Research Report

LAURA WHITAKER, SARITA D. LEE, AARYA SURYAVANSHI, SIERRA SMUCKER, TARA LAILA BLAGG, MARYLOU GILBERT, SUSAN TURNER, DIONNE BARNES-PROBY, STEPHANIE BROOKS HOLLIDAY

Evaluation of Two Court Interventions for Youth with Significant Clinical Needs

Los Angeles County's CARE Project and Juvenile Mental Health Court

For more information on this publication, visit **www.rand.org/t/RRA3217-1-v2**.

About RAND

RAND is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest. To learn more about RAND, visit www.rand.org.

Research Integrity

Our mission to help improve policy and decisionmaking through research and analysis is enabled through our core values of quality and objectivity and our unwavering commitment to the highest level of integrity and ethical behavior. To help ensure our research and analysis are rigorous, objective, and nonpartisan, we subject our research publications to a robust and exacting quality-assurance process; avoid both the appearance and reality of financial and other conflicts of interest through staff training, project screening, and a policy of mandatory disclosure; and pursue transparency in our research engagements through our commitment to the open publication of our research findings and recommendations, disclosure of the source of funding of published research, and policies to ensure intellectual independence. For more information, visit www.rand.org/about/research-integrity.

RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.

Published by the RAND Corporation, Santa Monica, Calif.

About This Report

The Juvenile Justice Crime Prevention Act (JJCPA), administered by the California Board of State and Community Corrections, provides funding to counties to support programs that have proved their effectiveness in curbing crime among at-promise youth (youth at risk of becoming involved in the juvenile justice system) and youth already involved in the juvenile justice system. In the County of Los Angeles, the Probation Department oversees the implementation of JJCPA-funded programs, which are approved by the Juvenile Justice Coordinating Council. The council comprises stakeholders from county agencies, city agencies, and community-based organizations. In 2019, the Probation Department selected RAND to provide evaluation and technical assistance services, including an annual gap analysis, related to JJCPA-funded programs. This report presents findings from the process and outcome evaluation of two court-based programs for youth with significant clinical needs, including mental health diagnoses and developmental disabilities. Findings will be of interest to Los Angeles County stakeholders, including program staff, Probation Department staff, and members of the Juvenile Justice Coordinating Council, and agencies in other locations that are interested in implementing programs of this nature. This report was originally published in September 2024 and was revised in December 2024 to include Appendix B.

Justice Policy Program

RAND Social and Economic Well-Being is a division of RAND that seeks to actively improve the health and social and economic well-being of populations and communities throughout the world. This research was conducted in the Justice Policy Program within RAND Social and Economic Well-Being. The program focuses on such topics as access to justice, policing, corrections, drug policy, and court system reform, as well as other policy concerns pertaining to public safety and criminal and civil justice. For more information, email justicepolicy@rand.org.

Acknowledgments

We would like to acknowledge our sponsor, the Los Angeles County Probation Department, and the Probation Department staff members who provided relevant materials for this report. We are grateful to the many individuals at the participating agencies for being involved in interviews and sharing documents and data, and to youth program recipients and their caregivers for participating in interviews. We would also like to thank our RAND colleague Hansell Perez for his assistance with quality control of interview notes. Finally, we thank our quality assurance reviewers Lisa Padilla and Amanda NeMoyer for their thoughtful feedback on this report.

Summary

Background

The Juvenile Justice Crime Prevention Act (JJCPA), administered by the California Board of State and Community Corrections, provides funding to counties to support programs that have proved their effectiveness in curbing crime among at-risk youth and youth involved in the juvenile justice system. Two of the programs funded by JJCPA are the Client Assessment Recommendation and Evaluation (CARE) Project and the juvenile mental health court (JMHC). These programs are court interventions for youth with significant clinical needs, including behavioral health disorders and intellectual or developmental disabilities. Both programs provide linkages to community-based services (e.g., mental health treatment, regional centers) and educational advocacy. We conducted a mixed-methods process and outcome evaluation of CARE and JMHC to answer the following research questions:

- How does the program operate? Specifically, we were interested in understanding details such as the program goals and services offered by the program, and what the client experiences from referral through program completion.
- What factors have shaped the implementation of these programs? For example, what have been the barriers and facilitators to implementing the program? How have considerations related to equity or resources influenced implementation?
- What are the outcomes of youth who participate in the program?

Methods

We conducted semistructured interviews with staff members from each program between March and December 2021, and these interviews were analyzed using a set of a priori codes based on the interview protocol. When analyzing data, we also used the Consolidated Framework for Implementation Research (CFIR), a well-known implementation science framework, to categorize the factors that have shaped implementation. In addition, we received data related to the youth served by each program. We conducted descriptive analyses related to youth characteristics and participation in each program.

Key Findings

Our key findings are as follows:

- Both programs cited staffing limitations as a challenge. CARE and JMHC serve youth with a high level of needs, and both reported increasing severity of youth needs within the programs.

Program staff reported having high caseloads, leading to overworked staff and concerns about serving enough youth or serving their cases as effectively as possible.

- Some of the major challenges faced by court interventions are beyond the scope of either program, including an insufficient number of suitable community-based resources, programs, or placements. Though this shortfall directly affects the work of both programs, it is beyond the control of the programs themselves to make needed changes. Agency coordination is also a challenge, and highly cooperative partnership and buy-in from agency leaders will be necessary to facilitate improvements.
- Despite challenges, staff report a number of facilitators of program implementation, particularly the quality of staff in both programs. Staff were very motivated to achieve successful outcomes for youth and described their colleagues as highly effective.
- Staff from both programs report strong perceptions of effectiveness. They noted the large proportion of youth involved in the juvenile justice system in Los Angeles County who have significant clinical needs and the importance of programs like CARE and JMHC to provide rehabilitation.

Recommendations

Based on our findings, we made the following recommendations relevant to both CARE and JMHC:

- *Increase the number of staff*. Both programs identified a need for increased overall staffing. In addition, for CARE in particular, it would be worth considering the addition of new staff roles, such as paralegals or case managers, to assist with CARE staff workloads.
- *Expand JMHC to other courts in the county*. JMHC serves the highest-need youth in the justice system for all of Los Angeles County, the most populous county in the country. However, it is currently offered at a single courthouse, and expanding to other courts would help to promote more equitable access to the service across the county.
- *Implement equity training*. Staff members of both programs could benefit from equity-related trainings at a regular cadence (e.g., annually). These trainings could address certain subpopulations that are commonly served by the program, whether by race, gender, language, or sexual orientation or gender identity.
- *Implement systems for tracking equity-related considerations*. Staff members from both programs acknowledged the significant disparities that can occur in juvenile justice involvement, and raised concerns about equitable access to services for certain groups (e.g., individuals who do not speak English). More formal monitoring could help to identify opportunities for improvement and address inequities associated with race and other youth identities.

We also identified the following recommendations related to future evaluation efforts:

- *Develop a system for inclusion of youth and caregiver input in the evaluation*. RAND attempted to collect data from youth and caregivers for the evaluation, but there were multiple barriers to

doing so. However, it is essential to include the voices of youth and families in evaluation to ensure that the program is being tailored to the needs of people receiving services.

- *Improve the availability of data to assess program effectiveness*. Due to limitations of the quantitative data available to our team, we were unable to explore the longer-term outcomes of youth enrolled in the programs. RAND is addressing this through ongoing data analysis, but it will be valuable to consider additional ways to increase the rigor of future evaluations, such as identifying a comparison group for outcome analyses.

Contents

Figures and Tables

Figures

Tables

Chapter 1

Introduction

Court Interventions for Youth with Significant Clinical Needs

A sizable proportion of youth involved in the juvenile justice system have significant clinical needs. Estimates suggest that as many as two-thirds of youth have a mental health disorder (Burke, Mulvey, and Schubert, 2015; Teplin et al., 2021). Diagnoses such as attention deficit/hyperactivity disorder appear to be more common than in the general population (Beaudry et al., 2021; Eme, 2008), as are certain developmental disabilities, such as fetal alcohol spectrum disorders (FASDs) (Fast, Conry, and Loock, 1999; Flannigan et al., 2018). Moreover, though diagnoses such as autism, learning disabilities, and other developmental disabilities are not necessarily more common among youth involved in the juvenile justice system (Kincaid and Sullivan, 2019), these individuals may face particular barriers navigating the system—including a lack of services to address their specific educational and other needs (Katsiyannis, Barrett, and Zhang, 2012).

Too often, however, these issues go undetected or unaddressed until the young person enters the juvenile justice system. Symptoms associated with conditions such as FASD can be written off as misbehavior and met with punishment rather than accommodations (Brown et al., 2015). If a young person is fortunate enough to receive a diagnosis, which serves as a gateway to clinical and educational supports, they may experience obstacles to obtaining an Individualized Education Plan (IEP)—or having their IEP honored—especially in correctional settings (Miller, 2019). A similar scenario can play out with mental health conditions—symptoms of a mental health condition, such as externalizing behaviors (e.g., aggression), or efforts to self-medicate with substances—which may put youth at risk for contact with the juvenile justice system (Underwood and Washington, 2016). And when these youth end up in the juvenile justice system, typical sanctions (e.g., probation, juvenile justice placement) do not address the root cause of the behavior, potentially perpetuating a cycle of juvenile justice system involvement.

One way that the system has evolved to better meet the needs of these youth is through the creation of court interventions that help to link youth with mental or developmental challenges to needed services. These programs can take a range of forms. Problem-solving courts, such as drug courts and mental health courts, are one such model that link youth to needed behavioral health services. Research has found that juvenile mental health courts (JMHCs) can vary with respect to certain characteristics, such as services provided or eligibility criteria, but broadly speaking, these courts are based on the principles of therapeutic jurisprudence—that is, bringing together legal and other professionals in a nonadversarial setting with the goal of linking youth to services that will address their risk of future justice system involvement (Development Services Group, 2010; Gardner, 2011). There is often a focus on providing these services within the least restrictive environment possible—often in the community (Heilbrun et al., 2017)—and the court provides oversight while

youth participate in services. Though research into these models in youth populations is somewhat limited (Heilbrun et al., 2017), there is evidence to suggest that these programs are associated with lower rates of future juvenile justice involvement (Applegarth, Jones, and Brooks Holliday, 2023).

Other court-based interventions for youth have been developed as well, such as youth diversion programs (Applegarth, Jones, and Brooks Holliday, 2023) and holistic defense models, which address youth legal and psychosocial needs (Phillippi et al., 2021). However, there is a need for more research on the effectiveness of these court interventions (Wilson and Hoge, 2013). Additionally, across all of these court interventions, there is value in having a more in-depth understanding of these program models, given the significant variation that can exist (Heilbrun et al., 2017; Wilson and Hoge, 2013), as well as the factors that shape the implementation of these programs.

Juvenile Justice Crime Prevention Act and Court Interventions in Los Angeles County

In Los Angeles County, the Juvenile Justice Crime Prevention Act (JJCPA) provides a key source of funding for youth involved in the juvenile justice system, as well as those youth who are at risk for involvement in the system. Two of the funded programs are court-focused programs for youth with significant clinical needs: the Client Assessment Recommendation and Evaluation (CARE) Project and JMHC.

The CARE Project has been operated by the Public Defender's Office since 1999 and currently operates out of all seven juvenile branches (Los Angeles County Public Defender's Office, undated-a).

Originally designed for pretrial populations, CARE now provides pre- and post-trial services to youth with mental illness, intellectual and developmental disabilities, learning disabilities, and other behavioral health needs (Los Angeles County Public Defender's Office, undated-a). Youth are first identified by the juvenile trial attorney; once they are referred and accepted to services, CARE provides holistic legal services to youth, including linkage to mental health services and educational advocacy, such as assisting youth with obtaining or honoring an IEP. This program provides an opportunity for youth with these needs to be identified at the stage of court contact and then connected with needed resources. Ultimately, CARE aims to achieve the least restrictive dispositional outcome for its clients. CARE first received JJCPA funds in 2017, allowing the Public Defender's Office to hire more staff and expand the availability of CARE services to a broader population of youth. A 2017 evaluation suggested that the program was associated with a reduction in future delinquency court involvement (Rabinowitz et al., 2017). However, the evaluation also found certain challenges to the implementation of CARE, including staff turnover and the need for more explicitly defined roles and procedures. The present evaluation provided an opportunity to reevaluate the program, especially in light of the expansion of the program to more youth made possible with JJCPA funds, as well as the influence of factors such as the coronavirus disease 2019 (COVID-19) pandemic.

JMHC has been in operation in Los Angeles County since 2001 and is operated by the Los Angeles County Superior Court. Similar to CARE, JMHC focuses on youth with mental health, intellectual, or developmental disabilities (Los Angeles County Public Defender's Office, undated-b). Consistent with typical mental health court models used in adult and juvenile populations, JMHC is a collaborative justice court. Its stated mission is to provide appropriate, comprehensive, and

multimodal rehabilitation plans that facilitate healthy trajectories for justice-involved youth with mental health disorders and developmental disabilities, with the ultimate goal of reducing recidivism among youth. A multidisciplinary team oversees the development and execution of a treatment plan for youth, following enrolled participants while they complete their probation term. Past quantitative analyses of the outcomes of JMHC participants found that participants had higher rates of arrest than youth who were identified as "near misses" for JMHC eligibility, though there were not statistically significant differences on other outcomes, such as incarceration and probation violations (Fain, Turner, and Shahidinia, 2018). However, there were limitations to these analysis—for example, the most common reason that people in the comparison group were a "near miss" for the program was that they had less serious cases than youth who were enrolled in the program; in addition, analyses were based on a relatively small sample of youth. This highlights the need for a larger-scale evaluation as well as a greater focus on implementation of the program, not simply outcomes.

Purpose of the Evaluation

RAND was funded by the Probation Department to evaluate the implementation and outcomes of the CARE Project and JMHC in Los Angeles County. The purpose of the evaluation was to gain an in-depth understanding of the way that the program operates and factors that may be facilitating or hampering implementation, as well as to explore the outcomes associated with the program. A better understanding of implementation and outcomes is valuable to the programs, as it may inform quality improvement efforts, as well as the Probation Department, which administers funds, and the Juvenile Justice Coordinating Council, which makes decisions regarding the use of JJCPA funds.

For each program, our specific evaluation questions included the following:

- How does the program operate? Specifically, we were interested in understanding details such as the program goals and services offered by the program, and what the client experiences from referral through program completion.
- What factors have shaped the implementation of these programs? For example, what have been the barriers and facilitators to implementing the program? How have considerations related to equity or resources influenced implementation?
- What are the outcomes of youth who participate in the program?

In the rest of this report, we begin by describing our evaluation methods (Chapter 2). We then present our findings from the process and outcome evaluation of the CARE Project (Chapter 3), as well as of the JMHC (Chapter 4). Finally, we summarize our findings and present cross-program takeaways and recommendations (Chapter 5).

Chapter 2

Methods

Qualitative Methods

We conducted semistructured interviews with staff members from each program between March and December 2021. Program leaders shared staff contact information for CARE-related staff across all Los Angeles County juvenile courts with our team. Of 18 staff invited for interviews, 17 participated in interviews. These included direct staff members—social workers and resource attorneys, as well as those who refer to and work closely with the program—public defenders, and deputy public defenders. We were connected to and interviewed nine participants related to the JMHC program, which included staff members who provided an array of legal and direct services to youth.

Interviews followed a semistructured interview protocol adapted from the RAND-developed Program Implementation and Evaluation Readiness model and the Consolidated Framework for Implementation Research (CFIR), informed by implementation science and program evaluation (Damschroder et al., 2022; Kaufman-Levy et al., 2003). In the interview, we asked questions about program design, goals and operation (evaluation question 1), perceived barriers and facilitators to program implementation and equity considerations (evaluation question 2), and perceived program effectiveness (evaluation question 3). Interviews were flexibly structured to capture details relevant to the participant's experience.

We conducted three interviews with program recipients or their caregivers using a semistructured interview protocol designed to assess perspectives on the program, including on enrollment, services received, relationships with program staff, and perceived benefits of the program. Youth who were interviewed received an incentive of $50 and caregivers received $30. We reached out to 33 CARE Project youth and caregiver pairs (in total, 66 potential interviewees) and 13 JMHC program youth and caregiver pairs (in total, 26 potential interviewees) via telephone and mail, but had very low response rates, perhaps because participants had to provide written consent (for caregivers) and assent (for youth) to participate. Because of a low sample, we do not report these results here, to protect confidentiality and prevent overinterpretation of these data.

All interviewed participants consented using an institutional review board–approved consent form, which obtained separate consent for participation and audio-recording. Responses were captured by taking notes during the interview as well as recording (if the participant consented). The interview notes were then anonymized, cleaned, and reviewed with the recording, if applicable. The audio recording was then deleted.

Clean notes were uploaded to Dedoose qualitative data analysis software and coded using a codebook based on the interview protocol (Appendix A). The codebook was developed based on the interview guide and therefore primarily guided by the Program Implementation and Evaluation

Readiness model. The codebook was refined using initial interviews to revise and develop additional codes. During this stage, each interview was coded by two to three members of the team to check for consistency in code. Members of the team met weekly to discuss and resolve inconsistencies or needed clarifications in the codebook. As changes were made to the codebook, additional interviews were coded to confirm consistency across interviewers. Once the codebook was agreed on and consistency in use of codes established, remaining transcripts were coded by the first author and the original coders continued to meet weekly or biweekly until all coding was complete. Coded excerpts were then analyzed according to our evaluation questions, using a directed approach (Hsieh and Shannon, 2005). To answer evaluation question 1, how the program operated, we summarized responses according to the following a priori codes: program goals, referral, program services, and staffing and training. Implementation themes were identified by noting and categorizing barriers and facilitators to implementation as described by staff. Findings for each program are presented according to these themes in Chapters 3 and 4 below. Relevant quotes are included with the summaries to illustrate the themes.

As a final stage of analysis, to understand the factors that shaped the implementation of CARE and JMHC, we mapped themes onto CFIR (which informed our interview guide). Each of the themes was therefore mapped to one of the five CFIR domains: (1) innovation, which describes the program itself, or components of the program; (2) outer setting, the external context or environment; (3) inner setting, the institution or setting that the program is implemented within; (4) individuals, the roles of those who implement the program; and (5) implementation process, the processes used to implement the program (Damschroder et al., 2022). In Chapter 5, we discuss implementation for both CARE and JMHC in the context of the CFIR domains.

Quantitative Methods

For each program, we received two sources of quantitative data. First, we received a file from each program that contained data that had been collected from the program on the youth served (referred to as *program data* for purposes of this report). These data were provided to the Probation Department by the programs as part of their contractual requirements and then shared with our team for the purpose of evaluation. We also received a data file for each program that was pulled from the Probation Department Information Services Bureau (referred to as *administrative data* for purposes of this report). These data contained court contacts data, and Probation Department staff pulled the information from their data system using the identifiers of youth who were included in the program data files. The administrative data file included information on arrests and court contacts associated with those arrests, including details of the arrest and charge (e.g., date, type of arrest, and type of charge). The file included some court contacts that resulted in "neutral" outcomes, such as a case continuance—termed "neutral" because it did not reflect an adverse juvenile justice outcome, such as being placed on probation. It also included dispositions resulting from each court contact, including whether the youth was being committed to a Division of Juvenile Justice facility, being committed to a Secure Youth Treatment Facility, being placed in a Los Angeles County juvenile camp, or being placed under supervision of probation but allowed to remain at home with a supervising adult. For each program, we merged data from these two sources to connect information on program enrollment

to juvenile justice outcomes. Unfortunately, when we attempted to merge these sources of data, there was often a significant mismatch between the youth represented within each data source (e.g., more youth reported in the program data than appeared in the administrative data). After several attempts to address this issue through revised data requests, we were unable to improve the number of matches. Therefore, in the initial version of this report (published September 2024), we opted to present information about the youth served based on program data only. Since that time, we have worked with the Probation Department to obtain updated data. We present findings related to these quantitative data analyses as an appendix to this report (Appendix B). In the main body of the report, we have retained the original analyses, which focus on the program data.

For the CARE Project, we received data from two fiscal years (FYs) of services: 2019–2020 and 2020–2021 (note that these files contained data about any youth who were active in services during those two fiscal years, but some youth had entered the program before July 2019). There were 556 youth included in the program file. The file included information about youth served, including gender, race/ethnicity, program start and end date, whether the youth received IEP advocacy, service provided by CARE social workers, and linkages to services. For the JMHC, we received data on youth served from 2001 to 2021. There were 793 youth in the program data file. The file contained information about youth served, including gender, race/ethnicity, program start and end date, and status of the youth at the time the data were submitted (i.e., active, successfully completed, unsuccessfully terminated). Note that for these programs, we received data on youth who used services supported by JJCPA funds. For each program, we conducted descriptive analyses focused on youth demographic characteristics and service utilization.

Chapter 3

CARE Project Findings

In this chapter, we present findings from our evaluation of the CARE Project, organized by our three evaluation questions. We begin by reporting findings for question 1, describing how the program operates and the population served. We then present findings related to question 2, program implementation. These include barriers and facilitators, as well as considerations related to equity. Finally, we discuss question 3, outcomes of youth who participate in the program, which are informed by staff's perceptions regarding program effectiveness and opportunities for improvement. Findings, including about program operation and perceptions of program effectiveness, are based entirely on our analysis of interviews with program staff and quantitative program data.

CARE Project Operation

According to staff interviewed, the CARE Project is a specialized court program that provides "services to youth with issues regarding mental health, education, disabilities, trauma." The program was started in response to a desire for a more holistic representation model for youth in the juvenile justice system. As part of the program, public defenders in the juvenile justice system are trained to identify whether their clients have social, mental health, or educational needs and connect them to dedicated staff who address each client's particular areas of need. CARE staff work in tandem with the youth's case, meaning that in addition to a public defender, youth in the program work with either an assigned social worker who assists with social or behavioral needs, a resource attorney who assists with educational needs, or both. Moreover, resource attorneys and social workers also advocate for the youth's eligibility for regional centers and seek services from regional centers. If youth in the program continue to have unmet needs beyond the close of the legal case, or if needs are identified at the probationary stage, the CARE Project may continue to serve youth past their disposition.

Program Goals

CARE staff described two main goals of the program: to meet the individualized needs of youth and to help youth obtain a more favorable judicial outcome. Regarding the goal of meeting the individualized needs of youth, staff members described the importance of painting a picture of the life course of the child, identifying their needs, and then ensuring that youth receive extra supports to address those needs. Regarding the goal of achieving a favorable judicial outcome, staff members emphasized their desire to help clients to obtain better dispositions and achieve the least restrictive court outcome. Staff members also highlighted that these two goals are typically interrelated. As one staff member said,

> What you're usually trying to accomplish in the legal case is the least restrictive environment in which the kid can thrive and be safe. You're trying to set that up in a sustainable way, not just set them up and have them crash and burn but to set them up with adequate services and supports that it's really sustainable.

Some staff described additional goals that they have for the clients they serve. For example, staff members reported that they hope this program provides clients with a better experience within the system, helps them to achieve stability, and equips parents with the education and resources they need to continue advocating for their child.

Referral Process

Consistent with the goals of the program, youth served are in active crisis or have experienced profound trauma, developmental delays, or school-related issues. Some staff noted that it is not uncommon for youth to be involved in the dependency system, which hears cases related to child abuse and neglect, and to have other significant psychosocial needs, such as those related to housing, poverty, or gang involvement. Interviewees shared that youth served by the program often have not had their needs met through other systems (e.g., schools) or the underlying issues have not been fully identified. In other cases, parents may not always recognize a concern or feel comfortable advocating for their child's needs, in part because they may not be aware of what resources are available (e.g., IEPs) or may experience pushback from local systems.

A youth can be referred to CARE in a couple of ways. Before assigning each case to a public defender, a deputy public defender reviews the youth's file and may at that stage flag them as a potential referral. Alternatively, after the case is assigned, public defenders review client records and meet with the client. During these stages, the public defenders may collect information that suggests that the youth would be a good referral for CARE (e.g., they have an IEP or history of mental health treatment). Interviewees said that there is not a specific set of eligibility criteria, but cases appropriate for the CARE resource attorney often involve academic needs, developmental delays, youth who already have an IEP, or youth who have school-related incidents or teacher reports such as disciplinary issues, school failures, or academic challenges. Cases appropriate for CARE social workers include clients with diagnosed and undiagnosed complex psychosocial and mental health histories, identified and unidentified developmental delays, substance use disorders, previous hospitalizations for mental health concerns, or need for other social or mental health linkages. Interviewees reported that referrals can be made at any stage of the case, including postconviction, but are most often made at the beginning of a case. Line public defenders (i.e., the youth's assigned public defender) submit referrals through a CARE request form, and then CARE staff determine how to decide the case. If public defenders have questions about whether a young person is a good fit for CARE, they can consult directly with a CARE resource attorney or social worker before making a referral.

According to staff, if a youth in the CARE Project has a severe mental illness, psychiatric hospitalizations, or need for more specialized attention, public defenders can refer them to JMHC, described in Chapter 4. CARE staff did not mention specific processes by which they determine whom to refer to JMHC, but Chapter 4 explains that JMHC provides public defenders with education and technical assistance for screening referrals.

Program Services

According to interviewees, there are two key staff roles that provide services within the CARE Project—resource attorneys and social workers—and youth may have one or both assigned depending on their needs. Once assigned, CARE staff operate as part of the youth's case and work closely with the public defender (and another CARE staff member as applicable) to relay information about the youth's needs, services provided, and how to communicate with the family so as not to overwhelm with multiple staff members. CARE staff explain their role to youth and families, and most clients accept offered services. CARE services are individualized for each youth, based on a review of the youth's case and meeting with the individual and their family.

Resource attorneys often focus on ensuring that clients have access to special education services, such as helping a child to obtain an IEP or ensuring that schools are complying with an existing IEP. In this capacity, according to staff interviews, resource attorneys sometimes interface directly with school districts, represent minors in school suspension or expulsion hearings, or bring in outside experts to officially evaluate or diagnose a youth to strengthen the evidence needed to advocate on behalf of the youth with the school. Resource attorneys also help clients to obtain access to regional centers, organizations that contract with the California Department of Developmental Services to support individuals with developmental disabilities (California Department of Developmental Services, undated). This might include collecting developmental information from diverse sources, creating referrals, orienting clients and families for the intake process, and advocating at each stage of intake, including in cases where youth are initially denied access to regional centers. Resource attorneys may also advocate for suitable services when the client is or becomes a consumer of the regional center. CARE Project social workers provide services to address behavioral health and other psychosocial needs and link families to needed resources. Staff explained that when a client is first referred, social workers do a thorough document review and psychosocial assessment to identify biopsychosocial factors affecting a client's life. Through this lens, social workers develop a picture of a client's life course that may offer mitigation. This is achieved, in part, through extensive clinical interviews and thorough document review.

Based on the findings, they can make linkages to services such as outpatient mental health services, substance use disorder treatment, prosocial activities, and basic needs (e.g., food, housing). If a youth needs additional support, social workers may refer families to a full-service partnership, a specialized program that provides intensive in-home services to youth and their families.

Social workers can also support families' efforts to obtain services through regional centers, including conducting psychoeducation on what it means to be a regional center consumer and its services. Additionally, they conduct an adaptive living skills assessment to evaluate a youth's level of functioning across various settings (e.g., home, school, workplace, community). Social workers may speak formally or informally in court as part of their advocacy. Based on their biopsychosocial assessment, they can also create disposition plans tailored to the youth's individualized needs. Interviewees mentioned that these plans may be used in court to articulate the trauma a youth may face and why certain treatments may be beneficial.

Staff members noted that the duration of CARE cases vary. Though some staff members estimated that cases are typically open from 4 to 12 months, there may be some instances in which a

client is followed for years (e.g., for youth undergoing severe crises or facing challenges in finding alternative housing, or in an application process with a long timeline with regional centers).

There can also be differences in the length of the case depending on whether a youth is pre- or postdisposition, as postdisposition youth are not limited to the timeline of their case. As one staff member described, youth can be served "post dispo[sition] [if there are] loose ends that we have to tie up on a case that didn't get resolved. . . . A lot of my cases, even when the tasks are done, sometimes the client still needs some additional support in order to successfully complete probation." In other words, youth may still receive CARE services once their legal case is resolved. CARE staff can follow these youth into another case if they are rearrested. Frequency of contact varies; it is tailored to each client's unique need and circumstance, with some happening as often as weekly. The CARE Project will keep a case open until both the delinquency case is resolved and the youth's needs are met—for example, obtaining an IEP. A case may remain open while longer-term efforts are pursued to connect youth to services (e.g., applying to regional centers); in this case, CARE staff may see the youth more infrequently.

Sometimes public defenders need a quick linkage, consultation, or one-off meeting of CARE staff and the youth, rather than ongoing services. In this scenario, a CARE referral can be initiated, during which the provider designates the referral as a "Brief Service," typically lasting 90 minutes or less.

At the time of the interviews, social workers estimated that their typical caseload is approximately 30 cases, and resource attorneys estimated that their caseload ranged from 35 to 45. However, caseload sizes can fluctuate over time. Caseloads may also vary due to the staffing structure within each court, as some courts have one or more devoted staff and others split staff between courts.

Staffing and Training

CARE staff work hand in hand with public defenders on the youth's case, communicating with the entire team to make sure there is no duplication in communication or services for the family. As one staff member explained, "It's certainly not just a referral and that's it. We're very much in constant communication." CARE social workers meet regularly together for clinical supervision and case consultation, and resource attorneys also meet bimonthly as a group. Both sets of staff reported regularly communicating with their colleagues to share challenges and solutions, with one interviewee saying, "We're very well connected and you can just call, you know, call someone at the drop of a dime and ask a question like that. Everybody's real supportive."

When hired, each public defender receives CARE Project–specific training on CARE staff services, ideal referral timing, and what information to include as part of the referral. Staff reported that training has recently become more standardized to include training directly from resource attorneys and social workers. As part of training, CARE staff encourage public defenders to consult with them before or during the referral process to ensure quality referrals (i.e., youth is a good fit for the program). Staff report that because of this level of open communication, the quality of referrals is quite strong and there's almost never a case where a public defender refers a youth who is not a good fit for the CARE Project.

Youth Served by CARE

We received data on 556 youth who were active in CARE during FY 2019–2020 and FY 2020–2021 (Table 3.1). The program largely served male youth, and most identified as Hispanic or Black.

There were 29 youth who had multiple program enrollments present in the program data (i.e., two separate enrollments in the data with distinct start and end dates). There were also 53 youth who had two separate enrollment dates but only a single end date, and it is unclear whether these are also youth who enrolled twice and were missing an end date for their first enrollment, or something different. Because this affects approximately 10 percent of the individuals in the data, we did not have enough confidence in the program completion data to report on the typical length of time that youth were enrolled in the program.

However, we were able to use the data to explore the types of services that youth received in the program. For these analyses, we focused on youth rather than enrollments—that is, if a youth received a given service during any enrollment, that was counted a single time. Regarding services provided by social workers, the most common were interagency advocacy—for example, with local school districts, the Department of Child and Family Services (DCFS), and the Department of Mental Health—followed by record retrieval and evaluation, which refers to the review of medical, educational, regional center, DCFS, and other records. Nearly half of youth received dispositional orders follow-up, in which social workers follow up with youth after they receive their court disposition to support them as they complete the terms of their disposition, to advocate for acceptance into community-based treatment, and to perform other follow-up activities. Social workers also help to determine what mental health, special education, and regional center needs youth might have in order to support attorneys in their advocacy and identify appropriate service linkages.

We also received data about youth service linkage. About 35 percent were linked to mental health services; a smaller percentage were referred to special education (18 percent) and regional centers (11 percent). Youth may also have been referred to other types of community services, though the methods for reporting on these data changed over time and therefore we do not report them here.

Table 3.1. CARE Participant Characteristics (FYs 2019–2021)

Demographic	Analytic File *N* = 556 % (*n*)
Gender	
Female	19.24 (107)
Male	80.40 (447)
Race or ethnicity	
Asian or Pacific Islander	1.62 (9)
Black	24.28 (135)
Hispanic	66.55 (370)
Another racial or ethnic group	2.52 (14)

Demographic	Analytic File *N* = 556 % (*n*)
White	5.04 (28)
CARE services	
IEP advocacy	21.76 (121)
Record retrieval and evaluation	45.68 (254)
Interagency advocacy	57.19 (318)
Department of Mental Health assistance	25.72 (143)
Special education assistance	26.98 (150)
Regional center assistance	16.73 (93)
Dispositional orders follow-up	47.48 (264)
Service linkage	
Linkage to regional center	10.97 (61)
Linkage to special education	17.63 (98)
Linkage to mental health services	34.35 (191)

NOTE: Gender and race or ethnicity were based on data submitted by the program, which were based on the youth's self-report to CARE Project staff. The categories are reported as they appeared in the program data, and we are unable to further tease apart race or ethnicity within these categories. Other gender categories were not reported due to low sample sizes.

CARE Implementation Findings

We found most implementation determinants belonged to three overarching themes: (1) staffing capacity and quality, (2) coordination with other agencies and services, and (3) needs of the population served. Additional themes emerged around the intervention itself, internal processes, and implementation in the context of the COVID-19 pandemic. These all closely match factors related to the needs of the population served, and findings related to these themes are presented in that section.

Overall, we present implementation findings according to the three overarching themes described above, as well as a fourth describing findings on equity, per evaluation question 2. Findings related to equity closely matched barriers related to the needs of the population served. However, as centering equity is an explicit guiding principle of the JJCPA portfolio (County of Los Angeles, 2023), we present it separately. By doing so, we also see that equity considerations tend to focus more distinctly on consequences for the youth as opposed to barriers to program implementation. Barriers and facilitators for each of the four overarching themes are depicted in Table 3.2.

Table 3.2. Barriers to and Facilitators of CARE Implementation

Overarching	Barriers	Facilitators
Staffing	Insufficient staff and high caseloads	High quality of staff

Overarching	Barriers	Facilitators
	Staff overworked, working across multiple offices	Remote work technologies
	Public defender turnover	
Working across agencies	Lack of coordinated communication and services across agencies	
	Quality of communication with partners	
	School partnerships and withdrawal of school district enrollment liaisons	
	Insufficient number of resources, programs, or placements	
Youth needs	Increasingly high needs within system	Initial trust building
	Youth or family denial of services because of stigma	
	Family engagement with systems	
	Identification of developmental issues because of families' downplaying	
	Engagement challenges due to COVID-19	
Equity	Discrimination against and resources needed for non-English-speaking families	Having Spanish-speaking staff
	Quality of available services based on location	
	School-to-prison pipeline	
	Black and Brown youth overrepresented in justice system	
	Client logistic and economic barriers	
	Discrimination against and resources needed for LGBTQ+ youth	
	Equity training	
	Equity tracking	

Staffing Capacity and Quality

CARE staff were asked about barriers to implementation of the program. One commonly mentioned barrier was **insufficient staff** to fully meet the high need for the program. Though several staff said caseloads were manageable, many noted that their caseloads were unusually high at the time of the interviews, limiting their availability to youth and families. One staff gave the example that there are "not enough staff to handle something that comes up last minute, for example meeting with a

youth and realizing they have a school hearing within days; or the RA [resource attorney] just can't make the hearing because schedule conflicts, etc." CARE staff have made some adjustments to offset the impact of staffing limitations and busy calendars; for example, public defenders will coordinate with CARE staff so that youth can interact with both parties when they are present at court. Public defenders may also attend a meeting or school hearing that CARE staff cannot make. As one interviewee described it, "We get creative in filling in the gap so that the family at least knows that they're not in it alone, we're still advocating for them." When caseloads are unmanageable, supervisors are very supportive and intervene to help "farm out cases" to other staff within or across offices.

However, several staff reported that recently departed staff were not replaced because of budget constraints, leaving the remaining **staff overworked**, with a number serving across multiple offices to cover needs. Though some courts were smaller and intentionally staffed by a resource attorney or social worker who works across multiple offices, interviewees also described limitations to this arrangement. For example, staff members who work or are referred across offices have more travel, meaning fewer appointments they can make in one day. They also may be less connected to resources or school districts for a specific placement area or not know the judges and other legal staff as well, connections that can take years to build. They are not consistently in the office to consult with other public defenders and staff, and therefore public defenders may not as readily consider a CARE referral or may not communicate as strongly with CARE staff.

Some staff also mentioned **public defender turnover** as a limitation to the program. They explained that lawyers do not typically specialize in juvenile cases because of the lack of promotions within the division. Therefore, they rotate to adult court as soon as they are able, meaning new public defenders constantly need to be trained and it may take time for them to gain experience and "gel" with the rest of the team.

Respondents reported many facilitators of program implementation that relate to staffing capacity and quality, with most related to the **excellent quality of social workers and resource attorneys**. Staff feel confident that their colleagues will give a high level of care, even when working with little time and few resources. Staff noted that institutional knowledge within the staff is incredibly important for understanding youth needs and maintaining the connections to appropriately place them. Public defender trainings, the subsequent high quality of referrals, and good supervision were all mentioned as program facilitators, in addition to the simplicity of the referral process and staff's access to each other for any needed discussion. Strong communication, good documentation, and evolving systems for saving documentation all lead to strong implementation. Respondents within some offices noted that additional monthly trainings and role clarification have helped the staff become a cohesive group and work more closely together.

Staff shared that having a manageable caseload, in terms of both quantity and client location, allowed staff to take more time with each case, making more home visits and attending more of their appointments. They pointed to the advantages of having all cases within one area where the staff know the judges, surrounding regional center, and schools very well. Some also discussed the utility of seeing each other in the office each day, mentioned both in the context of the COVID-19 pandemic and because of staff being split across multiple offices.

Many respondents mentioned that a strength of the program was that many resource attorneys previously were public defenders. Staff noted communication across the CARE team and court as a

facilitator, saying the process worked well when staff shared resources, they were readily communicative with the child's probation officer and others involved in their case, and the other justice stakeholders (such as the district attorney [DA] and court) were collaborative.

Coordination with Other Agencies and Services

Staff reported that an obstacle they have faced is an **insufficient number of suitable resources, programs, or placements** within the service area, typically a specific city or region within Los Angeles County. Staff made specific references to their own geographic area or the types of resources that were needed, while also talking about general "underfunding" for youth prior to justice system involvement, with one person stating they are "doing [their] best to link families to resources but the families need so much more than what's out there." One staff mentioned that a monthly stakeholder meeting in their area was a very helpful resource, but if they miss it they struggle to find resources for youth. Participants also explained that the dearth of programs leads to long wait times for wraparound services. Existing placements may also not be a great fit or not be offered for a long enough period to best address specific needs.

Another challenge in connecting youth to resources is a **lack of coordinated communication with other agencies** that serve the same population. Staff explained that the myriad of agencies involved in the clients' life have different timelines that can be difficult to match, and CARE staff do not have direct lines of communication with many of the agencies. For example, getting access to DCFS records—documentation that could be very useful—requires a formal request and could take months to receive. Staff noted that gaps in system coordination can cause significant problems for clients, such as clients being released without medication or prescriptions, or without an official form that says they were released. One participant gave an example of how the case duration may be affected by IEP timelines, noting, "They're just two different legal systems that were developed without reference to one another and you're trying to match them onto one another."

Staff noted **quality of communication with partners** could be a challenge. They said that while some agencies specifically have folks designated to coordinate, certain agencies or staff within agencies can be more helpful than others. Staff explained that agencies have their own staff shortages, which can mean they do not answer phones or call back, leading to extensive time-consuming follow-up for CARE staff or, in extreme cases, the necessity of filing compliance reports "to get them to do anything." One CARE staff member specifically alluded to attitudes within other agencies about youth involved in the juvenile justice system, suggesting that others may not consider youth in the criminal justice system to have similar needs that dependency or other youth may have. Additionally, CARE staff who work across districts may have less developed connections with partner agencies.

Several staff explained that a recent **withdrawal of school district enrollment liaisons** (district representatives who translate specific school processes) from the court because of funding cuts means CARE staff have less real-time assistance with how to proceed with youth school processes, particularly enrollment issues.

A number of **barriers specific to school partnerships** were also identified, including some already mentioned above, such as "not having school districts respond as we'd like them to," as one participant described it, and mismatched timelines. For example, CARE resource attorneys are unable to

intervene if school disciplinary hearings happened before the CARE referral. Working with the school systems can be much more challenging for those who are detained, since, as a staff member illustrated, "IEP and the regional center intake legal timelines are designed for non-detained people." Additionally, schools may set up legal or administrative barriers to avoid uptake of CARE recommendations. CARE staff reported that some school districts are more resistant to granting IEPs, and in these cases it is particularly important to "play nice" to make sure the IEP covers everything needed and the timeline stays on track. Youth may also change school districts with and following juvenile system involvement, which can complicate these issues.

CARE staff also mentioned some of the **challenges that youth and families encounter** in the program. Families and youth are motivated to downplay developmental issues, so identification can be difficult. When youth are released from detainment, even though they may have new supports in place, they often face the same issues present in their schools, communities, or homes that led to their initial detainment. As they do in working with partners, a challenge CARE staff may face with families is the extensive time-consuming follow-up. Families may not always have the ability or time to follow through on all linkages or assigned service plans and CARE staff must constantly track and follow up.

Needs of the Population Served

Though CARE staff acknowledged general client receptivity to their involvement and support, many described specific barriers to engaging youth and their families, including some who opt out of services altogether. The primary challenge was building initial trust with families, including getting parents' "sign off" to receive services and families' suspicion of "outsiders," particularly social workers, who are perceived to be mandated reporters. In particular, families who have been in multiple systems over time seem to be most difficult to establish rapport with, likely because of negative past experiences. One participant specified foster youth as an example:

> Where I've seen some resistance is with kids who've been in the foster care system, they've had a lot of negative experience with social workers and just it's overwhelming the amount of people that come in and out of their lives. Whether it's social workers or attorneys or therapists. I find that those kids can be very guarded, it takes a lot to gain their trust. Plus they know because they've been through it—people don't stay in their lives that long. Whether its professionals or relatives.

Staff also mentioned that youth or their family members may decline services because they deny that there are specific needs or are reticent to accept a diagnosis (e.g., FASDs) or a treatment that may seem stigmatizing, such as special education services or therapy. Some parents may also not want the school to know their child is involved in the delinquency system and therefore deny CARE support for school-specific services. Staff also note that families often need support to understand how the system works, their child's mental health needs, and their role in parenting justice-involved youth. Another challenge was lack of family follow-through on receiving or sustaining services. Staff say they spend a lot of time making consistent follow-up calls to parents to make sure the child is receiving needed services. Consistent contact with youth and families can be difficult to ensure, as youth are detained in various places throughout the county. Several staff also mentioned barriers that families face in engaging with CARE, such as having to learn the various roles of CARE staff as they are added

to the legal team. They may also find the request to share sensitive information difficult and have understandable barriers to building trust.

CARE staff shared many strategies for engaging with clients and addressing these barriers, including making the effort to meet in person, particularly somewhere that is comfortable for the family (i.e., not the court or their office). They also noted the importance of building rapport by taking the time to communicate and really work with the family to understand where the needs are. Some talked about persistence when impressing the benefits of services on families who may not be amenable. One participant explained that if a client does not want to participate, "we try to support and encourage the clients to accept the assistance. We don't give up easily." Another said that they "go down every road we think the client needs. [We] talk to client and family about the programs we recommend." One staff member gave an example of how they engage by taking the steps one at a time:

> I go through and try to explain specifically, dissolve some of the stigmas around special education and know that you're not agreeing to anything, all you're agreeing to do is get the person tested. . . . It doesn't mean they're stupid. It's just essentially just trying to get them to be open to the idea of finding out if there's something else that the big school can do to help.

Staff also note that engagement with the family can be facilitated by explaining to the family that accepting services will help their legal case.

Staff also stressed the importance of clarifying their role to both the youth and the "educational rights holder," who is typically the child's parent. Social workers noted that youth and families are more likely to engage if the social workers clarify up front that they function differently from social workers from DCFS: CARE staff are part of the youth's legal team, and therefore all information shared is confidential and will not be reported to social services.

Other engagement strategies included being immediately responsive to family needs, making sure the youth and families understand everything that happens in court, and consistently showing up and making sure the youth have a voice in their care. One staff member stressed the importance of "strik[ing] while it's hot": that is, if a client expresses a concern or willingness for treatment, the public defender should make sure they get connected to CARE immediately.

Interviews occurred in 2021 during the COVID-19 pandemic, and as such, participants described pandemic-related restrictions as a barrier to connecting with clients. Staff reported challenges with the frequency and mode of contact as well as difficulty engaging virtually. In particular, the pandemic made face-to-face contact more difficult, diminishing the rapport staff can build with youth and families. Respondents also mentioned the hardship of online learning and communication for youth and families, in particular youth with attention deficit/hyperactivity disorder, who may have a difficult time learning on Zoom.

On the other hand, some staff said that **remote work technologies**, adapted in response to the COVID-19 pandemic, increased efficiencies. By using Zoom instead of only offering in-person services, they were able to meet with many more families and partners, including schools and placement organizations. The increased availability of telehealth for youth and families was also noted as more convenient so families do not have to worry about getting to an office.

Respondents also talked about the **high level of needs** of youth in the juvenile justice system, as illustrated by a staff member who said, "It's the rare client that comes through the juvenile justice

system that doesn't need some type of assistance for linkage." Staff estimated that approximately 30–50 percent of juvenile youth received CARE services, and that percentage had increased recently because of changes in the population served by the court. Interviewees noted that a range of factors, including the newly elected DA, COVID-19, and other shifts within the justice system, have resulted in fewer youth entering the juvenile justice system. However, the youth who do enter typically have more serious charges and higher needs, translating to a larger percentage of CARE referrals. One staff summarized,

> It's fair to say that the vast majority of cases that are coming through now are appropriate for CARE referral because the vast majority of the limited number of cases that are coming through now are very serious. Either the charges are very serious and/or the underlying psychosocial circumstance of the child or family are very serious.

Because youth are coming in with more severe issues, it is more difficult to get a lighter sentence, and each case is more work.

Equity-Related Considerations in Program Implementation

CARE staff were asked about equity considerations within the program. Staff noted that systemic equity issues start well before youth reach CARE, as the program participants are youth in the juvenile justice system, where Black and Brown youth are overrepresented. Families with greater barriers to engaging in the program, such as limited transportation, may be less likely to benefit from program services. Interviewees noted that some barriers are not well known or understood. There are also ways that community inequities shape the implementation of CARE. For example, the availability of linkages to services within schools depends on where the youth live and which school they go to, and many academically underperforming schools are in the poorest neighborhoods. Interviewees noted that resource attorneys can try to get youth they serve into higher-performing schools but that school systems were often reticent to accept youth who had been involved in the system. Relatedly, interviewees cited the influence of factors such as the school-to-prison pipeline on creating and perpetuating disparities in system involvement.

Staff shared some opportunities to improve their approach to integrating an equity lens into program implementation. For example, staff were not aware of any efforts to systematically track race and gender data to examine demographic trends and determine whether there is any type of unequal treatment, such as profiling. Another staff member suggested that existing training on working with diverse populations could be improved.

Though the CARE team is diverse, interviewees also discussed opportunities to increase staff diversity. Several interviewees noted that it helps staff to be Spanish speaking or have the same race, ethnicity, or community as a client. Respondents stressed that many Hispanic cultures are represented in the justice system and it is important to recognize they can be quite different from one another. Staff report that not all materials are translated into Spanish, and even though there is an interpreter in court, most Spanish-speaking families, when asked, say they did not understand anything that happened in court.

At the same time, some interviewees suggested that CARE can be a mechanism for addressing inequities associated with race and other youth identities. One respondent said,

> The basic nature of our work addresses racial inequities and disparities. The idea of linking youth to services, getting them educational plans that are suitable and necessary for their needs. I think that does address, at least to some extent, problems in our societies because of historic racism.

Another interviewee highlighted their ability to draw on Los Angeles County resources for LGBTQ+ populations, though certain services are more or less accessible depending on where the youth live.

CARE Project Outcomes

While we intended to include quantitative outcomes in this section, we were unable to do so because of data limitations (as described in Chapter 2). However, we did ask about themes related to outcomes in qualitative interviews, and we present those findings here.

Perception of Program Effectiveness

We asked interview participants about their perceptions of the effectiveness of CARE. All respondents who spoke to program effectiveness said the CARE Project was effective in its goals to connect youth to services or respond to educational issues, with most overflowing with praise for the program or other staff members, which they described using terms such as "exceptional," "outstanding," and "phenomenal," to name only a few. Attorneys shared what an incredible resource it is to work closely with staff who can so effectively address clients' needs. One said,

> I don't have the training to advocate for our clients with the different school districts if they have educational needs. I don't have the training or experience to help our clients who have mental health issues and mental health needs as well. So, I think for the juvenile system to really work, it's essential to have the assistance of educational resources attorneys and psychiatric social workers.

Many staff respondents discussed the invaluable nature of linking youth to regional centers. Clients who are accepted into regional centers have more program options, which tend to be more comprehensive, have higher funding, and allow for more services. Receiving services from a regional center is a lifetime benefit.

Staff also suggested that this program may be having a positive impact beyond the individual youth and families that are served. They noted that, when CARE began, there were not programs like this in existence, but now other districts have started to adopt the model. This has helped contribute to the greater focus on youth rehabilitation that has been observed in recent years.

Perceived Opportunities for Improvement

CARE staff identified many opportunities to improve the program. **More staffing** was mentioned by most respondents, with many specifying that at least one resource attorney and one social worker were needed for each court room. At least one interviewee suggested that restructuring some resource attorney tasks for social workers could be a better use of program funds. Many respondents also discussed the **need for other types of staff, such as case managers or paralegals**, to assist with client follow-up, records retrieval, and other tasks. The need for more training for DAs and bench officers on trauma-informed approaches was suggested.

Respondents suggested having a **specific person as a point of contact for partner agencies** and **reinstituting court appearances of school enrollment liaisons**. CARE staff also would like to have access to agency records without a formal request, specifically DCFS and schools, which could help the program to get students enrolled faster and help resource attorneys advocate without delay.

Another recommendation for improvement was to **strengthen the process of transitioning the youth to the community** by including school records in youths' exit packages to help them with school entry and to ensure that all prescriptions and medications are included as part of the exit package.

Chapter Summary

In addition to sharing how the CARE Project operates, CARE staff shared barriers to and facilitators of program implementation and their perceptions of effectiveness. We found that staffing, external agency coordination, and the high needs of the youth were the primary factors affecting implementation. Despite many external barriers, CARE staff expressed that the program was highly effective. These themes closely match findings about JMHC, in Chapter 4, and therefore takeaways from both programs are discussed together in Chapter 5.

Chapter 4

Juvenile Mental Health Court

In this chapter, we present findings from our evaluation of the JMHC program, organized by our three evaluation questions. As in the previous chapter, we first present findings for question 1, program operation and population served, then findings related to program implementation, and finally, findings concerning outcomes of youth who participate in the program. Findings related to youth served are based on quantitative program data, and all other results in this chapter are from interviews with program staff.

Juvenile Mental Health Court Program Operation

JMHC is a full-time court specifically designated for the highest-needs youth in the Los Angeles County Juvenile Justice System.[1] The court focuses on IEP education advocacy, developmental delay advocacy, and mental health.

Program Goals

Staff described multiple goals for the program, primarily meeting the individualized needs of youth and providing stability through a rehabilitative focus. Though the program serves youth with needs in specific categories (i.e., IEP advocacy, developmental delay advocacy, mental health treatment), the definition of success might vary from youth to youth, in part because of the complexity and depth of issues these youth face. According to staff, goals for services include empowering youth to advocate and access services for themselves, securing dismissal of legal cases upon completion of the program (i.e., the court considers cases resolved), and reducing recidivism rates.

Referral Process

According to interviewees, youth served by the JMHC program have the most acute mental health needs or have difficult behavior issues and need more attention and a higher level of supervision or care. Staff highlighted that youth served typically have a history of mental health concerns, school-related issues, residential placements, or substance use. Staff described youth as having been failed by so many systems for a long period of time, with potential harms along the way, such as misdiagnosis,

[1] This program is sometimes referred to as the Special Needs Court in some JJCPA-related documentation and past evaluation reports.

that by the time they arrive in JMHC their condition is severe. One respondent said, "These are the kids that have fallen through every crack in every system and now are in trouble with the law."

Staff described youth as presenting with a lot of social, behavioral, and mental health needs and complex trauma, with many who have faced serious adversities. Mental health symptoms can be acute, including active psychosis, and many are at the level where they cannot be treated in the community, at least initially. Other common mental health conditions include anxiety disorders, bipolar disorder, posttraumatic stress disorder, and attention deficit/hyperactivity disorder. Developmental and intellectual disabilities are also common, including learning disabilities, FASD, and autism/spectrum disorders. With respect to charges, staff said they see a variety, though most of them involve physically acting out toward family or another person.

A public defender from any juvenile court in Los Angeles County can make a referral for their client, but a referral may also come from a bench officer or other source. The JMHC public defender works with courts to screen referrals and provide education about the purpose of JMHC. The referring public defender fills out a form that asks about the youth's history and current status, such as whether they have previously received mental health services or are taking medications. The form is submitted to the JMHC clerk and added to the court's calendar for a screening. The screening is a detailed assessment by the court's psychologist and psychiatrist, and it marks the beginning of the program activities for youth who are accepted to the court and the end of the referral process for youth who are not accepted. Staff report that there are very few cases that are rejected from the court. For those who are not a good fit, it may be because the staff thinks another court, such as the STAR (Succeeding Through Achievement and Resilience Court, which supports survivors of human trafficking) court or drug court, is a better fit, or because the youth's charges are too serious for the DA to agree to dismiss. In addition, the court is voluntary, so youth and caregivers have to opt in and must agree to receive treatment as a condition of participating. In the rare case that the youth is rejected, the team may still follow the youth's progression through the court system to ensure they are getting support.

Program Services

As noted, when a youth is referred to the court, the court's consulting doctors (i.e., a child psychologist and a child psychiatrist) conduct a full review of the youth's records, including the court file, educational records, and mental health records. The psychologist writes a report based on these sources and distributes a one-page summary to the other program staff. The doctors then interview the youth and caregivers with members of the JMHC team present. Afterward, the full JMHC team convenes to review the case. The doctors present to the team, and staff contribute additional information according to their individual expertise and ask questions related to what they will need to know to best serve the youth.

Youth who are accepted to the court no longer interact with other courts; instead, they exclusively work with and are provided services through JMHC. JMHC staff provide a holistic court experience to the youth as well as a range of services, including connecting youth to appropriate services and school placements; helping families navigate school-related activities, such as enrollment or IEP matters; and providing foundational knowledge to youth and families about mental health and

psychiatric diagnoses. JMHC staff are intentional about finding placements that are matched to the youth's individual needs. The court has a diverse staff who are privy to information that treating providers in juvenile halls do not necessarily have, and the staff can leverage that information for the youth's well-being and legal trajectory by communicating with providers in juvenile hall to adjust treatment plans. The court also follows up frequently with families to give additional support where helpful. Regarding school services, staff can accompany families into IEP meetings and support them in understanding their rights, their full gamut of options, and their consenting ability. The court also considers the screening and assessment process to be an advocacy service provided. The court's doctors assemble the youth's story, identify root conditions that may have led to symptomatic behaviors as well as gaps across the various systems. That information is provided to the families and can be used to advocate for their child.

The court is specifically designed so youth designated for the program always see the same team of people to ensure continuity of care. As one respondent described,

> That's the way the court is set up, the need for continuity so the kids will see the same DA, same judge, same everyone. A lot of these kids have abandonment issues, and it causes a lot of issues and we try to let them know we're there for them in the long run and that helps them open up about what they really need.

JMHC youth are typically followed for their full probation term, with staff making sure they stay on probation until services are successfully put into place. Those who successfully complete the program have their case dismissed, except in the very rare case that the court accepts the participant conditionally (DA terms).

Youth who are part of JMHC receive a lot of support and frequent contact with program staff. Staff reported they see the youth on average about once every four weeks but have the flexibility to see them more if they need additional services or connection or are having specific issues. Staff also have phone contact, with frequency that varies based on the youth and how much they need, ranging from twice a month to ten times a month.

Youth served by JMHC are typically in their home or in placement. If the youth is in placement while services are being put in place, they will typically remain there until services have been set up so that there is support available upon release.

At the time of the interviews, staff reported their typical caseload was approximately 40–50 cases (note each staff has a different role and interacts with all cases), though numbers could be as high as 70. Staff said that the intensity of services in this program meant that a lower caseload was beneficial.

JMHC interacts with a number of systems outside or connected to their program, including other courts and staff within the juvenile justice system, the Probation Department, schools, and placement organizations. JMHC has a close relationship with the Los Angeles County Department of Mental Health, which works closely with staff to check in on clients who are in juvenile halls and also can work with DCFS; the latter can sometimes be involved in cases and often takes over when a case is closed. Staff are connected to many agencies and have the unique ability to communicate within and across systems.

Staffing and Training

At the time of data collection, the JMHC staff members included a judge, a DA, a public defender, two probation officers, a social worker, an educational liaison, a psychologist, and a psychiatrist. Staff reported they look to the judge as the lead of the program and the public defender as the legal "boots on the ground." The DA was described as having the least interaction with youth and is the "gatekeeper to the prosecutorial side," examining underlying criminal behavior to determine whether the minor is appropriate for the court based on the severity of their criminal behavior. The psychiatrist and psychologist are the consulting doctors who review records, conduct the initial interview with youth, and summarize findings for JMHC staff. Following the initial assessment, they can work with the team by providing theoretical support to the social worker, who operationalizes their recommendations. The psychiatrist and psychologist can also liaise with providers and communicate with the juvenile hall if their assessment yields information that would affect medical decisionmaking for youth who are in juvenile hall. The team's social worker follows all youth until their cases are successfully closed. They participate in the intake with the team's doctors, helping to determine existing services and additional needs. Following intake, the social worker manages the intensity of each youth's care based on the individual needs of the youth. They provide follow-up and consultation with caregivers as well as mental health professionals who interact with the youth. The educational liaison works with families on school needs, such as IEPs, special education needs, and education history and records. Lastly, the team's probation officers provide probation support to the youth and split cases according to needs to ensure each youth is connected with only one probation officer for continuity.

Staff reported that team roles are very complementary; that all staff have their individual roles, which are all necessary; and that the team works well together. They described communication as fluid, with no formal team collaboration aside from each youth's postscreening meeting. Since all staff work in the courtroom, when there is an issue, everyone comes together and discusses it. One respondent said, "There was a time when we'd meet weekly to discuss. To brainstorm and see what the kid needs. But now we always just are talking by text, email, etc. This whole team thing just happens. It's great to have a team."

Legal-based staff receive outside trainings but did not necessarily have mental health backgrounds or specific mental health experience before working on JMHC. However, several staff report significant on-the-job learning through their experience working on JMHC cases, and one staff member commented that case summaries that used to take 20 minutes now last hours because of the sophistication of questions and input the team can now offer.

Youth Served by Juvenile Mental Health Court

Table 4.1 presents a summary of the 793 youth served by JMHC from 2001 to 2021 for whom data were available. Limited demographic information was available about these youth, but it indicates that most youth served have been male and Hispanic or Black.

Although there were 793 youth who were served by the program, 16 of those youth enrolled in the program twice during the time frame that data were available. Therefore, to understand the typical length of enrollment and reasons for exiting the program, we analyzed data at the enrollment level (*n*

= 809). As of June 2021, the majority of enrollments (72 percent) ended in successful completion of the program, though about 22 percent had been unsuccessfully terminated. Reasons why youth were terminated from the program included facing new charges, being unwilling to cooperate or noncompliant with the treatment plan, or walking away from their treatment program. The mean time enrolled in the program was computed for youth who had completed or been terminated; on average, youth were enrolled in the program for 15.56 months (standard deviation = 13.37, median = 13, range = 0 to 182).

Table 4.1. JMHC Participant Characteristics (2001 to 2021)

Demographic	**% (*n*) *N* = 793**
Gender	
Female	25.60 (203)
Male	74.15 (588)
Race or ethnicity	
Black	29.26 (232)
Hispanic	59.52 (472)
Another racial or ethnic group	2.27 (18)
White	8.58 (68)
Missing	0.38 (3)
Program Enrollment	**% (*n*) or median (standard deviation) *N* = 809**
Program status (as of June 2021)	
Successfully completed	72.19 (584)
Unsuccessfully terminated	22.87 (185)
Active	4.70 (38)
Another status (e.g., missing, deceased)	0.25 (2)
Average time enrolled	
Successfully completed	14.95 (11.87)
Unsuccessfully terminated	17.61 (17.31)

NOTE: Gender and race or ethnicity were based on data submitted by the program, which included more-nuanced categories and were based on the youth's self-report to JMHC program staff. End dates were missing for 11 youth who were successfully terminated and 13 youth who were unsuccessfully terminated. Youth who reported another gender status or whose status was missing were not reported due to small sample sizes.

Juvenile Mental Health Court Implementation Findings

As with our CARE findings, findings related to implementation of JMHC are presented according to the following overarching themes: (1) staffing capacity and quality, (2) coordination with other agencies and services, (3) needs of the population served, and (4) equity considerations; for JMHC, an additional category was identified: (5) implementation process. Barriers and facilitators for each of the four overarching themes are depicted in Table 4.2. In the conclusion section, we discuss how implementation themes for both CARE and JMHC match to CFIR domains.

Table 4.2. Barriers to and Facilitators of JMHC Implementation

Categories	Barriers	Facilitators
Staffing	High caseloads	High quality of staff
Working across agencies	Lack of coordinated communication and services across agencies	
	Insufficient number of resources, programs, or placements	
Youth needs	Increasingly high needs within system	Initial trust building
	Family engagement with systems	Learning the youth's history
	Engagement challenges due to COVID-19	
Equity	Discrimination against and resources needed for non-English-speaking families	
	Quality of services based on location	
	School-to-prison pipeline	
	Discrimination against and resources needed for LGBTQ+ youth	
	Tracking equity	
Process	Lack of technology, data infrastructure, and resources available in languages other than English	

Staffing Capacity and Quality

High caseloads were identified as a barrier, especially given the small number of JMHC staff, many of whom have part-time roles in JMHC. The court has a regular juvenile court calendar, meaning that the judge and DA see cases in addition to JMHC. Several staff have only contract roles, and there is only one social worker working with a large number of high-need youth. One respondent illustrated this by saying,

> [W]e know there's overwhelming psychiatric need in at least three-quarters of [youth in this system]. Sometimes it's even up to 90 percent. And then you have this one little mental health court for all of [Los Angeles] County, which is the largest juvenile justice system in the country.

Most respondents mentioned the **quality of the JMHC staff and team** as the greatest facilitator for the program. Specifically, each member has a specialized role within the team that brings particular value. The team facilitators include having people who are the "right fit" and "psychologically minded," and staff who know when to "step in and when to step back." Staff praised the team's collaborative nature and synchronicity in working toward the same goals. As one respondent described,

> We all work together really well and it's because we're all connected with these kids, the collaboration is the most important thing on the court, we get the psych perspective, the DA perspective, educational liaison, etc. We have team that's not afraid to give their opinion whether it comports with or is contrary to others and that's what helps make it work.

Coordination with Other Agencies and Services

JMHC staff identified similar barriers to those identified by CARE staff, primarily the **insufficient number of appropriate or suitable placements for youth**. Respondents explained that JMHC youth have specialized needs, and either specialized placements for those needs do not exist (e.g., youth with FASD, youth who have been sexually trafficked or exploited), or there are so few that wait times are lengthy. Staff especially noted that existing residential placement options are typically for very low-need or very high-need youth, and they highlighted the need for a therapeutic setting for youth with moderate needs. They also explained that placements have decreased over time and that they have not been able to rely on out-of-state options as they did in the past.

Staff mentioned other **partnership or systemic barriers**, such as lack of follow-up and other system-level gaps for transition-age youth, as well as inappropriate referrals to JMHC, which can increase the time that other youth have to wait to receive services. Some staff mentioned a lack of continuity with Medi-Cal (California's Medicaid program) from detention to the community, which had since been resolved.

JMHC staff shared some solutions for overcoming these barriers. Where placement needs are concerned, JMHC advocates for needed services by **holding agencies accountable** to what they claim to provide. They also work to find other agencies that may be able to serve the need. To fill gaps for transition-age youth, staff find extra supports and patch together available resources to serve their needs as much as possible. Staff use constant follow-up and maneuver treatment plans to best serve the individual youth. One respondent said, "We're not fighting just the barriers that are inherent in this community, we're also fighting the barriers in the system, like DCFS."

They also described other strategies used to preemptively solve barriers. For example, they try to predict the barriers that a youth may face to ensure they have the appropriate placement or are matched with the "right" school. Staff also back each other up with their expertise by writing reports or making phone calls for each other where helpful.

Needs of the Population Served

Few client engagement barriers were reported by JMHC staff. Staff with frequent youth contact reported that some kids can be difficult to understand, be resistant, and take time to open up or, as one person described, "are so sick that there's not a lot of connection," making them difficult to engage with. JMHC staff also discussed the difficulty of connecting with youth and families over a screen when in-person contact was limited during the COVID-19 pandemic.

Staff explained that it can take time to build rapport and noted the importance of working consistently together with youth over a period of time. For example, it can be harder to forge a connection with youth who have a history of abandonment, and stressing to those clients that staff are there for them in the long run can help to build trust and allow clients to feel safe opening up about what they need. One respondent summarized,

> I think them knowing that I'm there to help them instead of getting them in trouble, them knowing that I have their back makes a huge difference. . . . So you develop a relationship. So when I say, I have their backs, I make sure that when I'm . . . at that court hearing and if I have [anything else to say], I make sure they hear me say on record how I'm advocating for them.

They also explained that learning the history of a youth, during the intensive screening assessment, helps them understand the youth's behaviors.

Staff also described tenets of engagement that were important in working with justice-involved youth and their families, such as regularly reaching out to parents, providers, and the judge to build connections and make sure everyone is on the same page. They stressed the importance of personal connections, honesty and forthrightness, and talking to youth in a nonconfrontational way but still setting boundaries. They also noted the importance of reading each individual situation, considering the youth's background context, and looking deeper at the roots of the youth's issues. For example, this could include paying attention to which staff the youth is opening up to (or not) and which youth benefit more from being provided some degree of independence.

Equity-Related Considerations in Program Implementation

JMHC staff noted some of the same equity considerations that were mentioned by CARE staff, including the program's lack of research capacity to track equity. Staff also raised systemic issues related to inequities, such as the school-to-prison pipeline, lower-quality IEP and disability accommodation plans (known as "504 plans," as it's required by section 504 of the Federal Rehabilitation Act [U.S. Department of Education, undated]) observed in areas of the county with lower incomes and higher populations of marginalized racial/ethnic groups, and systemic racism against non-English-speaking Latinx families. An interviewee also noted the need for greater sensitivity to the needs of LGBTQ+ youth. Staff also cited youth- and family-specific challenges, such as difficult financial situations, transportation barriers for getting to placements, and difficulties caregivers face in understanding their rights or their child's IEP.

Implementation Process

Additional barriers included lack of technology, data infrastructure, and resources available in languages other than English, as well as an administrative dissonance between the program activities and the writing of the MOUs (Memorandum of Understanding; agreements that guide program activities). Staff explained that JMHC referrals were lighter because of the COVID-19 pandemic and that at the time of data collection, youth could not be drug tested because labs were inundated with COVID-19 tests, limiting their ability to create effective substance abuse treatment plans.

Juvenile Mental Health Court Program Outcomes

Perception of Program Effectiveness

JMHC staff reported that the program was successful on multiple levels: preventing recidivism, filling a gap in services for an underserved population, and identifying issues and creating treatment plans for each individual youth.

In particular, staff pointed to unique but replicable elements of the program as keys to its success. Embedding mental health professionals from different disciplines within the court gives youth a level of treatment they may not otherwise have had access to. As one staff member explained, "So the fact that these case plans, these treatment plans, are all individually based, and . . . how so many different members [of our team] from so many different areas of study come together and provide this individually unique treatment plan, is no service these youth would get anywhere else." JMHC also has different goals from other juvenile courts, to identify and treat root causes of misconduct, which staff perceive to be effective for youth. Staff believe that this program is effective because of their ability to adjust their clients' court experiences based on individual youth needs, and clients have continuity within their case and treatment plan by being served by one team whose members work closely with each other.

Respondents noted that other juvenile courts increasingly have elements that are similar to the services offered by JMHC, even if they do not have the formal program; in this way, they speculated that the existence of JMHC may be helping to change the landscape of services for probation-involved youth.

Several staff indicated that all youth, regardless of intensity, could benefit from specialized case work, and that the regular courts could better serve their youth if they incorporated elements of JMHC.

Additionally, staff have received feedback from many families that they had been wanting this type of assistance, particularly for communicating with schools. Throughout interviews, staff expressed that even youth who are not accepted into the program experience benefits: the JMHC psychological evaluation can be shared with the referring attorney, which can be used to strengthen their case and for families to advocate for treatment and services.

Perceived Opportunities for Improvement

Staff suggested **improvements to the process of transitioning from detention to community**, including automatic connection with other agencies to set up services in advance of the youth's release and allowing the JMHC probation officers to follow youth when they go back to the community. Staff also expressed a need for greater research capacity and more flexible administrative protocols. A few staff articulated a need for **more JMHC staff or staff time** for some positions.

Chapter Summary

As with the CARE Project, overarching factors related to implementation of JMHC included staffing, external agency coordination, and the high needs of the youth served. JMHC staff perceived strong program effectiveness and a need for more youth to receive program services. Conclusions about both programs are discussed together in Chapter 5.

Chapter 5

Conclusion

This report has summarized our evaluation of the CARE Project and JMHC in Los Angeles County. Though these are two distinct programs, there are similarities between them: in terms of operation (evaluation question 1), both are court interventions that serve youth with significant behavioral health and psychosocial needs, and the types of supports that youth and families receive can be similar (e.g., educational advocacy, mental health treatment linkage). (The details of program operations have been thoroughly described in Chapters 3 and 4, so we do not cover them in detail below.)

We also found similarities in the facilitators of and barriers to implementation (evaluation question 2) and the perceived effectiveness (evaluation question 3). Therefore, in this section, we summarize takeaway findings on implementation and effectiveness from across the two programs and present recommendations for future implementation.

Summary of Findings from CARE and Juvenile Mental Health Court

Factors affecting implementation were similar across both programs, with four overarching themes emerging: (1) staffing capacity and quality, (2) coordination with other agencies and services, (3) needs of the population served, and (4) equity considerations. There were also a few unique themes related to the interventions themselves, the process for implementation, and the context of the COVID-19 pandemic.

We mapped these factors onto the five CFIR domains, as CFIR provides a structured method for understanding implementation of a program. As shown in Table 5.1, we found that three of the four key barriers—needs of the youth served, coordination across multiple agencies and services, and equity considerations—are all part of the outer setting: that is, barriers outside the control of the programs. Facilitators of implementation are found at the level of the intervention itself and the quality of the staff. Modifiable barriers are staffing levels and equity tracking. These, as well as other recommendations for addressing the outer context and the evaluation context, are provided in the recommendations section below.

Table 5.1. Barriers and Facilitators to CARE and JMHC, by CFIR

	Barriers		Facilitators	
CFIR Domains	CARE	JMHC	CARE	JMHC
Intervention			Youth needs	Youth needs
Individuals			Staffing	Staffing
Process	Equity (tracking)	Equity (tracking)		
Inner context	Staffing	Staffing		
Outer context	Youth needs and coordination across multiple agencies and equity	Youth needs and coordination across multiple agencies and equity		

Processes across both programs were typically working well. A 2017 CARE evaluation recommended improving programmatic structure by clearly defining processes and staff roles and increasing referral training for public defenders (Rabinowitz et al., 2017). Though there were not formal structures around processes and roles, referral training was implemented by CARE before this evaluation, and staff commented on the high quality of referrals. Neither program had strict referral criteria, but both staff worked across systems to ensure attorneys or other referring parties were well aware of who should be referred, and that was working well for both programs.

Communication within teams was also generally found to be strong in both programs. CARE staff described keeping each other informed and working hand in hand, as has been previously documented in implementation evaluation (Rabinowitz et al., 2017). JMHC staff described the invaluable nature of their team as a unit and each person's crucial role in the full process.

When asked about the primary barriers and challenges to implementation, staff members of both programs described the need for increased resources: more staff to work current cases, more youth to be served and for more time, and more placements and more resources for youth.

Staff from both programs were overstretched. Staff resources are a challenge that the CARE Project has faced for some time, but they were still identified as a high-priority area for improvement at the time of our interviews (Rabinowitz et al., 2017). Though caseloads did appear to be decreasing, staff members described an increase in the severity of cases being referred to the programs, meaning that each case necessitated more time and effort.

Both programs' staff highlighted lack of coordination across agencies and services, and both recommended better interagency coordination as part of a youth's transition from detainment to release. Though this has been improved somewhat for CARE by the shift to allow service of youth postdisposition, both programs' staff cited challenges to implementing and sustaining services outside of detainment.

CARE and JMHC staff raised systemic equity issues affecting youth, including the overrepresentation of Black and Brown youth in the justice system and the effects of the school-to-prison pipeline on perpetuating inequities. Both programs reported a lack of tracking related to equity, such as collection of race and gender data.

Regarding effectiveness, staff from both programs indicated a distinct need for their programs within the juvenile justice system. They highlighted the number of youth with significant needs related to mental health and disability diagnoses, and the importance of having programs available that can connect youth with services to address those needs. In fact, staff from both programs noted that, without involvement in the juvenile justice system, the needs of many youth may have continued to go unmet. Some said that system involvement has become a default pathway to mental health services, though interviewees also underscored that it is unfortunate that youth have to fall into the system in order to get care they were not receiving previously.

Limitations

There are several limitations of this evaluation that should be kept in mind when interpreting the findings. First, the interviews for this evaluation were largely conducted in 2021, when restrictions related to the COVID-19 pandemic were still having a significant impact on the operation of the programs. We did ask providers to reflect on implementation prepandemic; however, it is likely that there are elements of the program that have evolved as a result of the pandemic. Therefore, the timing of interviews should be kept in mind. Second, we attempted to recruit more youth and caregivers to participate in interviews for this report. However, despite several rounds of outreach via phone and mail, we had only a very small number of youth and caregivers agree to participate. We believe that one barrier was the need to obtain signed consent and assent, which necessitated that we send paper packets of materials to participants. Though we included self-addressed envelopes, it is likely that this was a barrier to recruitment. We were also limited largely to virtual data collection because of the pandemic; it may be that recruitment in person at courthouses would have been more effective, but we were unable to do so for the present report. Because of these recruitment limitations, we do not include findings from caregivers and youth, missing a critical perspective.

There were also key limitations related to the quantitative data. We had very different time frames of data for the two programs, which should be kept in mind when interpreting the findings. In addition, there were many youth in the program data who were not reflected in the administrative data and vice versa, which drove our decision to focus on data submitted by programs about the youth served. Unfortunately, there were still fairly limited data available from these programs. This points to a need for additional evaluation, focused especially on quantitative indicators of implementation and outcomes, to complement the findings documented in this report. We are currently exploring methods of improving data quality with the Probation Department and could include such results in future publications if available.

Recommendations

In this section, we present recommendations relevant to both CARE and JMHC, organized by overarching themes.

Staffing Capacity and Quality

Increase number of staff. Both programs identified a need for increased overall staffing. While staffing across mental health fields is generally a challenge because of staff shortages, insufficient numbers to handle youth behavioral needs, and funding, staffing was one of the three overarching barriers identified. Of the three, it is the only one within the inner context, according to analysis of CFIR domains (Table 5.1). CARE staff described a number of barriers related to insufficient and overworked staff, including staffing resource attorneys and social workers to work across multiple offices, which meant more travel and less familiarity with each specific court system, its staff, and local resources (e.g., placements). As directly suggested by many interview respondents, each court should have at least one dedicated full-time resource attorney and social worker per court to increase staffing overall and improve efficiencies for the program. This may also help to mitigate disparities by zip code. JMHC staff explained that high caseloads and a small number of staff lead to gaps in the number of youth who can be feasibly served. Specifically, increasing the number of social workers and including a full-time education specialist (at the time of interviews, the education liaison was part time) could increase the number of youth and depth of service for each case.

We identified one recommendation specific to the CARE Project: *Consider adding new types of staff (e.g., paralegal, case manager) to assist with CARE staff workloads*. We recommended increasing overall staffing for both CARE and JMHC. However, this recommendation is distinct in suggesting new positions altogether. Though the core CARE Project model has been seen as effective, many interview respondents suggested new staff roles would help to offset the resource attorney and social worker workloads. Suggestions included case managers and paralegals who could assist with tasks such as client follow-up and records retrieval.

Coordination with Other Agencies and Services

Prioritize the process by which youth transition from juvenile halls and camps to the community. In both programs, significant attention should be paid to strengthening continuity of services overall, with particular emphasis on services for youth who are transitioning from juvenile halls or camps to community. Challenges primarily seemed to result from the lack of compatibility across agencies and systems. Findings suggest that bureaucracy across systems, such as formal records requests, can slow or completely prevent the flow of information, affecting services while youth are detained as well as when they are transitioning to the community. Staff from both programs suggested improvements to the transition process, such as automatic inclusion of school and medical records in youth's exit packages and automatic connection with other agencies to set up services in advance of a youth's release. CARE and JMHC staff should work with partnering agencies to improve processes, such as assigning specific agency points of contact, reducing restrictions and timelines for agency record sharing, and formally including school and medical records in youth release packages.

Needs of the Population Served

We also identified one recommendation specific to JMHC: *Expand JMHC to other courts in the county*. JMHC serves the highest-need youth in the justice system for all of Los Angeles County, the

most populous county in the country. Youth served have significant psychosocial needs, and sizable need still exists. Even if the program could reach all the county's highest-need youth and connect them to mental health treatment or regional centers in their local community, youth and families have to travel across the county to participate in court. Expanding to other courts would help to promote more equitable access to the service across the county. Building on facilitators cited in this report, preconditions for a successful court would include developing a strong multidisciplinary team, including an invested judge, a DA, probation officers, and sufficient clinical staff. Staff resources could be leveraged by other courts: the current JMHC judge serves additional cases in the juvenile justice system, and this model could be replicated. It is reasonable that additional legal staff could be leveraged from existing courts as well, though all staff would need to be within the same court system. Where additional staff (such as the educational liaison) would be difficult to scale, increased JJCPA funding may be needed.

Equity Considerations

Implement equity training. Relatedly, staff members of both programs could benefit from equity-related trainings at a regular cadence (e.g., annually). Findings suggest large outer contextual barriers to program implementation, many of which are addressed within the programs, according to staff. However, given the challenges faced by youth and their families, regular staff trainings structured around these barriers (e.g., trauma-informed care, cultural competency) are a relatively low-resource method for continued reengagement of staff to consider and address these issues. These trainings could address certain subpopulations that are commonly served by the program, whether by race, gender, language, or sexual orientation or gender identity. Training is not necessarily sufficient for fully addressing equity-related concerns but is an important step to ensuring that all staff are equipped with common knowledge and skills. This type of training could be especially beneficial because both programs bring together staff from different backgrounds (e.g., legal, social work, psychology); therefore, developing a common language and approach for culturally competent services could be beneficial.

Implement tracking for equity. Staff members from both programs acknowledged the significant disparities that can occur in juvenile justice involvement, noting that these trends are anecdotally apparent in their own programs. They also raised concerns about equitable access to services for certain groups, such as those who do not speak English. At the same time, it did not appear that either program had a systematic way to track or assess potential inequities in the populations they serve or the outcomes of services. More formal monitoring could help to identify opportunities for improvement and address inequities associated with race and other youth identities.

Evaluation-Specific Recommendations

Develop a system for inclusion of youth and caregiver input in the evaluation. Though RAND attempted to collect data from youth and caregivers for the evaluation, there were multiple barriers to doing so, particularly the requirement of written consent and assent from attorneys, caregivers, and youth. Though these requirements—imposed in part by the court system—are important to protect

youth, including the voices of youth and families in evaluation would help to ensure that the program is being tailored to the needs of the people receiving services, particularly if evaluation findings are used for ongoing quality improvement efforts. Programs should ensure systems are in place for seamless inclusion of program recipient voices, as it could maximize the implementation and effectiveness of the program.

Improve the availability of data to assess program effectiveness. Because of the significant limitations of the quantitative data available to our team, we were unable to explore the longer-term outcomes of youth enrolled in the programs—specifically, whether participation in the programs had any effect on future juvenile justice contact. Past evaluations of these programs have suggested promising findings; for example, a 2017 evaluation of CARE found that participation was associated with fewer negative interactions with the court after receiving CARE services than a comparison group of youth who were referred to CARE but received brief services (Rabinowitz et al., 2017). Similarly, an evaluation of youth receiving JMHC services in FY 2016–2017 found that 20 percent of youth were incarcerated after enrollment; therefore, data from this larger sample suggest even lower rates of negative juvenile justice outcomes (Fain, Turner, and Shahidinia, 2018). This is also consistent with other studies of JMHCs; for example, one study found that rates of recidivism ranged from about 38 percent while youth were still enrolled in the program to 7 percent after youth completed the program (Heretick and Russell, 2013). However, programs evolve over time, and it is critical to conduct ongoing evaluation to ensure that they continue to achieve the expected outcomes. Our team continues to work with the Probation Department to obtain outcome data, and relevant findings will be provided to the Department in a supplemental report.

Both programs collect certain data about youth who participate in them, such as demographic characteristics and dates of enrollment, as well as some other relevant service information (e.g., linkages, program outcomes). To support future evaluation efforts, both programs should continue to collect these types of data. The programs could also consider measuring short-term outcomes that might be observable while youth are participating in them. For example, did they engage in services they were referred to? Did they experience a more favorable case outcome? These types of program-specific outcome data could be used by future evaluators. However, it is also important that these data be able to be linked to juvenile justice outcomes—and to support this, it is essential that the Probation Department be sufficiently resourced to support this type of data collection and merging. Future evaluators should also explore whether a suitable comparison group could be identified for each program to support quasiexperimental outcome analyses (e.g., youth who would be eligible for the program but unable to participate due to capacity constraints).

Conclusions

The JJCPA-funded court-focused programs CARE and JMHC are meeting an important need, given the significant needs of juvenile justice-involved youth in Los Angeles County. Though there are barriers to implementation, many of them have to do with the volume of youth and size of program staff, suggesting a need for more resources. And low rates of recidivism suggest these programs are helping achieve expected outcomes—consistent with findings from the broader literature supporting the use of court interventions for justice-involved youth.

Appendix A

Staff Interview Protocol

Position Description

1. First, could you tell me a little bit about your current position(s) and the type of work you do at the organization?

    a) What are your primary job responsibilities at the organization?

        i) What are your specific responsibilities in the context of implementing the [NAME OF PROGRAM] program?
        ii) How long have you been in your current position? How long have you worked with at-risk or justice involved youth?
        iii) Can you tell me a bit about your day-to-day work and how you engage the youth that you work with?
            (1) How many youth do you serve at any given time?
            (2) What are some common needs that you see?
        iv) Have you ever participated in a program evaluation?

Program Description

2. In a few sentences, can you describe the [NAME OF PROGRAM] program?

    a) Do you have any materials you could send us that provide a description of the program or services?

Goals and Outcomes

3. What are the main goals and objectives of the program? Probe: measurable short- and long-term goals.

    a) What do you think is the target problem to be addressed by the program?
    b) Do you feel that these goals and objectives are attainable?

4. What individual, family, and/or system-level changes would you expect to see as a result of this program? Probes: measurable outcomes, length of time to see changes.

Services

5. What are the core services provided in the program? Probes: [LIST KNOWN SERVICES].
6. What promising practices or evidence-based practices are utilized in the [NAME OF PROGRAM] program?
7. Where are services typically delivered (e.g., staff office, conference room, community-setting, etc.)?

Clients and Outreach

8. Describe a typical client in the program (e.g., at-risk youth, probation youth, families of justice-involved youth).
9. How do clients find out about the program?
    a) What information is provided and what methods are used to convey this information (e.g., flyers, websites)?
10. How are clients referred to the program (e.g., program referral, self-referral)? Probe: relationships established with organizations to make referrals to the program.

Case Flow

[NOTE: If a case flow diagram is available, refer to diagram while asking these questions]

11. Imagine a "typical" client of the program. Walk me through what the client experiences from referral to the program until their services are completed.
12. What are your intake procedures?
    a) How do you open cases?
    b) What specific information is collected at intake?
    c) What types of assessments are used (if any)?
    d) How long is the intake process?
13. What are the most frequently used services?
14. How frequently do you interact with clients for each service (i.e., # of sessions)?
15. What is the typical duration of each service (i.e., length of service)?
16. What is the process for closing cases?
17. How do you document and track client participation in services?
18. Are there any concerns about the process for collecting and documenting this information (e.g., data entry issues, time constraints)?
19. Are there any requirements for number of individuals that your program serves, or for the level of services you must provide to participants?

Client Engagement/Retention

20. What strategies or approaches do YOU (staff) use to engage clients?
21. What are the biggest barriers to staff engagement with clients?
22. How does the program elicit client feedback on the program? How is this feedback used?

Perceptions of Program Effectiveness/Barriers/Facilitators

23. How well do you think the program meets the needs of the clients you serve?
    a) What does success look like for youth in this program?
24. Are there any challenges that youth encounter in this program? If so, what are they?
25. What challenges have you experienced in implementing this program?
26. THE FLIP SIDE: What has facilitated the implementation of this program? (probe: collaborations with other agencies, training, other resources)
27. Given the chance, is there anything you would change about this program?

Resources

28. Do you have the resources you need to implement this program?
29. What additional resources do you need to implement the program? (Potential probes: funding, training, staff)

Equity

30. We know there has been more focus in Los Angeles County on equity-related issues in the juvenile justice system. Are there equity-related considerations that come up in the work that your court does? Do you have any efforts to address equity (e.g., staff trainings, monitoring demographics of the youth who are engaged with the program)? Can you describe any efforts in your program (e.g., specific program requirements, staff efforts) to ensure equal access to services across different groups of people? This could refer to aspects of culture, including race/ethnicity, gender, or history of justice system involvement.
31. How effective do you think your program is in meeting the needs of diverse groups of people—including people of different racial and ethnic groups, genders, sexual orientations, language abilities, cultural traditions, etc.?
32. Do you have any recommendations for how services could be offered in a more equal way?

Staffing and Training

33. What is the staffing structure? Probes: # of staff, staff responsibilities.
34. What is the training plan for each staff member? Probes: minimum requirements, training types (e.g., trauma-informed) and providers, supervision, frequency of training and supervision.

a) Do you feel the training provided for the program is sufficient?

35. How do you monitor fidelity of implementation of the program? Probe: program manual or fidelity monitoring checklist.

Community Partners

36. What stakeholders/partner agencies do you work with?

a) Potential probe: How much contact do you have with Probation about the operation of this program?

37. What is the frequency and types of communication you have with partner agencies/organizations? Probes: discussing specific cases, submitting data, obtaining procedural/policy information about the program, receiving or making referrals.

38. What are the facilitators and barriers to working with community stakeholders/partner agencies?

Program Data and Evaluation

39. Do you maintain a database for case management and tracking participants?

40. What data do you currently include in the database? Probe: recruitment/outreach information, intake information, program participation (start and ending dates, dosage, active/inactive status), types of services, client contact information, client legal decisions, referrals for services, data format (multiple choice or open-ended)?

41. Are there any data that are currently collected, that don't need to be? Are there data that you wish you could collect? Do you have any other concerns about data collection? Probes: system limitations, quality of data, data entry issues.

42. What reports in your case management system do you use most often? How do you use them/for what purpose (e.g., grant reporting, data-driven decision-making)?

43. Have you participated in an outcome evaluation of your program in the past (internal or external)? What do you think are the advantages and disadvantages to participating in this type of evaluation?

a) Would it be feasible for us to conduct baseline interviews with clients?
b) In the interest of identifying a possible comparison group, how do the services provided to non-program clients (i.e., [NAME OF ORGANIZATION] clients who are not in the [NAME OF PROGRAM]) differ from services provided to [NAME OF PROGRAM] clients? Probe: possibilities for comparison group; similar characteristics; easily identified; clients do not overlap with [NAME OF PROGRAM] (no contamination)
    i) If the comparison group is unavailable from other [NAME OF ORGANIZATION] programs, what are other possible options in the community for a comparison group? Probes: similar characteristics; easily identified; clients do not overlap with [NAME OF PROGRAM] (no contamination)

c) How many clients do you see in the [NAME OF PROGRAM] each year? How many of those clients are ongoing clients (e.g., clients you've seen more than one time)?
d) Does the program have staff who can assume responsibility for overseeing an outcome evaluation?

Final Questions

44. Is there anything else you think would be valuable for me to know about this program?
45. Do you have any other questions for us at this time?

Appendix B

Juvenile Justice Contact Among CARE and JMHC Program Participants

This appendix summarizes findings from a supplemental quantitative data analysis. When we first completed the analysis of data from this report (in May 2024), we had received an initial delivery of quantitative data from the Probation Department, including data collected by the programs and data pulled from the Probation Department's Information Services Bureau. However, there was a mismatch between the youth who were reported in each of those datasets—i.e., some youth in the program data were not in the administrative data, and vice versa. Therefore, we presented basic descriptive information on program participants using only the program data in the main body of the report.

Since that time, we have worked with the Probation Department to improve the completeness of the quantitative data available for this analysis. We present our analysis methods and findings in this appendix.

Quantitative Methods

For each program, we received quantitative data from two sources. First, we received a file from each program that contained data that had been collected from the program on the youth served (program data). These data were provided to the Probation Department by the programs as part of their contractual requirements, and then the Probation Department shared them with our team for the purpose of this evaluation. We also received an administrative data file for each program that was pulled from the Probation Department Information Services Bureau. These data contained court contacts data and were pulled from the Probation Department's data system using the identifiers of youth who were included in the program data files. The administrative data file included information on arrests and court contacts associated with those arrests, including details of the arrest and charge (e.g., date, type of arrest, and type of charge), including disposition (i.e., whether the youth was being committed to a Division of Juvenile Justice facility, being committed to a Secure Youth Treatment Facility, being placed in a Los Angeles County juvenile camp, or being placed under supervision of the Probation Department but allowed to remain at home with a supervising adult). For each program, we merged data from these two sources to connect information related to program enrollment to juvenile-justice outcomes.

For the CARE program, we received data from two FYs of services: 2019–2020 and 2020–2021. This included 564 youth, 540 of whom also had administrative data available. For the JMHC program, we received data on 791 youth served from 2001 to 2021; administrative data were also available for 753 of these youth.

For each program, we began by conducting descriptive analyses that focused on youth's demographic characteristics, with the goal of describing the population each program served. This was followed by a basic analysis to understand whether youth had a disposition following an arrest that took place *before* enrolling in the program (i.e., preenrollment)—which, if there were an arrest, it could have been the offense that brought them into the program—and whether there was then a disposition following an arrest that took place *after* enrolling in the program (i.e., postenrollment).

Findings

CARE

We received data on 564 youth who were active in CARE during FY 2019–2020 and FY 2020–2021. Of these, 24 had no matching administrative data records. The findings presented here are based on the 540 youth with records in both the program and administrative data.

Regarding sociodemographic characteristics, the program largely served male youth, and most identified as Hispanic or Black (see Table B.1).

Table B.1. CARE Participant Characteristics (FYs 2019–2020 and 2020–2021)

Demographic	Participants ***N* = 540** **% (*n*)**
Gender	
Female	18.89 (102)
Male	80.74 (436)
Race or ethnicity	
Asian or Pacific Islander	1.67 (9)
Black	24.07 (130)
Hispanic	66.48 (359)
Multiracial	1.11 (6)
White	5.19 (28)
Another racial or ethnic category	1.48 (8)
Age at enrollment	
12	1.85 (10)
13	5.37 (29)
14	13.52 (73)
15	20.19 (109)
16	26.11 (141)
17	22.41 (121)

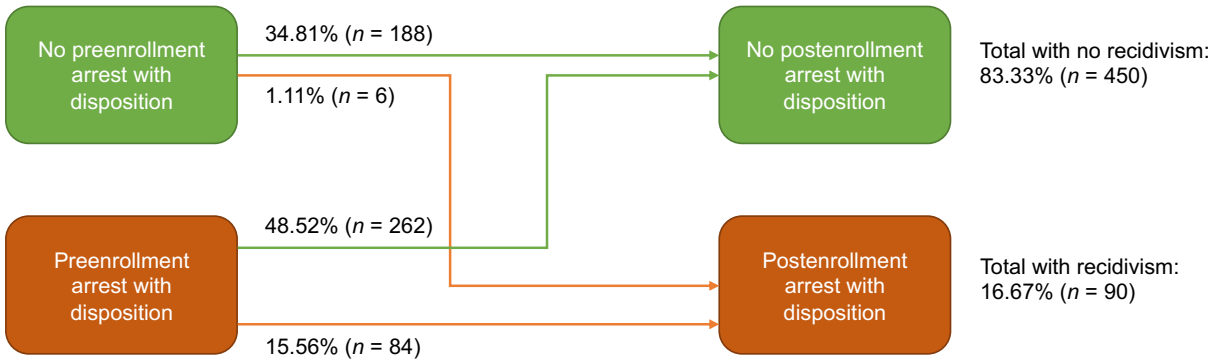
Demographic	Participants *N* = 540 % (*n*)
18 and older	10.19 (55)
Missing	0.37 (2)
Top five zip codes	
93535	3.70 (20)
90280	3.15 (17)
90003	2.96 (16)
90011	2.78 (15)
90201	2.78 (15)
93534	2.04 (11)

NOTE: Gender and race or ethnicity values are based on data submitted by the program, which reflect the youth's self-reports to CARE program staff. Other gender categories were not reported because of small sample sizes. Individuals of Native American descent were grouped into "Other" to eliminate identifiability. Age at enrollment information is created by subtracting the program data's enrollment date from the administrative data's date of birth information. Zip code information is from the administrative data. We include more than five zip codes because of a tie between two of them.

Figure B.1 summarizes the data related to youth dispositions for arrests occurring before and after program enrollment. The data included youth's court contacts. We were specifically interested in arrests that resulted in a disposition, defined as a commitment to a Division of Juvenile Justice facility, commitment at a Secure Youth Treatment Facility, placement at a county juvenile camp, or placement at home on probation.

There were 84 youth included in the program data who had multiple program enrollments (i.e., two separate enrollments in the data with distinct start and end dates or no end date, which suggests that those youth were still receiving services). Our analysis focused on any dispositions for arrests occurring after a youth's first enrollment date. In total, 64.07 percent (n = 346) of CARE youth had a preenrollment arrest that resulted in a disposition. Most youth with a preenrollment disposition went on to avoid a disposition after enrollment (262 of the 346 youth with a preenrollment arrest with disposition, or 75.72 percent). However, there were some youth who did not have a preenrollment arrest with disposition but who did experience one after enrollment in the program (six of the 194 youth with no preenrollment arrest with disposition, or 3.09 percent). In total, after enrollment in the program, 16.67 percent (n = 90) of youth had a new arrest resulting in a disposition

Figure B.1. Preenrollment and Postenrollment Arrests with Dispositions Among CARE Youth (*n* = 540)



Juvenile Mental Health Court Program

Table B.2 presents a summary of the 753 youth served by the JMHC program from 2001 to 2021 for whom data were available. Most youth served have been male and Hispanic or Black.

Table B.2. JMHC Program Participant Characteristics (2001–2021)

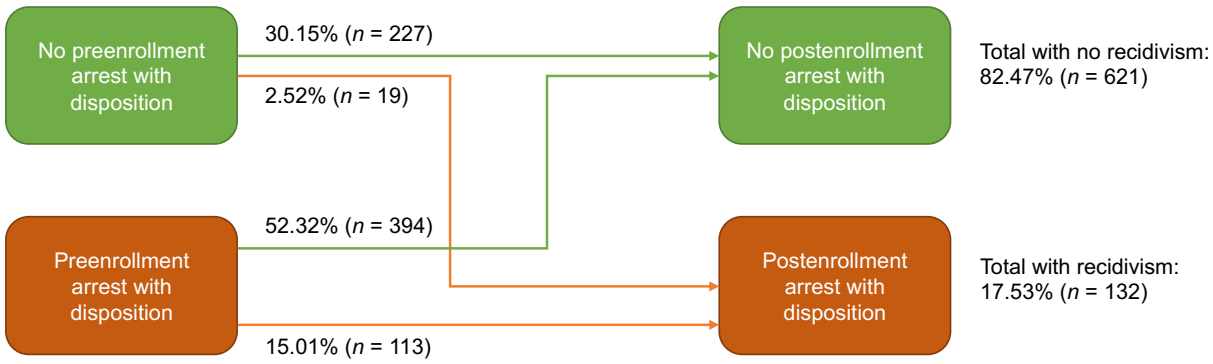
Demographic	Participants *N* = 753 % (*n*)
Gender	
Female	25.63 (193)
Male	74.10 (558)
Race or ethnicity	
Black	29.88 (225)
Hispanic	59.23 (446)
White	8.23 (62)
Another racial or ethnic category	2.39 (18)
Missing	0.27 (2)
Age at enrollment	
10 and younger	1.33 (10)
11	1.20 (9)
12	2.92 (22)
13	7.57 (57)
14	15.67 (118)
15	20.45 (154)
16	21.12 (159)

Demographic	Participants *N* = 753 % (*n*)
17	24.83 (187)
18 and older	4.91 (37)
Top five zip codes	
90011	2.66 (20)
90001	2.39 (18)
90805	2.26 (17)
90813	1.99 (15)
90003	1.99 (15)

NOTE: Gender and race or ethnicity values are based on data submitted by the program, which included more-nuanced categories and reflect youth's self-reports to JMHC program staff. Other gender categories were not reported because of small sample sizes.

Figure B.2 summarizes data related to youth dispositions for arrests occurring before and after program enrollment. Of the 753 youth who were included both datasets, 18 had multiple program enrollments. The analysis focused on the first enrollment date for these youth. In total, 507 of the youth who enrolled in the program (67.33 percent) had a disposition for an arrest occurring preenrollment. Regarding recidivism, 113 youth with a preenrollment disposition also had a postenrollment disposition, as did 19 youth with no preenrollment arrest with disposition, yielding an overall recidivism rate of 17.53 percent (n = 132).

Figure B.2. Preenrollment and Postenrollment Arrests with Dispositions Among JMHC Program Youth (n = 753)



Abbreviations

CARE	Client Assessment Recommendation and Evaluation
CFIR	Consolidated Framework for Implementation Research
COVID-19	coronavirus disease 2019
DA	district attorney
DCFS	Department of Child and Family Services
FASD	fetal alcohol spectrum disorder
FY	fiscal year
IEP	Individualized Education Plan
JJCPA	Juvenile Justice Crime Prevention Act
JMHC	juvenile mental health court

References

Applegarth, D. Michael, P'trice Jones, and Stephanie Brooks Holliday, *Promising Services for Justice-Involved Youth: A Scoping Review with Implications for the Los Angeles County Juvenile Justice Crime Prevention Act*, RAND Corporation, RR-A1663-2, 2023. As of January 5, 2023: https://www.rand.org/pubs/research_reports/RRA1663-2.html

Beaudry, G., R. Yu, N. Långström, and S. Fazel, "An Updated Systematic Review and Meta-Regression Analysis: Mental Disorders Among Adolescents in Juvenile Detention and Correctional Facilities," *Journal of the American Academy of Child & Adolescent Psychiatry*, Vol. 60, No. 1, 2021.

Brown, J., A. Russell, A. Wartnik, M. L. Hesse, D. Huntley, E. Rafferty-Bugher, and T. Andrews, "FASD and the Juvenile Justice System: A Need for Increased Awareness," *Journal of Law Enforcement*, Vol. 4, No. 6, 2015.

Burke, J. D., E. P. Mulvey, and C. A. Schubert, "Prevalence of Mental Health Problems and Service Use Among First-Time Juvenile Offenders," *Journal of Child and Family Studies*, 24, 2015.

California Department of Developmental Services, "Information About Regional Centers," webpage, undated. As of February 15, 2024: https://www.dds.ca.gov/rc/information-about-regional-centers/

County of Los Angeles, *Comprehensive Multi-Agency Juvenile Justice Plan: A Youth Development Mission, Continuum, and Funding Strategy, Fiscal Year 2024–2025*, December 6, 2023.

Damschroder, L. J., C. M. Reardon, M. A. O. Widerquist, and J. Lowery, "The Updated Consolidated Framework for Implementation Research Based on User Feedback," *Implementation Science*, Vol. 17, No. 1, 2022.

Development Services Group, *Mental Health Courts*, Office of Juvenile Justice and Delinquency Prevention, 2010.

Eme, R. F., "Attention-Deficit/Hyperactivity Disorder and the Juvenile Justice System," *Journal of Forensic Psychology Practice*, Vol. 8, No. 2, 2008.

Fain, Terry, Susan Turner, and Nima Shahidinia, *Los Angeles County Juvenile Justice Crime Prevention Act: Fiscal Year 2016–2017 Report*, RAND Corporation, RR-2401-LACPD, 2018. As of June 24, 2024: https://www.rand.org/pubs/research_reports/RR2401.html

Fast, D. K., J. Conry, and C. A. Loock, "Identifying Fetal Alcohol Syndrome Among Youth in the Criminal Justice System," *Journal of Developmental and Behavioral Pediatrics*, Vol. 20, No. 5, 1999.

Flannigan, K., J. Pei, M. Stewart, and A. Johnson, "Fetal Alcohol Spectrum Disorder and the Criminal Justice System: A Systematic Literature Review," *International Journal of Law and Psychiatry*, Vol. 57, 2018.

Gardner, P., *An Overview of Juvenile Mental Health Courts*, American Bar Association, 2011.

Heilbrun, Kirk, Naomi E. S. Goldstein, David DeMatteo, Rebecca Newsham, Elizabeth Gale-Bentz, Lindsay Cole, and Shelby Arnold, "The Sequential Intercept Model and Juvenile Justice: Review and Prospectus," *Behavioral Sciences & the Law*, Vol. 35, No. 4, 2017.

Heretick, D. M., and J. A. Russell, "The Impact of Juvenile Mental Health Court on Recidivism Among Youth," *Journal of Juvenile Justice*, Vol. 3, No. 1, 2013.

Hsieh, H. F., and H. E. Shannon, "Three Approaches to Qualitative Content Analysis," *Qualitative Health Research*, Vol. 15, No. 9, 2005.

Katsiyannis, A., D. E. Barrett, and D. Zhang, "Juvenile Offenders with Disabilities: Challenges and Promises," in *Handbook of Juvenile Forensic Psychology and Psychiatry*, Springer, 2012.

Kaufman-Levy, Deborah, Mary Poulin, Stan Orchowsky, Nancy Michel, and Eric Peterson, *Evaluability Assessment: Examining the Readiness of a Program for Evaluation*, Juvenile Justice Evaluation Center, Justice Research and Statistics Association, 2003.

Kincaid, A. P., and A. L. Sullivan, "Double Jeopardy? Disproportionality in First Juvenile Court Involvement by Disability Status," *Exceptional Children*, Vol. 85, No. 4, 2019.

Los Angeles County Public Defender's Office, "CARE Project," webpage, undated-a. As of February 15, 2024: https://pubdef.lacounty.gov/juvenile/care-project/

Los Angeles County Public Defender's Office, "Juvenile Mental Health Court," webpage, undated-b. As of February 15, 2024: https://pubdef.lacounty.gov/juvenile/jmhc/

Miller, A. A., "Navigating Barriers to Special Education in a Juvenile Detention Center," *Journal of Correctional Education*, Vol. 70, No. 2, 2019.

Phillippi, S., C. L. Thomas, Y. Yoshida, and H. Afaneh, "Holistic Representation in Juvenile Defense: An Evaluation of a Multidisciplinary Children's Defense Team," *Behavioral Sciences & the Law*, Vol. 39, No. 1, 2021.

Rabinowitz, M., D. McCahon, S. Garmisa, C. Ndubuizu, and S. Gonzalez, *Los Angeles County Public Defender CARE Project Evaluation Report*, Resource Development Associates, 2017.

Teplin, L. A., L. M. Potthoff, D. A. Aaby, L. J. Welty, M. K. Dulcan, and K. M. Abram, "Prevalence, Comorbidity, and Continuity of Psychiatric Disorders in a 15-Year Longitudinal Study of Youths Involved in the Juvenile Justice System," *JAMA Pediatrics*, Vol. 175, No. 7, 2021.

Underwood, L. A., and A. Washington, "Mental Illness and Juvenile Offenders," *International Journal of Environmental Research and Public Health*, Vol. 13, No. 2, 2016.

U.S. Department of Education, "Protecting Students with Disabilities: Frequently Asked Questions About Section 504 and the Education of Children with Disabilities," webpage, undated. As of July 18, 2024: https://www2.ed.gov/about/offices/list/ocr/504faq.html

Wilson, H. A., and R. D. Hoge, "The Effect of Youth Diversion Programs on Recidivism: A Meta-Analytic Review," *Criminal Justice and Behavior*, Vol. 40, No. 5, 2013.