

# **Year Eight Assessment of the Idaho Department of Juvenile Corrections' Clinical Services Program**

---

Prepared for the Idaho  
Department of Juvenile Corrections

by

Theodore W. McDonald  
Sandina Begic  
Makenzie Phillips

Center for Health Policy  
Boise State University

May 2016

## Executive Summary

During the past eight 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, 2012-2013, and 2013-2014 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 seven 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 seven 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 2007-2014 supported the funding of the CSP for another year, and in 2014 it continued in the 13 JDCs in Idaho (the 12 JDCs that have been a part of this evaluation since Year 1 (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 8 (Y8) Assessment. Similar to the Year 1 (Y1) – Year 7 (Y7) 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 Y8; these analyses were also performed in Y5 but were not completed in any of the other evaluation years. Finally, similar to what was done only in Y4, incident data were analyzed (consisting of documented cases of the use of restraints and suicide attempts in the JDCs), and interviews were conducted with willing JDC administrators and clinicians.

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 1,342 juveniles were analyzed**
  - **Data on a total of 1,375 detained juveniles were submitted. Data on 21 juveniles for whom multiple data entries were submitted were excluded from this report**
  - **Over 68% of the juveniles for whom data were included in the final analyses were boys, and nearly 32% were girls**
  - **Data on detained juveniles were submitted by clinicians at all 13 JDCs. Data from the JDCs in Lemhi and Valley counties, as well as the Shoshone-Bannock Tribal JDC, were excluded from this report because there were too few cases to guarantee anonymity (thus, the data in this assessment are from 10 JDCs). The JDCs that submitted the most data cases included those in Ada (nearly 19%), Kootenai (just over 17%), Canyon (nearly 16%), Bonneville (just over 11%), and Twin Falls (11%) counties. The JDCs in Fremont (less than 2%) and Bonner (less than 4%) counties submitted the fewest cases, followed by the JDCs in Minidoka (nearly 6%), Nez Perce (nearly 6%), and Bannock (just over 9%) counties**
- **The most common booking charges for juveniles across all 10 JDCs were “other crimes” not easily fitting one of the four Uniform Crime Recording (UCR) codes (many of these were probation violations), followed by drug crimes, property crimes, crimes against persons, and sex crimes**
- **Over 60% 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 69%) were statistically significantly more likely to meet the AST criteria for a mental health problem than were boys (nearly 56%)**
  - **Juveniles met the AST criteria for having a mental health problem at statistically significantly different rates across the 10 JDCs**
    - **Indications of mental health problems were highest among juveniles screened at the JDC in Canyon County (nearly 81%), followed by the JDCs in Twin Falls (nearly 77%) and Nez Perce (over 72%) counties. Indications of mental health problems were lowest among juveniles**

screened at the JDCs in Minidoka (nearly 22%), Bonner (just over 31%), and Bonneville (over 49%) counties

- **Nearly 35% 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 10 JDCs**
    - **Indications of substance abuse problems were highest among juveniles screened at JDC in Fremont County (just over 59%), followed by the JDCs in Nez Perce (over 53%) and Canyon (nearly 49%) counties. Indications of substance abuse problems were lowest among juveniles screened at the JDCs in Minidoka (over 1%), Bonner (nearly 9%), and Ada (over 27%) counties**
- **When the combination of AST indications of mental health and substance abuse problems were evaluated, it was found that nearly 69% of all screened juveniles had a mental health problem, a substance abuse problem, or both**
  - **Having indications for a mental health problem only was the most common single combination (at just over 34%), followed by having neither a mental health nor a substance abuse problem (just over 31%), both a mental health and a substance abuse problem (nearly 27%), and a substance abuse problem only (less than 9%)**
  - **A statistically significant difference existed in the combination of mental health and substance abuse indications between boys and girls. Whereas boys were more likely than girls to have indications of neither a mental health nor a substance abuse problem (34% to 25%) and a substance abuse problem only (10% to 5%), girls were more likely than boys to have indications of both a mental health and substance abuse problem (31% to 24%) and a mental health problem only (38% to 33%)**
  - **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 Bannock, Bonner, Bonneville, Kootenai, and Minidoka 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 Canyon, Fremont, and Nez Perce counties), and having a mental health problem only was most common in the JDCs in Ada and Twin Falls counties**
    - **Having a substance abuse problem only was least common in nine of the 10 JDCs. The one exception was the JDC in Minidoka County, where there was a tie for the least common combination between juveniles having a substance abuse problem only and juveniles having both a mental health and substance abuse problem**

- **Over 79% 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 1.31**
  - **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 (1.27)**
  - **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 no cases with documented previous diagnoses in this JDC)**
    - **Mean numbers of previous diagnoses were highest among juveniles in the JDCs in Bonner (1.67), Ada (1.50), and Nez Perce (1.48) counties. Mean numbers of previous diagnoses were lowest among juveniles in the JDCs in Bonneville (1.08), Kootenai (1.13), and Fremont (1.17) counties**
- **Nearly 61% 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 1.46. Diagnosis was deferred for less than 3% 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 (1.54) of mental health or substance abuse problems than were boys (1.42)**
  - **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 (1.74), Bonner (1.64), and Fremont (1.63) counties. The lowest mean numbers of provisional diagnoses were given to juveniles in the JDCs in Nez Perce (1.00), Minidoka (1.10), and Kootenai (1.30) 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 36% of those provisionally diagnosed), disruptive behavior disorders (over 23%), anxiety disorders (over 22%), and attention deficit disorders (over 16%)**
- **Recommendations for at least one service in the community were made for 998 juveniles. The mean number of service recommendations for juveniles who received at least one service recommendation was 1.51**
  - **Of all juveniles who received at least one service recommendation, 744 (or 75%) were given at least one provisional diagnosis and the remaining 254 (or 25%) received at least one service recommendation but were not given a provisional**

**diagnosis. Additionally, 42 juveniles were given at least one provisional diagnosis without receiving a service recommendation**

- **Of the 786 juveniles who received at least one provisional diagnosis, 744 (or nearly 95%) 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 Bannock (2.31), Twin Falls (1.96), and Canyon (1.59) counties. The lowest mean numbers of recommended services were given to juveniles in the JDC in Minidoka County (1.03), followed by the JDCs in Fremont (1.05) and Bonneville and Ada (1.16 each) counties**
- **The most commonly given recommendations for services were continuation of prior treatment (over 43%) and for individual counseling (33%). Other commonly received service recommendations were for substance abuse counseling/treatment (nearly 28%) and psychological/mental evaluation (nearly 17%)**
- **According to information gained by clinicians during 15-45 day post-release follow-up calls, 572 juveniles, or over 57% 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 1.38**
  - **A statistically significant difference in mean numbers of recommended services accessed was found as a function of JDC location**
    - **The highest mean numbers of recommended services accessed were found among juveniles released from JDCs in Bannock (2.03), Twin Falls (1.63), and Bonneville (1.33) counties. The lowest mean numbers of recommended services accessed were found among juveniles released from the JDCs in Fremont and Minidoka (1.00 each) counties, followed by the JDC in Canyon County (1.04)**

### **Wave Two: Parent Survey Data**

- **A total of 192 parents were contacted via telephone by callers from the Idaho Federation of Families (IFF) for Children's Mental Health. Of those, 91 parents agreed to complete the survey, for a response rate of 47%**
- **About 21% 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, over 68% reported that they were given recommendations for community-based services for their child by the JDC clinician**

- The service parents most often reported being recommended for their children was mental health counseling (over 46%). Fifteen percent of parents each reported receiving recommendations for their children for a mental health evaluation, substance abuse treatment or assessment, or some other service (e.g., diversion, juvenile probation). Just under 8% reported receiving a recommendation to continue previous treatment, and the same percentage reported that they could not remember what service recommendation had been made
- Every parent (100%) who received at least one service recommendation for their child reported that their child had accessed at least one service

### **Wave Three: Judge/Juvenile Probation Officer Survey**

- A total of 44 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 44 respondents, 25% were judges and the remaining 75% were CJPOs and others working with juveniles (e.g., JPOs, JDC administrators)
  - The regions with the highest percentage of respondents were Region 1 (over 27%) and Region 4 (just over 18%). The regions with the lowest percentage of respondents were Region 3 (less than 5%) and Region 2 (less than 7%)
- Over 95% 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 41 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 or received information from a clinician regarding one of the youth they were working with. Of those, 78% reported having been contacted by a clinician
  - The level of satisfaction with the contact from the JDC clinicians was very high, as nearly 91% of the judges, CJPOs, and others who reported having been contacted were very satisfied (nearly 63%) or satisfied (just over 28%) with the contact
- 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 97% reported having been given a recommendation
  - The level of satisfaction with recommendations provided by the JDC clinicians was very high, as nearly 94% of those judges, CJPOs, and others who reported receiving at least one recommendation were very satisfied (nearly 55%) or satisfied (nearly 39%) with the recommendation(s)

- 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, nearly 84% 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 and others working with juveniles was “extremely beneficial” (fully 75%), followed by “rather beneficial” (nearly 19%)
- When asked whether they would like to see the CSP continue, nearly 97% of the judges/CJPOs and others working with juveniles reported wishing to see it continue

#### **Wave Four: JDC Administrator and Clinician Interviews**

- Administrators and clinicians from five JDCs participated in interviews to discuss strengths/successes and weaknesses/challenges of the CSP in their facilities and communities, as well as give suggestions for future CSP implementation
- Commonly perceived strengths/successes of the CSP included reducing incidents (i.e., use of restraints and suicide attempts), building stronger partnerships between JDC staff and community partners/stakeholders (e.g., judges and JPOs, children’s mental health workers, staff in after-care facilities related to mental health and/or substance abuse, and strengthening staff relationships and training (e.g., on how to deescalate behavior and appropriately identify safety risks)
- Commonly perceived weaknesses/challenges of the CSP included lack of parent involvement or compliance with clinicians’ community-based service recommendations, lack of rural resources, inpatient facilities, or appropriate population-specific after-care options (e.g., girls-only programs and programs for sex offenders), and difficulties associated with Medicaid billing and Prison Rape Elimination Act (PREA) requirements
- Commonly mentioned directions for future program implementation included additional resources (e.g., time, pay) for clinicians, and additional focus on factors predicting juvenile delinquency (including “Adverse Childhood Experiences,” or “ACEs”)

#### **Wave Five: JDC Incident Data**

- Incident data were submitted for calendar years 2011-2013, and compared with previously collected data from the three years (2005-2007) prior to the implementation of the CSP

- There were 28,017 bookings in the three years (2005-2007) prior to the implementation of the CSP compared to 20,329 bookings in the three years (2011-2013) assessed in this evaluation
- The average use of restraints per 1,000 bookings decreased from 16.17 in the 2005-2007 “pre-clinician period” to 13.82 in the 2011-2013 “clinician period,” a 15% decline
  - The decline would have been greater but for one JDC with anomalously high use of restraints, mostly on one male juvenile during multiple detentions over several consecutive years
- The average suicide attempts per 1,000 bookings increased from 1.53 in the 2005-2007 “pre-clinician period” to 2.61 in the 2011-2013 “clinician period,” a 71% rise
  - Nearly all of the increase was accounted for by a single JDC, which may be partially attributed to better surveillance and more stringent documentation learned through national training on suicide prevention

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

- Over 33% of all juveniles who completed the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) screened positive for traumatic experiences
  - Unlike previous years, no statistically significant association was found between gender and traumatic experiences
  - A statistically significant association was found between the indication of mental health problems and traumatic experiences. Whereas nearly 76% of juveniles who screened positive for traumatic experiences also screened positive for a mental health problem, less than 53% of juveniles who screened negative for traumatic experiences did so

#### **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, 814 had a booking charge classifiable as one of the four UCR categories (drug crime, property crime, crime against persons, and sex crime)
  - There was a statistically significant association between AST indications (neither type of problem and a mental health problem only, a substance abuse problem only, or both types of problems) and the type of booking charge
    - Juveniles who were booked on drug crime charges were most likely to meet the AST criteria for a substance abuse problem only (nearly 69%) and least likely to meet the criteria for a mental health problem only (less than 15%)
    - Juveniles who were booked on property crime charges, crimes against persons charges, and sex crimes charges were most likely to meet the

AST criteria for a mental health problem only (34%, 42%, and 10%, respectively) and least likely to meet the criteria for a substance abuse problem only (20%, 11%, and 0%, respectively)

### **Additional Analysis 3: Regional Differences in Recommended Services Accessed**

- **Of the 998 juveniles who received at least one recommendation for services, 572 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 (just over 51%) were more likely to access at least one recommended service than those released from JDCs in rural or frontier counties (less than 38%)**
    - **The JDCs with the highest percentages of juveniles who accessed at least one recommended service were located in Bannock (nearly 81%), Twin Falls (nearly 79%), and Kootenai (over 65%) counties. The JDCs with the lowest percentage of juveniles who accessed at least one recommended service were located in Bonneville (nearly 14%), Canyon (over 26%), and Fremont (over 27%) counties**
    - **The JDCs with the highest percentages of juveniles who accessed at least one recommended service were located in Region 6 (nearly 90%), Region 5 (nearly 72%), and Region 1 (nearly 63%). The JDCs with the lowest percentage of juveniles who accessed at least one recommended service were located in Region 7 (nearly 16%), Region 3 (over 26%), and Region 2 (just over 48%)**

### **Additional Analysis 4: Judges/CJPOs Survey**

- **Of all respondents who received a recommendation from a JDC clinician, nearly 84% reported that these recommendations had affected a decision or treatment they advised for the youth, whereas 16% 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 ( $M = 4.69$ ) than those reporting that it had not ( $M = 4.00$ )**
  - **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 ( $M = 4.65$ ) than those reporting that it had not ( $M = 3.40$ )**
  - **On average, respondents reporting that the recommendation had affected a decision or treatment they advised for the youth rated the CSP as significantly more beneficial ( $M = 4.88$ ) than those reporting that it had not ( $M = 4.00$ )**

**Additional Analysis 5:**

- **Four of six MAYSI-2 subscales indications were found to be statistically significant predictors of AST mental health and substance abuse problems**
  - **Juveniles with Suicide Ideation MAYSI-2 indications were 2.4 times more likely than those without such indications to meet AST criteria for having mental health problems; similar findings were documented with those having positive MAYSI-2 indications for the Angry-Irritable (2.2 times more likely to meet the criteria for a mental health problem), Thought Disturbance (1.9 times more likely), and Traumatic Experiences (1.6 times more likely) subscales**
  - **Juveniles with Alcohol/Drug Use MAYSI-2 indications were 5.9 times more likely than those without such indications to meet AST criteria for having substance abuse problems; similar findings were documented with those having positive MAYSI-2 indications for the Traumatic Experiences (1.6 times more likely to meet the criteria for a substance abuse problem), Angry-Irritable (0.7 times more likely), and Depressed-Anxious (0.4 times more likely) subscales**

## Overview

The clinical services program (CSP) has been housing clinicians in juvenile detention centers (JDCs) in Idaho for nearly a decade. 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 seven 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), 2014 (Begic, McDonald, Gazieva, & Lindsay, 2014), and 2015 (Begic & McDonald, 2015). 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 eight 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-Y7), 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-Y7), 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 other 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-Y7 evaluations. Wave one data were subjected to additional analyses to explore 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 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 seven evaluations of the expanded CSP revealed a number of interesting findings. For example, it was found that high percentages of juveniles in all seven years met the AST diagnostic criteria for a mental health problem (the seven-year average for juveniles meeting the AST criteria for having a mental health problem was 60%, ranging from a low of 56% in Y6 to a high of 68% in Y1) and a substance abuse problem (the seven-year average for juveniles meeting the AST criteria for a substance abuse problem was 44%, ranging from a low of 38% in Y7 to a high of 54% in Y1). Very high percentages of juveniles were found to meet the AST criteria for at least one type of problem (the seven-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 82% in Y1), and substantial percentages were found to meet the criteria for both types of problems (the seven-year average for juveniles meeting the AST criteria for both types of problems was 32%, ranging from a low of 29% in Y4 to a high of 41% in Y1). Provisional diagnoses of at least one mental health or substance abuse problem were made for a majority of the juveniles in the last four evaluation years (i.e., Y4-Y7; a comparison to provisional diagnoses for Y1-Y3 is not feasible because problems were identified in how these were calculated in those years) (the four-year average for juveniles being provisionally diagnosed with at least one mental health or substance abuse problem was 64%, 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-Y7 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 five-year average [Y3-Y7] 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 six years (the six-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 87%, 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 six years (Y2-Y7). Most of the respondents reported being aware of the program (the six-year average was 89%, ranging from a low of 79% in Y3 to a high of 96% in Y7), having had contact with JDC clinicians (the six-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 six-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 six-year average was 90%, ranging from a low of 80% in Y5 to a high of 93% in Y2, Y6, and Y7), and nearly all reported wanting to see it continue (the six-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 and Y7, 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 all three years (i.e., Y5-Y7).

The CSP was granted funding for an eighth year (Y8), and IDJC contracted with the same team of BSU researchers to evaluate it. The 2015 evaluation was performed on data collected at the JDCs between July 1, 2014 and June 30, 2015. The procedures for collecting data for the clinicians' and parents' portions of the 2015 evaluation were identical to those used in the 2008-2014 evaluations. The procedure for delivering the judges/CJPOs survey was identical to that used in 2012 through 2014; however it differed somewhat from those used in the 2008-2011 evaluations. Finally, several waves of data collected only in Y4 were collected again in Y8, and several additional analyses utilizing data collected in waves one and three, which were completed in Y5-Y7, were again completed in the Y8 evaluation.

## Methodology

Similar to the Y1-Y7 assessments, data were collected in several separate waves in this Y8 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 eight years of evaluation (i.e., Y1-Y8). 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 eight 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 eight evaluation years; in the Y8 assessment, similar to Y6 and Y7, 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. The fourth wave of data collection involved a procedure that had only been used in Y4. This wave of data collection involved conducting qualitative, semi-structured interviews with JDC administrators and clinicians. The fifth and final wave of data collection, which was also unique to Y4, involved analysis of incident data provided by IDJC to the researchers at BSU. Each wave will be discussed sequentially below. Several additional analyses, conducted for the first time in Y5 and replicated in Y6 and Y7, were also performed in the Y8 evaluation. Each of the five 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 were 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-Y8). 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-Y8 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-Y8 evaluations, and results from all seven subscales were used for some additional analyses in the Y7 and Y8 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 some 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. A drop-down menu featured some generic options for clinicians to use if he or she chose (e.g., “Individual Counseling,” “Substance Abuse Treatment”), however, the clinicians could also elect to type in their service recommendations (and some chose to do so, particularly when they thought specificity was important). 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 eight 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 (in cases in which the juveniles' parents could not be reached, the clinicians gathered the information from a different source, such as the juveniles' JPOs). 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, 2014 and June 30, 2015. Data were submitted from all 13 JDCs; however, the data from the JDCs in Lemhi and Valley counties were not included in the final, aggregated dataset because too few cases were submitted by the JDCs in these counties to guarantee juveniles anonymity. Clinician data were sent directly to personnel at IDJC, who then forwarded an Excel spreadsheet containing aggregated clinician data from the remaining JDCs (with all identifying information removed) to the BSU researchers for analysis. In total, this data set consisted of 1,411 data entries. Upon inspection, it was found that there were too few cases to guarantee juveniles anonymity at the Shoshone-Bannock Tribal JDC as well; there were 18 data entries from only 13 juveniles, so it was jointly decided by the BSU team and an IDJC administrator to remove these cases from analysis. Upon realizing that multiple entries were provided for some juveniles, the BSU team and an IDJC administrator determined that the data on 21 juveniles from JDCs in three counties (19 from the JDC in Minidoka County and one each from the JDCs in Ada and Canyon counties) for whom multiple data entries were provided should be excluded from the analysis. This resulted in the exclusion of 51 data entries. Consequently, wave one data analyses included clinician data provided for 1,342 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-Y8.

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 2015 and wrote the parents' responses directly on paper copies of the survey. IFF returned the paper copies of completed surveys to IDJC in December 2015, 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 192 parents of recently released juveniles (the callers from IFF placed additional 61 calls; however, these calls were excluded from the analysis because there either was no response or the number was invalid). Of these, 91 parents agreed to complete the survey, for a response rate of 47%.

#### 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 and Y8 consisted of 10 items (several of which had follow-up questions), asking the judges/CJPOs: 1) to identify their 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 Y8 was identical to that used in Y5-Y7. 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 Y8 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 January 2016, 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 93 judges/CJPOs (51 judges and 43 CJPOs) on January 7, 2016. Respondents began to complete the survey the same day. The IDJC administrator sent a reminder email message after two weeks, encouraging potential respondents to complete the survey. The survey was closed on January 29, 2016, and at that time, a total of 44 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).

#### Wave Four: JDC Administrator and Clinician Interviews

The fourth wave of data collection involved interviewing of JDC administrators and clinicians, designed to capture these key stakeholders' perspectives on strengths and successes and weaknesses and challenges of the CSP in their JDCs, as well as to learn about how they felt the program could be improved or expanded, either in their own JDCs or across the state. This wave of data collection had only been performed once before, during the Y4 evaluation. In Y4, the BSU research team used structured interview questions with administrators, clinicians, and line staff. In Y8, a semi-structured interview format was used, asking the administrators and clinicians to comment more broadly on strengths/successes, weaknesses/challenges, and directions for future program implementation.

In October, 2015, requests to perform interviews were sent via email to JDC administrators for all eligible JDCs covered in this evaluation (the JDCs in Valley and Lemhi counties and the Shoshone/Bannock Tribal JDC did not have sufficient data for Wave One analyses and therefore no interviews were planned or conducted with these JDCs). Responses, all of which granted interviews, were received from administrators in six of the 10 counties, and five interviews were completed (an interview was granted by the administrator of the JDC in Minidoka County, however, the evaluation team was unable to complete it during the data collection period; no response was received from the administrators of the JDCs in Canyon, Bonneville, Fremont, and Twin Falls counties). From November, 2015 to April, 2016, the evaluation team interviewed administrators and clinicians from five JDCs either in person (at the JDCs in Ada, Bannock, and Bonner counties) or via telephone (at the JDCs in Kootenai and Nez Perce counties).

As noted above, the interview protocol focused on three main topics, and was semi-structured to allow for open-ended responses by both administrators and clinicians. Interviews were conducted with both administrators and clinicians together for four of the five JDCs; as a matter of convenience, the administrator and clinician were interviewed separately at the JDC in Bannock County. The interviews generally lasted between 45-60 minutes, and (with the permission of all interviewees) were audiotaped for later transcription.

#### Wave Five: Incident Data

The fifth wave of data collection involved the transfer of incident data from IDJC personnel to the BSU research team. The incident data consisted of the numbers of bookings, use of restraints, and suicide attempts for each of the 12 county JDCs (no data were submitted from the Shoshone-Bannock Tribal JDC, largely because it was not in operation for most of the data collection years) in Idaho for six calendar years, 2005-2007 and 2011-2013. Because implementation of the CSP began in 2008 for nearly all JDCs, the data from 2005-2007 represented the “pre-clinician period.” In Y4, the research team compared incident data from this pre-clinician period with the first three years of CSP implementation, in what was referred to as the “2008-2010 clinician period.” In Y8, the comparison was between the pre-clinician period and the “2011-2013 clinician period.” Because the numbers of bookings varied greatly across the six calendar years, the numbers of use of restraints and suicide attempts were converted to incidents per 1,000 bookings for analysis purposes to control for a possible bias that might have resulted from reporting raw numbers of use of restraints and suicide attempts.

#### Additional Analyses

When the results of the Y4 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 mental health problems and the association between mental health problems and traumatic experiences. Several additional questions were raised when the preliminary results of the Y5 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 Y8, similar to Y5-Y7 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 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 accesses across regions/counties. Wave Three data were utilized to explore factors that may be contributing to variations in judges’/CJPOs’ responses. Also, as was performed 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 1,342 juveniles detained at one of 10 JDCs throughout Idaho. Gender codes were entered for 1,300 juveniles. Of these, 889 (or 68%) were boys and 411 (or 32%) were girls. The total number of cases was somewhat lower than the average of the first seven years (denoted throughout the remainder of this report as the “seven-year average”) of CSP evaluations, which was 1,702 juveniles (ranging from a low of 1,336 in Y7 to a high of 2,066 in Y4). The percentages of boys and girls in Y8 were fairly similar to the seven-year average of CSP evaluations, which were 72% for boys and 28% for girls; in Y8 the percentage of girls was four points higher than the seven-year average, and the percentage of boys was four points lower.

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, 2014 (the period after data collection ended for the previous year’s evaluation) to June 30, 2015 (the end of the fiscal year). The JDCs in Lemhi and Valley Counties and the Shoshone-Bannock Tribal JDC submitted data for the study but these data were not included in the report because there were too few cases at each JDC to guarantee anonymity. The 10 JDCs that submitted sufficiently large amounts of data (i.e., more than 20 unique juvenile cases each) are included below in Table 1.

As seen below in Table 1, the largest percentage of cases submitted was from the JDCs in Ada County (with nearly 19% of the total cases), followed by the JDCs in Kootenai County (just over 17%) and Canyon County (nearly 16%). On the other hand, the smallest percentages of cases were submitted from the JDC in Fremont County (less than 2%), followed by the JDCs in Bonner County (over 3%) and Minidoka County (nearly 6%).

<b>Table 1: Number of Cases by Juvenile Detention Center (JDC) Location</b>		
<b>JDC Location</b>	<b>Number of Cases</b>	<b>Percentage of Total Cases</b>
Ada County	254	<b>18.9</b>
Bannock County (District 6)	123	9.2
Bonner County	45	<i>3.4</i>
Bonneville County (3B)	150	11.2
Canyon County (Southwest Idaho)	214	<b>15.9</b>
Fremont County (5C)	22	<i>1.6</i>
Kootenai County (District 1)	230	<b>17.1</b>
Minidoka County	78	5.8
Nez Perce County (District 2)	79	5.9
Twin Falls County (Snake River)	147	11.0

*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 1,336 of the juveniles, or 99.6% of all juveniles on whom data were collected, and two booking charges were noted for 257 (19.2%) 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 (nearly 44% of the booking charges most appropriately fit in this “Other” category); a large number of these were explicitly noted to be probation violations. Also as seen in Table 2, substantial numbers of juveniles were booked for drug crimes (nearly 28%), property crimes (just over 21%), and crimes against persons (just over 20%). Sex crimes were relatively uncommon among booking codes (accounting for less than 5% of all codes). The research team was unable to confidently classify 24 (less than 2%) of the listed booking codes.

<b>Booking Charge</b>	<b>Number of Cases</b>	<b>Percentage of Total Cases</b>
“Other” crimes not easily fitting a category (e.g., probation violation, runaway, incorrigible, disturbing the peace)	587	43.9
Drug crimes	368	27.5
Property crimes	283	21.2
Crimes against persons	270	20.2
Sex crimes	61	4.6
Unable to classify (e.g., discretionary days)	24	1.8

*Note.* The percentages in this table are calculated out of the 1,336 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 10 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 60% 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 35% of the juveniles screened with the AST met the criteria for having a substance abuse problem. The 60% figure for the percentage of juveniles who met the AST criteria for having a mental health problem is identical to the seven-year average of 60% (ranging from a low of 56% in Y6 to a high of 68% in Y1). The 35% 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 seven-year average was 44%, ranging from a low of 38% in Y7 to a high of 54% in Y1).

<b>Condition</b>	<b>Number of Cases</b>	<b>Percentage of Total Screened Cases</b>
Mental health problem	806	60.1
Substance abuse problem	469	34.9

*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 69% of the girls who were screened using the AST met the criteria for having a mental health problem, whereas nearly 56% of the boys appeared to have a mental health problem. A chi-square test revealed that the difference in mental health problems was statistically significant,  $\chi^2$  (df = 1) = 21.17,  $p < .001$ . 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 34% and 37%, 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 seven of eight evaluation years suggests that the actual prevalence of substance abuse problems in these populations is indeed similar.

<b>Condition</b>	<b>Number of Cases</b>		<b>Percentage of Total Screened Cases</b>	
	<b>Male</b>	<b>Female</b>	<b>Male</b>	<b>Female</b>
Mental health problem	497	285	55.9	69.3
Substance abuse problem	300	150	33.7	36.5

*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 10 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 22% to 81% 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 (nearly 81% of screened juveniles met the criteria for a mental health problem), Twin Falls (nearly 77%), and Nez Perce (over 72%) counties. The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a mental health problem were in Minidoka (nearly 22%), Bonner (just over 31%), and Bonneville (over 49%) counties. A chi-square test revealed that the differential rate of mental health problems as a function of JDC location was statistically significant,  $\chi^2$  (df = 9) = 137.92,  $p < .001$ .

<b>JDC Location</b>	<b>Number of Cases</b>	<b>Percentage of Total Screened Cases</b>
Ada County	153	60.2
Bannock County (District 6)	69	56.1
Bonner County	14	<i>31.1</i>
Bonneville County (3B)	74	<i>49.3</i>
Canyon County (Southwest Idaho)	173	<b>80.8</b>
Fremont County (5C)	15	68.2
Kootenai County (District 1)	121	52.6
Minidoka County	17	<i>21.8</i>
Nez Perce County (District 2)	57	<b>72.2</b>
Twin Falls County (Snake River)	113	<b>76.9</b>

*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 in Fremont County (where over 59% of the screened juveniles met the criteria for a substance abuse problem), followed by the JDCs in Nez Perce and Canyon (over 53% and nearly 49%, respectively) counties. The three JDCs with the lowest percentages of juveniles meeting the AST criteria for having a substance abuse problem were in Minidoka (over 1%), Bonner (nearly 9%), and Ada (just over 27%) counties. A chi-square test revealed that the differential rate of substance abuse problems as a function of JDC location was statistically significant,  $\chi^2$  (df = 9) = 97.54,  $p < .001$ .

<b>Table 6: AST Indications of Substance Abuse Problems by JDC Location</b>		
<b>JDC Location</b>	<b>Number of Cases</b>	<b>Percentage of Total Screened Cases</b>
Ada County	69	27.2
Bannock County (District 6)	52	42.3
Bonner County	4	8.9
Bonneville County (3B)	48	32.0
Canyon County (Southwest Idaho)	104	<b>48.6</b>
Fremont County (5C)	13	<b>59.1</b>
Kootenai County (District 1)	82	35.7
Minidoka County	1	<i>1.3</i>
Nez Perce County (District 2)	42	<b>53.2</b>
Twin Falls County (Snake River)	54	36.7

*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 (just over 34%) who were screened with the AST met the diagnostic criteria for a mental health abuse problem only. The next largest group of juveniles (just over 31%) met the AST criteria for neither a mental health problem nor a substance abuse problem, followed by those who met the criteria for both a mental health problem and a substance abuse problem (nearly 27%). The smallest group of juveniles (over 8%) met the criteria for a substance abuse problem only.

<b>Table 7: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both</b>		
<b>Condition</b>	<b>Number of Cases</b>	<b>Percentage of Total Screened Cases</b>
Neither mental health nor substance abuse problem	417	31.1
Mental health problem only	457	34.1
Substance abuse problem only	113	8.4
Both mental health and substance abuse problem	355	26.5

*Note.* The percentages in this table are calculated out of the juveniles who were screened with the AST for both conditions. Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

Again to determine whether boys and girls differentially met the diagnostic criteria for mental health problems and substance abuse problems (or neither or both), we analyzed how male and female juveniles were distributed across the four diagnostic categories (neither type of problem, a mental health problem only, a substance abuse problem only, and both types of problems). As seen below in Table 8, differences in the rates at which boys and girls fell into the four categories were found, and a chi-square test revealed that these differences were statistically significant,  $\chi^2$  (df = 3) = 22.46,  $p < .001$ . In terms of raw percentages, the largest difference was in rates of meeting the diagnostic criteria for having neither type of problem; boys (at nearly 34%) were considerably more likely than girls (at over 25%) to fall into this category. On the other hand, girls (at over 38%) being considerably more likely than boys (at nearly 33%) to meet the criteria for having a mental health problem only. Girls were also considerably more likely to meet the criteria for having both types of problems (at just over 31%) than boys (nearly 24%). Lastly, boys were found to be much more likely to meet the criteria for having a substance abuse problem only (at nearly 10%) than girls (just over 5%). 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 seven 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	299	104	33.6	25.3
Mental health problem only	290	158	32.6	38.4
Substance abuse problem only	88	21	9.9	5.1
Both mental health and substance abuse problem	212	128	23.8	31.1

*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.

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 10 JDCs fell into the four categories were found, and a chi-square test revealed that these differences were statistically significant,  $\chi^2$  (df = 27) = 229.07,  $p < .001$ . 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 Bannock, Bonner, Bonneville, Kootenai, and Minidoka counties), juveniles meeting the criteria for a mental health problem only were the single largest group in two JDCs (in Ada and Twin Falls counties), and juveniles meeting the criteria for both types of problem were the single largest group in three JDCs (in Canyon, Fremont, and Nez Perce counties). The least common diagnostic category was much more uniform across JDCs, with juveniles meeting the criteria for a substance abuse problem only being the single smallest group in eight of the 10 JDCs (the

exceptions were in Minidoka County, where juveniles meeting the criteria for a both a mental health problem and a substance abuse problem was the single smallest group, and the JDC in Bonner County, where there was a tie for single smallest group between juveniles meeting the criteria for a substance abuse problem only and those meeting the criteria for having both a mental health and substance abuse problem).

<b>Table 9: AST Indications of Mental Health Problems, Substance Abuse Problems, and Comorbid Existence of Both, by JDC Location</b>				
<b>JDC Location</b>	<b>Neither MH nor SA</b>	<b>MH only</b>	<b>SA only</b>	<b>Both MH and SA</b>
Ada County	33.9 (N = 86)	<b>39.0</b> (N = 99)	5.9 (N = 15)	21.3 (N = 54)
Bannock County (District 6)	<b>30.1</b> (N = 37)	27.6 (N = 34)	13.8 (N = 17)	28.5 (N = 35)
Bonner County	<b>64.4</b> (N = 29)	26.7 (N = 12)	4.4 (N = 2)	4.4 (N = 2)
Bonneville County (3B)	<b>40.7</b> (N = 61)	27.3 (N = 41)	10.0 (N = 15)	22.0 (N = 33)
Canyon County (Southwest Idaho)	11.2 (N = 24)	40.7 (N = 87)	7.0 (N = 15)	<b>41.1</b> (N = 88)
Fremont County (5C)	22.7 (N = 5)	18.2 (N = 4)	9.1 (N = 2)	<b>50.0</b> (N = 11)
Kootenai County (District 1)	<b>36.1</b> (N = 83)	27.4 (N = 63)	9.6 (N = 22)	27.0 (N = 62)
Minidoka County	<b>76.9</b> (N = 60)	21.8 (N = 17)	1.3 (N = 1)	0.0 (N = 0)
Nez Perce County (District 2)	16.5 (N = 13)	31.6 (N = 25)	11.4 (N = 9)	<b>40.5</b> (N = 32)
Twin Falls County (Snake River)	12.9 (N = 19)	<b>51.0</b> (N = 75)	10.2 (N = 15)	25.9 (N = 38)

*Note.* The percentages in this table are calculated out of the juveniles at each JDC who were screened with the AST for both conditions. N denotes the number of cases in each table cell. Percentages are rounded to the first decimal place, so the total percentage across rows may not equal 100. The highest row percentages are presented in bold, and the lowest row percentages are presented in italics.

#### Previous and Provisional Diagnoses

During the clinical interview for each juvenile, the clinicians at each JDC asked whether the juvenile had ever been diagnosed with a mental health or substance abuse problem in the past. If the juveniles reported that they had been diagnosed with such a problem in the past, the clinicians asked them how many separate diagnoses they had been given. This information (along with, as noted in the Methodology section, information about any psychotropic medications a juvenile might be taking) was used to create a number of “previous diagnoses” for each juvenile.

At least one previous diagnosis of a mental health or substance abuse disorder was recorded for 1,059 juveniles, or just over 79% 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 74% in Y7; the seven-year average for percentage of juveniles with at least one previous diagnosis is 69%). The mean number of previous diagnoses for juveniles (of both genders and across the 10 JDCs) with at least one previous diagnosis was 1.31, with a standard deviation of .66. The range of previous diagnoses for those juveniles for whom at least one previous diagnosis was noted spanned from one to five. In Y8, similar to Y3, Y4, and Y7 (but unlike in Y1, Y2, Y5, and Y6), girls (1.40) reported or were identified with significantly more previous diagnoses than boys (1.27),  $t(df = 1,025) = -2.98, p < .01$ . 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 none of the 78 juveniles from that JDC was listed as having a previous diagnosis),  $F(8, 1,050) = 7.25, p < .001$  (this result is similar to that found in all seven previous evaluation years). As seen below in Table 10, the JDCs with the highest number of mean previous diagnoses were those in Bonner (1.67), Ada (1.50), and Nez Perce (1.48) counties. The JDCs with the lowest number of mean previous diagnoses were in Bonneville (1.08), Kootenai (1.13), and Fremont (1.17) counties.

<b>JDC Location</b>	<b>Number of Cases</b>	<b>Mean</b>	<b>Standard Deviation</b>
Ada County	238	<b>1.50</b>	.87
Bannock County (District 6)	82	1.39	.72
Bonner County	3	<b>1.67</b>	1.15
Bonneville County (3B)	147	<i>1.08</i>	.27
Canyon County (Southwest Idaho)	210	1.32	.66
Fremont County (5C)	18	<i>1.17</i>	.38
Kootenai County (District 1)	178	<i>1.13</i>	.39
Minidoka County	0	NA	NA
Nez Perce County (District 2)	44	<b>1.48</b>	.85
Twin Falls County (Snake River)	139	1.36	.61

*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 other 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 791 juveniles, or nearly 61% of all juveniles on whom data were collected. Thirty-three of the

juveniles (or less than 3% of all those on whom data were collected) received a provisional diagnosis indicating ‘diagnosis deferred,’ which meant that a clinician did not feel comfortable making a specific provisional diagnosis based on the clinical interview, but suspected an underlying mental health or substance abuse problem that could be identified in a more thorough, post-detention assessment. The mean number of provisional diagnoses for juveniles (of both genders and across the 10 JDCs) with at least one provisional diagnosis (excluding ‘diagnosis deferred’) was 1.46, with a standard deviation of .68. The range of provisional diagnoses for those juveniles for whom at least one provisional diagnosis was noted spanned from one to five. 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 (1.54) and boys (1.42), with girls receiving significantly more provisional diagnoses than boys,  $t(df = 760) = -2.27, p < .05$ . As was the case in all seven previous evaluation years, the mean number of provisional diagnoses significantly differed as a function of JDC location,  $F(9, 781) = 6.61, p < .001$ . As seen below in Table 11, the JDCs with the highest number of mean provisional diagnoses were in Canyon (1.74), Bonner (1.64), and Fremont (1.63) counties. The JDCs with the lowest number of mean provisional diagnoses were in Nez Perce (1.00), Minidoka (1.10), and Kootenai (1.30) counties.

<b>JDC Location</b>	<b>Number of Cases</b>	<b>Mean</b>	<b>Standard Deviation</b>
Ada County	154	1.44	.78
Bannock County (District 6)	62	1.40	.69
Bonner County	11	<b>1.64</b>	.81
Bonneville County (3B)	103	1.32	.49
Canyon County (Southwest Idaho)	194	<b>1.74</b>	.75
Fremont County (5C)	8	<b>1.63</b>	.74
Kootenai County (District 1)	135	<i>1.30</i>	.50
Minidoka County	30	<i>1.10</i>	.40
Nez Perce County (District 2)	1	<i>1.00</i>	0.00
Twin Falls County (Snake River)	93	1.44	.58

*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 786 cases. A content analysis procedure was used to classify all provisional diagnoses entered by the clinicians into conceptually consistent diagnostic categories. 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 36% 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 23% of

juveniles for whom a provisional diagnosis was listed. The latter was given to over 22% 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 just over 10% of juveniles. Interestingly, the five most common provisional diagnoses in Y8 were the same as in all previous evaluation years—in exactly the same order. Provisional diagnoses that did not fit one of these categories were listed as “Other,” and these were given to more than 16% of the juveniles. The most common “Other” notation indicated that the juveniles had suffered trauma; this was the case for 72 juveniles (or 9.2% of all juveniles who received a provisional diagnosis).

<b>Provisional Diagnosis</b>	<b>Number of Cases</b>	<b>Percentage of Total Cases</b>
Mood disorders (e.g., depression, bipolar disorder)	307	39.1
Substance abuse disorders (e.g., marijuana or alcohol abuse)	279	35.5
Disruptive behavior disorders (e.g., oppositional defiant disorder, disruptive disorder, conduct disorder)	182	23.2
Anxiety disorders (e.g., post-traumatic stress disorder)	175	22.3
Attention deficit disorders (e.g., ADHD/ADD)	79	10.1
Other (e.g., trauma, developmental delay)	128	16.3

*Note.* The percentages in this table are calculated out of 786 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 998 juveniles. This number is higher than the total number of juveniles who received at least one provisional diagnosis (786 juveniles received at least one provisional diagnosis). Of all juveniles who received at least one service recommendation, 744 (or 75%) were also given at least one provisional diagnosis. The remaining 254 (or 25%) received at least one service recommendation but were not given a provisional diagnosis. Additionally, 42 juveniles (or just over 5% 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 (744) by the number of juveniles who received at least one provisional diagnosis (786). The resulting figure is 94.7%, meaning nearly 95% of the juveniles who should have received a service recommendation did in fact receive at least one. The mean number of recommended services for those juveniles (of both genders and across the 10 JDCs) who were given at least one service recommendation was 1.51, with a standard deviation of .87. 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 and Y7, no statistically significant difference in the number of recommended services was found between girls and boys (the mean number of recommended services was 1.58 for girls and 1.49 for boys). However, similar to all seven

previous evaluation years, the mean number of recommended services was found to differ significantly as a function of JDC location,  $F(9, 988) = 27.54, p < .001$ . As seen below in Table 13, the JDC with the highest number of mean recommended services was in Bannock County (2.31), followed by the JDCs in Twin Falls (1.96) and Canyon (1.59) counties. The JDC with the lowest number of mean recommended services was in Minidoka County (1.03), followed by the JDC in Fremont County (1.05) and the JDCs in Ada and Bonneville counties (1.16 in each).

<b>JDC Location</b>	<b>Number of Cases</b>	<b>Mean</b>	<b>Standard Deviation</b>
Ada County	159	<i>1.16</i>	.41
Bannock County (District 6)	106	<b>2.31</b>	1.58
Bonner County	23	1.22	.52
Bonneville County (3B)	104	<i>1.16</i>	.40
Canyon County (Southwest Idaho)	199	<b>1.59</b>	.65
Fremont County (5C)	20	<i>1.05</i>	.22
Kootenai County (District 1)	140	1.28	.50
Minidoka County	29	<i>1.03</i>	.19
Nez Perce County (District 2)	74	1.36	.54
Twin Falls County (Snake River)	144	<b>1.96</b>	1.04

*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 998 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 (just over 43% 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 (33%), substance abuse counseling/treatment (nearly 28%), and psychological/mental evaluation (nearly 17%). Smaller numbers of recommendations were made for family counseling (nearly 6%), medication evaluation (2%), and residential treatment (just over 1%). Psychosocial rehabilitation, IDJC commitment (i.e., commitment in a state-operated Juvenile Corrections Center), or some other recommended service (e.g., “contact probation”) were listed rarely (less than 1% for each).

<b>Service Recommendation</b>	<b>Number of Cases</b>	<b>Percentage of Total Cases</b>
Continue (unspecified) prior treatment/Already in treatment	430	43.1
Individual counseling (e.g., Cognitive Behavioral Therapy)	329	33.0
Substance abuse counseling/treatment	277	27.8
Psychological/mental evaluation	167	16.7
Family counseling	55	5.5
Medication evaluation	20	2.0
Residential treatment	11	1.1
Psychosocial rehabilitation	5	>1.0
DJC commitment	4	>1.0
Other	4	>1.0

*Note.* The percentages in this table are calculated out of the 998 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 572 juveniles, or over 57% of the 998 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 10 JDCs) who were given at least one service recommendation and accessed at least one recommendation, was 1.38, 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 11 (approximately 43% of the juveniles receiving at least one service recommendation had not yet accessed a service). Similar to all seven previous evaluation years, the mean number of recommended services accessed differed significantly as a function of JDC location,  $F(9, 562) = 13.41, p < .001$ . As seen below in Table 15, the JDC with the highest number of mean recommended services accessed was in Bannock County (2.03), followed by the JDCs in Twin Falls (1.63) and Bonneville (1.33) counties. The JDCs with the lowest number of mean recommended services accessed were the JDC in Fremont and Minidoka counties (1.00 in each), followed by the JDC in Canyon County (1.04).

<b>JDC Location</b>	<b>Number Of Cases</b>	<b>Mean</b>	<b>Standard Deviation</b>
Ada County	128	1.15	.40
Bannock County (District 6)	87	<b>2.03</b>	1.44
Bonner County	10	1.20	.42
Bonneville County (3B)	18	<b>1.33</b>	.49
Canyon County (Southwest Idaho)	56	<i>1.04</i>	.19
Fremont County (5C)	6	<i>1.00</i>	.00
Kootenai County (District 1)	102	1.21	.46
Minidoka County	13	<i>1.00</i>	.00
Nez Perce County (District 2)	37	1.14	.35
Twin Falls County (Snake River)	115	<b>1.63</b>	.82

*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 192 calls were placed by the callers from the IFF, 91 which were successful (i.e., they resulted in a survey completion by a parent), yielding a 47% response rate. Parenthetically, the callers from the IFF placed additional 61 calls; however, these calls were excluded from the analysis because there either was no response (35 cases) or the number was invalid (26 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 91 parents who completed a survey answered this question. Of these parents, 19 (nearly 21%) 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 19 parents who completed this item, 13 (or over 68%) 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. Thirteen 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. Two parents each (over 15%) reported recommendations for a mental health evaluation, substance abuse treatment or assessment, or some other service, and one each (nearly 8%) reported a recommendation that their child continue previous treatment, receive substance abuse treatment or assessment, or that they could not remember what service or services had been recommended for their child.

<b>Table 16: Most Commonly Received Service Recommendations</b>		
<b>Service Recommendation</b>	<b>Number of Cases</b>	<b>Percentage of Total Cases</b>
Counseling (unspecified, mental health, family)	6	46.2
Mental health evaluation	2	15.4
Substance abuse treatment or assessment	2	15.4
Other (e.g., diversion, juvenile probation)	2	15.4
Can't remember	1	7.7
Continue previous treatment	1	7.7

*Note.* The percentages in this table are calculated out of the 13 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 13 parents who completed this item, all 13 (or 100%) reported that their child had accessed at least one recommended service.

### Barriers to Access

The final question on the survey was to ask 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. Because all parents who reported receiving at least one recommended service reported that their child had accessed at least one recommended service, no parents were asked this question.

### 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 44 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 44 respondents who completed this survey, 11 (or 25%) identified themselves as judges and 31 (or nearly 71%) identified themselves as a CJPO. Two respondents (less than 5%) identified themselves as a JDC director and a JPO, respectively. Similar to what was done in Y7, the two 'other' respondents were placed, for analytical purposes, with the CJPOs to form a category of 'CJPOs and others working with juveniles.'

As seen below in Table 17, judges, CJPOs, and others working with juveniles in Region 1 (over 27%) accounted for the largest percentages of respondents, followed by those in Region 4 (over 18%). On the other hand, judges, CJPOs, and those working with juveniles in Region 3 (nearly 5%) accounted for the smallest percentage of respondents, followed by those in Region 2 (nearly 7%).

**Table 17: Number of Respondents, by Region**

<b>Region</b>	<b>Number of Respondents</b>	<b>Percentage of Total Respondents</b>
Region 1 (Bonner and Kootenai counties)	12	27.3
Region 2 (Nez Perce County)	3	6.8
Region 3 (Canyon County)	2	4.5
Region 4 (Ada County)	8	18.2
Region 5 (Minidoka and Twin Falls counties)	6	13.6
Region 6 (Bannock County)	6	13.6
Region 7 (Bonneville, Fremont, and Lemhi counties)	6	13.6

*Note.* Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

### 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 43 respondents who completed this item, 41 (or over 95%) 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 41 respondents who completed this item, 32 (or 78%) 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 91% of the respondents who completed this item reported being very satisfied (nearly 63%) or satisfied (just over 28%) with the contact with the JDC clinician. Of those who did not report satisfaction with contact from the JDC clinician, two were neither satisfied nor dissatisfied, with just one being dissatisfied.

<b>Item</b>	<b>Very Dissatisfied</b>	<b>Dissatisfied</b>	<b>Not Satisfied or Dissatisfied</b>	<b>Satisfied</b>	<b>Very Satisfied</b>
How satisfied were you with the contact you had with the mental health clinician?	0.0% (N = 0)	3.1% (N = 1)	4.1% (N = 2)	28.1% (N = 9)	62.5% (N = 20)

*Note.* The percentages in this table are calculated out of the 32 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 difference in the level of satisfaction with contact with JDC clinician were found between judges and CJPOs and others working with juveniles. Because the response rate was lower in Y8 than in Y6-Y7 (the other years tests were conducted on possible regional differences), the usual test of significance (a one-way analysis of variance, or ANOVA) could not be employed to analyze the data; instead, a more conservative, non-parametric test (a Kruskal-Wallis ANOVA) appropriate for use with small samples—such as the one respondent in Region 3 and the two respondents in Region 2—was used for analytical purposes. This test did not reveal a statistically significant difference in levels of satisfaction with contact as a function of region. However, because the means did differ in observable ways, they are presented for inspection in Table 19 below.

<b>Region</b>	<b>Mean</b>	<b>Standard Deviation</b>
Region 1 (N = 8)	4.88	0.35
Region 2 (N = 2)	4.00	1.41
Region 3 (N = 1)	2.00	0.00
Region 4 (N = 6)	4.33	0.52
Region 5 (N = 6)	4.67	0.82
Region 6 (N = 4)	4.75	0.50
Region 7 (N = 5)	4.40	0.55

*Note.* Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values.

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 32 respondents who completed this item, 31 (or nearly 97%) 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, nearly 94% of the judges, CJPOs, and others working with juveniles who completed this item reported being either very satisfied (nearly 55%) or satisfied (nearly 39%). Of those who did not report satisfaction with recommendations from the JDC clinician, one (representing just over 3% of the sample) reported being neither satisfied nor dissatisfied, and one reported (just over 3%) being dissatisfied.

<b>Item</b>	<b>Very Dissatisfied</b>	<b>Dissatisfied</b>	<b>Not Satisfied or Dissatisfied</b>	<b>Satisfied</b>	<b>Very Satisfied</b>
How satisfied were you with the recommendations made by the mental health clinician?	0.0% (N = 0)	3.2% (N = 1)	3.2% (N = 1)	38.7% (N = 12)	54.8% (N = 17)

*Note.* The percentages in this table are calculated out of the 31 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-Y7, no statistically significant difference in the level of satisfaction with recommendations received from the JDC clinician were found between judges and CJPOs and others working with juveniles. To again control for the small sample sizes within each district, a conservative non-parametric test was employed to assess for regional differences in satisfaction with recommendations; this test revealed no statistically significant differences.

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 31 respondents who completed this item, 26 (or nearly 84%) reported that the recommendations they received had affected a decision or treatment advised for the youth.

No statistically significant difference 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. Both judges (100% of whom reported that recommendations received from JDC clinicians affected decisions or treatment made regarding youth) and CJPOs and others working with juveniles (81%) reported using clinicians' recommendations regarding youth they worked with.

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 21 below, the fully three-quarters 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 19% reported it to be rather beneficial, yielding an overall beneficial rate of 94%. Of those who did not report thinking that it was beneficial to have a clinician in the JDCs, one (representing just over 3% of the respondents) reported a neutral option and one reported it was not at all beneficial.

<b>Item</b>	<b>Not at all Beneficial</b>	<b>Not Very Beneficial</b>	<b>Neutral</b>	<b>Rather Beneficial</b>	<b>Extremely Beneficial</b>
How beneficial do you think it is to have a mental health clinician in the detention center?	3.1% (N = 1)	0.0% (N = 0)	3.1% (N = 1)	18.8% (N = 6)	75.0% (N = 24)

*Note.* The percentages in this table are calculated out of the 32 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-Y7, 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. To again control for the small sample sizes within each district, a conservative, non-parametric test was employed to assess for regional differences in satisfaction with recommendations; this test revealed no statistically significant differences. However, because the means did differ in observable ways, they are presented for inspection in Table 22 below.

<b>Region</b>	<b>Mean</b>	<b>Standard Deviation</b>
Region 1 (N = 8)	5.00	0.00
Region 2 (N = 2)	4.50	0.71
Region 3 (N = 1)	1.00	0.00
Region 4 (N = 6)	4.83	0.41
Region 5 (N = 6)	4.67	0.82
Region 6 (N = 4)	4.50	0.58
Region 7 (N = 5)	4.60	0.55

*Note.* Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values.

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. Thirty-one (or nearly 97%) of the 32 respondents who completed this item reported that they would like to see the CSP continue. This approval rate tied Y4 as the third-highest of the eight CSP evaluations; the two years that had slightly higher approval ratings were Y2 (100%) and Y7 (99%).

#### JDC Administrator and Clinician Interviews

As noted in the Methodology section of this report, the primary purpose of the JDC administrator and clinician interviews was to document these key informants' perspectives of the CSP's strengths/successes, weaknesses/challenges, and directions for future program implementation.

### Program Strengths/Successes

The first area covered in the interviews was related to documenting particular successes that JDC administrators and clinicians at each facility believed had been generated by continued implementation of the CSP; often these successes were discussed in terms of perceived strengths of the program. Although the responses varied somewhat by JDC, a number of administrators and clinicians identified strengths/successes as occurring in the areas of declining incidents (e.g., use of restraints, suicide attempts), community partnerships, and staff relationships.

#### JDC Incidents

Several JDC administrators and clinicians reported that having the CSP in place had decreased facility incidents of using restraints and suicide attempts. An important contextual component of this success as expressed by several administrators and clinicians was that often a large percentage of incidents recorded involved a single juvenile who required being restrained multiple times or who had attempted suicide on more than one occasion. This seemed important information, as it helped demonstrate that even if a JDC had a high number of use of restraints or suicide attempts, this would not necessarily be evidence that problems are systemic or pervasive in that JDC. Instead, one or two juveniles with particularly serious emotional or behavioral problems could have so many incidents that the numbers reported by that JDC might appear artificially inflated.

#### Community Partnerships

Some of the JDC administrators and clinicians reported stronger partnerships with community stakeholders as a result of continued implementation of the CSP. These partnerships were described as consisting of frequent communication and case coordination between JDC staff and invested community partners, including probation officers, judges, prosecutors, children's mental health workers, and staff in after-care facilities related to substance abuse or mental health treatment. These partnerships were viewed as particularly important given a perceived lack of parental investment and follow-up after juveniles have been identified as likely having a mental health and/or substance abuse problem, which will be discussed below. In the absence of this investment and follow-up, JDC administrators and clinicians believed that community stakeholders demonstrated reliable and consistent advocacy for the juveniles in most counties. However, administrators and clinicians at several JDCs did indicate a lack of follow-through in several of the communities within their "catchment areas," so in some sense community partnerships should be noted as a potential challenge as well as a success.

#### Staff Relationships and Training

Administrators and clinicians interviewed at four of the five JDCs indicated that CSP implementation had fostered supportive relationships between the clinician and the line staff, and in turn between the line staff and the juveniles. Administrators across the board indicated that having trained, experienced line staff was invaluable. Through the CSP, many clinicians had been able to develop and offer specialized training to line staff to help them learn how to deescalate tense situations without using restraints whenever possible, and to help line staff

streamline the identification of safety risks and assess appropriate security measures for staff, especially during “off-peak” hours when clinicians were not available at the JDCs. Several administrators and clinicians noted that their JDCs are in buildings that have clinical units either onsite or nearby, and this was overwhelmingly identified as an asset for those facilities.

### Weaknesses/Challenges

The second area the evaluation team was interested in exploring was related to perceived weaknesses or challenges with respect to the CSP, including obstacles to implementation and/or perceived barriers for juveniles who had been identified as possibly having mental health and/or substance abuse problems. The most frequent themes were identified as parental involvement, access to community resources, and detention population characteristics. Several of the JDC administrators and clinicians mentioned more specific challenges based on the size of the facility’s catchment area, the Medicaid billing process, and treatment centers specializing in high-risk populations.

### Parental Involvement

Several of the administrators and clinicians mentioned that lack of parental involvement was an ongoing challenge for their juvenile offenders, citing parental mistrust of government agencies, parental mental health or substance abuse problems, parental incarceration or criminal history, and parental lack of cooperation as elements that restrict juveniles from accessing recommended community-based services after release. Quite simply, many parents of juveniles in need of post-release services were perceived as unwilling or unable to help their children utilize these services. Although there seemed some level of resignation that this was a problem that would never be solved, several administrators and clinicians stated that new approaches to facilitate parent engagement would be desirable and likely produce better outcomes for released juveniles. Several also expressed a perception that the current effort to survey parents of released juveniles was not offering much in the way of understanding whether and why parents play an active role in helping their children access the community-based services recommended by clinicians.

### Community Resources

Administrators and clinicians at each JDC reported identifying and accessing community-based services for after-care was as challenging. Most commonly, a lack of resources (particularly in rural areas) and a lack of inpatient treatment facilities were listed as significant problems in identifying appropriate referral sources for juvenile offenders. Less commonly mentioned resource issues were identified as population-specific treatment programs, including girls-only programs and programs for sex-offenders. Although administrators and clinicians at some facilities indicated that there were after-care services available, they noted that getting a juvenile immediate access to these facilities (particularly inpatient treatment for mental health and substance abuse) was difficult—if not impossible—in some counties. Long waiting lists, facilities (including state hospitals) not accepting juveniles who were considered “too mentally ill,” and not having nearby facilities were mentioned as barriers to appropriate treatment options by several JDC administrators and clinicians.

### Miscellaneous

Several of the JDC administrators and clinicians identified challenges related to a cultural mistrust of ‘government’ services in some of the more rural counties, including a reluctance to follow up on referrals unless they were court-ordered. Staff at several of the smaller JDCs, who did not have a full-time billing specialist available to them, indicated that the process for billing through Medicaid was time-intensive and frustrating. Many of the clinicians indicated that the characteristics of the juveniles have also changed over time, reporting more severe mental health diagnoses and arresting offenses being more violent in nature. Although it is difficult to speculate why this might be the case, it is relevant to note that working with more troubled or difficult youth is often more time intensive and resource-taxing on clinicians specifically, and administrators and line staff as well.

### Directions for Future Program Implementation

Finally, members of the research team asked administrators and clinicians to identify any ideas or suggestions for the CSP moving forward. The interview protocol phrased the question without parameters on funding or staff in order to develop a broad sense of the directions in which the staff wanted to move. It was made clear to the interviewees that although their feedback was extremely valuable, the research team could in no way guarantee implementation of these changes or suggestions but would communicate them to IDJC.

The most common response, voiced by administrators and clinicians at all five JDCs, was that personnel at each site overwhelmingly believe in the usefulness of the CSP and want funding to continue. In JDCs where the clinician position was not employed full-time, administrators indicated that if funding for a full-time position were available, it would enhance their ability to consistently serve the detention population. Several administrators and clinicians mentioned interest in the Adverse Childhood Experiences (ACE) screening tool as a potential addition to clinical assessments in order to better understand factors associated with juvenile crime. Additionally, it was suggested by multiple interviewees that interviews with other stakeholders may be particularly valuable to the evaluation process, including line staff, probation officers, judges, service providers, and parents.

### Incident Data

The final wave of data collection involved the transfer of incident data from IDJC to the researchers at BSU. As discussed earlier in this report, the incident data consisted of the number of two types of incidents—use of restraints and suicide attempts—for each JDC for each of six years, calendar years 2005-2007 and 2011-2013. Because most JDCs began implementing the CSP in 2008, the primary analysis involved assessing for possible differences in the number of times restraints were used and the number of suicide attempts in the three years prior to the implementation of the CSP (i.e., 2005-2007) and the three most recent years for which complete incident data was available (i.e., 2011-2013).

As seen below in Table 25, the number of incidents of use of restraints and suicide attempts (in the third and fourth columns) differed markedly across the six years. However, because the

number of bookings also varied considerably across the six years (see the second column), a comparison of raw incident data (i.e., the number of use of restraints and suicide attempts alone) would be biased; therefore, the number of bookings was controlled for by converting the number of use of restraints and suicide attempts to a number per 1,000 bookings. As seen in the fifth and sixth columns of Table 23, the weighted number (i.e., controlled for differences in number of bookings) of use of restraints and suicide attempts also varied from year to year. Some random fluctuation is to be expected, of course, so the key calculation involves the aggregation of incident numbers per 1,000 bookings across the three years prior to and after the implementation of the CSP. As seen in Table 25, average use of restraints per 1,000 bookings decreased from 16.17 in the 2005-2007 “pre-clinician period” to 13.58 in the 2011-2013 “clinician period”. This represents a 15% decline. Also as seen in Table 31, average suicide attempts per 1,000 bookings increased from 1.53 in the 2005-2007 pre-clinician period to 2.61 in the 2011-2013 clinician period. This represents a 71% increase.

<b>Year</b>	<b>Bookings</b>	<b>Use of Restraints</b>	<b>Suicide Attempts</b>	<b>Use of Restraints per 1,000 Bookings</b>	<b>Suicide Attempts per 1,000 Bookings</b>
2005	9,595	161	15	16.78	1.56
2006	9,027	159	18	17.61	1.99
2007	9,395	133	10	14.16	1.06
<i>2005-2007</i>	<i>28,017</i> <i>(total)</i>	<i>453</i> <i>(total)</i>	<i>43</i> <i>(total)</i>	<i>16.17</i> <i>(average)</i>	<i>1.53</i> <i>(average)</i>
2011	7,127	145	30	20.35	4.21
2012	6,879	93	15	13.52	2.18
2013	6,323	43	8	6.80	1.27
<i>2011-2013</i>	<i>20,329</i> <i>(total)</i>	<i>281</i> <i>(total)</i>	<i>53</i> <i>(total)</i>	<i>13.82</i> <i>(average)</i>	<i>2.61</i> <i>(average)</i>

*Note.* The 2005-2007 pre-clinician period years are in unshaded cells; the 2011-2013 clinician period years are in shaded cells. Totals and/or averages for both periods are shown in italics.

The 15% decline in use of restraints between the 2005-2007 pre-clinician period and the 2011-2013 clinician period was expected; this finding was similar to the 13% decline reported between the 2005-2007 pre-clinician period and the 2008-2010 clinician period reported by McDonald, Begic, and Howard (2012) in the Y4 CSP report. Across most JDCs, the drop was more dramatic than the overall figure. Upon examination of the JDC-specific incident rates, it was noted that one facility accounted for an unusually large percentage of the use of restraints; for example, whereas this facility had less than 12% of all JDC bookings in 2011, it had nearly 25% of all JDC use of restraints that year. In 2012, when the same JDC had 14% of the bookings, it had nearly 36% of the use of restraints; similarly, in 2013, the same JDC had 14% of the bookings but 21% of the use of restraints. When the research team interviewed an administrator and clinician in this facility, both JDC staff were asked about the disproportionately high use of restraints at their JDC between 2011-2013, and the administrator quickly remarked that in at least two of those years “about 75%” of the use of restraints involved one male juvenile who had been repeatedly detained and who was very aggressive and difficult to manage. In any case, if the data from this one anomalous JDC were removed, the use of restraints per 1,000 bookings would have fallen from 20.35 to 17.35 in 2011, from 13.52 to 10.14 in 2012, and from 6.80 to

6.25 in 2013. The overall use of restraints per 1,000 bookings across the years 2011-2013 would have fallen from 13.82 to 11.51 with the one anomalous JDC removed.

The 71% increase in suicide attempts between the pre-clinician period 2005-2007 and the clinician period 2011-2013 was wholly unexpected. As reported by McDonald et al. (2012), during the Y4 evaluation, a 32% decrease was found between the 2005-2007 pre-clinician period and the 2011-2013 clinician period. To better understand the reasons for the unexpected rise in suicide rates, JDC-specific results were examined. It was found that nearly all of the increase was accounted for by suicide attempts at one JDC. Across the three evaluation years, whereas this JDC accounted for less than 13% of all JDC bookings over the years 2011-2013, it had over 43% of all suicide attempts (30%, 60%, and nearly 63% in 2011, 2012, and 2013, respectively). When the research team inquired with the administrator of this JDC about the higher rates of suicide attempts, the administrator provided some context that may at least partially explain the discrepancy. In particular, he noted that his staff had received extensive in-service training from the National Partnership for Juvenile Services (NPJS) on suicide prevention, with the staff learning better how to recognize signs of suicidal behavior and suicide attempts. He speculated that his staff were now documenting as suicide attempts behaviors that may not have been so labeled prior to the training, and that might not be so labeled by staff in other JDCs who had not participated in the NPJS training. In any case, if the data from this one anomalous JDC were removed, the suicide attempts per 1,000 bookings across 2011-2013 falls from 2.61 to 1.69.

#### 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, Y7, and Y8 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 not, within the Y8 juveniles, an association between gender and traumatic experiences. This finding is contrary to those from Y5-Y7, when a significantly greater percentage of girls were found to screen positive for traumatic experiences on the MAYSI-2 than boys. As seen below in Table 24, a slightly higher percentage of girls

(36%) screened positive for traumatic experiences than boys (33%), however because this difference was not statistically significant, it should be concluded that girls and boys in Y8 have experienced trauma at similar rates.

MAYSI-2 Indication	Gender			
	Number of Cases		Percentage of Total Screened Cases	
	Male	Female	Male	Female
Positive screen for traumatic experiences	291	149	32.7	36.3
Negative screen for traumatic experiences	598	262	67.3	63.7

*Note.* The percentages in this table are calculated out of the juveniles who were screened with the MAYSI-2 for the relevant condition.

Collapsed across gender, MAYSI-2 traumatic experiences indications were, as in Y5-Y7, significantly associated with AST mental health problems,  $\chi^2$  (df = 1) = 66.91,  $p < .001$ . As seen below in Table 25, this finding is accounted for by a greater percentage of juveniles with traumatic experience indications (nearly 76%) meeting the AST criteria for having a mental health problem than juveniles without traumatic experience indications (over 52%). A binomial logistic regression procedure revealed that, without controlling for the effects of other MAYSI-2 subscales, juveniles with traumatic experience indications were 2.8 times more likely to meet the AST criteria for a mental health problem than juveniles without traumatic experience indications.

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	109	337	24.4	75.6
Negative screen for traumatic experiences	427	469	47.7	52.3

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

Because no significant association was found between gender and traumatic experiences, there was no further exploration of the extent to which differential traumatic experience exposure as a function of gender could at least partially explain the gender difference in AST mental health indications.

#### 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. In these analyses, only the first booking code was used, as over 80% of the cases had only one booking charge listed. 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 419 juveniles who met the AST criteria for neither a mental health nor a substance abuse problem, 62% (or 261 juveniles) had at least one booking charge that could be classified as one of the four UCR categories. Of the 917 remaining juveniles (those who met the AST criteria for a mental health problem, a substance abuse problem, or both types of problems), 60% (or 553 juveniles) had at least one booking charge that could be classified as one of the four UCR categories. Similar to Y5 and Y6 (but unlike Y7) no statistically significant differences were found in the types of booking charges between juveniles with neither AST indications of a mental health nor a substance abuse problem and juveniles with at least one AST indication,  $\chi^2$  (df = 3) = 6.32,  $p = .10$ . As seen below in Table 26, booking crime distributions were mostly similar, with drug crimes being the most common booking charge for both groups, and sex crimes being the least common booking charge for both groups.

Condition	Booking Charge			
	Drug Crime	Property Crime	Crime Against Persons	Sex Crime
Neither mental health nor substance abuse problem	<b>33.7</b> <b>(88)</b>	31.8 (83)	25.3 (66)	9.2 (24)
All other diagnostic categories combined (mental health problem only, substance abuse problem only, or both types of problems)	<b>34.4</b> <b>(278)</b>	28.6 (158)	31.5 (174)	5.6 (31)

*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. The highest row percentage is presented in bold, and the lowest row percentage is presented in italics.

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,  $\chi^2$  (df = 9) = 119.63,  $p < .001$ . As seen in Table 27 below, juveniles who were booked on drug crime charges were most likely to meet the AST criteria for a substance abuse problem only (nearly 69%), and least likely to meet the criteria for a mental health problem only (less than 15%). The exact opposite was true of property crime charges; juveniles who were booked on property crime charges were most likely to meet the AST criteria for a mental health problem only (nearly 34%), and least likely to meet the criteria for a substance abuse problem only (over 20%). The latter pattern also held true for booking charges for crimes against persons and sex crimes; in both cases, juveniles booked on charges of both crimes against persons and sex crimes were most likely to meet the AST criteria for having a mental health problem only (42% for

crimes against persons and 10% for sex crimes) and least likely to meet the criteria for having a substance abuse problem only (nearly 11% for crimes against persons and 0% for sex crimes).

<b>Table 27: Booking Charge, by AST Diagnostic Category</b>				
<b>Booking Charge</b>	<b>AST Diagnostic Category</b>			
	<b>Neither Problem</b>	<b>Mental Health Problem Only</b>	<b>Substance Abuse Problem Only</b>	<b>Both Problems</b>
Drug crime	33.7 (87)	14.6 (41)	<b>68.8</b> (44)	50.2 (106)
Property crime	31.8 (82)	<b>33.5</b> (94)	20.3 (13)	24.6 (52)
Crime against person	25.6 (66)	<b>42.0</b> (118)	10.9 (7)	23.2 (49)
Sex crime	8.9 (23)	<b>10.0</b> (28)	0.0 (0)	1.9 (4)

*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 10 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 10 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 three (Bonner, Fremont, and Minidoka) were classified as rural/frontier. Unlike in Y5 and Y6, 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, but like Y7, when such an association was found, a chi-square test revealed a statistically significant association between these two variables in Y8,  $\chi^2 (df = 1) = 5.17, p < .05$ . As seen in Table 28 below, juveniles released from JDCs in urban counties (just over 51%) were statistically significantly more likely to access at least one recommended service than those released from JDCs in rural/frontier counties (nearly 38%).

Type of County	Recommended Services Accessed	
	Number of Cases	Percentage of Cases
Urban	544	51.1
Rural/Frontier	29	37.7

*Note.* The percentages in this table are calculated out of the juveniles for whom information about recommended service access was available.

Next, we analyzed whether the rate at which at least one recommended service was accessed varied across counties. As seen in Table 29 below, there was a large spread of percentages of juveniles by county who accessed at least one recommended service, ranging from less than 14% to nearly 81%. The three counties housing JDCs with the highest percentage of juveniles who accessed at least one recommended service were Bannock (nearly 81%), Twin Falls (nearly 79%), and Kootenai (over 65%). The three counties housing JDCs with the lowest percentages of juveniles who accessed at least one recommended service were Bonneville (less than 14%), Canyon (over 26%), and Fremont (over 27%). In Y8, similar to Y5-Y7, 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,  $\chi^2$  (df = 9) = 230.22,  $p < .001$ .

County	At Least One Recommended Service Accessed	
	Number of Cases	Percentage of Cases
Ada County	128	44.6
Bannock County	87	<b>80.6</b>
Bonner County	10	43.5
Bonneville County	18	<i>13.5</i>
Canyon County	56	<i>26.4</i>
Fremont County	6	<i>27.3</i>
Kootenai County	102	<b>65.4</b>
Minidoka County	13	40.6
Nez Perce County	38	48.1
Twin Falls County	115	<b>78.8</b>

*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 10 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 and Fremont counties). As seen in Table 30 below, the three regions housing JDCs with the highest

percentages of juveniles who accessed at least one recommended service were Region 6 (nearly 90%), Region 5 (nearly 72%), and Region 1 (nearly 63%). The three regions housing JDCs with the lowest percentages of juveniles who accessed at least one recommended service were Region 7 (nearly 16%), Region 3 (over 26%), and Region 2 (just over 48%). In Y8, similar to Y5-Y7, 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,  $\chi^2$  (df = 6) = 209.67,  $p < .001$ .

Type of County	At Least One Recommended Service Accessed	
	Number of Cases	Percentage of Cases
Region 1	112	<b>62.6</b>
Region 2	38	<i>48.1</i>
Region 3	56	<i>26.4</i>
Region 4	128	55.4
Region 5	128	<b>71.9</b>
Region 6	87	<b>80.6</b>
Region 7	24	<i>15.5</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 Y8, similar to Y5-Y7, 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 was 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 Y8, similar to Y6 and Y5, statistically significant differences on all three 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 (in Y7, statistically significant differences were found on the first two items, but not the third). As seen in Table 31 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 ( $M = 4.69$ ,  $SD = .47$ ) than those reporting that recommendations had not affected a decision or treatment advised ( $M = 4.00$ ,  $SD = 1.00$ ),  $t(29) = 2.47$ ,  $p < .05$ . 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 ( $M = 4.65$ ,  $SD = .49$ ) than those reporting that recommendations received had not affected a decision or treatment advised ( $M = 3.40$ ,  $SD = .89$ ),  $t(29) = 4.59$ ,  $p < .001$ . Finally (again as seen below in Table 31),

respondents reporting that recommendations had affected a decision or treatment advised had significantly higher perceptions of how beneficial the program housing clinicians in JDCs was ( $M = 4.88$ ,  $SD = .33$ ) than those reporting that recommendations received had not affected a decision or treatment advised ( $M = 4.00$ ,  $SD = .71$ ),  $t(29) = 4.52$ ,  $p < .001$ .

<b>Table 31: Judges/CJPOs Ratings of Contact with JDC Clinicians, Clinicians' Recommendations, and Program's Value, by whether Recommendations Affected Decisions or Recommendations Advised for Youth</b>		
<b>Perception of Program Element</b>	<b>Recommendations Affected Decisions or Recommendations Advised for Youth</b>	
	<b>Yes</b>	<b>No</b>
Satisfaction with contact from JDC clinicians	4.69 (.47)	4.00 (1.00)
Satisfaction with recommendations from JDC clinicians	4.65 (.49)	3.40 (.89)
How beneficial is it to have a clinician in the JDCs	4.88 (.33)	4.00 (.71)

*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 five 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, four of the five respondents reported that the juveniles were already receiving the recommended services or that the recommendations were in line with what the respondents were already doing. The remaining respondent reported that the letter to parents regarding recommended services does not contain much information, presumably suggesting that he or she has not used the recommendations because he or she was not sure what the recommendations were. Subsequently, comments provided by 19 judges, CJPOs, and others working with juveniles (or approximately 46% of those who indicated that they were aware that the nearby detention center had a 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 (just under 90%) 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:

- A clinician in a detention setting is an invaluable tool because it is the only person formally educated in mental health. With the rise of mental health issues in detention centers, having a clinician assist staff and probation officers w/ how to best serve youth is extremely important. In addition to conduct risk screening for suicide and PREA.

- Extremely beneficial to youth, families, and probation officers as well as the detention center staff!
- Having someone immediately available to meet with our youth is very beneficial. Further their firsthand information on detained youth at Rule 19 Screenings has been very helpful. Often times the clinician will provide information not obtainable elsewhere and they usually have more accurate information than someone from the outside who has only met with the youth in the office setting.
- I believe it is paramount to have a clinician in the detention center as a resource and someone who is knowledgeable of mental health-related issues. It would appear the longer I do this job, the more mental health youth have been recognized and treated appropriately both in the detention center and within the community as a result.
- It is a critical bridge between what is happening in a facility and the community. It also assists with a continuum of care and treatment.
- It is extremely beneficial to the population in detention as well as collateral information for Probation and Judges.
- It is extremely helpful to be able to staff my clients' mental health concerns with a clinician I know and trust.
- It is so valuable to us to have information to help us identify needs and potential resources to help a child be more successful. We have great confidence in the Mental Health Therapist that provides service at the Snake River Juvenile Detention Center.
- It is very useful to the probationer, the probationer's family, and the PO to get these issues identified and to hopefully get an early start on the road to treatment.
- It's effective especially when new youth are placed in detention, it gives the court an idea how to proceed.
- Our clinician is a valuable asset in dealing with the needs of the youth in our community. Losing this service would be detrimental to our ability to service the juveniles in our community.

Two respondents (or approximately 10%) commented somewhat negatively on the program. These comments are presented below:

- I think it needs to be reevaluated. I think it is beneficial for suicide prevention to an extent, and is more beneficial to some facilities than others based on size, population, and how the clinician is actually used. I think some of the money is being wasted and there could be more direct services to the juveniles/families.
- The Clinician in District 3 does not seem open to working with others outside of the detention facility. He does not reach out to POs when making recommendations for juveniles already on probation have many services in place. This Clinician's recommendations do not consider what has already been done or what is working for those juveniles. You have to go to him if you want any type of information, when he is approached, he guards the information and claims he is bound by the contract to release any information to POs. This program could be much helpful to the youth of District 3 if there was a provider willing to work together and in the best interest of the youth.

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 41 respondents who indicated that they had been contacted by a mental health clinician, 13 (or nearly 32%) provided a comment when

asked whether they had any recommendations that would help improve the mental health services in detention centers. Four comments simply conveyed a desire for the program to be continued. The remaining comments are presented below.

- An actual written report would be useful in court.
- Do a re-evaluation of each center and what they are actually doing. Some have clinicians on site part-time or full-time, while others just drop in at the time of intake to do a quick 10 minute assessment, come back later to check in with the juveniles, for a total on-site time of 1-2 hours per week but get paid 20k a year. I don't think it is wise use of the funds.
- I would suggest that in addition to crisis management, that the Clinician provide suicide prevention, problem solving groups, and MRT, just suggestions.
- It would be helpful to have a process to have the Department of Health and Welfare provide a mental health assessment on a quick time frame (less than five days when juveniles are in detention and their mental health is a major reason for staying in detention). Currently the Court is presented with leaving a child in custody with no other options through Children's Mental Health even when the parent wants services.
- More hours for the clinician to work.
- Ongoing training for the people doing this work on the specific needs and issues of our juvenile populations.
- Our Clinician Robyn Jacobson at District 1 Juvenile Detentions is phenomenal. The only recommendation I would request is to get her an intern to help with the paperwork that takes up her time.
- Somehow increase the pay so we can retain excellent clinicians.
- Would like to see therapeutic programming expanded within the detention center while the client is in custody.

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

The next set of analyses involved two binomial logistic regression tests to determine which, if any, MAYSI-2 subscale indications were significant predictors of juveniles meeting the AST diagnostic criteria for having a mental health and/or substance abuse problem. As seen below in Table 32, four of the seven MAYSI-2 subscale indications were found to be predictive of whether juveniles met the AST criteria for having a mental health problem. The strongest predictor was Suicide Ideation subscale indication; juveniles who had a positive indication of suicide ideation were 2.4 times more likely than those with a negative indication to meet the AST diagnostic criteria for a mental health problem. Odds ratios were less large, but still impressive (and statistically significant), for the Angry-Irritable (juveniles scoring positive were 2.2 times more likely to meet the criteria for a mental health problem), Thought Disturbance (1.9), and Traumatic Experiences (1.6) subscale indications.

<b>MAYSI-2 Indications</b>	<b>Significance Level</b>	<b>Odds Ratio</b>
Alcohol/Drug Use	None	N.A.
Angry-Irritable	$p < .001$	2.2
Depressed-Anxious	None	N.A.
Somatic Complaints	None	N.A.
Suicide Ideation	$p < .001$	2.4
Thought Disturbance	$p < .05$	1.9
Traumatic Experiences	$p < .01$	1.6

*Note.* N.A. denotes “not applicable” as when a MAYSI-2 subscale indication is not significantly predictive of an AST problem, any observed odds ratio is considered spurious in nature.

Four of the seven MAYSI-2 subscale indications were also found to be predictive of whether or not juveniles met the AST criteria for having a substance abuse problem. As seen below in Table 33, unsurprisingly the strongest predictor was the Alcohol/Drug Use subscale; juveniles who had a positive indication of alcohol or drug use were 5.9 times more likely than those with a negative indication to meet the AST criteria for having a substance abuse problem. Other significant predictors included the Traumatic Experiences (juveniles scoring positive were 1.6 times more likely to meet the criteria for a substance abuse problem), Angry-Irritable (0.7), and Depressed-Anxious (0.4) subscale indications.

<b>MAYSI-2 Indications</b>	<b>Significance Level</b>	<b>Odds Ratio</b>
Alcohol/Drug Use	$p < .001$	5.9
Angry-Irritable	$p < .05$	0.7
Depressed-Anxious	$p < .001$	0.4
Somatic Complaints	None	N.A.
Suicide Ideation	None	N.A.
Thought Disturbance	None	N.A.
Traumatic Experiences	$p < .001$	1.6

*Note.* N.A. denotes “not applicable” as when a MAYSI-2 subscale indication is not significantly predictive of an AST problem, any observed odds ratio is considered spurious in nature.

## Summary and Conclusions

The material in this report describes the results of the eighth-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

In many respects, the methodology utilized in Y8 was virtually identical to that employed in the past several evaluation years. The first-wave data submitted by clinicians and provided by IDJC to the BSU research team were the same elements as in all other years, however it is noteworthy that they were much easier to work with in several regards. Specifically, a newer data system developed by IDJC allowed clinicians to use more comprehensive drop-down menus for provisional diagnoses and community-based service recommendations, which decreased the amount of typing clinicians had to do and the amount of coding the research team had to do (in order to categorize typed information into conceptually-similar themes). There were fewer inappropriate multiple entries in the data set as well. Thus, the wave one data were cleaner and easier to work with than in previous years.

No changes were made to the second wave data collection process between Y7 and Y8. Following a pattern first seen in Y7, however, the number of calls that resulted in a survey being completed was down significantly from the historic average. Whereas between Y2-Y6 there had been an average of 202 completed surveys, in Y7 the number fell to 111 and in Y8, the number was 91. It is difficult to ascertain why the number of completed surveys has dropped so markedly. Increasingly, there is a perception that a parent survey is not yielding the kinds of information that is helpful in the evaluation of the CSP, and plans for the Y9 evaluation include trying a different mechanism (namely parent interviews) to understand parents' perceptions of the CSP and whether their children accessed services recommended by a JDC clinician.

The methodology for data collection for the Judges'/CJPOs' survey was identical to that used in Y6 and Y7 (prior to this, several demographic questions did not exist on the survey and prior to Y5, a mail survey was used rather than an internet-based survey). The number of respondents to the survey was lower in Y8 than Y7 (44 as compared to 94), however, the number of judges and CJPOs who were invited to participate was also lower. As was the case in Y7, there were some respondents to the survey who were not judges or CJPOs; these individuals were forwarded the invitation from the original recipient. The number of respondents who were not judges or CJPOs was substantially lower in Y8 than Y7, suggesting that the invitation was not inappropriately shared as often as in the previous year.

## 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. In the last several reporting years (i.e., Y4-Y7), the average prevalence rates excluded those from Y1, which were notably higher than in subsequent years. However, in Y8 the decision was made to include Y1 prevalence rates back into the annual average, as there are now enough other prevalence rates to reduce the impact of Y1's outlying values (in fact, the difference between Y1-Y8 and Y2-Y8 annual averages was only one percentage point). Being able to average all years of the CSP, without having to explain and/or justify the exclusion of one year's prevalence rates, seems an improvement in the overall evaluation methodology. In any case, the average annual prevalence rates for both AST mental health and substance abuse remain striking. As seen in Table A2 in Appendix A, the average annual percentage of juveniles in JDCs throughout the state who met the AST criteria for having a mental health problem was 60% across all eight years of the CSP, ranging from a low of 56% in Y6 to a high of 68% in Y1. As seen in Table A3 in Appendix A, the average annual percentage of juveniles in JDCs throughout the state who met the AST criteria for having a substance abuse problem was 43% across all eight years of the CSP, ranging from a low of 35% in Y8 to a high of 54% in Y1. As has been noted in other evaluation reports (e.g., Begic & McDonald, 2015), one interesting discrepancy between the average annual prevalence rates for AST mental health and substance abuse problems is that, in most years, mental health problem prevalence rates have clustered closely around the overall mean of 60%, substance abuse problem prevalence rates have fallen in a fairly linear pattern, with each year's prevalence rate lower than the prior year (see Table A3 in Appendix A) (possible explanations for this discrepancy will be discussed later in this section of the report). As seen in Table A4 in Appendix A, the percentage of juveniles with at least one AST indication across the eight evaluation years was 72%, ranging from a low of 66% in Y6 to a high of 82% in Y1. That more than 70% of juveniles detained in Idaho between 2008-2016 have been found to meet the screening criteria for having a mental health and/or substance abuse problem is perhaps the most noteworthy result of the entire CSP evaluation. This finding, and the enormous implications it has for policy and practice, will be elaborated on later in this section of the report.

In each evaluation year, it has been found that a fairly large minority of the juveniles have met the criteria for having both a mental health problem and a substance abuse problem, which is often referred to as having a dual diagnosis (or co-occurring disorders). The prevalence of dual diagnosis in the first seven years of the CSP was 32%, ranging from a low of 29% in Y4 and Y7 to a high of 41% in Y1. As noted earlier in this report, in Y8, 31% of the detained juveniles met the criteria for having a mental health and a substance abuse problem, leaving the eight-year average (like the seven-year average) at 32%. As noted in earlier reports and throughout the scientific literature (e.g., Horsfall, Cleary, Hunt, & Walter, 2009; Kelly, Daley, & Douaihy, 2012; Peters, Lurigio, & Wexler, 2015) the high degree of complexity and difficulty in treating dual diagnoses or co-occurring disorders means that comprehensive and coordinated treatment strategies will be needed to assist juveniles who are released from JDCs with indications of both mental health and substance abuse problems.

Another of the most striking findings (and one with many policy and practice implications), across all eight years of CSP evaluation, is that detained girls meet the AST screening criteria for a mental health problem at a much higher rate. As seen in Table A6 in Appendix A, in each of the eight years, the mental health problem prevalence rates for girls have been statistically significantly greater than for boys; the eight-year mental health problem prevalence has averaged 70% for girls (ranging from a low of 67% in Y4, Y5, and Y6 to a high of 76% in Y1) versus 57% for boys (ranging from a low of 53% in Y6 to a high of 65% in Y1). When observing the data at a finer level, as depicted in Table A9 in Appendix A, girls have historically met the criteria for a mental health problem only, and both a mental health problem and a substance abuse problem, more often than boys (who in turn have historically met the criteria for having neither type of problem or a substance abuse problem only more than girls). As discussed in previous reports (e.g., Begic et al., 2013), there is a large national literature on how females (i.e., both girls and women) more often meet the diagnostic criteria for many (though not all) mental health problems than males (i.e., both boys and men), and this has been reported in both the general population (e.g., Doherty & Kartalova-O'Doherty, 2010; Eaton et al., 2012; Kessler, Chiu, Demler, & Walters, 2005) and in detained populations (e.g., Steadman, Osher, Clark-Robbins, Case, & Samuels, 2009). There have been a number of different explanations for this phenomenon, including that females are more likely to self-disclose symptoms of mental health problems (e.g., Mackenzie, Gekoski, & Knox, 2006) and that they are also more likely to internalize difficulties so that they manifest in symptoms of mental health problems rather than externalize them so that they manifest themselves in behavioral problems (Eaton et al., 2012). Whatever the reason for the discrepancy between prevalence rates in AST mental health indications between girls and boys in Idaho's JDCs, the phenomenon itself has important implications that will be discussed later in this section of the report.

Starting in Y5, members of the BSU research team began exploring whether differential experiences of trauma exposure (as measured by the MAYSI-2 Traumatic Experiences, or TE, subscale) could partially explain why girls meet the AST screening criteria for mental health problems more often than boys. In the Y5-Y7 analyses, an interesting pattern of results consistently appeared. This pattern showed that girls did report traumatic experiences at a statistically significantly higher rate than boys, but that this difference in traumatic experience exposure did not completely explain the difference in mental health prevalence rates; in short, traumatic experience exposure was a stronger predictor of mental health problems, however, when controlling for the effects of traumatic experience exposure, a significant difference simply as a function of gender remained. In Y8, a deviation from the previous pattern was found. For the first time, girls and boys being processed into a JDC did not differ significantly in terms of the rates to which they reported traumatic experiences. Traumatic experience exposure, independent of gender, did continue to predict AST mental health indications. It is possible that the Y8 results were an anomaly, and that girls entering Idaho JDCs really have been exposed to more traumatic experiences than boys, and this possibility will continue to be monitored in the future. In any case, it is very clear that traumatic experience exposure is a consistent predictor of AST mental health indications. Given that traumatic life experiences have been found to predict the frequency and the depth of penetration into the justice system (e.g., Gunter, Chibnall, Antoniak, McCormick, & Black, 2012), however, it seems wise that clinicians focus closely on juveniles who have MAYSI-2 TE indications, and be particularly diligent in recommending appropriate community-based services to remediate the effects of the traumatic experience exposure.

Several other important findings noted in previous CSP evaluations were found again in Y8. One was that a high percentage of detained juveniles were found to have previous diagnoses of mental health and/or substance abuse problems. Across the previous seven years of evaluation, the percentage of juveniles with a previous diagnosis was 68%, ranging from a low of 59% in Y1 to 74% in Y7. The percentage of detained juveniles with a previous diagnosis in Y8 was the highest yet, at 79%; this raised the eight-year average to 70%. One reason the percentage may be increasing over time is that JDC clinicians may be the ones previously diagnosing juveniles (e.g., a juvenile first diagnosed by a clinician in Y6 or Y7 may be detained again in Y8), however, in any case, it is very likely that many of the juveniles were first diagnosed in the community (e.g., by family physicians, child therapists, or school counselors), prior to their first detention. The implications of this finding will be discussed later in this section of the report. The second important finding diagnoses was that, for the eighth consecutive year, the most common clusters of disorders were mood disorders, substance abuse disorders, disruptive behavior disorders, anxiety disorders, and attention deficit disorders. The order of these disorder clusters has always been the same, which has strong implications for the types of clinical expertise both JDC clinicians and community service providers will need to work with juveniles who are or have recently been detained.

The examination of JDC incident data in Y8 also comments, although somewhat indirectly, on mental health and substance abuse problems among juveniles detained in Idaho's JDCs—as well as how the CSP empowers JDC staff to effectively address these problems and their behavioral consequences. In short, a goal of the CSP is for JDC clinicians to train line staff to de-escalate mental health- and substance abuse-related problems among juveniles so that the staff can avoid the use of unnecessary restraints and deter suicide attempts. In Y4, the research team found that during the first three years of the CSP (i.e., 2008-2010), the use of restraints decreased 13% and suicide attempts decreased 32% per 1,000 bookings relative to the last three years before the CSP was implemented (i.e., 2005-2007). These results provided support to the notion that the CSP is successful in achieving the goals of reducing use of restraints and suicide attempts in Idaho's JDCs. The replication of analysis of these data in Y8 were somewhat mixed. It was again found that in the CSP's last three years of complete incident data (i.e., 2011-2013), use of restraints was down 15% relative to the last three years before the implementation of the CSP (i.e., 2005-2007). An interesting, more difficult to explain finding was that during the last three years of CSP implementation, suicide attempts increased 71% between the CSP's last three years of complete incidence data compared to the last three years before the implementation of the CSP. As noted earlier, this could be due primarily to improved training around suicide and increased surveillance and documentation of events as "suicide attempts" at one of the larger JDCs. However, even the appearance of rising suicide attempts in Idaho's JDCs should be a concern, and it seems warranted to continue to monitor this issue in future evaluations years.

### Service Recommendations and Access

Over the first seven years of CSP evaluations, JDC clinicians have appeared to be very successful in recommending community-based services to juveniles who are provisionally diagnosed with mental health and/or substance abuse problems. Y8 was no exception, as 95% of the 786 juveniles who received at least one provisional diagnosis received at least one community-based service recommendation. According to clinicians' records, 57% of those

juveniles who received at least one community-based service recommendation had accessed at least one such service by the time of the 15-45 day follow-up call. As has been the case in other evaluations, parents' reports of receiving recommendations are inconsistent with the clinicians' reports about providing such recommendations, but the veracity of parents' reports has always been in question due to recall error, lack of understanding what the recommendations are, and so forth. As documented earlier, every parent who reported receiving a community-based service recommendation reported that their child had accessed that service, and that certainly seems a positive development.

### Stakeholder Perceptions

Historically, the stakeholder group that has contributed the most to CSP evaluations has been the judges/CJPOs. Whether surveys were distributed by mail or in a web-based format, the response rate has consistently been acceptable, and because the vast majority of respondents have reported an awareness of the CSP, they have been able to provide important feedback about it. Similar to previous years, the judges, CJPOs, and others who completed surveys in Y8 (as previously discussed, several individuals who work with juveniles other than judges and CJPOs completed the survey in Y8) responded very positively regarding the CSP, with the vast majority being aware of the program (95%), being satisfied with contact from a JDC clinician (91%), having received recommendations from the JDC clinician (97%), and being satisfied with the recommendation received from the clinician (94%). A majority also reported that recommendations received from the JDC clinician affected decisions they made regarding their youth (84%) and felt that the CSP program was beneficial (94%), and nearly all wanted to see it continue (97%). 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. Overall, it is very clear that judges, CJPOs, and others working with juveniles in Y8, as in all seven previous years, are convinced of the value of the CSP and the effect it has on juveniles processed in Idaho's JDCs.

In Y8, similar to Y4 (and Y4 only), some additional stakeholders—namely JDC administrators and clinicians—were queried about their experiences with the CSP. Obviously, the administrators and clinicians are also participants in the CSP, however, the research team's experience with members of both populations is that they tend to be quite objective and forthcoming about what works well and areas where they struggle with respect to the program. As described earlier in this report, interview questions were broadly designed to determine what the administrators and clinicians perceived as successes/strengths and challenges/weaknesses of the CSP, as well as their thoughts on how the program could be improved or expanded upon in the future.

### Additional Analyses

As already noted, several additional analyses that were conducted for the first time in Y5 and replicated in Y6-Y7 were also completed in Y8. Similar to the previous two years, these analyses yielded some important findings in Y8. One of the findings was interesting primarily because it was discrepant with what was found in Y5-Y7; whereas there was a clear tendency in each of those years for girls to screen positive for traumatic experiences on the MAYSI-2 more often than boys, in Y8, no such statistically significant difference was found. What exactly this means is difficult to determine at this time. Given that the difference was found in three years of evaluation but not in only one, it seems likely that the finding in Y8 is anomalous (i.e., that in general, detained girls in Idaho really have experienced trauma more often than boys), however, conducting the same analysis in future years of CSP evaluations will better flesh the question out. The finding, reported in the evaluations from Y5-Y7, 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, was replicated in Y8. Thus, although whether gender is significantly associated with traumatic experience exposure was called into question in the Y8 evaluation, the finding that traumatic experience exposure is significantly associated with mental health problems was not. The latter finding is highly consistent with what has been reported elsewhere, perhaps most notably by the Centers for Disease Control and Prevention (2013). These reports have suggested that traumatic experience exposures in childhood, often operationalized as “adverse childhood experiences” or “ACEs,” are associated with increased risk of negative health and social outcomes in adulthood, including a host of medical and mental health problems, substance abuse, criminality, and suicidal behavior. Given that a fairly high percentage of the juveniles detained in Idaho’s JDCs screen positive for traumatic experiences on the MAYSI-2, training on trauma-informed care seems desirable for JDC personnel, and trauma-informed community-based services should be identified for recommendations.

An assessment of whether juveniles who met the criteria for at least one AST problem (i.e., met the criteria for a mental health problem, a substance abuse problem, or both types of problems) differed from juveniles who met the criteria for neither type of problem in the types of booking charges, no statistically significant difference was found. This finding was consistent with what was found in Y5 and Y6 (the first years this additional analysis was performed), but not with what was found in Y7; in Y7, a significant difference was found suggesting that juveniles who met neither criteria more often were booked on property crimes, whereas juveniles who met at least one criterion more often were more often booked on drug crimes. The reason for this discrepancy is not clear, but given that no difference was found in three of four evaluation years suggests that the Y7 result was anomalous. In other words, it is likely that the general state of affairs is that juveniles that meet and do not meet at least one AST criterion tend to commit (or at least be booked for) similar types of crimes. When a separate analysis of how booking charges were distributed against all four diagnostic categories (i.e., neither type of problem, mental health problem only, substance abuse problem only, and both types of problems), a statistically significant association between booking charges and AST diagnostic category. This association was accounted for by juveniles being booked for drug crimes being most likely to meet the criteria for having a substance abuse problem only, whereas juveniles who were booked for

property crimes, crimes against persons, and sex crimes were most likely to meet the criteria for having a mental health problem only.

Several additional analyses were performed to better understand factors related to whether juveniles access the community-based services that are recommended for them. The first analysis showed a statistically significant difference in recommended service access as a function of whether the JDC the juveniles were housed in was in an urban or rural county; juveniles detained in urban counties were found to more often access at least one recommended service within the 15-45 day follow-up period. This result (which was also found in Y7 but not in either Y5 or Y6) could be due to fewer services existing in rural areas, or it could be due to barriers that are either structural (e.g., transportation or travel distance) or cultural (e.g., stigma, distrust of service providers or government). Further exploration of the reasons for this difference seems desirable, as increasing the likelihood (if possible) that juveniles who are released from JDCs in rural counties access recommended services would be expected to reduce the likelihood they come in future contact with the justice system.

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; it was also predictive of how beneficial they felt it is to have clinicians in the JDCs. 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.

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. 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. Thirteen judges, CJPOs, and others working with juveniles provided recommendations for how the CSP program could be improved in the future. Recommendations included expanding the scope of services clinicians offer in JDCs, more hours for clinicians to work, and better pay for clinicians to better retain them. Others included better cooperation with IDHW to have juveniles assessed for mental health more quickly and to do a comprehensive evaluation of what the CSP consists of in each JDC.

A final set of analyses were performed to determine which MAYSI-2 subscale indications were significant predictors of juveniles meeting the AST criteria for having a mental health problem. Four of the seven subscales were found to be significant, with juveniles who had positive indications on the Suicide Ideation, Angry-Irritable, Thought Disturbance, and Traumatic Experiences subscales being more likely to meet the AST criteria for having a mental health problem. Indications for the Alcohol/Drug Use, Depressed-Anxious, and Somatic Complaints subscales were not significantly predictive of whether juveniles met the AST criteria for a mental health problem.

### Concluding Comments

As in the final section of most previous years' CSP evaluation reports, we must call attention to the stark challenge that administrators, clinicians, and line staff in Idaho's JDC face annually: Most of the juveniles who are detained in their facilities have not only committed criminal offenses, but a large majority of them are struggling with a mental health problem, a substance abuse problem, or both types of problems. As seen in Tables A2, A3, A4 and A8 in Appendix A, there has been some level of variation in the prevalence rates of these problems across the years, however most years cluster closely around the eight-year averages of 60% of juveniles meeting the AST screening criteria for a mental health problem, 43% of juveniles meeting the AST screening criteria for having a substance abuse problem, 72% of juveniles meeting the AST criteria for having at least one of these problems, and A8 of juveniles meeting the AST criteria for both types of problems. Idaho's prevalence rates of these problems in detained juveniles are comparable to or slightly higher than the rates reported in studies in other states (e.g., Cauffman et al., 2007; Fazel, Doll, & Langstrom, 2008; Wasserman et al., 2003). As has been noted elsewhere, having a high percentage of detained persons with mental health and or substance abuse issues is a serious problem for detention/correctional centers (Anthony et al., 2010). Quite simply, these types of facilities were not designed to serve as inpatient mental health or substance abuse treatment centers. Although the CSP has, by nearly all stakeholder accounts, helped serve detained juveniles with these types of problems, the fact remains juveniles' that mental health and substance abuse problems should be treated in mental health and substance abuse centers—not JDCs. Given this fact, it is all the more disturbing that several different JDC administrators and clinicians commented that state hospitals in Idaho have refused to accept detained juveniles with severe mental and behavioral problems, classifying them as too unhealthy for state hospitals (that are supposed to treat such problems) and relegating them to detention or correctional facilities (that are not).

Juvenile crime has many social and economic costs, and these costs tend to amplify greatly if juvenile offenders become adult offenders and continue their criminal behavior. As noted in earlier evaluation reports (e.g., Begic et al., 2013), it seems to make great sense to engage in efforts that reduce the likelihood that juveniles become involve with the justice system to begin with. There is a plethora of research suggesting that there are measurable factors that steer juveniles toward criminal behavior (often through the development of mental health and/or substance abuse problems), and that many of these (including adverse childhood experiences) are rooted in the family system. In the two years (i.e., Y4 and Y8) that formal interviews of JDC administrators and clinicians were conducted, such personnel mentioned repeatedly that many of their detained juveniles have parents and/or home environments that are more seriously

disordered than the juveniles themselves. These administrators and clinicians have noted that many of the juveniles would have never materialized in a JDC had their parents and/or home environments not been such toxic influences, and they have also noted that many juveniles likely do not access or receive recommended community-based services because their parents struggle so seriously with mental health and/or substance abuse problems that they are unable or unwilling to facilitate it.

Given that the family systems of juveniles are so closely linked with their likelihood of being involved with the juvenile justice system, interventions that target the family system seem the best suited to deter future juvenile crime. As noted in previous CSP evaluation reports (e.g., Begic et al., 2013) and in the national literature (e.g., Piquero, Farrington, Welsh, Tremblay, & Jennings, 2009), many of the best, evidence-based, interventions focus as much on the mental health and substance abuse needs of the parents as they do on those of children. It is axiomatic that preventing problems is preferable to treating them, regardless of whether the problems are related to mental health, substance abuse, and/or criminal behavior. If the State of Idaho wishes to reduce or avoid the costs of these problems, it would be well advised to invest in the types of early-identification and -intervention (e.g., pediatric screening, evidence-based home visiting, school counseling) programs that could help remediate toxic family environments that are associated with future juvenile delinquency.

Understanding what happens after juveniles who are provisionally diagnosed with a mental health and/or substance abuse problem are released from detention has always seemed a missing element in CSP evaluations. In the proposed Year 9 (Y9) evaluation, a concerted effort to better understand this issue has been planned. The evaluation team and IDJC administrators have developed a plan to randomly select a cohort of juveniles who were provisionally diagnosed in a prior evaluation year (e.g., Y6) and, working with JDC and juvenile probations staff, attempt to ascertain whether participation in the CSP (either through therapeutic interventions with JDC clinicians, accessing recommended community-based services, or both) affected their future life trajectories (e.g., whether they recidivated, whether they completed high school, and so forth). A plan to interview a small group of parents (likely including subsets of parents whose juveniles accessed recommended community-based services and those whose juveniles did not) about their experiences regarding interaction with JDC clinicians and subsequent coordination of mental health and/or substance abuse services should also help flesh out what happens to provisionally diagnosed juveniles after release.

After eight years of evaluation, the BSU research team remains highly impressed with the way the CSP seems to positively affect juveniles in Idaho's JDCs. Although we have learned that how clinicians define the scope of their duties and perform those duties varies somewhat across JDCs (e.g., some perform therapeutic interventions with juveniles and even their parents, whereas others focus more closely on screening and service coordination), the program itself seems genuinely supported by administrators and staff. The need for the program is evident; if approximately 70% of the juveniles entering a JDC in any given year suffer from a mental health problem, a substance abuse problem, or both types of problems, it seems it would be negligent not to have a program such as the CSP in place. In Y8, as in previous years, the CSP appears successful in identifying detained juveniles with likely mental health and substance abuse problems, providing recommendations for community-based services (which are usually

accessed with the 15-45 day follow-up period), and providing critical information to guide the decisions made by judges and CJPOs. As a result, continuing efforts to support the CSP, or expand the scope further, 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](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>
- Doherty, D. T., & Kartalova-O'Doherty, Y. (2010). Gender and self-reported mental health problems: Predictors of help seeking from a general practitioner. *British Journal of Health Psychology, 15*, 213-228. doi: 10.1348/135910709X457423
- Eaton, N. R., Keyes, K. M., Krueger, R. F., Balsis, S., Skodol, A. E., Markon, K. E., Grant, B. F., & Hasin, D. S. (2012). An invariant dimensional model of gender differences in mental disorder prevalence: Evidence from a national sample. *Journal of Abnormal Psychology, 121*, 282-288. doi:10.1037/a0024780
- 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.

Gunter, T. D., Chibnall, J. T., Antoniak, S. K., McCormick, B., & Black, D. W. (2012). Relative contributions of gender and traumatic life experience to the prediction of mental disorders in a sample of incarcerated offenders. *Behavioral Sciences & the Law, 30*, 615-630. doi: 10.1002/bsl.v30.5/issuetoc

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>

Kelly, T. M., Daley, D. C., & Douaihy, A. B. (2012). Treatment of substance abusing patients with comorbid psychiatric disorders. *Addictive Behaviors, 37*, 11-24. doi: 10.1016/j.addbeh.2011.09.010

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 617-627. doi: 10.1001/archpsyc.62.6.617

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

Mackenzie, C. S., Gekoski, W. L., & Knox, V. J. (2006). Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Aging & Mental Health, 10*, 574-582. doi: 10.1080/13607860600641200

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

Peters, R. H., Lurigio, A. J., & Wexler, H. K. (2015). Co-occurring substance use and mental disorders in the criminal justice system: A new frontier of clinical practice and research. *Psychiatric Rehabilitation Journal*, 38, 1-6.

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

Steadman, H. J., Osher, F. C., Clark-Robbins, P., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60, 761-765.

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

<b>Table A1: Number of Detained Juveniles in Analyzed Database by Evaluation Year</b>	
<b>Evaluation Year</b>	<b>Number of Juveniles</b>
Year 1	2,060
Year 2	1,941
Year 3	1,669
Year 4	2,066
Year 5	1,481
Year 6	1,366
Year 7	1,336
Year 8	1,342
<i>Years 1-7 Average (Comparison Years for Year 8)</i>	<i>1,702</i>
<i>Years 1-8 Average</i>	<i>1,658</i>

<b>Table A2: Percentage of Juveniles with AST Mental Health Indications by Evaluation Year</b>	
<b>Evaluation Year</b>	<b>Percentage of Juveniles</b>
Year 1	68
Year 2	59
Year 3	62
Year 4	59
Year 5	59
Year 6	56
Year 7	59
Year 8	60
<i>Years 1-7 Average (Comparison Years for Year 8)</i>	<i>60</i>
<i>Years 1-8 Average</i>	<i>60</i>

*Note.* Percentages are rounded to whole numbers.

<b>Table A3: Percentage of Juveniles with AST Substance Abuse Indications by Evaluation Year</b>	
<b>Evaluation Year</b>	<b>Percentage of Juveniles</b>
Year 1	54
Year 2	46
Year 3	44
Year 4	43
Year 5	41
Year 6	40
Year 7	38
Year 8	35
<i>Years 1-7 Average (Comparison Years for Year 8)</i>	<i>44</i>
<i>Years 1-8 Average</i>	<i>43</i>

*Note.* Percentages are rounded to whole numbers.

<b>Table A4: Percentage of Juveniles with at Least One AST Indication by Evaluation Year</b>	
<b>Evaluation Year</b>	<b>Percentage of Juveniles</b>
Year 1	82
Year 2	75
Year 3	76
Year 4	72
Year 5	69
Year 6	66
Year 7	67
Year 8	69
<i>Years 1-7 Average (Comparison Years for Year 8)</i>	72
<i>Years 1-8 Average</i>	72

*Note.* Percentages are rounded to whole numbers.

<b>Table A5: Percentage of Boys and Girls with AST Mental Health Indications by Evaluation Year</b>	
<b>Evaluation Year</b>	<b>Percentage of Juveniles</b>
Year 1: Boys	65
Year 1: Girls	76
Year 2: Boys	54
Year 2: Girls	71
Year 3: Boys	59
Year 3: Girls	73
Year 4: Boys	56
Year 4: Girls	67
Year 5: Boys	55
Year 5: Girls	67
Year 6: Boys	53
Year 6: Girls	67
Year 7: Boys	54
Year 7: Girls	71
Year 8: Boys	56
Year 8: Girls	69
<i>Years 1-7 Average (Comparison Years for Year 8): Boys</i>	57
<i>Years 1-7 Average (Comparison Years for Year 8): Girls</i>	70
<i>Years 1-8 Average: Boys</i>	57
<i>Years 1-8 Average: Girls</i>	70

*Note.* Percentages are rounded to whole numbers.

<b>Table A6: Percentage of Boys and Girls with at Least One AST Indication by Evaluation Year</b>	
<b>Evaluation Year</b>	<b>Percentage of Juveniles</b>
Year 1: Boys	81
Year 1: Girls	85
Year 2: Boys	73
Year 2: Girls	79
Year 3: Boys	74
Year 3: Girls	81
Year 4: Boys	71
Year 4: Girls	76
Year 5: Boys	68
Year 5: Girls	73
Year 6: Boys	63
Year 6: Girls	73
Year 7: Boys	65
Year 7: Girls	72
Year 8: Boys	66
Year 8: Girls	75
<i>Years 1-7 Average (Comparison Years for Year 8): Boys</i>	71
<i>Years 1-7 Average (Comparison Years for Year 8): Girls</i>	77
<i>Years 1-8 Average: Boys</i>	70
<i>Years 1-8 Average: Girls</i>	77

*Note.* Percentages are rounded to whole numbers.

<b>Table A7: Percentage of Boys and Girls with AST Substance Abuse Indications by Evaluation Year</b>	
<b>Evaluation Year</b>	<b>Percentage of Juveniles</b>
Year 1: Boys	55
Year 1: Girls	53
Year 2: Boys	48
Year 2: Girls	41
Year 3: Boys	45
Year 3: Girls	44
Year 4: Boys	44
Year 4: Girls	40
Year 5: Boys	42
Year 5: Girls	38
Year 6: Boys	39
Year 6: Girls	42
Year 7: Boys	36
Year 7: Girls	40
Year 8: Boys	34
Year 8: Girls	37
<i>Years 1-7 Average (Comparison Years for Year 8): Boys</i>	44
<i>Years 1-7 Average (Comparison Years for Year 8): Girls</i>	43
<i>Years 1-8 Average: Boys</i>	43
<i>Years 1-8 Average: Girls</i>	42

*Note.* Percentages are rounded to whole numbers.

<b>Table A8: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both Indications by Evaluation Year</b>				
<b>Evaluation Year</b>	<b>Percentage of Juveniles</b>			
	<b>Neither MH nor SA</b>	<b>MH only</b>	<b>SA only</b>	<b>Both MH and SA</b>
Year 1	18	28	14	<b>41</b>
Year 2	25	29	16	<b>30</b>
Year 3	24	<b>32</b>	13	31
Year 4	28	<b>30</b>	13	29
Year 5	<b>31</b>	29	11	30
Year 6	<b>34</b>	26	9	31
Year 7	<b>33</b>	29	8	29
Year 8:	31	<b>34</b>	8	27
<i>Years 1-7 Average (Comparison Years for Year 8)</i>	28	29	12	32
<i>Years 1-8 Average</i>	28	30	12	31

*Note.* Percentages are rounded to whole numbers, so total row percentages may not equal 100.

<b>Table A9: AST Indications of Mental Health Problems, Substance Abuse Problems, and Dual Diagnosis of Both Indications by Evaluation Year, by Gender</b>				
<b>Evaluation Year</b>	<b>Percentage of Juveniles</b>			
	<b>Neither MH nor SA</b>	<b>MH only</b>	<b>SA only</b>	<b>Both MH and SA</b>
Year 1: Boys	19	26	16	<b>39</b>
Year 1: Girls	15	32	9	<b>44</b>
Year 2: Boys	27	25	19	<b>29</b>
Year 2: Girls	21	<b>39</b>	8	33
Year 3: Boys	26	<b>29</b>	16	29
Year 3: Girls	19	<b>37</b>	8	36
Year 4: Boys	<b>29</b>	27	15	29
Year 4: Girls	24	<b>36</b>	9	31
Year 5: Boys	<b>32</b>	26	13	29
Year 5: Girls	27	<b>34</b>	6	32
Year 6: Boys	<b>37</b>	24	10	29
Year 6: Girls	27	31	6	<b>35</b>
Year 7: Boys	<b>36</b>	28	10	26
Year 7: Girls	28	35	4	<b>36</b>
Year 8: Boys	<b>34</b>	33	10	24
Year 8: Girls	25	<b>38</b>	5	31
<i>Years 1-7 Average (Comparison Years for Year 8): Boys</i>	29	26	14	30
<i>Years 1-7 Average (Comparison Years for Year 8): Girls</i>	23	35	7	35
<i>Years 1-8 Average: Boys</i>	30	27	14	29
<i>Years 1-8 Average: Girls</i>	23	35	7	35

*Note.* Percentages are rounded to whole numbers, so total row percentages may not equal 100.