total	a+c	b+d	Total N	
	Sensitive $a/(a+c)$	Specific $d/(b+d)$		

Note. Overall accuracy = $(a+d)/N$

Table 2: Sensitivity, Specificity, Positive Predictive Value (PPV), and Negative Predictive Value (NPV) for AST and MAYSI-2 Subscales				
AST Subscale	MAYSI-2 Subscale			
Mental Health	Angry/Irritable			
	Sensitive	0.40	PPV	0.84
	Specific	0.89	NPV	0.50
	Accuracy	0.60		
Mental Health	Depression/Anxiety			
	Sensitive	0.24	PPV	0.87
	Specific	0.94	NPV	0.46
	Accuracy	0.53		
Mental Health	Somatic			
	Sensitive	0.30	PPV	0.81
	Specific	0.90	NPV	0.46
	Accuracy	0.54		
Mental Health	Suicidal			
	Sensitive	0.34	PPV	0.88
	Specific	0.93	NPV	0.49
	Accuracy	0.58		
Mental Health	Thought Disturbance			
	Sensitive	0.15	PPV	0.87
	Specific	0.97	NPV	0.44
	Accuracy	0.48		
Mental Health	Traumatic Experience			
	Sensitive	0.35	PPV	0.78
	Specific	0.86	NPV	0.47
	Accuracy	0.55		
Substance Abuse	Alcohol/Drug Problem			
	Sensitive	0.28	PPV	0.84
	Specific	0.97	NPV	0.69
	Accuracy	0.71		

Table 3: 2X2 Contingency Tables for AST and MAYSI Subscales			
MAYSI-2 Subscale	AST Subscale		
Angry/Irritable	Mental Health		
	True	False	Total
True	316	59	375
False	482	486	968
Total	798	545	1,343
Depression/Anxiety	Mental Health		
	True	False	Total
True	195	30	225
False	603	515	1,118
Total	798	545	1,343
Somatic	Mental Health		
	True	False	Total
True	236	57	293
False	562	488	1,050
Total	798	545	1,343
Suicidal	Mental Health		
	True	False	Total
True	268	37	305
False	530	508	1,038
Total	798	545	1,343
Thought Disturbance	Mental Health		
	True	False	Total
True	122	19	141
False	676	526	1,202
Total	798	545	1,343
Traumatic Experience	Mental Health		
	True	False	Total
True	278	78	356
False	520	467	987
Total	798	545	1,343
Alcohol/Drug Use	Substance Abuse		
	True	False	Total
True	140	26	166
False	363	814	1,177
Total	503	840	1,343