Research Report

P'TRICE JONES, SIERRA SMUCKER, SARITA D. LEE, AARYA SURYAVANSHI, SAMANTHA MATTHEWS, LAURA WHITAKER, EMILY ALLENDORF, SUSAN TURNER, MARYLOU GILBERT, DIONNE BARNES-PROBY, TARA LAILA BLAGG, STEPHANIE BROOKS HOLLIDAY

Evaluation of Two Mental Health-Focused Programs for Justice-Involved Youth in Los Angeles

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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 proven their effectiveness in curbing crime among at-risk youth and youth involved in the juvenile justice system. In Los Angeles County, the Probation Department oversees the implementation of JJCPA-funded programs, which are approved by the county through 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 related to JJCPA-funded programs, including an annual gap analysis. This report presents findings from the process and outcome evaluation of two programs that provide mental health treatment services to justice-involved youth: the Mental Health Screening, Assessment, and Treatment program, which operates in Los Angeles County juvenile halls and camps, and the Multisystemic Therapy program, which provides community-based treatment. Results will be of interest to the Los Angeles County Probation Department, program staff, the Juvenile Justice Coordinating Council, and other jurisdictions interested in providing mental health services to justice-involved youth.

Justice Policy Program

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Summary

The Los Angeles (L.A.) County Department of Mental Health (DMH) receives funding from the Juvenile Justice Crime Prevention Act to operate programs for youth with mental health disorders. Two of these programs are what we refer to as the Mental Health Screening, Assessment, and Treatment program (MHSAT), which serves youth placed on probation by the L.A. County Probation Department who are detained in county juvenile halls, and the Multisystemic Therapy (MST) program, which serves youth on probation (both those detained in juvenile halls and those living in the community). We conducted a qualitative evaluation of these two programs, with a focus on understanding the following:

- How does each program operate?
- What have been barriers and facilitators to implementing each program?
- What other factors have shaped implementation, such as considerations related to equity or resources?
- What are the outcomes associated with each program?

Methods

To address these research questions, we conducted qualitative interviews with leadership and staff members from each of the two programs. We interviewed 12 MHSAT program staff members and seven MST program staff members. Data were coded using Dedoose with a codebook that was developed deductively (i.e., we based the codebook on our interview protocol) and inductively (i.e., we allowed for additions to the codebook once team members reviewed the data). We did not have quantitative data available for analysis as of this writing in spring 2024, but we have since obtained those data and included those analyses as an appendix to this report.

MHSAT Findings and Recommendations

For MHSAT, our key findings are as follows:

- MHSAT staff screen and assess all youth who are detained at an L.A. County juvenile hall using an assessment that includes the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and a psychosocial assessment, among other tools. Youth who have mental health needs are provided with services, including therapy, while they are at the juvenile hall.
- There are challenges to serving youth through MHSAT, including the limited length of time some youth spend at the facility and their busy schedules while there. However, staff have

developed strategies to engage youth, including taking steps to build rapport and using kinesthetic strategies (e.g., creating artwork or playing games).

- Barriers to implementation include (1) differences in the philosophies and goals of mental health program staff and Probation Department staff, (2) the need to educate Probation Department staff on ways mental illness manifests in detained youth, (3) inadequate staffing, and (4) the limited ability to refer youth to services upon discharge from the facility.
- Facilitators of implementation include support from supervisors and among program staff, communication between Probation Department and mental health program staff, and involvement of family in the provision of services.

Drawing on these findings, we recommend the following:

- **Increase the availability of staff trainings.** Although some staff noted that their current trainings are sufficient, others described an interest in additional training opportunities, such as evidence-based treatment options, strategies for working with youth exhibiting disruptive behaviors, and approaches to better engage youth who are from diverse backgrounds with respect to race and ethnicity, gender, and other characteristics.
- **Continue to increase knowledge of and partnerships with community-based organizations.** MHSAT staff described their commitment to engaging family members and facilitating youth transition back to the community after discharge from the facility. Partnerships with community-based organizations can help with both of these efforts.
- **Continue hiring diverse staff.** Interviewees noted that MHSAT already hires staff from diverse backgrounds with respect to race and ethnicity, gender, and other characteristics, and doing so helps staff members connect with youth in the facilities, especially because many youths come from marginalized backgrounds. Continuing to hire a diverse workforce can ensure that youth have access to therapists who may be a better fit for their specific needs.
- **Provide additional resources to staff that will enable them to offer a greater variety of activities and services to youth.** MHSAT staff members already do their best to creatively meet the needs of the youth in their care and keep them engaged. Although funding can be a limiting factor, these types of activities can be cost-effective (e.g., purchasing decks of cards or board games). Interviewees suggested that investing in these resources will lead to greater success in keeping youth busy with prosocial activities while they are detained, meeting the needs of youth who have a variety of coping mechanisms, and keeping youth engaged in treatment.
- **Provide additional supports for program staff.** Working with youth with mental health disorders in the juvenile halls can be a high-intensity job. Support for staff may include continuing to provide them with consultation and clinical supervision, providing enhanced training, ensuring effective leadership, and making mental health supports available to employees.

MST Program Findings and Recommendations

For the MST program, our key findings are as follows:

- MST is an evidence-based, family-centered, and strengths-based therapy approach for justice-involved youth.
- MST therapists work with an MST consultant who provides ongoing training and helps ensure fidelity to the program model.
- There are some barriers to program implementation. It can be challenging to engage clients' families, but once the program's therapists are able to build rapport with families, it can become easier for the therapists to treat the youth. This process was made more challenging by the coronavirus disease 2019 pandemic, because therapists were more limited in their ability to do in-person check-ins. There was also a decline in referrals to the program during the pandemic, and interviewees described issues with staff retention and hiring.
- There have also been facilitators of implementation. During the pandemic, the ability to provide telehealth services eased connections with some parents and clients. MST program staff also reported feeling connected with Probation Department staff and supported by their supervisors and the consultant. In addition, the program was well positioned to provide services to diverse youth, such as by having staff who provided treatment in both English and Spanish. Finally, staff expressed confidence in the strong evidence base for the program.

Drawing on these findings, we recommend the following:

- **Continue to provide support to staff members to improve hiring and retention.** The MST program already has several supports in place that might be helpful in mitigating staff turnover, including strong clinical supervision, training opportunities, and support for staff self-care. However, it would be worthwhile for DMH and the MST program to explore the feasibility of increasing staff salaries to remain competitive with other mental health providers in the region.
- **Expand prevention-oriented MST options.** When we conducted our interviews, the MST program was undergoing efforts to increase the availability of MST for youth who are not on probation or detained in the juvenile halls, specifically through the MST-in-schools initiative. Continuing to expand this referral pathway could be an important strategy to prevent at-risk youth from entering the juvenile justice system and provide families with needed supports before their children's behavior becomes more difficult to manage.
- **Bolster partnerships with social service organizations to address families' basic needs.** Staff members noted that they were already working to connect families with organizations that provide resources to address basic needs (such as food and housing). Continuing to form partnerships with these types of organizations could be valuable, because families might be able to engage in the MST program more meaningfully if their basic needs are met.

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Chapter 1

Introduction

The total number of youths detained on any given day in the United States is estimated to be more than 48,000 (Sawyer, 2019). In 2019, the juvenile courts handled more than 700,000 cases, and 26 percent of these cases resulted in detainment, typically in a juvenile facility (Hockenberry and Puzzanchera, 2021). The majority of youth who are detained in juvenile facilities is either awaiting trial (56 percent) or awaiting sentencing or placement (36 percent). Although rates of juvenile arrests have decreased in the past decade, the number of youths who are arrested and therefore at risk of detainment is alarmingly high. Recent estimates of national crime statistics indicate that youth arrests decreased from approximately 700,000 in 2019 to about 400,000 in 2020, likely because of coronavirus disease 2019 (COVID-19) stay-at-home orders; nevertheless, the number of arrests still reflects a substantial number of youths entering the juvenile justice system (Office of Juvenile Justice and Delinquency Prevention, 2022; Puzzanchera, 2021). Arrest data from 2021 reveal that more than 1,900 youth were arrested exclusively in Los Angeles (L.A.) County (Board of State & Community Corrections, 2023).

Evidence demonstrates that justice-involved youth have high rates of mental health issues that might be exacerbated by interaction with the justice system. Researchers estimate that up to 70 percent of youth in the juvenile justice system meet criteria for a psychological disorder (Wasserman et al., 2002; Shufelt and Cocozza, 2006). A recent meta-analysis of incarcerated youth found that among the most-common disorders were conduct disorder (68 percent of male youth and 64 percent of female youth), oppositional defiant disorder (26 percent and 28 percent, respectively), and depression (17 percent and 29 percent, respectively). Posttraumatic stress disorder and anxiety disorders were especially common among female youth, and a notable proportion of youth had a history of suicide attempts (16 percent of male youth and 27 percent of female youth) (Livanou et al., 2019). Moreover, comorbid diagnoses are the norm rather than the exception: An estimated 79 percent of detained youth with a diagnosed mental health disorder also meet criteria for additional mental health disorders (Shufelt and Cocozza, 2006). Justice-involved youth also have higher rates of complex trauma and substance use relative to youth in the general population. Studies indicate that about 90 to 95 percent of detained youth have experienced at least one traumatic event (Abram et al., 2004; Ford et al., 2008; Cruise and Ford, 2011; Becker and Kerig, 2011), and nearly half (46 percent) demonstrate symptoms of substance use disorder (McClelland et al., 2004; Shufelt and Cocozza, 2006). To decrease the likelihood of youths becoming involved with the justice system after their initial detention, and to help families support their children, it is critical that justice system officials address these mental health needs.

To address the psychopathology of youth in detained populations, many jurisdictions have implemented programs intended to treat mental health symptoms and reduce recidivism among youth. Such programs have included providing justice-involved youth with psychotherapy and other

therapeutic interventions, including cognitive behavioral therapy, motivational interviewing, and substance use treatment (Applegarth, Jones, and Holliday, 2023). Overall, programs that use these approaches are effective in reducing recidivism and substance use but have mixed success in reducing mental health symptoms (Applegarth, Jones, and Holliday, 2023).

In L.A. County, the Juvenile Justice Crime Prevention Act (JJCPA) is one source of funding that supports programs for youth who are at risk for involvement in the juvenile justice system or who have already entered the juvenile justice system. These funds are administered by the L.A. County Probation Department but are generally disbursed to city and county agencies to support programs to prevent crime and delinquency. The L.A. County Department of Mental Health (DMH) is among the agencies that receive funding. Two of the DMH programs funded by JJCPA are specifically designed to support youth and their families in addressing mental health and behavioral issues while interacting with the justice system.

The Mental Health Screening, Assessment, and Treatment program (MHSAT) serves youth in the L.A. County juvenile halls, which are intended to be short-term facilities where youth might spend several days to several months while they await the next stage of their case (e.g., trial or transfer to a California Department of Juvenile Justice facility). Its overarching goal is to provide youth who have mental health treatment needs with services while they are detained at juvenile halls. This program also provides discharge support by linking youth to additional services to ensure continuity of care after they leave the juvenile hall. Prior research found that this program is effective in improving detained youths' mental health (Fain, Turner, and Shahidinia, 2018; Fain and Turner, 2017).

DMH also uses JJCPA funds to support Multisystemic Therapy (MST), an evidence-based, family-centered, strengths-based therapy that has been tested specifically among justice-involved youth. It is a therapeutic approach that engages both youth and parents to increase factors associated with lower recidivism and prosocial behavior. MST draws on a variety of techniques, including cognitive and behavioral approaches, parent-management training, and family therapies. The effectiveness of MST is well documented. Studies show that MST reduces the likelihood of recidivism and incarceration of justice-involved youth compared with treatment as usual (Tan and Fajardo, 2017; Markham, 2018; van der Stouwe et al., 2014; Fain et al., 2014). MST is also associated with reduced delinquent behavior and substance use among this youth population (Zajac, Randall, and Swenson, 2015; Baldwin et al., 2012). MST can lead to an increase in protective factors as well, including positive peer relationships and engagement at school, work, and home (van der Stouwe et al., 2014; Fain et al., 2014; Zajac, Randall, and Swenson, 2015). Importantly, MST can improve family functioning in general and reduce the need to rehouse children away from their families (Markham, 2018; van der Stouwe et al., 2014; Zajac, Randall, and Swenson, 2015; Letourneau et al., 2009). MST has been studied in the L.A. County context as well. Fain and colleagues (2014) examined the impact of MST on youth on probation in L.A. County between 2003 and 2010 and found that the program led to lower incarceration rates and significantly higher rates of completion of community service. The authors also found that savings in criminal justice costs related to high-risk youth far outweighed the cost of the program over time.

Since these reports were published, however, there have been significant changes to the juvenile justice population in L.A. County, including an overall reduction in the number of youths on probation and some evidence that youth detained by the Probation Department have more-serious

clinical needs (California Department of Justice, undated). In addition, previous evaluations focused largely on quantitative outcomes associated with the MST program. We built on the existing literature by conducting a mixed-methods process and outcome evaluation of both MHSAT and the MST program.

The evaluations presented in this report were conducted as part of RAND's role as the contracted JJCPA evaluator. Consistent with our scope of work for the evaluation, we set out to address the following questions for each program:

- How does the program operate?
- What have been the barriers and facilitators to implementing the program?
- What other factors have shaped implementation, such as considerations related to equity or resources?
- What are the outcomes associated with the program?

In the chapters that follow, we begin by describing our process and outcome evaluation methods (Chapter 2). We then present our findings from the evaluation of MHSAT (Chapter 3) and the MST program (Chapter 4). We conclude with a high-level summary of our findings and recommendations (Chapter 5).

Chapter 2

Methods

For both program evaluations, we used a mixed-methods approach. We interviewed key staff members from a variety of positions and partners who worked with core staff. Although we took a similar approach to both evaluations, we were flexible and allowed the nature of the program to shape data collection, particularly regarding qualitative data. We summarize the process used for collecting and analyzing data for each program below.

Qualitative Methods

Recruitment

To recruit individuals from these JJCPA-funded programs, we collaborated with program leadership. Our overarching approach to recruitment involved requesting contact information for up to 15 program staff members who provided services, with the goal of having enough interviewees to reach saturation with respect to qualitative themes (Guest, Namey, and Chen, 2020). In other words, some programs are small and have fewer than 15 staff members and we aimed to interview as many staff members as we could. With both programs, our goal was to recruit individuals from various staff positions, including clinicians, program coordinators, and leadership, to elicit a variety of perspectives on program function and implementation.

For MHSAT, we invited 15 individuals to participate in interviews and were able to conduct semi-structured interviews with 12 staff members from the two L.A. County juvenile halls that were in operation at the time of the interviews. Interviewees included clinical psychologists, psychiatric social workers, psychiatric technicians, and program managers. These interviews took place between April and December 2021.

For the MST program, we invited eight program staff members to participate and conducted semi-structured interviews with seven individuals between March 2021 and February 2022. Interviewees included clinicians and individuals in supervisory roles. During this time, the COVID-19 pandemic was still affecting the operations of these programs, so all interviews were conducted virtually. Participation was voluntary, and participant responses were confidential.

Interview Protocol and Methods

Our interviews followed a semi-structured protocol informed by research from implementation science and program evaluation. Specifically, the protocol focused on topic areas related to program success, such as barriers to connecting with and recruiting clients, resources needed to implement the program, and strategies that program staff members used to engage and support youth from a variety

of backgrounds. We were flexible in our questioning and tailored our questions based on interviewees' responses to ensure that we captured details relevant to their experiences and central components of their program. We captured participants' responses by taking notes during the interviews, and, if interviewees consented to being recorded, we used recordings to supplement our notes. Interviews lasted approximately 45 to 60 minutes, on average. Following each interview, one team member anonymized, cleaned, and filled any gaps in the notes with the recording transcript, as needed, then deleted the recording.

Analysis

To analyze the interview data, we uploaded the notes to Dedoose, a qualitative data analysis software program. We developed a codebook deductively (i.e., we based the codebook on our interview protocol) and inductively (i.e., we allowed for additions to the codebook once team members reviewed the data). Before individually coding, two to three team members coded at least one recording transcript together and one transcript separately (using the blind-coding feature in Dedoose) to reach agreement on the meanings and use of the codes and to ensure consistency in coding. The respective team members then met weekly to discuss any challenges in coding and to clarify the use of codes. When disagreements arose during this process, the team members discussed the issue until they reached consensus.

Once coding was complete, one team member led the analysis of the results of each program's interviews. Team members analyzed the data in part using tools within Dedoose to assess the content of each code and develop themes. Findings were then summarized, and relevant quotes were selected to illustrate the broader experiences and perceptions of the interviewees.

Quantitative Methods

As of this writing in spring 2024, we were collaborating with the Probation Department to obtain quantitative data related to youth who participated in each program. For both programs, we received data collected by MHSAT and the MST program on youth served (referred to as *program data* for purposes of this report) from three fiscal years (FYs) of services: FYs 2018–2019, 2019–2020, and 2020–2021. For the MST program, we also received a data file from the Probation Department's Information Services Bureau (referred to as *administrative data* for the purposes of this report), which included identifiers of the youth who were also listed in the programmatic data files.

The administrative data included information on arrests and court contacts associated with those arrests, including details of each arrest and charge (e.g., the date, type of arrest, and type of charge) and the outcome resulting from each court contact. These details included dispositions, such as whether the youth was being detained in a California Department of Corrections and Rehabilitation Division of Juvenile Justice (DJJ) facility;[1] being detained in a Secure Youth Treatment Facility; being placed in an L.A. County juvenile camp; and being placed under the Probation Department's supervision but allowed to remain at home with a supervising adult. However, as of this writing, complete

[1] DJJ closed on June 30, 2023.

administrative data were not available for all youth in the programs. 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.

Chapter 3

Mental Health Screening, Assessment, and Treatment Program

In this chapter, we present findings from our evaluation of MHSAT. We first describe the program and share implementation findings, which were based on qualitative interviews with MHSAT staff. We then present additional interview findings related to the program's outcomes. We close the chapter by summarizing our findings and presenting recommendations for improving the program going forward.

Program Description

MHSAT is designed as a short-term program that identifies and treats youth in need of mental health support while they are being detained at juvenile halls and camps operated by the Probation Department. The original memorandum of understanding covered services in both juvenile halls and camps, but the majority of the funding has covered mental health services in the juvenile halls; therefore, for this evaluation, we focused on the services provided in two juvenile halls: the Barry J. Nidorf Juvenile Hall (referred to informally by interviewees as "Barry J.") and the Central Juvenile Hall (informally referred to as "Central"). The aims of the program, as described by staff, are to reduce the risk of recidivism by providing mental health services; identifying risk factors for recidivism at the individual or environmental level; and creating a safe space for youth, in part by facilitating a connection to a supportive contact person. Program goals were reported to include facilitating a smooth adjustment to detainment, stabilizing client symptoms, and improving overall functioning while also normalizing and validating the anxiety experienced by detained youth, encouraging a healthier lifestyle, and reducing recidivism. Program staff teach coping and anger management skills and strategies for youth to address any past trauma and make healthier life decisions. MHSAT staff also assist youth in creating individualized long-term goals and a treatment plan, providing support and linking youth with resources to ensure continuity of care once they leave the program. In the longer term, the hope is that the program will also reduce recidivism rates.

Screening and Assessment

All youth are screened and assessed by a mental health professional when detained at one of L.A. County's juvenile halls. Probation Department and medical staff at the halls begin the intake process, and mental health program staff are notified when youth are ready to be evaluated for such symptoms. Youth are screened for such symptoms within the first 72 hours of detainment, as mandated by the

California Department of Justice. The screening process gives staff a broad understanding of each youth's background, environment, symptoms (such as when they began), strengths, and familial relationships or losses. Staff reported using a structured, validated measure, the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), which comprises 52 questions and was specifically designed for youth involved in the juvenile justice system. The screening questions ask about each youth's current mental health symptoms and level of functioning. Staff also conduct a comprehensive psychosocial assessment, which covers such areas as previous abuse, medical or mental health history, social or developmental history, family history, prior detentions, risk of being trafficked, and substance use, including the frequency, intensity, and duration of substance use. Staff might also contact family members (e.g., parents), legal guardians, or social workers for additional information. Using the responses to this assessment, staff make a preliminary diagnosis, identify the appropriate level of care, and make referrals to assign a psychiatrist for follow-up services with the consent of each youth to continue treatment.

There are other ways that youth might be referred for an assessment prior to the standard screening and assessment process. For example, Probation Officers can alert medical staff when youth demonstrate concerning symptoms, such as suicidal ideation or attempts, or recent hospitalizations, during the intake process, and these youth are prioritized for a mental health assessment. Medical staff are required to complete a self-harm and suicidal ideation assessment with youth if they receive this alert from the Probation Department. Clinicians also assess each youth's suicide risk at every clinical contact.

The screening and assessment process was altered during the COVID-19 pandemic. During our interview period (April to December 2021), youth were subject to a quarantine period, which took approximately three days, to confirm that they were not infected by the SARS-CoV-2 virus. Therefore, this screening was conducted through a closed door where staff could see their clients through a window. During the quarantine period, staff reported that they sometimes taught clients coping skills or provided them with activities (e.g., journaling, writing letters, word searches, puzzles).

Following the intake and screening, youth are assigned to a specific housing unit by the Probation Department based on their age, gender, severity of their symptoms, severity of crimes, or level of functioning, although DMH can make recommendations regarding the appropriate housing unit. Those with more severe symptoms (e.g., psychosis) or those presenting with behaviors that make them a danger to themselves and others (such as self-harm behaviors, suicide attempts, or aggression) are placed on enhanced supervision. These youth receive direct supervision and are seen daily by their assigned clinician. A specialized unit for these youth is located at Central, and youth from either juvenile hall can be referred to the unit or placed on enhanced supervision. Youth on enhanced supervision are monitored by a Probation Officer for 24 hours each day. Youth can be moved to a lower level of supervision if their symptoms improve.

Clients with complex clinical needs can be assigned to a small, specialized mental health unit, termed the CARE Unit, at Central. Youth assigned to the CARE Unit might have serious symptoms but tend to be more stabilized than those referred to enhanced supervision. Youth from either juvenile hall can be referred to this unit. This unit also houses youth detained for the first time or those who have difficulty following instructions. Some youth assigned to this unit might also be vulnerable targets because of their age or body size, or because they are not involved with gangs. From this unit,

youth that improve can join the general population at the juvenile hall. Once in the general population, youth with open mental health cases continue to receive treatment in accordance with their treatment plans.

There are other specialty units at the facilities. These include a regional center unit for youth who have such diagnoses as developmental disabilities or a history of seizures. Another unit exclusively houses youth who are 13 years old or younger. Finally, the Probation Department can transfer a youth to the Hope Center, or what one interviewee described as a "cool down" unit, if the individual is having difficulty adjusting to the facility's rules or is acting out and the situation cannot be de-escalated.[2] In this unit, staff complete what DMH refers to as a Behavior Chain Analysis for youth who are confined to a room after an incident.

Across all units, there are ongoing efforts to assess each youth's mental health. Any of the staff members in the juvenile halls can refer a youth for assessment if they have a concern, and youth can also submit a request for an assessment. These reassessments also provide the opportunity for youth to be reassigned to a housing unit with a higher or lower level of supervision, as appropriate.

Services and Treatment

Interviewees described using a variety of treatment approaches with youth. These approaches include cognitive behavioral therapy, trauma-focused approaches, and reality-based interventions. Many staff members discussed the role of trauma in clients' mental health conditions. Because of the short-term nature of MHSAT, staff are not able to treat the root causes of their clients' trauma but attempt to provide support for daily habits, such as managing stressors and anxieties (e.g., worrying about a court appearance). In interviews, staff said that services are delivered in the juvenile housing units, with some services provided via telehealth using kiosks that are available in every unit.

The frequency with which staff meet with youth and the length of those meetings depends on a variety of factors, including each youth's level of need (e.g., the acuity of their symptoms) and the schedule of activities set by the Probation Department. Meetings with clients reportedly can range from a quick chat of a few minutes to a longer session that lasts about an hour.

Mental health program staff reported some variation in the size of their caseloads, though reports generally ranged from ten to 16 youths. The interviewees also revealed that caseloads were reduced during the height of the COVID-19 pandemic. Before the pandemic, staff were conducting one intake assessment every day on average, in addition to seeing their own clients and prioritizing high-risk youth. Although it was rare for staff to conduct two assessments in one day, this would happen if the facility was short on staff or there were youth who needed immediate assessment. Since the pandemic, the number of intake assessments per week ranges from zero to seven.

The length of program participation depends on the amount of time that clients are housed at a juvenile hall. Mental health program staff noted that the length of time youth are housed in the juvenile hall can range from a few hours to more than a year, with the average being four to six weeks. This wide range can depend on a variety of factors. For example, some youth might be released after their first court hearing, which is typically within three days of detainment. Youth in a specialized unit

[2] As of the writing of this report in 2024, the Hope Center is available only at Central.

or those with a developmental delay might stay in the facility for several months, while youth with serious charges tend to have multiple court hearings and are detained longer, possibly up to a year. Interviewees reported that some youth might stay at the facility for years until they are released to DJJ (note that interviews were conducted before the closure of DJJ facilities) or sent to an adult correctional facility. Furthermore, youth who do not have homes to go to upon discharge also stay at the facility for a longer period until the Probation Department arranges an adequate placement (i.e., a place for youth to go after their release, such as a group home or a relative's home).

Client Characteristics

As described, clients served by MHSAT reside in L.A. County juvenile halls. Interviewees described youth as having traumatic life experiences, school difficulties, family-related challenges, or involvement with Department of Children and Family Services (DCFS). Many clients are involved or affiliated with gangs, or they live in communities with a high gang presence.

Many of the youth in the program present with mood disorders, trauma- and stressor-related disorders, psychosis, and attention deficit hyperactivity disorder. Of the stressor-related disorders, there are high rates of acute stress, posttraumatic stress disorder, anxiety, and unresolved grief. Of note, clients typically have multiple detainments, and about half have received mental health treatment before entering the juvenile hall. A history of substance use, particularly marijuana use, is also common among clients. Staff members reported that the majority of clients identify as Black or Hispanic.

Discharge Procedures

Treatment services formally end when a youth is released or transferred from the juvenile hall. Typically, the youth and mental health program staff member have some idea of the date the youth will be released; however, there are times when the client has a court appearance and does not need to return to the juvenile hall. Staff are then notified by the Probation Department of their client's release. Staff reported that a client's case is closed one month after the youth does not return to the juvenile hall or if the youth is sent home or discharged elsewhere. When the client is being discharged, the court notifies the Probation Department, and if the youth is on medication, the department notifies DMH so that the youth can be provided with their prescriptions to ensure continuity of medication management. Case managers then write closing notes in the clinical record. The youth is then released home, to placement (e.g., a group home or a relative's home), to DCFS, or (at the time of our interviews) to a DJJ facility. Less commonly, a youth might be released to an out-of-state placement.

Although regular services end after release, staff described efforts to provide additional support to youth for this transition. For example, for youth who are released home, staff might supply clients with community-based resources and work with case managers to send additional information to their clients' guardians. Furthermore, staff assist youth and their guardians with securing outpatient therapy by connecting clients to services based on their medical insurance and providing local referrals to aftercare services. Aftercare services are typically provided through DMH or DMH-contracted providers. Occasionally, there are youth who are taking medication or have acute mental health needs

but do not have a placement set up in the community. These clients are often referred by staff to Juvenile Justice Transitional Outpatient Treatment Services (JJ-TOTS). JJ-TOTS is a DMH-operated program that provides psychotropic medication and linkage services to youth released from Probation Department camps and juvenile halls until youth are connected to a community agency (Los Angeles County Department of Mental Health fact sheet, undated). This program follows up with families to provide youth with medication support in addition to offering such services as case management, psychoeducation, therapy, family counseling, or insurance reinstatement services. JJ-TOTS also provides referral appointments for youth to connect with mental health therapists, psychiatrists, or more-permanent outpatient care.

For youth released to a placement, there are efforts to ensure continuity of care. Typically, the placement has therapists and psychiatrists who can provide mental health services to youth, but interviewees noted that case managers from the juvenile halls follow up with youth in this context. DMH clinicians are available to consult with the clinical staff at youth placements regarding the care that was provided during detention.

MHSAT Implementation Findings

One key goal of our interviews was to understand barriers and facilitators to program implementation with a focus on client engagement, resources needed, and equity-related considerations. We also asked staff members about suggestions they had to improve the program.

Barriers and Facilitators to Client Engagement

We asked staff members to describe barriers to engaging clients in MHSAT services; see Table 3.1 for a list of identified barriers and strategies that have been used to address those barriers.

Table 3.1. Barriers to Client Engagement and Program Implementation

Barrier	Did the Barrier Affect Client Engagement, Program Implementation, or Both?	Solution(s) Implemented
Impersonal intake assessment	Client engagement	Contact families to provide additional information on clients; build rapport with returning youth
Difficulty contacting families on the phone	Client engagement	*No strategy identified through interviews*
Refusal of clients and families to engage in services	Client engagement	Use the intake assessment to identify client symptoms that cannot be verbalized; communicate between staff about youth; engage youth outside of meeting space or during their high-risk periods; offer support and initiate informal conversations with youth; engage youth in kinesthetic strategies; respect family's decision and allow client to discuss this decision

Barrier	Did the Barrier Affect Client Engagement, Program Implementation, or Both?	Solution(s) Implemented
Stigmatization of mental health care	Client engagement	Communication with Probation Department staff for updates on clients; speak with families to reframe negative perceptions of mental health care
Youth scheduling conflicts	Both	*No strategy identified through interviews*
Limited physical space	Both	*No strategy identified through interviews*
Unknown length of service	Both	*No strategy identified through interviews*
Engagement of families of high-risk youth	Client engagement	Reassure and update parents on client services
Distrust of the criminal justice system	Client engagement	Provide support to families during DCFS phone calls
Disagreements among staff	Program implementation	Share youth triggers to help staff understand conduct issues; encourage Probation Department staff to continue youth treatment outside of mental health services
Limited staff or staff turnover	Program implementation	Hire more staff; maintain a low client-to-staff ratio
References to providers outside the facility	Program implementation	*No strategy identified through interviews*
Matching intensity of services to youth needs	Program implementation	*No strategy identified through interviews*
Lack of knowledge around resources	Program implementation	*No strategy identified through interviews*
Staff expectations	Program implementation	Provide support and validation to clients; acknowledge to clients and families about the lack of answers or immediate relief of symptoms; build rapport and be consistent with youth; address meeting changes with clients; work on coping skills with youth

Several interviewees discussed challenges resulting from program changes during the COVID-19 pandemic. For example, prior to the pandemic, the initial intake was administered in person; however, after the onset of the pandemic and through the period during which we held interviews (April to December 2021), staff had to conduct the initial intake through a door during clients' approximately three-day quarantine period. Interviewees described this intake process as impersonal, because staff

were often unable to observe their clients. Some interviewees also noted difficulty in being able to hear their clients through the door in an already loud environment. Clients had to frequently repeat themselves or speak louder. With other youth and Probation Department staff nearby, privacy and confidentiality between the mental health program staff and clients became an additional concern. This impersonal and indiscreet process might have weakened staff rapport with clients and limited the information provided by clients.

Program changes because of the COVID-19 pandemic also restricted family engagement in treatment, according to some interviewees. During the pandemic, staff had to contact family members via phone. Interviewees noted difficulties with this form of communication, particularly the challenge of establishing a trusting relationship with the family member over the phone. Prior to the pandemic, family visitors could come to the juvenile hall to participate in family therapy, although in-person family attendance had its own hardships.

Another barrier reported by interviewees was client and family unwillingness to engage in services. According to interviewees, youth may generally be hesitant to discuss their mental health symptoms with professionals, either in their first few sessions or at all; other clients may be uncomfortable with face-to-face interactions with staff and, therefore, are closed off to personal conversations. One interviewee described how clients may not acknowledge their own symptoms. Additionally, another interviewee mentioned that family members have sometimes rejected any involvement in the youth's treatment process.

Relatedly, a stigma toward mental health care and a distrust of the justice system presented an additional challenge. For example, interviewees stated that youth were concerned that they would be perceived negatively by their peers for participating in such services. Concerns were also raised about whether Probation Department staff were open to youth participation in mental health treatment. For example, interviewees reported that there have been instances in which Probation Department staff suggested that youth are faking their symptoms or that staff perceived behavioral issues as a youth acting out rather than as a potential symptom of a behavioral health concern. In turn, there were also concerns that youth might feel too intimidated to seek services because Probation Department staff express disbelief about youth needing them, or youth might fear retaliation if they are placed on a unit of a different level as a result of seeking services. When DMH clinicians have concerns about these types of situations, they can report the situation to their supervisors, who have a direct line of communication with Probation Department supervisors. More serious circumstances can also be reported through more formal channels. Stigma could also come from family members; as one interviewee noted, some families assumed that youth with mental health symptoms would *choose* not to change their behavior. As a result, these youths were less likely to participate in treatment. Other interviewees noted that past negative experiences with the juvenile justice system affected youths' willingness to participate in treatment, and some parents may have also feared the involvement of DCFS because their children participated in mental health services.

Interviewees also described administrative or logistical barriers to client engagement. First, the busy schedule of youth in a facility made it difficult to spend enough time with clients to build rapport. Interviewees reported challenges in finding time to meet with clients during their busy time at the juvenile hall because clients were often occupied with school, activities, and other sessions conducted by court and medical personnel. Interviewees described mental health program staff having limited

private space in the facility to meet with clients and needing to provide services in public areas with other people present. Furthermore, because staff do not always know how long a youth will spend at the facility, and because mental health or conduct issues can have deep-rooted causes, staff members have to adjust the intensity of treatment without having adequate time to address underlying issues. Lastly, one interviewee detailed challenges in engaging families when clients are deemed a high risk, because this group of youth must be accompanied by Probation Department staff to the visiting center for family sessions instead of being allowed to meet among the juvenile hall's general population.

Despite these challenges, interviewees described various ways they aim to increase client engagement in services. Many of these strategies centered on efforts to build rapport and trust with clients. Staff build connections with youth by providing consistent support, validating youth, and normalizing their symptoms. For example, one respondent detailed the value in supporting clients with multidisciplinary team meetings by preparing youth beforehand and by helping their clients advocate for themselves during these meetings. Another respondent discussed their trauma-informed approach to better understand and support youth with aggression issues.

Staff members also found it helpful to ease youth into treatment by starting with more-frequent but more-informal conversations. One staff member said that these check-ins help staff members demonstrate consistent support and give youth more autonomy to participate in treatment. Interviewees stated that these informal conversations may begin by discussing youth interests or backgrounds and that staff members use humor or sarcasm in their conversations with youth to identify and connect with their clients. The intake assessment was described as a useful tool in this process, because it helps youth identify and verbalize their mental health symptoms.

Some interviewees also mentioned the use of kinesthetic strategies, such as making art or music or playing games, to engage their clients. These activities help staff encourage conversations with youth by making them feel more comfortable, thus giving clients the opportunity to discuss different topics. This is particularly helpful with youth who are more introverted, reserved, or uncomfortable interacting with others. For youth who are especially anxious or bored while at the facility, these activities help keep their minds occupied during their downtime.

Several interviewees mentioned engagement strategies to support families in a child's treatment. To include families, staff gain the client's permission then call the parents or guardians on the phone to request participation in family therapy sessions. Client permission is key, as interviewees noted that some youth may be triggered by the involvement of their families. To support families, staff reassure parents that their children are receiving appropriate services. One respondent gave an example of how they explain the assessment and treatment process to parents who may be reluctant to have their children on medication. These interviewees also disclosed how they follow up with parents, when appropriate, to provide information and updates on their children's well-being. Education was described as another part of family engagement. For example, one clinician noted the following:

> Psychoeducation is a big piece. Usually there is a miscommunication between youth and parents because there is trauma exposure or mental health issues and the parents don't understand that that is underneath their [children's] aggressive or assaultive behavior. Once you uncover that, you see what is really going on.

Family engagement was seen as an important aspect of improving the quality of mental health treatment for youth. As one respondent mentioned, staff can gain more insight into the client's

symptoms and family history when family members are engaged in the process. Another staff member appreciated having more time to engage family members in their clients' treatment as a result of a lower caseload during the COVID-19 pandemic.

Barriers to Program Implementation

In addition to asking about client engagement, we asked interviewees about barriers to implementing MHSAT. Interviewees' responses to both subjects were similar in some cases. For example, respondents spoke about scheduling conflicts, lack of private spaces, and the uncertainty of clients' release dates—which were barriers to client engagement—as barriers to providing services. One interviewee referred to the challenge of having a client moved by Probation Department staff to a different part of the facility, which was also cited as a challenge to client engagement.

Many interviewees described tension between mental health program staff and Probation Department staff as a barrier to implementation. Interviewees said that Probation Department staff may trivialize mental health symptoms and advocate for youth to be assigned to a specific level within a housing unit that may not be appropriate for the youth's needs. Interviewees wondered whether Probation Department staff might be reluctant to designate youth as having severe behavioral issues, which would require youth to have more-intensive supervision. One respondent noted that Probation Department staff seemed to discourage the mental health program staff from meeting with clients by making their presence feel like an inconvenience.

Another barrier that emerged was inadequate staffing levels at the juvenile halls. Interviewees said that there was a limited number of Probation Department staff, which resulted in safety concerns and made it challenging for interviewees to meet with clients or provide them with adequate services. Moreover, interviewees reported that youth may be encouraged to interact with peers as part of their treatment in building social skills, but that this is not feasible unless there are enough Probation Department staff to supervise these interactions. When there were not enough Probation Department staff, this service was not offered. Staff turnover within MHSAT also had an effect on implementation: When new supervisors came on board the program, the current staff members had to re-create the work culture and get in sync as a new team.

A few interviewees also revealed challenges with referring youth to services once youth are discharged from the facility. Mental health program staff follow up with youth and their families to ensure clients have access to care, but interviewees described challenges searching for suitable referral options when they cannot bill for their time spent searching for such resources. In addition, interviewees noted that the bridge to outside services is weak, and it can often take several weeks or months for a youth to meet with a psychiatrist or to get placed, and the facilities that are available may be too far for families. Moreover, linking clients to resources is made more difficult because staff do not know their clients' exact release dates.

Interviewees also discussed challenges in matching the intensity of services to youth needs. Youth are placed in different units in the juvenile halls based on the severity of their mental health symptoms. When youth symptoms improve, staff can no longer justify youth being at a higher unit level and the youth must move to a lower-level unit. But if symptoms become more severe, being in a unit with an inadequate amount of supervision poses its own risk.

Related to a youth's needs are the needs of youth who belong to certain groups. Two interviewees mentioned how working with girls can be a challenge because they have "more going on" and they tend to talk more than the boys in the facility, implying that youth needs differ by gender. Other barriers include the lack of supplemental services, such as mindfulness art groups or social skills sessions, and challenges addressing structural factors that may be related to youth mental health concerns, such as poverty or language barriers. Staff are often expected to "fix" mental health symptoms relatively quickly, as one interviewee stated, but they noted that this assumption minimizes the complexity of youth psychopathology and is not as easily done as it sounds to others.

A few interviewees also reported a general lack of knowledge of how to obtain job-related resources, such as training information, housing assistance, or working with specific youth populations. Specifically, one interviewee mentioned how leaders in the program may not know where to find the above information; however, when the information exists, resources are not being shared among all staff members. A case manager mentioned how resources from DMH are inaccurate, incorrect, or hard to navigate, making it difficult for staff to access certain information quickly and easily.

Facilitators to Program Implementation

We asked interviewees what factors helped facilitate their implementation of MHSAT. Several interviewees mentioned the value of supervisor support, whose assistance and availability reduced the stresses of the job. One respondent remarked that supervisors support staff by allowing flexibility in the way staff members provide services and engage with clients. As a result, staff did not feel micromanaged or judged. This flexibility also helped address the scheduling conflicts that interviewees commonly mentioned as a barrier to program implementation. One supervisor noted that feedback from staff helped the supervisor understand the support staff needed to improve programming.

Interviewees said that support from other staff at the facility—both mental health program staff and other partners—had been beneficial, with one interviewee reporting that it was a "breath of fresh air" to have a team that works together so well. Regular meetings of supervisors and staff allowed everyone to stay up to date on clients' health, and the meetings ensured that youth would not have to repeat their history or trauma to every staff member. One interviewee described the value of this communication among staff members:

> Sometimes the kids, what I've noticed is that they might be a little bit more hesitant to open up with us when we first start meeting, but when they have the appointment with the psychiatrist, I notice sometimes they give more information. So I think it's great that at least they're telling the psychiatrist, [because] they can determine their [medication] better with all the information they have and then we also communicate with the psychiatrist, so if I'm concerned about something or they notice a concern or the kid tells them something, we can communicate pretty well and make sure that everyone on the team is aware of what's going on.

Staff who manage requests and provide follow-up recommendations were also seen as a source of support for interviewees.

Another facilitator was communication between the Probation Department and mental health program staff. Some interviewees said that communication with Probation Department staff helps them stay up to date on their clients and allows them to feel safe in the units. This communication also helps Probation Department staff to be knowledgeable about each youth, allowing them to have better relationships and play a role in managing their symptoms. Some interviewees mentioned that they had provided training to Probation Department staff to help them understand mental health diagnoses among detained youth and find ways to accommodate clients' mental health needs.

Some staff members described the value of involving family members in services, when appropriate, and how doing so facilitates implementation. One interviewee emphasized that the success rate for youth was higher when family was involved. Another discussed how providing families with outpatient treatment resources helps youth and their families feel less stressed once youth are released.

Finally, interviewees appreciated the trainings and resources that are provided to mental health program staff.

Resources Needed to Support Implementation

When asked about whether there are enough resources to implement the program, interviewees provided mixed responses. Some staff reported that there are sufficient resources to implement the program, citing adequate staffing levels and resources they use with clients during sessions. Other interviewees reported that they did not have the resources they need to implement the program. These staff members described how resources are difficult to obtain, particularly L.A. County mental health and substance use disorder resources. One respondent noted that staff would benefit from additional funding to acquire materials for activities, artwork, or feelings charts. Others wished there were additional services available to youth, or that staff could have additional designated space in the facilities to meet with youth, even though DMH has an office in each juvenile hall.

Regarding training, many interviewees said that they received sufficient training and they described the available trainings as accessible, interesting, helpful, and responsive to specific requests. However, others reported a need for more training, such as formal training on accessing resources and information. One respondent recommended a psychoeducational training for all therapists to further understand the contextual disadvantages that contribute to youth conduct and behavioral issues. In general, interviewees agreed that more trainings would improve the quality of services for clients because staff would have a consistent level of knowledge and an improved understanding of trauma history or systemic obstacles that lead to incarceration.

Equity-Related Considerations

Interviewees were asked to describe efforts to ensure youths' equitable access to services. Of those who were asked, all interviewees reported that MHSAT is effective in meeting the needs of youth who are diverse with respect to race and ethnicity, gender, and other characteristics. The interviewees revealed the ways in which program staff work to ensure equal access to services, which focused on hiring staff from diverse backgrounds. Interviewees reported that a therapist or advocate with

specialized training is available to work with clients who identify as lesbian, gay, bisexual, transgender, queer/questioning, or another sexual orientation (LGBTQ+). Some staff can also provide services in languages other than English to accommodate non-English-speaking clients and their families. In addition to hiring diverse staff, one interviewee explained that they are responsive to discussions on race with their clients who mention the topic. Interviewees also mentioned that the program accommodates client requests to change therapists.

In general, staff discussed the importance of supporting individuals with marginalized identities. With respect to gender identity, staff reported being mindful and respectful of a client's pronouns. For transgender youth, staff also reported that facilities had separate housing or housing aligned with the gender identity of a client. Interviewees stated that the program accommodates other youth needs, including educational needs of youth with developmental disabilities or youth with certain dietary needs. Interviewees noted that they used formal and informal trainings to stay knowledgeable on best practices and interventions for working with their clients based on their clients' specific backgrounds.

Among the recommendations to improve equitable treatment, some interviewees suggested hiring diverse staff, expanding service options, and improving the intake assessment. Interviewees noted that hiring staff with backgrounds similar to those of youth could make staff more relatable to their clients, and having staff dedicated to youths' specific identities, such as LGBTQ+ youth, could improve service quality and access to community resources. Interviewees also recommended expanding services for youth, particularly group therapy, and improving the intake assessment to better screen for various populations of youth, although interviewees were not clear about how they would modify the assessment.

MHSAT Outcomes

Perception of Program Effectiveness

Interviewees were also asked to report on the effectiveness of MHSAT in meeting the needs of clients. Most interviewees stated that they feel that they are able to meet the needs of their clients. They referred to the benefits of "planting the seeds" for clients and parents on coping with mental health symptoms, because youth who refuse services initially may accept resources at a later time. Other interviewees described how they do the best they can to meet the needs of clients with the resources available to them. However, they also acknowledged that they would like to do more but that there is not enough time to work with youth with severe mental health issues. One respondent cited challenges in assigning a single indicator of program success but stated that the program is effective as long as youth are open to receiving services.

We also asked interviewees to report any changes they would make to the program. Some interviewees stated that they would not make any changes to the program, detailing how the Probation Department appropriately assigns and monitors youth prior to DMH staff arriving at the facility. However, some interviewees noted that they wished there were additional ways to increase their clients' receptivity to engage in services.

Staff Recommendations for Improvement

Throughout the interviews, respondents offered recommendations to improve the program. As one interviewee noted, "In terms of, like, mental health, I think we definitely do a good job. I think it would be great if the kids had other programs here." Many interviewees offered recommendations related to implementing additional services, including those that involve families, as well as adding to the current repertoire of therapy and psychoeducational groups, such as providing mindfulness art groups or social skills sessions. Another interviewee suggested including services that focus on access to and continuity of treatment.

A few of the interviewees suggested changes related to staffing and staff responsibilities within the facility. Specifically, one interviewee recommended hiring a dedicated substance abuse counselor for youth. Another interviewee recommended always having Probation Department staff close by for high-risk youth, in addition to having general increased support from Probation Department staff.

Another common recommendation was related to staff trainings. Interviewees suggested increased training for a variety of facility staff, including supervisors, mental health professionals, and Probation Department staff. Interviewees recommended leadership training for supervisors to help them better support their team and reduce burnout among staff. Interviewees recommended that therapists receive education on the external factors that contribute to incarceration. Trainings for Probation Department staff include instruction on youth psychopathology and their symptom presentations and best practices to support youth development outside of treatment. Moreover, interviewees suggested that trainings for Probation Department staff should teach a rehabilitative model with a cognitive-behavioral approach as opposed to a punitive model of punishment. Currently, the Probation Department has policies against the use of punitive models and does provide training related to the positive youth development model and concepts related to certain evidence-based practices, such as dialectical behavior therapy. However, this staff recommendation suggests that there may be some Probation Officers whose approach varies from these practices, or perhaps that additional trainings could be useful.

Some staff suggested that the client assessment process could be improved by using an electronic rather than paper questionnaire and by administering an additional assessment prior to discharge to measure the effect of mental health services on client symptoms.

MHSAT Conclusion and Recommendations

In this section, we summarize the results of our analysis related to the implementation of MHSAT and present our recommendations based on that analysis.

Given high rates of youth with behavioral health needs in L.A. County juvenile halls, MHSAT fills a critical need. The length of time that youth stay in the juvenile halls can vary substantially, and many youths have only a brief stay in the halls; however, these types of quick transitions can be destabilizing for youth with mental health needs, underscoring the importance of their having access to mental health services during this time.

Several strengths of MHSAT were identified in our interviews. All youth are assessed with a structured intake and validated mental health assessment upon entering the facility, ensuring that those with clinical needs are referred to treatment. Staff described their use of evidence-based and

trauma-informed treatment approaches and were responsive to the needs of the youth in multiple ways, including through the treatment modalities provided and the frequency with which staff see youth. Staff also highlighted the value in engaging youths' family, when appropriate, and in supporting youth during their transition out of the juvenile halls.

Interviewees also described several challenges to implementation. These included competing demands on youths' time, the time needed to build rapport with youth, limited physical space to meet with youth, and the stigma of mental health treatment that many youth experience. Limited availability of Probation Department staff also made it difficult for MHSAT staff to meet with youth because Probation Department staff need to escort youth to their sessions with mental health program staff. This limited availability also leads to increased safety concerns for youth and staff. Staff called for opportunities to improve the availability of training and other resources and described the importance of strong partnerships between MHSAT staff and other staff at the juvenile halls. They also talked about challenges in developing transition plans for youth and the desire to help link families to resources. Although program staff described their efforts to address the needs of youth with marginalized identities (e.g., transgender youth) or youth who may have other distinct service needs (e.g., non-English-speaking youth and their families), they also highlighted the importance of hiring diverse staff and continuing to tailor their work to the needs of a diverse youth population.

Drawing on our findings, we make the following recommendations for the ongoing implementation of MHSAT:

- **Increase the availability of staff trainings.** Although some staff noted that their current trainings are sufficient, others described an interest in additional training opportunities. Trainings could address such topics as evidence-based treatment options, strategies for working with youth exhibiting disruptive behaviors, and approaches to better serve diverse youth (e.g., LGBTQ+ youth or youth from marginalized racial and ethnic backgrounds). There could also be value in offering cross-training opportunities—that is, opening these trainings to Probation Department staff. Doing so would build the knowledge base of both groups and would likely help improve their collaboration to serve youth. Such training could be offered on a structured schedule to emphasize its value (e.g., biannual or quarterly cross-training seminars).
- **Continue to increase knowledge of and partnerships with community-based organizations.** MHSAT staff described their commitment to engaging family members and facilitating youth transition back to the community. Partnerships with community-based organizations can help with both these efforts. Staff members could create handouts describing available services to give to family members, and staff could also work directly with community-based organizations to facilitate a smooth transition after youth are released.
- **Continue hiring diverse staff.** Interviewees noted that MHSAT already hires diverse staff, and this helps staff members connect with youth detained in the facilities, especially because many youth come from backgrounds similar to those of the staff. Continuing to hire a diverse workforce can ensure that youth have access to therapists who may be a better fit for youths' specific needs. Having therapists with a shared background or who have had similar experiences can also make clients and families more engaged by making them feel more comfortable (Alegría et al., 2013; Meyer and Zane, 2013).

- **Provide additional resources to staff that will enable them to offer a greater variety of activities and services to youth.** MHSAT staff members are resourceful and creative in how they meet the needs of youth in their care and in how they keep them engaged. For example, staff members described the value of integrating art, music, and games into their work. Although funding can be a limiting factor, these types of activities can be low cost (e.g., purchasing decks of cards or board games or having basic art supplies available). The interviewees suggest that investing in these resources will lead to greater success in terms of keeping youth busy with prosocial activities while they are detained, meeting the needs of youth who have a variety of coping mechanisms, and keeping youth engaged in treatment.
- **Provide additional supports for program staff.** Working with youth with mental health concerns in the juvenile halls can be a high-intensity job, and program staff must contend with other factors that can make their work challenging: low staffing levels and high caseloads; scheduling conflicts; uncertainty about client release dates; and the need to coordinate with a variety of people, including Probation Officers and family members. According to interviewees, there would ideally be structural solutions to some of these barriers. There are also constraints that come with working in a secure facility that can be difficult to address. Moreover, given nationwide staffing shortages in the behavioral health workforce, it is essential to support current staff and their immediate needs, which can be done by continuing to provide consultation and clinical supervision, providing enhanced training, ensuring effective leadership, and making mental health supports available to employees (Substance Abuse and Mental Health Services Administration, 2022; Adams et al., 2019).

Chapter 4

Multisystemic Therapy

In this chapter, we present findings from our evaluation of the MST program. As in Chapter 3, we begin with a description of the program. We then present qualitative interview findings related to program implementation. The chapter concludes with a summary of findings and our recommendations based on the evaluation.

Program Description

MST is an evidence-based therapy model for justice-involved youth offered in a standardized way across the country and even internationally (Henggeler et al., 1998; U.S. Department of Health and Human Services, 1999; U.S. Department of Health and Human Services, 2001). Although our MHSAT evaluation uses interview data to explore program operations and goals, the description of the MST program presented in this section draws on both interview data and published literature because of the program's standardized nature.

According to the literature, MST takes a family-centered, strengths-based approach to addressing the needs of justice-involved youth (Henggeler et al., 1998; U. S. Department of Health and Human Services, 1999; U. S. Department of Health and Human Services, 2001). Therapists using MST work with parents to increase factors associated with lower recidivism and prosocial behavior and to reduce the risk factors associated with reoffending and antisocial behaviors. The MST program's goals include reducing criminal activity and other types of antisocial behavior, such as substance use, and, as a result, reducing incarceration and out-of-home placements (MST Services, undated). MST draws on intervention techniques from behavior therapy, parent-management training, cognitive behavioral therapy, and family therapies. The program also relies on pharmacological interventions when needed, such as for diagnoses of attention deficit hyperactivity disorder (MST Services, 2014). To ensure fidelity to the MST model, there is a specific consultation program in which all MST providers participate.

In L.A. County, JJCPA-funded MST services were provided by three community-based organizations during our interview period. These community-based organizations also work with an MST consultant who is employed by MST Services, a national organization that trains MST providers. Community-based organizations employ staff members and therapists to implement the MST program, and in this section we refer to them as 'MST staff' and 'MST therapists,' respectively. We use "MST consultant" to refer to the consultant who provides training to MST providers.

In interviews, staff indicated that the goal of the MST program is to improve family functioning to increase prosocial behaviors, which is consistent with the MST model. Providers noted that this focus stems from academic research that finds a variety of prosocial behaviors and adult monitoring decrease the risk of delinquent behaviors. MST staff provide parents with the tools they need to encourage

youths' involvement in activities in which they are engaged, entertained, and monitored by a responsible adult. By connecting youth and parents to prosocial community groups, parents also connect with other support systems and adults who can help them support their children. As one interviewee described,

> [a] big part of what leads to these problems is being unsupervised and association with negative peers. Those are two of the main things that lead to kids getting involved in the juvenile justice system. And so, if we build up kind of the family's ability to look at, "Hey, how can we keep your kid monitor[ed]—or the monitoring gaps, how can we fill those with prosocial activities?" [A]nd then helping us to set up [a] rewards and consequences plan so that way it reinforces them engaging in this thing that's fun. And really try to personalize that picture.

The staff strive for outcomes that align with the fundamental theory of change grounding the MST model. MST is based on the contention that greater supervision and connection with prosocial peers and prosocial adults can decrease a youth's risk of antisocial behavior. Measurable outcomes include attendance at school, improved grades, and involvement in prosocial activities such as sports.

The MST model centers on supporting the caregiver to support the child. As one staff member summarized, "[W]e work more with the parent than the youth, but it is called family therapy." Although the MST model is highly standardized, interviewees noted that each family is different and MST program staff adjust their approach according to the needs of each family. MST providers aim to improve parenting skills, increase the level of care between the child and parent, and decrease the child's defiance. One staff member summarized the ultimate goals of the program: "The ideal outcomes, just very basic, would be just maybe increased communication within the home, decreased defiance, whether that may be a truancy, arguing, [or] angry outbursts." Another staff member emphasized the importance of improving parenting to ensure that the MST program has long-term effects and that staff are helping families develop tools they can continue to use in the future.

Referral and Assessment

Referrals to the MST program primarily come from the L.A. County Probation Department, although some referrals are received from schools with which the MST program partners. Once a referral is received, an MST program supervisor assigns the youth to a therapist who contacts the youth typically within two days of a referral. These therapists remain in constant communication with the Probation Department about any barriers to contacting the youth and what the key issues are with the youth.

After referral and contact, MST staff will work with caregivers to identify goals. Staff will also receive advice from the Probation Department staff or school administrators on how to best work with the youth. Then, MST staff work with family members to identify patterns of behavior and identify moments for intervention. With these key objectives and moments for intervention identified, staff focus on family strengths to create a plan. As one staff member summarized,

> a big part of this [is] really identifying, you know, what are the strengths and barriers for a family? What kind of things are driving that problematic behavior, and then developing a plan based off of family strengths. Also, the support systems that are

> working with the family and the strength to help out [with] supervision and monitoring the youth. Us developing a behavior plan. Maybe augmenting the communication style between the caregiver and the youth and then also trying to identify what [is] some prosocial activity that we can get them engaged in as well.

MST therapists report that their clients have several common traits. First, almost all are on probation, although some are referred through the school system. Behaviorally, clients have typically demonstrated defiant behaviors and poor communication with adults in their lives or engaged in assault, substance use, and truancy in schools. Staff also noted that parents demonstrate similar tendencies as well. Most clients have parents who are struggling to exert authority over their children. Some parents have stopped disciplining their children or are afraid of their children.

Staff reported that some referred clients are not a good fit for the MST model. Interviewees noted that because MST is based on a system of rules, rewards, and consequences, children who typically do not respond to such a system, such as children with autism, are not always a good fit for the program. Furthermore, youth charged with certain sexual assault charges or other serious crimes and who do not have additional charges of antisocial behaviors would not always benefit from the program. MST staff make efforts to ensure that staff at referral sources understand the acceptance criteria for the MST program.

Services and Treatment

According to the literature, MST is implemented by a single MST therapist who works with four to six families at a time to provide intensive services (MST Services, 2014). Interviewees confirmed that therapists typically have six clients at a time; however, interviewees said that staffing shortages could sometimes result in caseloads of up to 12 clients, which was especially true during our interview period. The MST therapist is supported by a team of two to four other therapists and a supervisor. Together, this group provides continuous support to families using an "on call" system similar to what clinicians use. The group works with clients in the community and at clients' homes in an effort to remove barriers to service and to increase clients' level of comfort with the program. MST therapists also aim to maintain regular contact with the youth's Probation Officer and school, integrating care as much as possible to relieve pressure on families (MST Services, 2014).

As reported by interviewees, this method of intense intervention and contact with caregivers continues throughout the youth's involvement in the MST program. Staff reported that they meet with clients between two to three times per week for three to six months (depending on the youth's length of detention in the juvenile hall) while working closely with caregivers to increase positive youth behavior and protective factors. In some instances, staff reported seeing the family four or five times per week in cases in which, as one interviewee put it, the "youth [is caught in] possession of weapons [or] gang involvement." These youths are considered at high risk for further antisocial behavior. Because of the high demands this schedule places on MST therapists, the therapists typically limit their caseload to up to six clients.

In keeping with the structure of MST, staff described regular check-ins with their supervisors and an MST consultant to ensure that efforts are implemented with fidelity to the MST approach. To ensure that the client is benefiting from the program, clients provide feedback to therapists. As one

interviewee described, "Every month with the MST [program], we do something called a TAM [Therapist Adherence Measure]. It's kind of a survey that goes to the parent to make sure that we're aligning with the parent, with the youth, you know, how are they doing, make sure they're progressing." TAM surveys also feed into a larger pool of data from all MST therapists around the world, which supports further research into MST's impact across a variety of families.

Another important part of the MST program, as reported by staff, is the commitment to documentation. All staff members reported careful documentation of all meetings and progress with the clients. As one senior MST staff member noted, "Everything is documented on a system that we have that goes to DMH, every contact that is made, whether they answer, they don't answer, it's all documented."

Discharge Procedures

The MST program typically ends after four months. One interviewee described the two reasons that a client would be released from the program: first, because they met their agreed-on goal for the program (e.g., decreasing defiant behavior) and, second, because they were released from Probation Department custody. The interviewee noted that youth are sometimes released from Probation Department custody before they complete treatment; because treatment is court mandated, the MST providers allow the youth to decide whether they would like to continue treatment. The interviewee noted that most youth opt not to continue with treatment once they are off probation.

In rare cases, the MST therapist will request to keep a client in the program for an additional two months (up to a total of six) because they are at a high risk for further antisocial behavior and the MST therapist wants to ensure a connection with an additional service or organization that could support the youth after leaving the program. For example, one therapist gave an example of a client who was being connected with services at his school, and, because the process was taking longer than expected, the therapist decided to keep the youth on their caseload to ensure that the youth was connected with appropriate services before discharge.

Staff reported that at the end of a youth's involvement in the program, an MST staff member will review the key skills that the caregiver learned and develop a plan to sustain the changes implemented during the program. An interviewee described the importance of this process:

> A big part of it is . . . developing a sustainability plan with them [the caregiver(s)], so that way after therapy is done they can think like, "Hey, these are all the strengths, these are the things that we have, how can we utilize that for things that could come up in the future." And so the end of therapy, the last, like, session or last few sessions is focused on "now that we have taught you these skills, how are we going to use this moving forward?"

Staffing and Training

MST includes extensive quality assurance and continuous quality improvement practices. Staff receive training and ongoing support from the MST Institute and from their immediate supervisors. MST includes measures of model fidelity and adherence based on feedback from clients, therapists,

and supervisors. Adherence measures, work sample reviews, and discharge review forms are uploaded to the MST Institute's website for monitoring by the larger organization. These mechanisms ensure fidelity to the original MST model.

The interviewees confirmed that JJCPA-funded MST therapists participate in extensive fidelity assurance processes to ensure that clients receive high-quality programming. The MST program includes multiple feedback streams that provide therapists with opportunities to talk through cases, receive advice and support, and develop their process in response to feedback. Staff not only meet with their supervisor but also meet regularly with an MST consultant who works with a broader swath of therapists in the L.A. area and is highly trained in MST implementation. Through these measures, staff reported feeling highly supported by their colleagues and leadership. As one MST supervisor summarized,

> [m]y therapists meet with me on Mondays for an hour to really talk about these clients, if there's any barriers. Then, again, we meet on [Wednesday] with someone called our MST consultant. She does not work directly for [the MST program] but she is a big part of the MST [community] and being [an] adherent to that modality. So we do have to talk with her, and she also makes sure that she supports the therapists with any barriers as well. And we try to make sure that me and the consultant are on the same page in terms of what type of intervention and support that we're providing.

Before starting as MST therapists, staff receive extensive training from the agencies that employ them. This program is a five-day training program—though staff noted that it was extended to six days during the pandemic because of adjustments made for at-home learning. Once the training is complete, new therapists are sent into the field with a supervisor or clinician to do field-based training, which consists of watching experts work with families and absorbing information. When a new therapist begins to work with families, there is a weekly supervision consultation with the person overseeing the new MST therapist. This consultation covers the clinician's summary of the work, supervisor feedback, and discussions about aspects of the work or training that should be augmented.

Therapists also participate in additional training sessions—or "booster" trainings, as one interviewee put it—every three months with an MST consultant. These trainings cover a variety of topics, and therapists can select topics with which they are most interested. One therapist noted that these boosters often reflect topics that come up most often in their conversations with the MST consultant, suggesting that the consultant listens carefully to the needs of staff. This therapist stated, "I feel like the MST Institute is very, very supportive. Every three months we get boosters on topics that we want to get more information [on, and] we feel like are valid to what's happening with us right here, right now. So again, we feel like the MST Institute and our consultant really . . . listens to our needs."

MST therapists emphasized the positive impact of agency support on their work. Despite the high intensity of the MST program, staff reported high satisfaction in their participation. One supervisor highlighted the fact that, as a result of the training and supervision, clinicians go into every session with their clients with a specific plan for their work. Another staff member reported that the agency understands and values self-care and resting to make sure MST therapists can provide families with high-quality support.

MST Program Implementation Findings

Barriers and Facilitators to Client Engagement

Interviewees described the MST program's central strategy of supporting clients' parents as a facilitator to client engagement. Interviewees found that working within the MST program made it easier to build trust with parents. In a sense, this focus on working with parents made it easier to provide services, even if a child was hesitant to engage with the therapist. Getting full parental commitment to the MST program was still a challenge for many interviewees. One staff member described some of the initial sentiments that parents express when paired with an MST therapist, noting, "I think it all comes down to their . . . understanding of MST. Sometimes parents who, or even our . . . young people who maybe are not bought into the MST model or don't understand its impact . . . don't want to do it." Some clients also expressed resistance to being in therapy because of stigmas against it.

Interviewees emphasized the importance of a strengths-based approach to engaging parents. Before working with an MST therapist, families were reported to feel exhausted, helpless, and judged as bad parents by staff in the justice system and other programs. To help overcome this, therapists are trained to communicate the benefits of MST in a way that emphasizes parents' strengths and desires to be the best parents they can be. As one interviewee said, "[W]e do kind of a sales pitch—the line I use is, you know, no one knows your son or daughter better than you. And let's talk about some of the things that you've tried and let's try something different, because I know some of what you're trying isn't working, so let's give this a chance, and maybe try this." Therapists emphasized a need to decrease parents' hopelessness and encourage renewed energy to provide structure for their child.

Another strategy that interviewees use to build rapport and gain the trust of parents is to provide additional resources from which the parents might benefit. By connecting parents with tangible supports, therapists build trust in the program, which facilitates parent engagement. Doing so underscores the message that therapists are there to help the parents and the child rather than punish them.

Barriers to Program Implementation

MST staff reported several barriers to providing services to clients. First, staff reported that it could take time to build trust and rapport with clients, and that this was made even more challenging by the move to telehealth during the COVID-19 pandemic. Before the pandemic, therapists typically met with families at their homes at least some of the time, but the remote nature of services during the COVID-19 pandemic made it more difficult to build the connection needed to engage families. As one therapist noted,

> I think the challenges that I feel like we've had is . . . not really having that rapport that you might have had before—previously, if they [the family members] don't answer your phone call, then you could do what we call a drive-by and drive by their home and say, "Hey, I tried calling you three times," and [they're like,] "Oh yeah, I know, I was busy," and you can provide the services once you are there.

Staff reported that they were still able to provide high-quality services during the pandemic but that implementing the program took more time than usual.

Another challenge related to COVID-19 that interviewees identified was a decline in referrals to the program. Interviewees provided some theories for the decline: Because youth were home from school and not socializing in public as often as they had before the pandemic, there were fewer opportunities for antisocial behavior, such as fighting at school. This likely led to fewer youth on probation and therefore fewer referrals to the program. There was also a reported increase in the proportion of youth referred to the program from those who did not qualify for detainment. In interviews we conducted later in the evaluation period, interviewees stated that more youth were returning to school, and MST program staff noted that the number of referrals they received were increasing and approaching prepandemic levels.

Interviewees discussed issues with staff retention and hiring as barriers to implementation. One staff member noted that the supply of therapists was decreasing with the limited pipeline of recent graduates who might otherwise fill these positions, underscoring the competition for therapists at other local agencies. Compared with other programs, the paperwork requirements for DMH and the MST Institute were described as more burdensome (e.g., documenting services, administering assessments). As one interviewee said, "[I]f you get [any] complaining from staff, it's usually the paperwork . . . more so than having them go out in the field and working late hours, having to meet a family at 7 in the morning."

Facilitators to Program Implementation

MST program staff outlined several factors that facilitated the implementation of the MST program. Although COVID-19 imposed challenges on typical MST program operations, interviewees said that the increased ability to provide telehealth eased connections with some parents and clients, despite the challenge of telehealth making it more difficult to establish rapport with clients and their families. Telehealth allowed for therapists to work around difficult client schedules and to more easily access adults living outside the child's home.

Across interviews, staff emphasized the importance of collaborating with other organizations. A close connection with staff at the Probation Department office has made providing care much smoother for MST program staff. One therapist reported that they are able to express their insights about a client to Probation Department staff, who will then incorporate the feedback into their decisionmaking. The interviewee noted, "We actually have an amazing collaboration with the Probation Department . . . if they want to place someone on a high level of care or even [in a juvenile hall], they will give us either a heads up or they will have a discussion with us. . . . I feel like we have a really great collaboration there." Another MST program staff member reported a strong collaboration with a school that is able to make referrals directly to the MST program via the MST in schools initiative, which is a recent expansion to the role of JJCPA-funded MST programming in L.A. County. This collaboration, according to MST program staff, means that therapists can intervene before a child even comes into contact with the justice system.

Support for MST therapists' quality of life has also improved staff members' ability to successfully implement the program. As discussed previously, MST therapists reported feeling well supported by

their MST program supervisors and the MST consultant. The intensive training in particular provided therapists with a strong foundation for providing care and with the confidence they need to overcome barriers to treating clients. Staff also reported feeling that leadership prioritized their well-being. One staff member reported that before COVID-19 restrictions took hold, staff spent time participating in fun activities to relieve stress and connect with each other.

Resources Needed to Support Implementation

Staff nearly unanimously stated that they possess the resources needed to provide MST services for their clients. However, MST therapists reported that they felt that their ability to support youth and their families was undermined when clients struggled to meet basic needs. Some MST therapists noted that clients had needs outside the juvenile halls that the MST program did not address, such as housing or material items (e.g., beds, diapers). When presented with these requests from clients, staff discussed linking clients to other organizations and people who can connect them with those resources. For example, therapists provided clients with information about food banks or organizations that provide diapers. MST staff also relied on other staff members to help draw suggestions and identify additional resources. Even with appropriate links to services, however, MST therapists were not always able to meet the needs of clients. Housing in particular was reported to be a serious issue for some clients, and MST therapists reported feeling unable to help with this significant issue.

Equity-Related Considerations

MST program staff reported that their services were provided in an equitable way to all families by recruiting staff with diverse experiences, providing services in English and Spanish, and adhering closely to the MST model. Staff noted that the MST model stresses the importance of aligning the provision of support with families' language and culture. Team leadership reported intentionally recruiting therapists who have worked with diverse populations and implementing cultural sensitivity trainings to ensure existing staff are well equipped to support families from different backgrounds. In addition, the teams include bilingual (Spanish and English) speakers, which allows therapists to support families who are bilingual or who speak only Spanish.

MST program staff said that they have seen MST's effectiveness in practice and, coupled with MST's use around the world, they are confident that the model and services provided could be appropriate regardless of a client's background. One staff summarized this by saying, "I think there can be different considerations through different cultures. I think overall, MST can fit most populations, I feel. I know the MST is, you know, not just in the U.S., but it's in so many different countries. It's being applied in different countries, and it's seen positive, you know, results all around." Moreover, interviewees noted that when the assigned therapist and the family were not a good fit, the team was ready to change providers to be more responsive to family needs.

MST Program Outcomes

Perceptions of Program Effectiveness

MST staff reported strong confidence in the impact of the program on clients. Therapists noted that although it could take time for clients to be engaged in the program, once clients (and often clients' parents) became accustomed to the program, they found great value in it. Another therapist emphasized a "never give up" mentality of staff members and how that attitude improved the likelihood of positive impact, sharing, "I believe over 85 percent of the time we meet the needs of the family. We have a philosophy of doing whatever it takes. Whatever we can do to help the family. If we need to meet on a Sunday afternoon because the family is too busy during the week, we'll make that happen." Staff members reported feeling proud of their accomplishments through their work in the program, with one staff member noting that their group had been used as a model for other counties.

Staff Recommendations for Improvement

Despite having the resources necessary to implement the program successfully, MST therapists identified ways the program could be improved. For example, when describing the mental health program's staffing shortages, one interviewee noted that other local organizations were seen as offering more-competitive pay, suggesting that more-competitive pay would help retain therapists.

Another MST staff member emphasized the value of greater prevention work, or intervening with children before they become involved with the Probation Department and the justice system. The therapist drew on their own experience in another position to highlight the value of a preventive MST program:

> I used to do, like, a preprobation service . . . it was involved in the diversion program that served Santa Monica and it was great because it was more preprobation, so they're [the youth] not in the system so it gives them, like, a better, a greater chance of not re-entering the system or even, like, you know, re-offending. So, I think that maybe if [the] MST [program] was, you know, more like a preventative measure instead of, like, an intervention measure, then we could, you know, support families and the young people before they're involved in the system.

MST Program Conclusion and Recommendations

In this section, we summarize the results of our analysis related to the implementation of the MST program and present our recommendations based on these findings.

MST has a strong, well-documented track record of improving outcomes for justice-involved youth and youth who are at risk of becoming involved in the justice system. Our interviews with MST therapists working with these youth provided an in-depth understanding of the program, including its case flow, typical clients and families, barriers and facilitators to implementing the program, and expected outcomes for participants. MST program staff working with the Probation Department demonstrated commitment to upholding the key tenets of the MST program, regularly checking in

with each other and supervisors to ensure high-quality and consistent program delivery. Staff described benefits of the standardized elements of MST, particularly the regular supervision and MST consultation. Staff members also generally reported confidence in the program, noting that they believe most families benefit and youth outcomes improve following the program's completion.

That said, staff members also discussed implementation challenges and ideas for improving the program and increasing client benefits. For example, the COVID-19 pandemic disrupted their work by reducing the number of referrals, limiting the opportunity to serve more clients, and undermining the in-person portion of typical service delivery. Staff expressed their wishes to further assist clients with meeting these needs, such as housing and obtaining such necessities as diapers or food, noting that it was challenging for families to focus on therapy when these needs were not met. Issues with staff retention and hiring, particularly uncompetitive salaries, have also been barriers to implementation.

Drawing on our analysis, we make the following recommendations:

- **Continue to provide support to staff members to improve hiring and retention.** The MST program already has several supports in place that may be helpful in mitigating turnover, including strong clinical supervision, training opportunities, and support for staff self-care. That said, interviewees specifically noted that their salaries were perceived to be less competitive than those offered by other local agencies. Therefore, it would be worthwhile for DMH and the MST program to explore the feasibility of increasing salaries to remain competitive with other mental health providers in the region.
- **Expand prevention-oriented MST options.** When we conducted our interviews, the MST program was undergoing efforts to increase the availability of MST for youth who are not on probation or detained in the juvenile halls, specifically through the MST in schools initiative. However, this program had been slow to provide referrals because of the COVID-19 pandemic. Continuing to expand this referral pathway could be an important strategy to prevent at-risk youth from entering the juvenile justice system and to provide families with needed supports before youths' behavior becomes more difficult to manage.
- **Bolster partnerships with social service organizations to address families' basic needs.** Staff members noted that they were already working to connect families with organizations that provide resources to address basic needs. Continuing to form partnerships with these types of organizations could be valuable, because families might be able to engage in MST more meaningfully if their basic needs are met. Given that families may face significant obstacles to finding affordable housing in L.A. County, linking families to housing programs could be particularly beneficial. It is worth considering how JJCPA resources might be used to bolster housing supports for justice-involved youth in L.A. County.

Chapter 5

Conclusion

This report documents the results of a process and outcome evaluation of two mental health treatment programs funded by JJCPA. Both programs provide important services for youth with mental health needs who are involved in the juvenile justice system. MHSAT ensures that youth with mental health needs who are detained in juvenile halls are identified and provided with services for the duration of their stay, which experts state is critical to promoting stability at a challenging time in youths' lives. The program also engages families and creates continuity of care for youth when they are released from the juvenile hall. The MST program provides evidence-based therapy for justice-involved youth and their families. It provides intensive treatment for a limited period, often bringing services directly to families in their homes. It is also increasingly becoming more of a preventive intervention by accepting referrals from schools.

Despite some of the differences in the nature of these two programs, we found that the programs face similar challenges in implementation. For example, both programs require that staff develop rapport with clients and their families, who may be reluctant to receive services or who are distrustful of mental health providers. Staff in both programs have found that clients have needs beyond those that can be met by the programs, including the need for ongoing community-based treatment and more-basic needs, such as housing. Both programs also face difficulties hiring and retaining staff. At the same time, the programs share many key facilitators of success, including committed staff who are willing to be flexible in their approaches to engaging clients. The MST program also benefits from its structured approach to supervision, consultation, and progress monitoring.

When interpreting findings from this evaluation, it is important to keep certain limitations in mind. First, interviews were largely conducted in 2021 and early 2022. During this time, both programs were affected by the COVID-19 pandemic and associated restrictions in L.A. County. Therefore, some of the challenges documented in this report might have changed since the interviews, though it is likely that some factors remain an issue (e.g., the influence of the ongoing shortage of mental health providers). Second, there were limitations to the quantitative data that were available to our team. In particular, there was a lack of overlap between the program data and administrative data for each program, as detailed in Chapter 2. We are currently working with the Probation Department to obtain additional data, and analyses based on those quantitative data will be documented in a separate annex to this report. Third, we were unable to interview youth and family members who were engaged in the programs as part of our evaluation. For the MST program, we did receive the names of some program participants, though these were largely youth referred through schools. Our attempts at reaching these youth were unsuccessful. For MHSAT, we faced additional obstacles to recruiting youth. Youth are detained while receiving services, which made it difficult to collect data related to accessing the juvenile halls, especially given the COVID-19 restrictions in place during the period of our interviews. Moreover, our approvals from the court related to interviewing required written

consent from attorneys before we could conduct outreach to family members and youth, which would have been difficult to accomplish for detained youth. During the limited time that youth are held at the juvenile hall, we would have needed to identify each individual's attorney, reach out to that attorney and obtain their consent to speak with their client, and reach out to parents and receive their consent—all prior to receiving written consent from the youth. Nevertheless, we believe in the importance of understanding youth and family perspectives on these programs, and this remains an important avenue for future research.

Despite these limitations, these evaluations provide useful information on program operations, including the populations served and the nature of the services provided. These findings are consistent with past research on these programs, which also suggests that these programs are associated with positive youth outcomes (Fain et al., 2014; Fain, Turner, and Shahidinia, 2018; Fain and Turner, 2017). Given that these past evaluations were more focused on outcomes, this report provides an important contribution to understanding the factors that have shaped program implementation in the early 2020s, in addition to more-recent outcome data.

Appendix

Juvenile Justice Contact Among MHSAT and MST Program Participants

This appendix summarizes findings from a supplemental quantitative data analysis. When we first completed the analysis of data for 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, complete data were not available, and therefore, our evaluation focused on qualitative interview findings.

Since that time, we have worked with the Probation Department to improve the completeness of the quantitative data available for this analysis. Our analysis methods and findings are presented in this appendix.[3]

Quantitative Methods

For each program, we received quantitative data from two sources. First, each program collected data on the youth it served (program data) and then provided that data to the Probation Department as part of the program's contractual requirements. The Probation Department then shared each program's data file with our team for the purpose of this evaluation. We also received an administrative data file for each program with data pulled from the Probation Department's Information Services Bureau. These data contained court contacts data, and the Probation Department pulled the information from its data system using 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) and disposition (i.e., whether the youth was committed to a DJJ facility, committed to a Secure Youth Treatment Facility, placed in an L.A. County juvenile camp, or 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 involvement.

For both programs, we received programmatic data (i.e., data collected by MHSAT and the MST program on the youth they served) from three FYs: 2018–2019, 2019–2020, and 2020–2021. MHSAT data covered 2,141 youth who the program served, 2,033 of whom also had administrative

[3] Portions of this appendix were taken from Whitaker et al., 2024.

data available. For the MST program, we received data on 431 youth served in that period; administrative data were also available for 356 of these youth.[4]

For each program, we began by conducting descriptive analyses that focused on youth demographic characteristics with the goal of describing the population served by each program. 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

MHSAT

Table A.1 summarizes the demographics of youth who received mental health treatment through MHSAT from FY 2018–2019 to FY 2020–2021. Most youth were between the ages of 14 and 17, and the majority of youth were Hispanic or Black, which is consistent with the broader population of youth under Probation Department supervision. Most youth were male. (Note that we present the five most common zip codes in the data because the Probation Department is interested in understanding the areas of the county with the most at-promise or juvenile justice–involved youth.)

Table A.1. MHSAT Participant Characteristics

Demographic	Participants *N* = 2,033 % (*n*)
Gender	
Female	20.86 (424)
Male	79.14 (1,609)
Race or ethnicity	
Black	33.94 (690)
Hispanic	57.94 (1,178)
White	6.39 (130)
Another racial or ethnic group	1.48 (30)
Missing	0.25 (5)
Age	
12 or younger	1.92 (39)
13	3.79 (77)
14	12.69 (258)

[4] The datasets included youth who received services funded by JJCPA.

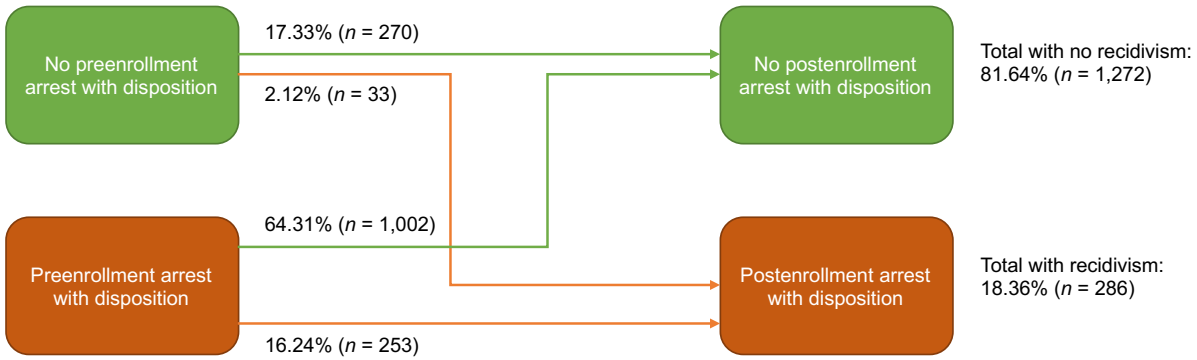
Demographic	Participants *N* = 2,033 % (*n*)
15	20.07 (408)
16	26.76 (544)
17	30.45 (619)
18 or older	4.28 (87)
Missing	0.05 (1)
Five most common zip codes	
93535	5.21 (106)
93550	3.49 (71)
90003	2.46 (50)
93534	2.36 (48)
91331	2.31 (47)

NOTE: Gender, race or ethnicity, and zip code values are based on administrative data for program participants. We report on demographic categories that appear in the dataset. Age at enrollment is based on program data and administrative data.

We examined the percentage of youth who had contact with the juvenile justice system that resulted in a disposition after enrolling in the program, including whether a youth was committed to a DJJ facility, committed to a Secure Youth Treatment Facility, placed in an L.A. County juvenile camp, or placed under supervision of the Probation Department but allowed to remain at home with a supervising adult. There was a subset of youth (n = 475) who had multiple enrollment dates in the program data file. From our discussions with DMH, we learned that there could be several scenarios that led to multiple enrollment dates. For example, some youth may have been formally released to the community but then came back into contact with the juvenile justice system and therefore ended up at a juvenile hall a second time. However, some youth may have been transferred from a juvenile hall to a different secure setting, such as a juvenile camp or a DJJ facility, but then were transferred back to the juvenile hall for some reason (e.g., an upcoming court date). Because a subset of these youth might have remained in a secure facility after leaving the juvenile hall, and, therefore, had less opportunity to reoffend in the community during the follow-up period, we excluded them from the analysis.

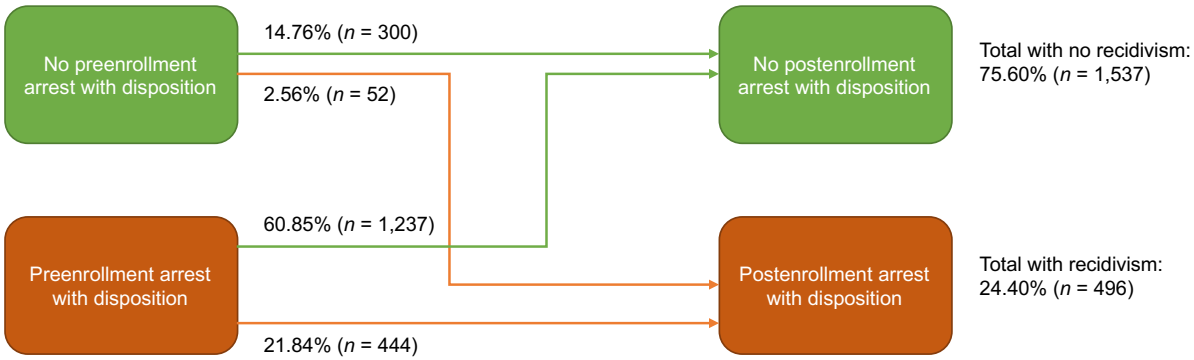
Figure A.1 summarizes data related to youth dispositions for arrests occurring before and after enrollment in the program for youth with only one program enrollment. In total, 1,255 of the youth who enrolled in the program (80.55 percent) had a disposition for an arrest occurring prior to enrollment. Rates of recidivism after enrollment in the program were as follows: 253 youth with a preenrollment disposition also had a postenrollment disposition, as did 33 youth with no preenrollment disposition, yielding an overall recidivism rate of 18.36 percent (n = 286).

Figure A.1. Preenrollment and Postenrollment Arrests with Dispositions Among MHSAT Youth with a Single Enrollment (*n* = 1,558)



We conducted a sensitivity analysis by analyzing the full sample of 2,033 youth, which included youth with multiple enrollment dates. For this analysis, we focused on recidivism occurring after the first enrollment date. A similar percentage of youth had a preenrollment arrest resulting in a disposition (82.69 percent). However, the total rate of recidivism following enrollment was somewhat larger in this sample (24.40 percent). Figure A.2 summarizes these findings.

Figure A.2. Preenrollment and Postenrollment Arrests with Dispositions Among MHSAT Youth, Including Youth with More Than One Enrollment (*n* = 2,033)



NOTE: For any youth with more than one enrollment, we accounted for a disposition only after the youth's first enrollment.

MST Program

Table A.2 summarizes the demographics of youth served by the MST program from FY 2018–2019 through FY 2020–2021. Most youth who participated were 15 to 17 years old, and most were males. Consistent with the broader population of youth served by the Probation Department, youth primarily identified as Hispanic or Black.

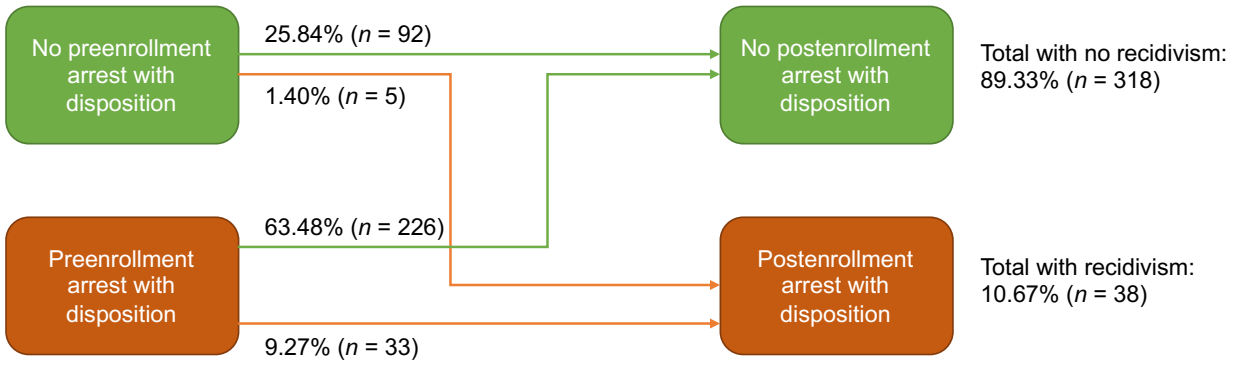
Table A.2. MST Program Participant Characteristics

Demographic	Participants *N* = 356 % (*n*)
Gender	
Female	17.42 (62)
Male	82.58 (294)
Race or ethnicity	
Black	34.55 (123)
Hispanic	58.71 (209)
White	4.49 (16)
Another racial or ethnic group	1.40 (5)
Missing	0.84 (3)
Age	
13 or younger	4.21 (15)
14	7.02 (25)
15	18.26 (65)
16	29.49 (105)
17	32.87 (117)
18 or older	8.15 (29)
Five most common zip codes	
93550	12.64 (45)
93535	8.99 (32)
90813	5.34 (19)
93552	4.21 (15)
93534	3.65 (13)

NOTE: Gender, race or ethnicity, and zip code values are based on administrative data for program participants. We report on demographic categories that appear in the dataset. Age at enrollment is based on program data and administrative data.

Figure A.3 summarizes data related to youth dispositions for arrests occurring before and after enrollment in the program. In total, 259 youth who enrolled in the program (72.75 percent) had a preenrollment arrest with disposition. However, rates of recidivism were fairly low after enrollment: 33 youth with a preenrollment arrest with disposition also had a postenrollment arrest with disposition, as did five youth with no preenrollment arrest with disposition, yielding an overall recidivism rate of 10.67 percent (n = 38).

Figure A.3. Preenrollment and Postenrollment Arrests with Dispositions Among MST Program Youth, Including Youth with More Than One Enrollment (*n* = 356)



NOTE: For any youth with more than one program enrollment, we accounted for a disposition only after the youth's first enrollment.

Abbreviations

COVID-19	coronavirus disease 2019
DCFS	Department of Children and Family Services
DJJ	Division of Juvenile Justice
DMH	Department of Mental Health
FY	fiscal year
JJCPA	Juvenile Justice Crime Prevention Act
JJ-TOTS	Juvenile Justice Transitional Outpatient Treatment Services
L.A.	Los Angeles
LGBTQ+	lesbian, gay, bisexual, transgender, queer/questioning, or another sexual orientation
MAYSI-2	Massachusetts Youth Screening Instrument II – Second Version
MHSAT	Mental Health Screening, Assessment, and Treatment program
MST	Multisystemic Therapy

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