Juvenile Court Mental Health Advocacy Project

Interim Report of Baseline and Follow-up Evaluation Data

December 30, 2016

Prepared for

Health Law Advocates

by

The Boston University School of Public Health Evaluation Team
Led by: Emily Feinberg, ScD, CPNP and Patricia Elliott, DrPH

Department of Community Health Sciences

EXECUTIVE SUMMARY

This report presents interim evaluation findings of the Juvenile Court Mental Health Advocacy Project (J-MHAP) for the analysis period of February 1, 2015 to July 15, 2016. The report is organized into four main sections: (1) Family Profiles, (2) the Work of Mental Health Advocates (MHAs), (3) Evidence of Program Impacts, and (4) Stakeholder Perspectives. Data is presented for all youth in J-MHAP and for the subset of youth and families who participated in the evaluation (i.e. evaluation subset).

Section 1. Family Profiles: Includes demographic characteristics, youth court involvement, school engagement, use of school and mental health services, and measures of parent/guardian and youth mental health risk.

- The majority of youth in J-MHAP identified as male (62%) and White (64%).
- Over 80% of youth were appointed a MHA on a Child Requiring Assistance (CRA) case, though 37% had court involvement in addition to the case for which the MHA was appointed. Of these youth, the most common pattern was for youth appointed a MHA on a CRA who also had a delinquency case.
- Parents/guardians and youth in the evaluation subset completed standardized measures to assess overall mental health related risk. Participants scored higher (worse) on nearly every measure of risk compared to comparison groups reported in the published literature, suggesting a significantly elevated risk profile among participants.

Section 2. The Work of the MHAs: Includes types of goals set for youth and MHAs' recorded effort within systems.

- Of cases which ended by July 15, 2016, 85% of goals had been completed by case closure. The percentage of goals completed increased with length of time in the program.
- The most common types of goals related to school placement or other school issues and accessing appropriate mental health services.
- MHAs had the most contact with families and the court system. MHAs also worked frequently with school systems, the Department of Children and Families (DCF), and the agencies that provide services as part of the state's Children's Behavioral Health Initiative (CBHI).

Section 3. Evidence of Program Impacts: Includes analysis of effects on court involvement, six-month follow up comparison of youth and family risk measures, and case successes and setbacks.

- Among 21 youth with open delinquency cases, MHAs successfully advocated to avoid or shorten pre-trial detention in 7 cases, for reduction in sentence in 3 cases, and for treatment instead of detention in 1 case.
- As would be expected given the relatively small number of participants who completed follow-up interviews at time of analysis, few statistically significant changes in youth and family risk measures were found. However, three areas showed change in the preliminary analysis: the impact of youth difficulties on the youth and family, youth quality of life, and youth-reported conflict with a parent or guardian. These measures all showed improvement from baseline to six-month follow-up.
- In-depth, de-identified case examples for four youth showing the work of MHAs on specific cases.

Section 4. Stakeholder Perspectives: Includes analysis of data from qualitative interviews conducted by the evaluation team with both primary and secondary stakeholders, as well as key informants.

- As of August 15, 2016, 33 interviews had been completed with J-MHAP families, and 20 interviews had been completed with stakeholders and key informants.
- Stakeholders discussed themes related to implementation and sustainability and scale-up.

Summary

The analyses conducted thus far indicate that the J-MHAP pilot has produced important results. The MHAs have completed their work in a timely manner and seem to have filled a needed role within the court system while navigating complex needs among families with high mental health risk profiles. Stakeholders and key informants suggest the need for further investigation into options for strengthening the service systems of which J-MHAP is a part. Additional analyses of future finalized data will yield more conclusive results on the impact of J-MHAP.

INTRODUCTION

This report has been prepared for Health Law Advocates by the Boston University School of Public Health Evaluation Team to present interim findings of the evaluation of the Juvenile Court Mental Health Advocacy Project (J-MHAP). The data presented covers the 18-month period from February 1, 2015 when the J-MHAP pilot began, through July 15, 2016. The goal of the report is to convey findings from data collected through baseline and six-month follow-up interviews with youth and families, initial views expressed by stakeholders, and in-depth case examples detailing the work of the Mental Health Advocates (MHAs). The report is organized into four main sections: (1) Family Profiles, (2) the Work of MHAs, (3) Evidence of Program Impacts, and (4) Stakeholder Perspectives. The methods and data sources used to obtain the data are described in each section.

1. Family Profiles (pages 4 to 9)

This section details demographic characteristics of J-MHAP youth and families; court involvement and use of school and mental health services; and data about parental and family risks. Key questions addressed include:

- What are the demographic characteristics of youth in J-MHAP? How does the subset of youth participating in the evaluation compare to all youth in J-MHAP?
- On what types of court cases are MHAs appointed? To what extent do youth have court involvement outside of the case on which the MHA was appointed?
- What are the mental health risk profiles of families in J-MHAP?
- Which youth are being served by J-MHAP? What are the mental health-related needs of youth enrolled in J-MHAP? To what extent are youth receiving school and mental health services at the start of their involvement with J-MAHP?

2. Work of Mental Health Advocates (pages 10 to 12)

This section documents MHAs' work based on recorded effort within different systems; the types of goals established with families; and completion of those goals. Key questions addressed include:

- What is the nature of the MHAs' work?
- How do MHAs invest their time? How much time do MHAs spend interacting with different systems?
- How do MHAs use their legal training in their role?
- What are the types of goals that MHAs work on for youth?
- What proportion of goals are met by MHAs while youth are in J-MHAP?

3. Evidence of Program Impacts on Youth and Family Outcomes (pages 12 to 21)

This section includes analysis of six-month follow-up family risk profiles, the impact of the MHAs on court involvement, and in-depth case examples detailing the work of the MHAs. Key questions addressed include:

- Are there changes in youth and family mental health-related risk and functioning over time in J-MHAP?
- How does the work performed by MHAs affect youth's trajectories?
- What are MHAs able to accomplish for youth and families?

4. Stakeholder Perspectives on Implementation and Sustainability of JMHAP (pages 22 to 29)

This section explores themes from interviews with stakeholders related to the implementation of J-MHAP to date and includes recommendations from stakeholders to support continued program development and sustainability. Key questions addressed include:

- What are the needs and gaps that J-MHAP is working to fill? How effective has it been in meeting these needs?
- How well does J-MHAP fit within the court system? Is J-MHAP sustainable as an institutionalized program within the court system?
- What are some recommendations for increasing sustainability and scalability?

SECTION 1. FAMILY PROFILES

Overview: Between February 1, 2015 and July 15, 2016, 122 youth were appointed a MHA in the Middlesex and Essex Juvenile Courts (61 in each). Of the 122 youth who received J-MHAP services, 46 families (i.e. parent and/or youth) participated in the evaluation. This section will describe the demographics of families, the services they used, and their baseline risk characteristics.

Methods: Data on the demographics of youth enrolled in J-MHAP were recorded by HLA and de-identified prior to analysis by the BU evaluation team. Individual, more comprehensive data was collected from a subset of youth and/or their parents or guardians who gave informed consent to participate in the evaluation. The evaluation team met with this subset of youth and families (n=46) for in-depth interviews related to family functioning and their experiences with use of mental health and school services. These interviews were conducted one time at the beginning of their work with the MHA (baseline) and at least one additional time a minimum of six months after the initial meeting (follow-up). Follow-up interviews and brief phone calls conducted quarterly included questions about youth and family experiences in J-MHAP. Given the ongoing nature of MHA appointments, youth and families are enrolled in the evaluation at different points in time and new participants continue to be enrolled.

1A. DEMOGRAPHIC CHARACTERISTICS OF YOUTH

Most of the 122 youth who received J-MHAP services at time of the analysis were white, male, and English speaking. Nearly two-thirds of youth who received a MHA identified as male, just over one-third identified as female and one youth identified as other. The majority were white and English speaking with only four youth reported as non-English speaking. Latino/Hispanic and Black youth were 20% and 7% respectively; 8% reported as other, and approximately 3% did not report race or ethnicity. Race and ethnicity were similar by site. The ages of the youth ranged from seven years to 21 years, with an average of 15 years of age (both mean and median = 15 years).

The 46 youth who were included in the evaluation subset were very similar demographically to all youth in J-MHAP, improving the ability to generalize from this subset to the larger group served by J-MHAP. Youth identified as Black, Latino, and other race/ethnicity were proportionately represented in the evaluation subset. A comparison of racial and ethnic characteristics is presented in **Table 1**.

A subset of participants (n=6) withdrew from the evaluation prior to the six-month follow-up. These participants were compared to those who did not withdraw in order to understand whether there were differences between the two groups that might contribute to bias in the follow-up findings. The subset of participants who withdrew were similar to the group of participants who remained in the study in terms of youth race/ethnicity, gender, type of cases, and family mental health risk profiles. However, due to the small number of participants who withdrew, it is difficult to draw conclusions about this subgroup.

Table 1.Youth Demographic Characteristics of All J-MHAP and the Evaluation Subset		
Demographic	**All J-MHAP (122 youth)**	**Evaluation Subset (46 youth)**
Race/Ethnicity	Number of Youth (%)‡	Number of Youth (%)‡
White	78 (64%)	27 (59%)
Latino/Hispanic	23 (19%)	4 (9%)
Black	8 (7%)	2 (4%)
Other	9 (7%)*	7 (15%)**
Missing	4 (3%)	6 (13%)
Primary Language		
English	112 (92%)	36 (78%)
Non-English	4 (3%)	2 (5%)***
Missing	6 (5%)	8 (17%)
Gender		
Male	76 (62%)	29 (63%)
Female	45 (37%)	11 (24%)
Other	1 (1%)	2 (4%)
Missing	0 (0%)	4 (9%)

*Biracial (n=5), Brazilian (n=2), Cape Verdean (n=1), Asian (n=1).

** Biracial White and Black/African American (n=5), Biracial White and Hispanic/Latino (n=2).

*** English and Portuguese (n=1), English and Spanish (n=1)

‡ Percentages should be interpreted with caution due to the small number of participants in the evaluation subset and inherent instability of percentages.

1B. YOUTH COURT INVOLVEMENT

The vast majority of youth were appointed a MHA on a CRA case (over 80%). Approximately 7% received a MHA on a Delinquency case, 7% on a Care and Protection case, and 2% on a Permanency case. However, over a third of youth (37%) had court involvement in addition to the case for which the MHA was appointed.[i] Of youth with additional court involvement, the most common pattern was youth who received a MHA on a CRA case but also had a pending Delinquency case, also referred to as dual-status youth (n=14).

The scope of MHAs' work is defined by the judge when the appointment is made. **Table 2** details a breakdown of these scopes. Some youth (n=22) had only one scope selected, but most had two or more, with five youth having five scopes. Cases had an average of 2.4 scopes at the initial appointment.

Table 2. % of Cases Containing Category of Scopes‡	
Begin or improve special education services	64%
Coordinate mental health services	41%
Secure community-based mental health services	39%
General education services	21%
Secure services from Department of Children and Families	21%
Other (defined by judge)	16%
Become eligible for services from Department of Mental Health	14%
Secure services from Department of Mental Health	12%
Become eligible for services from Department of Children and Families	7%
Assist with health insurance coverage	4%
Secure services from Department of Developmental Services	4%
Become eligible for services from Department of Developmental Services	1%

‡ All youth in J-MHAP

[i] Data on additional court involvement is only available for the 76 closed cases.

J-MHAP is designed with initial court appointments lasting up to six months. However, in some cases, appointments may be extended by a judge to allow for continued efforts. As of July 15, 2016, 76 cases were closed with an average appointment time of 6.9 months. Among the cases that were closed at time of analysis, most had received an extension with the average extension being 12.2 weeks **(Table 3)**. Common reasons for case extensions beyond six months included: time of year prevented the MHA from ensuring school services would be in place at the end of appointment, youth and/or specific family challenges or setbacks prevented the MHA from completing the scope in six months, systemic challenges or setbacks, and other reasons.

Table 3. Duration of Closed Cases‡	
Duration	**% of Closed Cases**
Open for 6 months	19%
Open < 6 months	26%
Open > 6 months	55%

‡ All youth in J-MHAP

1C. USE OF SCHOOL, MENTAL HEALTH AND RESIDENTIAL SERVICES

The scopes assigned by the judges clearly indicate education and mental health services as the top priorities. In-person interviews conducted with the subset of youth and families participating in the evaluation provided information about youth status in school at the start of the MHA appointment. To better understand school-related indicators of risk, data was obtained on school attendance, grade retention, and disciplinary actions. Youth attendance during the three months prior to baseline was reported by parents. At baseline, 25% of youth were not attending school at all and another 5%, who purportedly were attending school, missed almost every day. Another 30% missed more than one day each week. Grade retention and disciplinary actions were common. 26% of youth had repeated one grade in school and 9% had repeated two grades. In addition, 44% had received at least one suspension in the past year. **Table 4** summarizes these indicators of school risk.

Table 4. Indicators of School Risk‡	
Attendance in the past 3 months	**% Youth**
Didn't go at all or missed almost every day	30%
Missed more than one day/week	30%
Missed one or two days/month	15%
Attended almost every day	24%
School suspensions in the past 12 months	**% Youth**
1 or more	44%
5 or more	9%
10 or more	6%

‡ Evaluation subset

Use of school services was also assessed. The majority of youth had received additional school services or special placement in the year prior to MHA appointment. Approximately two-thirds of youth had received some type of in-school counseling, 38% were placed in a special education classroom, and 30% were placed in a special school for emotional or behavioral needs (**Table 5)**. Three youth had not received any type of additional school services. The most common reasons youth reported for being placed in a special school included anxiety or nervousness, drinking or drug use, depression or sadness, fighting, life stress and other reasons.

Table 5. Additional School Services in Past Year‡		
Type of Service / Placement	**% Youth with Service**	**Average Yrs Received (max)**
In-school therapy or counseling	67	2.0 (8.8)
Special classroom for learning, emotional or behavioral needs	38	2.5 (10.8)
Special school for youth with emotional or behavioral needs	30	1.4 (5.8)

‡ Evaluation subset

Parents also reported youth use of both outpatient and overnight mental health services in the year leading up to the baseline interview **(Table 6)**. Outpatient mental health services included seeing a provider, participating in a day program, using emergency or crisis services, or taking prescription medications. The majority (70%) of youth

had seen an outpatient mental health provider. Youth who used crisis services (in-home crisis services or emergency room) for mental health or substance use needs (70%) used these services an average of 3.6 times within the year, with a minimum of one and maximum of 10 times.

Overnight services used included inpatient hospital care, residential treatment and drug and alcohol treatment. Over half of youth had at least one stay in an inpatient or residential facility during the year before baseline. Among youth who had an inpatient stay in a hospital or drug or alcohol clinic (49%) in the past year, the average length of stay was 18.8 days, with a minimum of two and maximum of 74 days (not always in succession).

Youth's reasons and motivations for participating in mental health services varied. Among youth who saw a professional in the past year for mental health related needs, 13% said they went because they wanted to do it, 53% said they went because someone else put pressure on them, and 27% said that both were true. Youth identified pressure from parents, judges or court personnel, and other providers.

Table 6. Mental Health Services Received in Past Year‡	
Type of Service	**% Youth**
Outpatient Services:	
Mental Health Provider	69.9
Crisis or Emergency Services (emergency room, in-home crisis services)	69.9
Took medication for emotional, behavioral, or substance use reasons during past year (at least 1 week)	44.2
Day Treatment (Partial hospital or drug/alcohol clinic)	18.6
Overnight Services:	
Hospital	47.7
Residential Treatment Facility	36.4
Drug/Alcohol Treatment Unit	6.8

‡ Evaluation subset

Some youth also had out of home placements in emergency shelters, group homes, detention centers, prisons, and jails during the year prior to baseline (**Table 7).**

Table 7. Out of Home Placement in Past Year‡	
Type of Service	**% Youth**
Group Home	11.4
Detention center/prison/jail	11.4
Emergency Shelter	6.8
Foster Home	2.3

‡ Evaluation subset

1D. FAMILY RISK CHARACTERISTICS

The overall risk profile of J-MHAP families was assessed during baseline interviews with 46 families, including parents (n=43) and/or youth (n=27). Eight standardized instruments were used to assess family risk across three domains: family, parents, and youth. Adult measures assessed overall health, general stress, family conflict, and depression symptoms. Youth answered questions about quality of life, strengths and difficulties, and family conflict. Each of the tools used were selected because of their wide use among youth and their families, as well as the existence of published norms for each measure, which were established using community or national samples. The selection of measures allows for the comparison of J-MHAP participants and the broader population.

J-MHAP participant scores were averaged and compared to a published community sample, or "norm." We report scores based on the number of standard deviations (presented as an absolute number) J-MHAP participant scores deviate from this norm. This approach was used to allow readers to better contextualize family risk. In a normally distributed population, 68 percent of values will fall within one standard deviation from the mean (average), and 95 percent of values will fall within two standard deviations from the mean. Results of this analysis showed that J-MHAP parents/guardians and youth scored higher on almost every measure of risk compared to the norms,

suggesting a significantly elevated risk profile among participants. **Table 8** presents scores for J-MHAP evaluation participants compared to norms of the general population.

The measures for which participant scores deviated most from published norms were measures of family conflict and distress and youth strengths and difficulties. Scores on the Conflict Behavior Questionnaire, which captures family distress, were 1.1 (youth) to 3.5 (parent) standard deviations greater than the published norm.[1] Scores on the Strengths and Difficulties Questionnaire (SDQ), which measures children's behavioral strengths and difficulties, were 2.5 standard deviations greater than the reference group.[2] The SDQ Impact Supplement measures distress, impairment, and effects on the youth and family due to the child's difficulties. On this measure, parents and guardians rated the impact of their child's difficulties an average of 4.5 standard deviations greater than the norm, placing youth within the highest "very high" category of impact.

Parental mental health was also assessed, as parental depression has a well-documented negative effect on child functioning across multiple domains.[3,4] J-MHAP parents and guardians reported depressive symptoms 1.4 standard deviations greater than the comparison community-based sample on the Center for Epidemiologic Studies Depression Scale (CES-D), a screening measure for depressive symptoms.[5] Moreover, 63% of J-MHAP parents and guardians met the CES-D cutoff for at least mild depression, compared to only 19% in the published community data.[5] Of these, almost half had scores that indicate major depression (score >27) which is associated with impaired functioning.

Table 8. Family Risk at Baseline‡

Domain	Measure	Number of standard deviations from norm
Family	Parent perceived conflict	+ 3.50
	Youth perceived conflict	+ 1.10
Parent	Parental stress	+ 1.26
	Parental depression	+ 1.39
	Overall mental health	+ 0.70
	Overall physical health	- 0.65
Youth	Total difficulties (Parent on youth)	+ 2.46
	Impact of difficulties (Parent on youth)	+ 4.46
	Total difficulties (youth completed)	+ 1.12
	Impact of difficulties (youth completed)	+ 2.75

+ indicates the mean score is higher than the norm (worse)
- indicates the mean score is lower than the norm (better)

‡ Evaluation subset

Additional youth measures assessed overall quality of life and trauma symptoms. The Los Angeles Symptom Checklist PTSD subscale was used to measure of PTSD symptoms among youth in J-MHAP. Data from the general population was unavailable for this measure, so J-MHAP youth scores were compared to those of other groups of youth in the published literature. On this measure, J-MHAP youth's average score of 22.7 was slightly higher than that of a published sample of incarcerated youth, with a difference of about 0.10 standard deviations.[6] However, J-MHAP youth scored almost one full standard deviation higher (0.98) than a comparison sample of youth enrolled in continuation or alternative schools.[7]

The Youth Quality of Life (YQOL) scale was used to measure overall quality of life among J-MHAP youth. Lower scores indicate a lower perceived quality of life. J-MHAP youth scored about 15% lower than a sample of youth with no condition (70.2 vs. 82.2) and 7% lower than a sample of youth with ADHD (70.2 vs. 75.2). For full details of baseline and comparison scores see **Appendix A.**

The risk profiles of youth were also assessed through analysis of formal diagnoses for youth and parent-rated youth mental and physical health. Almost 90% of youth had more than one diagnosis or condition, with an average of four mental health related conditions. The most common conditions are listed in **Table 9.** Parents and guardians were also asked to rate their children's mental and physical health on a scale of zero to ten, with zero being the worst possible and ten being the best possible. On average, parents and guardians rated youth a four for mental health and an eight for physical health.

Overall, scores of both parents/guardians and youth suggest a substantially greater risk profile among participants compared to community populations and indicated a high level of family vulnerability and stress. These data indicate the existing mental health needs not just of the youth, which is recognized by the court through the appointment of the MHA, but of the adults in the household, as well.

Table 9. Youth Mental Health Conditions‡

Condition	% Youth*
Depression	71%
Anxiety Disorder	64%
ADHD	60%
Oppositional Defiant Disorder	31%
Learning Disability	31%
Bipolar or Psychotic Disorder	31%
Substance Use Disorder	19%
Self-injuring Behavior	17%
PTSD	14%
Autism Spectrum Disorder	14%
Obsessive Compulsive Disorder	9.5%
Eating Disorder	2.4%

‡ Evaluation subset

*Numbers do not sum to 100% as youth may report more than 1 condition

Family risk was also assessed based on the barriers parents and guardians reported facing when trying to access needed services for youth. Barriers were assessed using the Child and Adolescent Services Assessment (CASA).[8] **Table 10** lists the percent of parents who reported each type of barrier. Structural barriers were the most commonly reported type of barrier. Almost 80% of parents and guardians reported experiencing challenges related to cost, time, transportation, bureaucratic delay, being denied services, and lack of beds when accessing or engaging in services. A smaller subset of parents and guardians said that fear of consequences (e.g. worry about out-of-home placement or loss of parental rights) interfered with their ability to access services for their child. Child or parent/guardian refusal of treatment and concerns related to quality of services interfered with accessing services in 16% and 14% of families, respectively. Issues related to stigma served as a barrier to treatment in only 5% of families. Overall, 81.4% of parents/guardians said that services were affected by any of these barriers. For more detailed descriptions of each type of barrier, see **Appendix B.**

Table 10. Barriers to Accessing Services‡

Type of barrier	% Parents who reported barrier*
Structural barriers	79.1%
Bureaucratic delay	41.9%
Transportation to treatment/services	27.9%
Incomplete information	25.6%
Time	16.3%
Service not available nearby	16.3%
Cost of treatment/services	11.6%
Refusal to treat	11.63%
Fear of consequences	18.6%
Child or parent refuses treatment	16.3%
Quality of services	14.1%
Stigma	4.7%

‡ Evaluation subset

* Numbers do not sum to 100% as parents may report more than 1 barrier

SECTION 2. THE WORK OF THE MENTAL HEALTH ADVOCATES

Each case a MHA received required a tailored approach to meet the needs of the youth, family and scope as defined by the judge. The work the MHAs performed was captured in two main ways. The first was through monitoring of case-specific goals. The second was through documentation of MHA time allocation. The overview, methods and results for MHA goal monitoring and time allocation are described in more detail below.

2A. GOALS

Overview: MHAs worked with families to create specific goals that corresponded to the judges' scope of work and youth and family needs. Goals guided MHAs' work and helped monitor progress on cases. Due to the shifting needs of youth and families, goals often changed over the course of an appointment.

Methods: During the appointment, MHAs documented progress toward goals and goal completion status for all J-MHAP participants. Using de-identified data, the evaluation team coded goals based on whether they had been 1) completed, 2) in progress at time of analysis, or 3) not completed with no progress documented. Goals were also coded into 6 categories based on the focus of each goal.

Results: Of the cases which ended by July 15, 2016, 85% of goals had been completed by case closure. The percentage of goals completed increased with length of time in the program, with 75% of goals completed for cases open beyond nine months. Cases had an average of five goals (range 1 to 15) each. Goals varied in their scopes; some had very targeted and measurable outcomes, whereas others were broad (e.g. monitor youth's transition at school). As a result, some goals marked "in progress" had substantial work completed on them but were not coded as complete. Goals considered "in progress" on closed cases are goals for which progress was made but there was no final determination of "complete." Proportions of goals met according to case status are shown in **Table 11.**

Table 11. Goal Progress by Case Status as of July 15, 2016‡

Case status	Length of time in J-MHAP	Goals completed %	Goals in progress %	Goals not completed (no progress documented) %
Case Closed	**All closed cases (range: 2 to 10 months)**	85.0%	13.2%*	1.3%
Case Open	**Up to 3 months**	5.6%	38.9%	55.6%
	3 to 6 months	38.0%	33.7%	28.3%
	6 to 9 months	59.2%	23.7%	17.1%
	9 to 12 months	75.0%	15.0%	10.0%

‡ All youth in J-MHAP

*For closed cases, "goals in progress" reflects goals that had progress but were not marked complete at case closure.

The categories of goals and completion status by category are found in **Table 12.** The most common types of goals were those related to school placement or other school issues and accessing appropriate mental health services. Proportions of goals completed were consistent across categories with the exception of goals in the "access to other services" category. This category had the highest proportion of goals in progress, which suggests that goal completion may increase as cases progress. Please note that all goal categories include open cases with ongoing advocacy.

Table 12. Goal Progress by Type of Goal as of July 15, 2016‡				
Type of goal	**Type of goal (as % of all goals)**	**Goals completed %**	**Goals in progress %**	**Goals not completed (no progress documented) %**
School Placement/Issues	28.9%	74.6%	16.0%	9.5%
Access to Appropriate Mental Health/DCF	27.1%	67.7%	22.2%	10.3%
Case Coordination	16.6%	71.1%	17.5%	11.3%
Case Assessment and Planning	13.9%	84.1%	8.6%	7.4%
Access or Coordinate Evaluation for Youth	8.2%	65.0%	25.0%	10.4%
Access to Other Services*	2.9%	47.1%	41.2%	11.8%
Court/Juvenile Justice Issues	2.2%	69.2%	30.8%	0.0%

‡ All youth in J-MHAP

*Goals related to other types of services including but not limited to housing and health insurance.

2B. MHA Effort Within Various Systems

Overview: In order to achieve the goals represented above and, ultimately, the scope assigned by the judge, the MHAs divided their time connecting with multiple systems and agencies, appearing in court, and meeting with families. This time was documented by each MHA.

Methods: The MHAs recorded how they spent their time on each case in HLA's database. This documentation included the type of activity, length of time spent, the system with which they were interacting, and the specific role of others involved. These data were shared with the evaluation team after all identifiable personal data were removed. The total length of time spent on individual cases was calculated and MHA interactions were further categorized and analyzed for the proportion of effort allocated to specific constituents and systems based on number of events and amount of time.

Results: The total hourly investment of time was greatest among cases that were open for six or more months (38 hrs/case) and averaged approximately 33 hours per case for cases that closed prior to analysis. It is assumed that the recorded effort underestimates the full workload of the MHAs as additional responsibilities like travel, scheduled supervision, and internal meetings were not consistently documented.

A breakdown of MHA effort may be found in **Table 13**. MHAs had the most contact with families and the court system. Communication with families encompassed working directly with the youth themselves as well as parents, guardians and caregivers. When the MHAs worked with families, the vast majority of contacts were with parents (89%) while communication directly with youth was only 7%. Court-related activities included working with attorneys, probation officers, and court officials as well as accompanying the youth to court appearances. Of these interactions, two thirds were spent directly with attorneys. This includes the youth and parent attorneys as well as those representing various agencies or the school system. MHAs also worked frequently with school systems, the Department of Children and Families (DCF), and the agencies that provide services as part of the state's Children's Behavioral Health Initiative (CBHI).

The time allocated to interactions with systems was relatively proportional to the number of contact events, with the exception of court interactions, which consumed more time. Many communications were limited to brief 15-minute phone conversations or e-mails. This is exemplified by interactions with DCF and CBHI, with whom MHAs had many contacts that were brief in duration.

Table 13. MHA Recorded Effort by System		
System	% Contact Events	% Time
Family	23%	21%
Court	22%	31%
Children's Behavioral Health Init.	12%	9%
School/Education	12%	12%
Dept. of Children and Families	12%	10%
Not Specified	5%	5%
Outpatient Mental Health (non-CBHI)	5%	3%
Programs (Group Homes, Residential Treatment)	5%	5%
Inpatient Mental Health or Substance Use (Hospital, CBAT)	2%	2%
Other Gov Agency	1%	1%
Dept. of Mental Health	1%	1%
Outpatient Substance Abuse	<1%	<1%
Inpatient Substance Abuse	<1%	<1%
Dept. of Youth Services	<1%	<1%

Perhaps the most interesting finding of this analysis is that the MHAs spent over 30% of their time interacting with youth's and parents' attorneys, probation officers, court clinicians, diversion programs, and clerks, as well as appearing in court. This highlights the utilization of the MHA's legal background and training in their advocacy for youth.

SECTION 3. EVIDENCE OF PROGRAM IMPACTS

While the J-MHAP pilot is not yet complete, the evaluation data collected to date allows for interim analyses of program impacts. At this stage of the evaluation, we have focused on three specific areas of impact: youth court involvement, youth and family functioning, and the trajectories of individual youth. Overviews, methods, and results are presented below.

3A. EFFECTS ON COURT INVOLVEMENT/DIVERSION

Overview**:** One of the central goals of J-MHAP is to prevent youth from becoming more deeply involved with the juvenile court system. A look at the court experience for youth receiving MHA services provides some insight into the impact of the pilot.

Methods**:** MHAs documented youth court involvement at appointment and case closure. De-identified data were shared with the evaluation team and used for analysis of the impact of the MHAs on youth court involvement. It is important to note that MHAs were able to document only information of which they were aware. It is likely that the MHAs' documentation does not account for all court involvement. To date, data maintained by the juvenile courts has been made unavailable for review to inform this analysis. Obtainment of comprehensive court data is necessary to understand the complete impact of MHAs on youth court involvement.

Results: MHAs avoided arraignment on delinquency charges for five youth by advocating for participation in a diversion program or by assisting youth at a clerk magistrate's hearing. Among youth for whom MHAs avoided arraignment, all had the MHAs appointed on a CRA case rather than a delinquency case. Among the 21 youth with open delinquency cases, MHAs successfully advocated to avoid or shorten pre-trial detention for seven youth, for reduction in sentence for three youth, and for treatment instead of detention for one youth. MHAs were able to prevent Care and Protection cases by securing needed services for nine youth.

3B. YOUTH AND FAMILY FUNCTIONING: SIX-MONTH FOLLOW-UP

Overview: The risk-profiles of youth and their families, presented earlier as baseline characteristics, are dynamic and may change over time. By looking at these profiles again, more than six months after the MHA was appointed, it is possible to see if the MHAs could have helped stabilize youth and/or families at high-risk.

Methods: In order to understand whether there was any change in the overall risk profile of J-MHAP families during participation in the program, six-month follow-up interviews were conducted with a subset of youth (n=10) and their parents/guardians (n=16). Scores on the measures of risk for youth and parents at six-month follow-up were compared to scores at baseline to determine if there were any changes in risk over time.

Results: These follow-up findings represent preliminary results, based on limited follow-up to date. Given the relatively small number of participants who completed follow-up interviews as of July 15, 2016, change in risk profile measures from baseline was minimal as would be expected. However, three primary areas showed change in this preliminary analysis: youth total difficulties and the impact of youth difficulties on the youth and family, youth quality of life, and family conflict. These measures all showed improvement from baseline to six-month follow-up. For full details in the change in scores see **Appendix C**.

Changes from baseline are reported as effect sizes. 'Effect size' is the standardized mean difference between the two groups and simply a way of quantifying the size of the difference between two groups – in this evaluation the difference between youth/family risk scores at baseline and follow-up. In behavioral studies, effect sizes between 0.3 and 0.5 are considered moderate and suggestive of a clinically relevant effect. Effect sizes of greater than 0.3 were found on measures of family conflict, parent physical health, parent-reported youth total difficulties, the impact of youth difficulties (both youth- and parent-reported), and youth quality of life. **Table 14** summarizes the measures and highlights those which, based on preliminary data, show potential evidence of a clinically relevant effect. The report which will be submitted in February will include more detailed findings of change over time as more youth complete the follow-up period.

Table 14. Change in Family Risk Preliminary Results from 6 mo Follow Up‡

Family	Effect Size (Cohens' d)
Parent perceived conflict	**.34**
Youth perceived conflict	**.44**
Parent	
Parent Stress	.26
Parental Depression	.04
Overall Mental Health	.01
Overall Physical Health	**.36**
Youth	
Total Difficulties*	**.32**
Impact of Difficulties*	**.98**
Total Difficulties**	.21
Impact of Difficulties **	**.72**
Youth Quality of Life Scale (Y-QOL)	**.31**

‡ Evaluation subset
*reported by parent
**reported by youth

3C. CASE SUCCESSES AND SETBACKS

Overview: Beginning in June 2015, MHAs began recording information about specific case setbacks and successes. These data provide insight into pivotal moments in a youth's course that, when combined with other information, create illustrative youth profiles.

Methods: At the time of this analysis, case success and setbacks were recorded for 84 youth. The overall pattern demonstrates the complexity of the cases referred for advocacy. Overall, there were 161 case successes and 104 case setbacks recorded, which is an average of 1.9 successes and 1.2 setbacks per case. Most youth experienced setbacks in their cases, even when very positive progress was occurring. Below are four detailed case examples, one from Essex Juvenile Court and three from Middlesex Juvenile Court. Documentation of case successes and setbacks was combined with information from MHA contact and goal logs to illustrate the work of the MHAs. Baseline and six-month participant interviews and school and medical records provided additional information.

Case 1: 13-year-old from the Lowell Court with a CRA

Summary

Demographics: Youth is a 13-year-old White male.
Case type: Child Requiring Assistance (CRA)
MHA Appointment: 9/18/15 - 3/16/16

Scope: The judge set three case scopes: community based services; secure appropriate or improved Department of Children and Family (DCF) services, and secure Department of Mental Health (DMH) services. The judge commented that the youth particularly needed assistance finding appropriate placement and services.

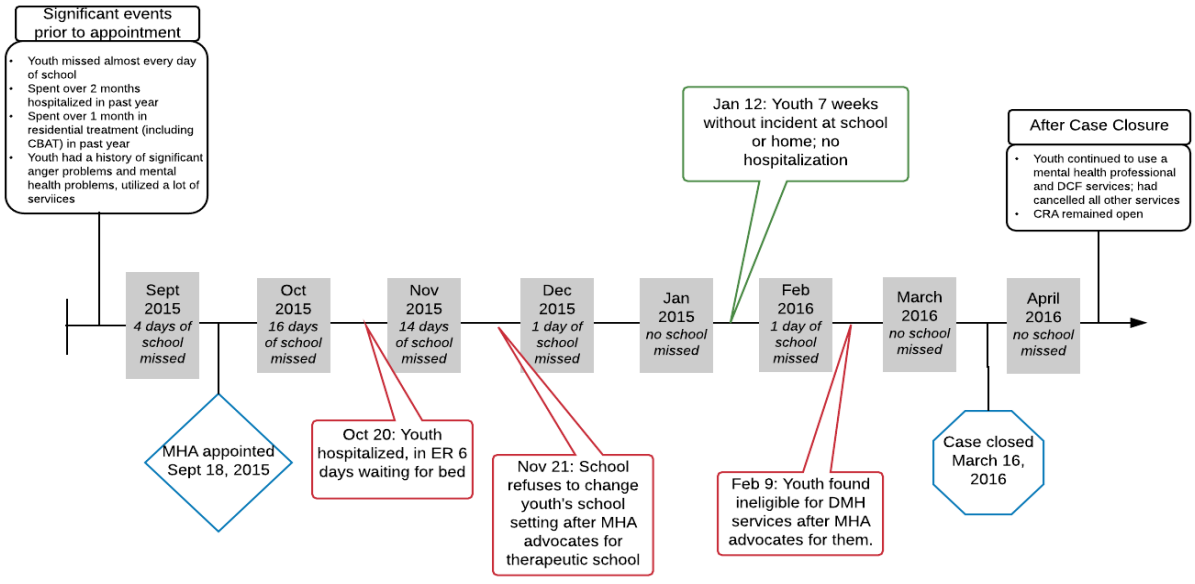
MHA Goals

The MHA set the following eight goals for the case:

1. Assess need for DCF placement
2. Ensure that child receives appropriate services from DCF
3. Collaborate with DMH regarding eligibility
4. Assess outpatient services
5. Follow up on records from partial hospitalization program
6. Attend team meeting and secure improved educational services
7. Assess school placement
8. Support family through Bureau of Special Education Appeals process

Outcomes: The case was open for six months. By case closure, six of the eight goals had been completed. The two goals that remained incomplete were "8. Support family through the Bureau of Special Education Appeals process," and "2. Ensure that child receives appropriate services from DCF." The CRA remained open at the end of the MHA appointment.

Timeline



Detailed Case Timeline

History: Prior to the MHA appointment, the youth had substantial difficulties in school and at home. For example, past behavior and symptoms included anger, aggressive and impulsive behavior, assault, and destruction of property, resulting in repeated hospitalizations over the previous two years. He was in a therapeutic class at school, though he missed almost every day. The youth had formal diagnoses of Autism Spectrum Disorder,

Oppositional Defiance Disorder, Attention Deficit Hyperactivity Disorder, a learning disability, anxiety, and Bipolar Disorder. He utilized numerous services provided through CBHI and DCF. These services included a therapeutic mentor, outpatient mental health clinical services and Intensive Case Coordination, among others. Despite the numerous services, he continued to demonstrate behavioral difficulties. In the previous two years, he used in-home crisis services on two occasions. He had one emergency room visit for behavioral and mental health issues, and two stays in a psychiatric hospital for 34 days in total. He stayed in three residential treatment centers for a total of 44 days. His behavior problems led his mother to file a CRA.

Case details: The MHA's goals were broad, spanning multiple service systems, including DMH, DCF, the school system, and the mental healthcare system. According to the youth's mother, the MHA primarily worked on securing his school placement. Over the six-month appointment, the MHA devoted over 50 hours to the case. She spent the most time (35.8%) working within the legal system in communication with attorneys and the youth's probation officer, as well as in court. Communicating with family members (24.9%) and mental health services (19.9%) consumed a substantial amount of time as well. Despite a focus on school services, only 6.5% of the MHA's effort was spent interacting directly with the school system and less was devoted to DMH and DCF.

At the start of the MHA appointment, the youth spent three days in the emergency room due to behavioral issues, used in-home crisis services within five days of discharge, then stayed at a Community Based Acute Treatment Center (CBAT) for nine days. Within one month after MHA appointment, the youth spent six days overnight in the ER while he waited for a psychiatric bed. Through October and November, the MHA worked on getting the youth into a different school setting. She attended meetings with school officials about the youth's placement. According to the youth's mother, the MHA tried to facilitate his placement in a therapeutic school. In November, there was a major case setback when the MHA learned that the school district refused to change the youth's school setting despite a letter from the youth's partial hospital program (PHP) strongly recommending the youth enter a therapeutic school.

The case shifted in January, as the MHA began advocating for DCF and DMH services. She contacted DCF five times and made her only contact with DMH during this period. She had far fewer points of contact with the family and less time was spent interacting within the legal system. In February, DMH determined that the youth was not eligible for services. In early 2016, a staffing transition resulted in the family beginning work with a new MHA.

During the case, the youth missed substantially less school than he had previously and, by January, had gone six weeks without hospitalization.

After case closure: The case was vacated on March 16, though the CRA was still open. After case closure, the youth continued to receive therapy from a mental health professional and DCF services. All other services had been discontinued. The youth's mother noted that they had stopped "fighting" for the school placement they had hoped for and no longer sought academic testing. While the mother reported very positive interaction and support for the initial MHA, she mentioned that transitioning from one MHA to another was very difficult.

Key Learnings

This case illustrates the critical role of the MHA in the lives of the youth and families participating in the program. Even though specific goals may not be met, the MHA's support may help the family change the trajectory of the youth's behavior at school and at home. For example, in this case the MHA provided the youth's family much needed support. Specifically, the youth's mother found that the MHA effectively navigated "the system," used her expertise to talk to the appropriate people, and participated in meetings for the youth. She also noted that the MHA consistently communicated with the family about the youth's case. According to the youth's mother, these supportive efforts were particularly helpful. Moreover, this case highlights that it is important for the MHA to assess where the levers are to achieve the case goals and that MHAs work within many different systems to push for changes for youth depending on their assessment and strategy. For example, in this case, the MHA primarily pursued case goals within the court system, rather than the school system, even though the goal was to obtain an alternative school placement.

Case 2: 17-year-old from the Lowell Court with CRA and Delinquency Cases

Summary

> **Demographics**: Youth is a 17-year-old Hispanic male.
> **Case type**: The MHA was appointed on a CRA, though the youth also had a delinquency case open at the time of appointment.
> **MHA Appointment**: 4/14/15 – 12/08/15

Scope: The scope of the case set by the judge was: coordinate mental health services and obtain special education services. The judge commented that the youth might need a referral to determine which agency should take the lead on getting appropriate services and that he, "may require a group care placement with an [educational] component."

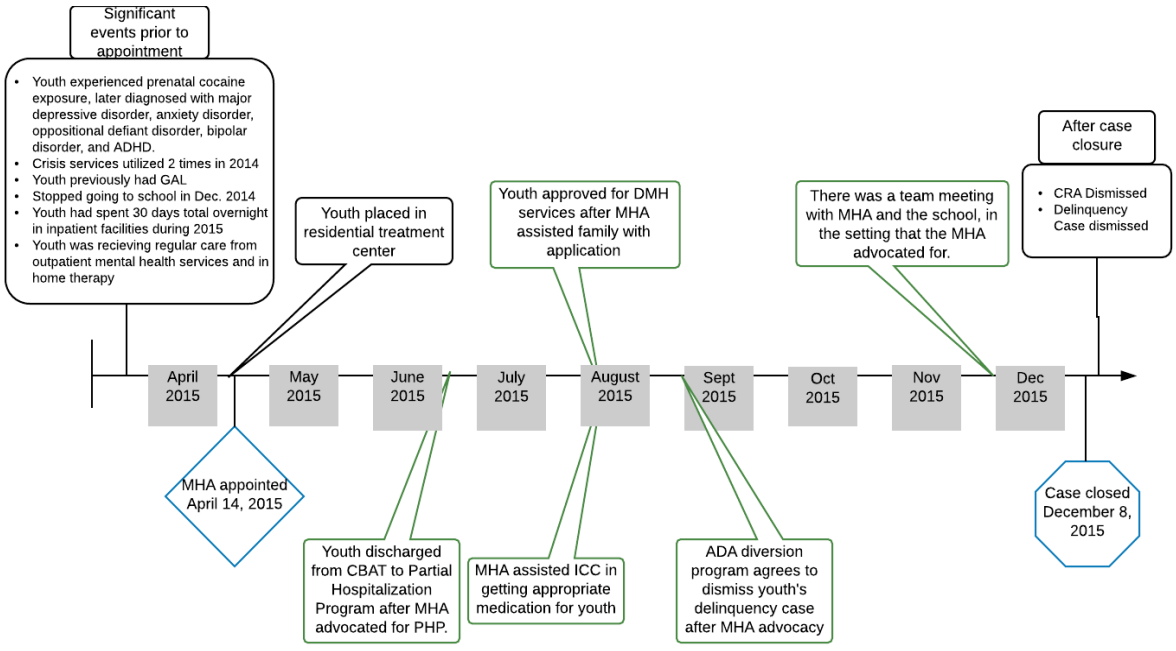
MHA Goals

The MHA set the following case goals:

1. Extend the youth's stay at a residential treatment facility
2. Assist in securing an appropriate discharge plan from the CBAT
3. Coordinate with a residential treatment facility about the youth's discharge
4. Complete and submit DMH application for the youth
5. Advocate for DMH services
6. Assess outpatient services
7. Advocate for the youth to have his delinquency case dismissed
8. Schedule IEP meeting and advocate for appropriate services

Outcomes: The case was extended eight weeks past the original six-month appointment because the youth was hospitalized for a substantial portion of the first few months of the case. By the end of the case, all of the goals had been completed. The youth's parent had dismissed his CRA and his delinquency case had also been dismissed. The court-related outcomes were largely due to the MHA's advocacy.

Timeline



Detailed Case Timeline

History: Prior to the MHA appointment, the youth had significant difficulties related to his mental health. His medical history consisted of prenatal cocaine exposure and diagnoses of Major Depressive Disorder, Anxiety Disorder, Bipolar Disorder, Oppositional Defiant Disorder, and Attention Deficit Hyperactivity Disorder. The youth transferred to an alternative school in the fall of 2014 due to excessive absences and aggressive behavior, but stopped attending by December 2014. He was not attending school at the time of the appointment. Earlier in 2014, the youth had been to the emergency room one time for emotional/behavioral problems and had utilized crisis services on two occasions. In 2015 just before the MHA appointment, the youth was hospitalized for behavioral issues two times, including a stay on a medical unit, for a total of 30 days.

Case details: On April 15, the day after the MHA appointment, the youth entered an Intensive Community Based Acute Treatment (ICBAT) facility following a referral from the court clinic. At the end of April, he was set to be discharged, but the MHA was concerned that he was not ready to return home due to ongoing symptoms, and successfully advocated for his stay to be extended. In early May, the youth was placed in inpatient level of care due to worsening symptoms. The MHA advocated that he enter a PHP upon discharge. Her advocacy successfully influenced a clinician who initially disagreed with the need for a PHP. In June, the youth was discharged to a PHP.

The MHA then focused her efforts on advocating to have the youth's delinquency case dismissed. She worked with the Middlesex County Juvenile Diversion Program to have the program's terms waived, as she believed the youth was unable to complete them. She obtained a letter from the youth's therapist confirming this and the terms were waived. As diversion programs typically have specific requirements for youth to participate, in this case the MHA was able to advocate for an individualized approach for this youth. The Diversion Program agreed to dismiss the delinquency case in August.

During this period, the MHA also helped the youth's family advocate for DMH services, for which he was approved. She also assisted the youth's CBHI intensive care coordinator to secure a prescriber so the youth could obtain medication. The youth's mother noted that getting medications was a key success for her son.

The youth started attending school again in the fall of 2015 at the initial placement (regular public school). Toward the end of the case, the MHA was involved in getting appropriate educational services for the youth, and attended an IEP meeting. The youth was reported to be making progress in school in the fall of 2015. Of the almost 80 hours spent on this case, the MHA spent the most time (28.8%) in contact with the youth's CBHI providers. Substantial time was also devoted to working with non-CBHI therapist and inpatient providers (22.7%).

After case closure: The case was vacated on December 8, 2015. At case closure, the youth's parent had dismissed the CRA. The delinquency case had also been dismissed. Youth continued to be enrolled in school with an IEP through March 2016, despite continued difficulty with attendance.

Key Learnings

This case demonstrates the MHA's potential role in as a cross-system advocate for multisystem involved youth. It also highlights the MHA's role in diverting youth from further involvement in the justice system. In this case, the MHA used her expertise to advocate for greater involvement in mental health services and connected the youth and his family to a new system. In doing so, she prevented the youth from moving deeper into involvement in the court. She filled a gap in the system by connecting the mental healthcare and legal systems.

Case 3: 15-year-old from the Salem Court with a Delinquency/CRA case

Summary

Demographics: Youth is a 15-year old biracial (White and African American) male.
Case type: Delinquency, amended to CRA
MHA Appointment: 2/17/15 – 1/11/16, case amended on 3/24/15

Scope: The judge set three scopes for the case: obtain community based services, special education services, and possibly a medical evaluation for medications. The judge specifically noted, "Child needs improved community based support services and possibly medical evaluation for medication. Child needs a review of IEP and improved educational services."

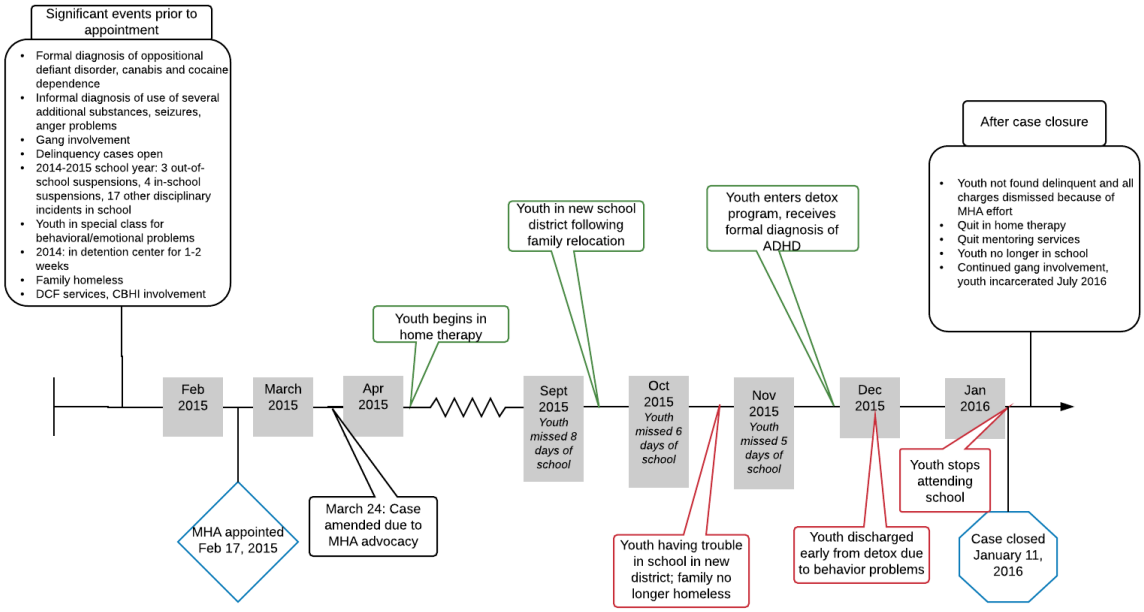
MHA Goals

The MHA set six goals for the case:

1. Obtain updated social emotional assessments of youth
2. Ensure continuity of mental health supports
3. Reach out to Public Schools regarding his transition
4. Reach out to DCF worker and advocate for mentor services
5. Attend IEP eligibility meeting and advocate for services
6. Advocate for child to go into substance abuse treatment rather than DYS

Outcomes: The original six-month appointment was extended 18 weeks because the family moved and required additional assistance getting services in their new location. The MHA successfully advocated to avoid pre-trial detention. Because of her involvement, the judge delayed sentencing to keep the MHA involved. When the youth did well with the MHA involved, the judge dismissed the delinquency cases, which the MHA advocated for.

Timeline



Detailed Case Timeline

History: When the MHA was appointed, the youth had open delinquency cases. His family was homeless and living in a shelter. Medically, he had formal diagnoses of Oppositional Defiant Disorder, and cannabis and cocaine dependence. He had informal diagnoses of seizures and had used several additional substances. He also had a history of trauma, gang involvement, and difficulty with anger. The youth was attending a public high school, where he had accrued several in-school and out-of-school suspensions, along with other disciplinary actions. He had services from DCF and CBHI.

Case details: Following the initial appointment, the MHA advocated for the judge to delay sentencing and she successfully advocated to avoid detention. The case was amended to a CRA one month after appointment. After the MHA appointment, the youth's parent decided to stop the youth's services due to feeling that they were ineffective.

During the first four months of the appointment (February-June), the MHA worked with the CBHI Community Service Agency (CSA) to ensure that the youth's case remained open. The goal was for him to continue receiving mental health support through the CSA, which the MHA successfully accomplished. During this period, she also spent time ensuring that the youth received the appropriate social/emotional assessments.

In June, the family secured housing and moved to a new town. Accordingly, the MHA worked with the new public school system to ensure the youth had resources in place for his transition. Specifically, she focused on obtaining evaluations for special education services at his new school.

After the initial six-month appointment, the case was extended for 18 weeks so the MHA could help the family get appropriate services in the new town. After transitioning to the new school, the youth was still having trouble in school and missed one to two days per week. In November, the MHA helped the youth enter a detox program, where he was given a formal diagnosis of Attention Deficit Hyperactivity Disorder; however, he was discharged after seven days for behavioral problems. The MHA worked on setting up outpatient substance abuse treatment for youth. The youth was reported to be staying out of trouble and more stable, so cases were dismissed.

While the MHA attempted to obtain educational testing for the youth to receive special education services in school, he missed the testing appointments and was unable to complete testing because of school absences. By January, the youth had dropped out of school.

Notably, the MHA spent the most time (24.0%) interacting with the school. This was followed by her time spent in court (20.8%), communicating with the family (18.0%) and interacting with providers (12.6%).

After case closure: The case closed in January 2016. After case closure, the youth was reported as being involved in a gang and was incarcerated again in the spring of 2016.

Key Learnings:
This case demonstrates the positive role that MHAs can play preventing deeper involvement in the juvenile justice system as well as the complexity of interfacing with families and multiple service systems. The MHA was successful in helping the youth access mental health treatment as an alternative to going deeper into the juvenile justice system. The MHA's advocacy prevented at least one of the youth's court cases from ending in a finding of delinquency.

The case also highlights the complexity of working with families who may have contentious relationships with legal, school, and social services systems. Overall, families welcomed the involvement of MHAs. However, as this case demonstrates, some families have had negative experiences with existing service systems, or may view the MHA as either ineffectual or allied with systems which they perceive as unsupportive or unjust. The MHA role requires skills to develop an alliance with families, sometimes under very difficult conditions. Despite the efforts of the MHA, the parent of this youth did not feel that mental health services in place were helpful and did not think

that such services, including the MHA, were the right approach for the youth. The parent believed that it would have been easier for him to handle his son's court-related issues on his own. He felt as though the family's lawyer and social worker were "calling the shots" and that the MHA did not have "power" over them.

Finally, the case reveals the limits of current systems to address the needs of youth with complex needs, specifically dual concerns of substance use and behavioral problems. The MHA successfully advocated to place the youth in a setting where he could receive detox services but the setting was not equipped to manage his behavioral needs.

Case 4: 17-year-old from the Lowell Court with a CRA Case

Summary

Demographics: Youth is a 17-year-old White female.
Case type: Child Requiring Assistance (CRA)
MHA court appointment: 4/17/2015 - 9/24/15

Scope: The one scope defined by the judge was to become eligible for Department of Mental Health (DMH) services, describing the DMH referral as, "absolutely vital."

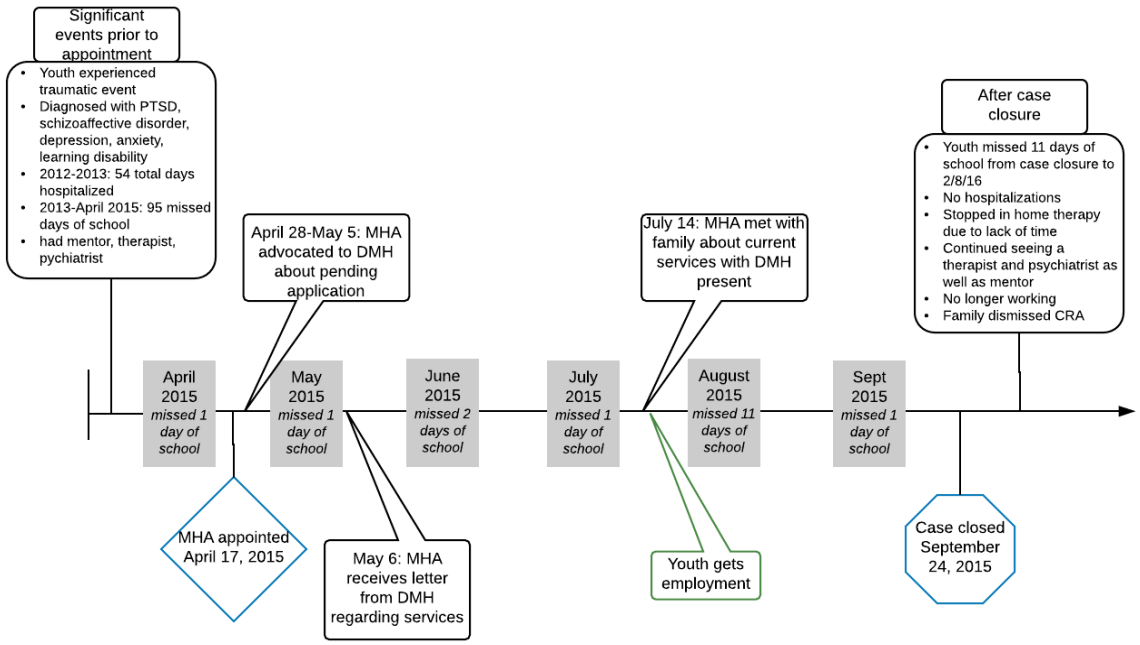
MHA Goals

The MHA outlined three specific case goals:

1. Advocate to DMH regarding the youth's application
2. Advocate to DMH regarding appropriate services
3. Communicate with the family regarding existing services

Outcomes: By case closure, the MHA had completed two of the three goals. She was able to advocate to DMH regarding the youth's application and advocate to DMH regarding appropriate services. The MHA helped the youth and the youth's family dismiss the CRA in favor of DMH services.

Timeline



Detailed Case Timeline

History: Prior to the MHA appointment, the youth was attending a therapeutic school due to mental health as well as behavioral and learning needs. From the time the youth enrolled in this school in March 2013 to the MHA appointment in April 2015, she missed 95 days of school. In 2013-2014, she repeated a grade due to mental health difficulties. The youth had been diagnosed with Post-traumatic Stress Disorder, a psychotic disorder, and an anxiety disorder, as well as impaired social and occupational functioning. She had used several services, including in home crisis services, and regularly saw a therapist, psychiatrist, and mentor. Between May 2012 and September 2013, the youth was hospitalized for approximately 50 days due to psychotic episodes. A traumatic event that the youth experienced contributed significantly to her mental health difficulties.

Case Details: The MHA was appointed in April, 2015. Over half (51.2%) of the time she devoted to the case was spent interacting within the legal system, including with attorneys, the youth's probation officer, and in court. One quarter of the time was spent in communication with the family. Substantially less time was spent communicating with CBHI (11.9%) and DMH (7.1%).

Despite the fact that the MHA spent the least amount of time communicating with DMH, she made progress on the goal to advocate to DMH regarding services for the youth in the first month of the case. In total, she contacted DMH five times. DMH responded to the MHA's effort by providing a letter about available services. In June, July, and August, the MHA interacted with CBHI providers almost exclusively, specifically an Intensive Care Coordinator and in-home therapy clinicians. In court in July, the MHA met with the family about their existing services, with DMH present.

In July, the youth successfully obtained a job. During most months of the MHA appointment (April – July), she missed only one or two days of school.

After Case Closure: The case was closed in September 2015. With the help of the MHA, the youth's family decided to dismiss the CRA and instead, began getting services from DMH. Following case closure, the youth had not been hospitalized and had continued seeing a therapist, a psychiatrist, and a mentor. The youth stopped in home therapy due to lack of time and was no longer working at their job. She missed about 10 days of school from September 2015 to February 2016.

Key Learnings

This case highlights the potential of the MHA to intervene early and access needed services to prevent further court involvement. As this example shows, the youth was falling through the cracks despite being placed in a supportive school environment. The example highlights the role of the MHA in filling gaps in existing service systems for youth with mental health needs. Over the course of the case, the youth was able to get services from DMH through the help of the MHA. This was influential in the family's decision to dismiss the CRA. The MHA's ability to advocate to DMH to secure services for the youth illustrates the ability of the MHA to navigate across multiple systems.

SECTION 4. STAKEHOLDER PERSPECTIVES ON IMPLEMENTATION AND SUSTAINABILITY OF J-MHAP

Overview: To further understand J-MHAP's implementation to date, the evaluation team conducted qualitative interviews with both primary and secondary stakeholders, as well as key informants. Primary stakeholders are those who benefit from or use the program, like parents and youth. Secondary stakeholders are those who implement, fund, monitor or partner with the program.[9] These secondary stakeholders can be internal like those working for HLA or external like providers within the juvenile court and youth mental health systems. Key informants are those with relevant insight but little stake or involvement in J-MHAP, for example experts in the field.

Methods: The evaluation team conducted qualitative interviews with youth and families three months after the date of MHA appointment and at the six-month follow-up interview to learn about their experiences with the program. Interviews were also conducted with leaders at HLA and with the Mental Health Advocates.

Secondary stakeholders and key informants were identified using a systematic process of identification and prioritization based in the science of improvement. The evaluation team, J-MHAP leaders, and members of the evaluation advisory board developed a comprehensive list of individuals using a set of identification questions focused around expectations, goals and responsibilities (found in **Appendix D**). Individuals were then categorized as either stakeholders or key informants based on the definition above and ranked by J-MHAP leaders based on the individual's (1) power and (2) interest. Priority scores were generated using a sum of these scores. Potential stakeholders and key informants were ranked, and those with the highest rank were contacted to participate in qualitative interviews. Additional key informants were selected based on specific areas of expertise. This systematic approach allowed us to identify a broad - yet high value - sample of stakeholders who represented different systems and levels of investment in J-MHAP. This multi-step process for identification and prioritization of stakeholders is rigorous and allowed the evaluation team to efficiently collect information from those most relevant to future leadership decision making regarding program improvement or scale up.

Members of the evaluation team conducted semi-structured in-person or telephone interviews which lasted between 20 minutes and 1 hour. The interview guide was developed using the Consolidated Framework for Implementation Research (CFIR), a widely used framework for assessing the various elements involved in program implementation. The comprehensive guide **(Appendix E)** was adapted for the specific stakeholder to illicit the most relevant information. For example, some may be more versed in the day to day needs of court-involved-youth and would be asked targeted questions regarding "client needs and resources," while others have an expertise in the policy arena and would be asked about "policy considerations" and "relative priority" to other current initiatives. Interviews were transcribed and coded for key themes. The CFIR was used to anchor these themes within an analysis based in implementation science.[10] Analyses of these data will continue as more stakeholder data are collected. The results presented here are preliminary.

Results: As of August 15, 2016, 33 interviews had been completed with J-MHAP families, and 20 interviews had been completed with stakeholders and key informants. **Table 15** provides a breakdown of interviews to date by agency or role of the interviewee.

Table 15. Completed Stakeholder Interviews as of Aug 15, 2016

Agency or Role	Number of stakeholders interviewed
Primary Stakeholders	
J-MHAP Families	33
Secondary Stakeholders- Internal	
Health Law Advocates	4
Secondary Stakeholders- External	
Court-appointed Attorneys	4
Court Clinics	2
Department of Youth Services	1
Department of Mental Health	1
District Attorney's Office	1
Juvenile Court Judges	2
Probation Officers	2
Key Informants	
Boston Children's Hospital	2
Massachusetts Advocates for Children	1

The findings from the key informant and stakeholder interviews are organized into two main domains and 6 questions outlined below:

Implementation

1. What are the main gaps within the juvenile court and children's mental health systems?
2. What is the experience like of those served by J-MHAP? Are MHAs seen as helpful by youth and families?
3. What are necessary skills and competencies a MHA must have? How are MHAs different from other providers?
4. How does the process for appointing MHAs work? Is this process effective for targeting youth with the highest level of needs?

Sustainability and Scale Up

5. To what extent is J-MHAP serving to meet key unmet needs?
6. How does program design affect sustainability and scalability? What changes would support these aims? Are there opportunities that HLA can leverage in identifying where J-MHAP can be situated?
7. What role can J-MHAP play to address potential inequities in youth experience within the juvenile justice and mental health service systems?

These themes reflect a preliminary analysis of perspectives shared by stakeholders. Additional interviews and further analysis of transcripts will continue during the next phase of the evaluation.

4A. IMPLEMENTATION

1. What are the main gaps within the juvenile court and children's mental health systems?

Stakeholders shared their perspectives of the major unmet needs within the juvenile court and mental health systems and the degree to which J-MHAP is seen as meeting these needs. Needs identified fell into two main categories: 1) systemic gaps and 2) individual youth/family needs.

Systemic gaps

Those interviewed confirmed known gaps in the court, mental health, child welfare, and school systems. One stakeholder noted that compared to 10 years ago, youth are being served "far better" on a broad level, but that significant gaps remain. A MHA discussed the unique needs facing 16-22-year-old youth, especially those who are no longer in school and easily fall through gaps in service structures and lack oversight.

Court system gaps included a lack of sufficient support or resources to meet the needs of youth and families. As one court system professional explained "we can't get help…we need all the help we can get." Mental health system gaps included the lack of inpatient beds, lack of quality out-of-home placements, poor quality of certain residential placements, youth being kept in "holding patterns" in programs as well as the "revolving door" in which youth are pushed out prematurely. A stakeholder within the court system discussed the difficulty of accessing residential placements for youth in need. Other gaps included waiting lists for community services and a lack of services for youth with dual diagnoses.

Stakeholders also discussed challenges related to state agencies, including concerns about DCF inadequately meeting youth's needs, agencies denying responsibility for youth and "throwing" youth "back and forth" between agencies, and fractured care, with many parties involved with limited scopes. These gaps were also apparent in parents' discussions of barriers faced in accessing services. Care coordination was seen as a challenge even in cases with a CBHI care coordinator.

School system gaps identified included difficulty working with schools, substantial differences between school districts' resources and willingness to accommodate student needs, a need for quality vocational programming for

youth receiving special education services, and the criminalization of youth of color for behavioral or mental health related issues.

Individual needs

Stakeholders explained that families in court are by definition "in crisis." Youth face challenges in terms of mental health needs, risky behavior, gang involvement, aggression, self-harm, substance use, trauma histories, poverty, family turbulence, and unmanaged physical health issues. In addition to managing youth's difficulties, parents and guardians may have their own mental or physical health issues. Some stakeholders discussed resistance on behalf of families or youth to accepting mental health or special education labels and "fractured relationships" between families and schools. In addition to the challenges that bring families to court, stakeholders discussed the difficulty for families of navigating the court, educational, and social service structures, something one stakeholder said is "hard enough for an experienced person to deal with" and another said can be "overwhelming" and "extremely stress-producing."

2. What is the experience like of those served by J-MHAP? Are MHAs seen as helpful by youth and families?

Interviews with parents/guardians and youth (i.e. participants) provided insight into the experiences of those served by J-MHAP. Overall, a majority of families reported positive experiences with J-MHAP. A common theme discussed by participants was hoping that the program expands so that more families have access to it, or alternatively, that more families should be aware that this program exists. When asked if having a MHA could help other families, one participant responded by saying "Absolutely. I think that if we didn't have the advocate, the legal advocate that we had, it may not have turned out as well as it did."

When asked about what was helpful or going well in their work with the MHA, participants discussed themes including the MHA's advocacy within court, school, and mental health services; specific accomplishments; and more general family support. Advocacy work performed by the MHA was discussed as impactful regardless of outcome. For example, one parent noted:

> [MHA] was at basically every hospital meeting every time [youth] was hospitalized, so she was like my voice of basically that I don't want him home because it's not safe. Most are ready just to send him home, send him home because you can only [be] at place for like a month and then the insurance cuts you off. So, that was a struggle that she helped me with.

Specific accomplishments included securing school services, desired out-of-home placements, outpatient services, rehab programs, DMH services, and evaluations or appointments. Accomplishments also included keeping youth out of DYS commitment and helping with the guardianship process. General accomplishments were also described, as one parent remarked:

> She gets things done. It's that simple. I could constantly be asking people, 'Can you do this? Can you look into that? Is this an option,' and it's, 'No, no, no,' or, 'We'll get to it.'...I can call her, and then she'll call, and then like magic, stuff happens, and I get information...it actually worked. I mean, that by itself kinda surprised me because I'm so used to, 'Oh, we're gonna do this, and it's gonna be wonderful and magical, and we're gonna turn her around.' It was basically setting me up to getting disappointed every single time, but when I would bring up a concern to her, I wasn't stressed about it after that because I knew it was gonna get taken care of, so I just liked that it worked at all.

Support provided by MHAs included being present in meetings and hearings; helping navigate the court system; explaining terms and services; helping parents understand their rights; frequent and reliable communication with families; general guidance; sharing options, resources or information; and overall family support. MHAs were also seen as helpful for bringing a mental health perspective to the table and keeping parents "in the loop" or connected to the youth's care team. Support was also described as helping reduce stress for parents or youth. In

discussing working with the MHA, one participant stated: “she’s been very supportive to help me so that I don’t have to do what they’re telling me to do…she tells [me] you have a right, tells [me] there are other things we can do.” Another parent put it very simply by saying “they know how to fight for what it is that the family wants for their child.” The level of dedication of the MHAs was evident in many comments. For example, when discussing the MHA, one parent remarked: “she cares really deeply about what she thinks is right and will go after it.” MHAs were discussed as different from other providers due to their ability to help navigate the court system, ability to achieve certain goals and “get things done,” and knowledge related to mental health.

When asked about challenges related to work with the MHA, a minority of parents and youth discussed challenges including limited communication with the MHA, perceived low level of MHA involvement, and disruption related to a MHA staffing transition. Additional challenges included the MHA being appointed late in the process of seeking help for the youth, and a lack of clarity around the function and scope of the MHA role or not knowing why the MHA was appointed.

Participants also discussed the process of completing work with the MHA. Themes discussed included wanting the MHA to continue working with the family until the youth’s case was closed in the court and wishing the family still had the MHA to help navigate new or ongoing difficulties.

3. What are necessary skills and competencies a MHA must have? How are MHAs different from other providers?

Key elements of the MHAs’ role evident in stakeholders’ discussions included assessing youth and family needs, coordinating care across agencies, advocating for youth and family needs, writing comprehensive reports for the court and providing recommendations, supporting families to navigate court and other systems, and other responsibilities specific to cases.

Stakeholders working directly with MHAs shared consistently positive feedback about their work. Specific skills and competencies were discussed as important to the effectiveness of MHAs, including interpersonal and concrete advocacy skills. Skills in diplomacy, including the ability to foster relationships with agencies and simultaneously advocate aggressively for youth were seen as important to the MHA role. Stakeholders discussed the importance of MHAs’ ability to work with parents who may have their own mental health issues or who don’t understand the role of the MHA. The specialization and expertise of the MHAs in the court, mental health services, and school systems were seen as allowing them to diagnose issues and more effectively meet youth’s needs. Stakeholders also highlighted the importance of experience related to educational advocacy. For example, one stakeholder remarked:

> You don’t know how many times I think the [MHAs] have changed the path of the kid’s education which greatly impacts what his future’s going to be. You can get that kid the right educational setting and then that kid can do better at school. He can graduate high school and be able to move on. It has a tremendous impact… It’s life-changing when you have someone that can advocate for the right services in an educational setting.

MHAs’ level of specialization was also seen as supported by their more limited caseloads compared to some other types of providers. The MHAs’ role in advocating for the best interest of the youth (rather than expressed interest) was seen as an important and unique aspect of their role. MHAs were seen as an objective or neutral party who can look out for the youth’s best interest without an agenda like those of other parties or agencies. MHAs and other internal stakeholders also discussed the skills they draw on most in their work and the way in which their work differs from other providers. MHAs discussed the need to respond quickly and prioritize amidst crises and to listen and “meet families where they are at, literally and figuratively.” MHAs mirrored external stakeholders’ comments regarding the importance of relationship building with many parties and agencies as well as families

and youth. One internal stakeholder discussed the role of the MHAs in reframing the conversation around youth with severe trauma manifest as behavioral issues, work that "changes the paradigm for how people look at these kids." Internal stakeholders discussed the importance of supervision and ongoing training.

Many J-MHAP families work with a host of agencies. In participant interviews, themes discussed included the large amount of providers families were working with and confusion regarding the specific role of the MHA or what the MHA was working on for the youth. Distinguishing the role of the MHA in initial contact with families so that their function is visible and easily differentiated by youth and providing regular updates to families about MHA progress toward goals may alleviate this confusion.

Some stakeholders shared recommendations for MHAs in their work. Recommendations included that MHAs need more time to build strong relationships and build trust with families, continue to strengthen communication with other agencies, learn about ongoing statewide initiatives and programs related to their work, and increase program dissemination throughout the court system.

4. How does the process for appointing MHAs work? Is this process effective for targeting youth with the highest level of needs?

A MHA can be recommended on a case by probation, family, or a youth's attorney, and the final decision to appoint a MHA is made by a judge. The decision to appoint a MHA relies on judicial judgment and "triage" to prioritize the highest need cases. This process was generally seen as adequate, but stakeholders shared some challenges and recommendations for further formalization of the process.

Some concerns were raised about the potential for implicit bias to affect referrals to the program and, in turn, affect which youth are appointed a MHA. A stakeholder working within the court system described the difficulty of determining which youth's needs were more critical. The lack of a formal waitlist for MHA involvement was identified as partly responsible for a lack of clarity and difficulty triaging cases.

Recommendations included a system for identifying MHAs' current caseloads and implementation of an initial assessment in every case to determine whether a MHA is needed. Some stakeholders shared a desire that more MHAs be available due to the observed need for MHA advocacy. For example, one stakeholder said that in an ideal world, MHAs could be appointed on a majority of cases that come to the court.

4B. SUSTAINABILITY AND SCALE UP

5. To what extent is J-MHAP serving to meet key unmet needs?

Overall, the need for J-MHAP was seen primarily as a function of their specialized role, which in addition to advocacy was described as that of a mediator or arbitrator. For example, based on the needs and gaps identified by stakeholders, a common theme discussed was the need for a more comprehensive approach to coordinate court, mental health, and school needs, including advocacy, strong communication, and service coordination. Some stakeholders saw MHAs as currently engaged in this type of role, while others were less clear on whether J-MHAP might fill this need. For example, one stakeholder working in the court system referred to the MHA as a "hub" with the skill to bring parties together and prevent duplication of work. Discussing a need for J-MHAP, another stakeholder remarked, "any time, I think, an individual sits in two worlds and they have a level of trust by the attorneys, district attorneys and the judge, and they have a level of trust by the family, they can be a powerful arbitrator." Another stakeholder described a need for advocates with power to develop and coordinate coherent plans for multisystem involved youth to remedy fractured care systems.

Those working regularly with J-MHAP through the court system (i.e. judges, attorneys and probation officers) consistently described a strong need for J-MHAP. Some discussed heavy caseloads and a need for the work MHAs perform for clients who need extra attention and intensive case management. One attorney remarked, "We can't get the proper supports for kids on a lot of cases without their help." Another stakeholder working in the court system stated, "I think they're more comprehensive. I think we get a better [evaluation], I think we get a better understanding of what the needs are and what recommendations there are…I think in terms of the court, they're really kind of spot on with what we need here."

A theme discussed by some stakeholders and key informants in more administrative roles, or who worked less directly with the program, described J-MHAP as important but in need of restructuring or re-organization to better meet system level needs or enhance sustainability.

The need for J-MHAP was also discussed as a function of its role addressing individual or systemic needs. Stakeholders consistently described J-MHAP as working to fill individual needs facing youth and families, especially those resulting from systemic gaps. Stakeholders and key informants differed in the degree to which they felt J-MHAP addresses system-level problems. Some stakeholders noted that they did not believe J-MHAP is designed to effect systemic changes. On the other hand, an attorney working within the juvenile court system saw J-MHAP as contributing to broader system-level change by raising awareness within the court system around mental health issues. Other stakeholders proposed ideas for enhancing J-MHAP's ability to address systemic needs, including policy advocacy and serving as a mechanism for system learning by aggregating lessons learned.

6. How does program design affect sustainability and scalability? What changes would support these aims? Are there opportunities that HLA can leverage in identifying where J-MHAP can be situated?

Themes related to sustainability included a perceived need for further consideration of where J-MHAP fits within the broader system and concerns about the sustainability and scalability of J-MHAP as it is currently designed. Ideas for modified designs were shared. This theme reflects issues and trends in the larger policy context in which J-MHAP operates and the systems with which it interacts, including the school, court, and state and national mental health care systems.

Stakeholders and key informants shared perspectives related to changes to program structure necessary if J-MHAP expands. Many stakeholders, especially those working within the court system, said that they did not think any changes were needed except for increasing J-MHAP's capacity to take on cases. One idea to enhance sustainability and scalability involved having attorneys provide leadership and supervision for a larger cohort of "extenders" who would carry out any work that does not require a legal background.

Themes related to sustainability and scalability included the location of J-MHAP within the court system. Some stakeholders offered thoughts about where J-MHAP might be situated in order to enhance sustainability and meet the greatest need for its service. Alternatives to situating J-MHAP within the court system included situating J-MHAP within Accountable Care Organizations (ACOs) or Family Resource Centers (FRCs). Situating J-MHAP within an ACO, one key informant explained, would place it within the system in which the "wave of change is happening," and would provide added evaluation support. One key informant raised the question of J-MHAP's target population, suggesting that this would play a role in determining where to situate the program. They noted that while the push within the court system at the federal level is toward diversion, given that a relatively small proportion of J-MHAP youth are involved with delinquency cases, diversion does not appear to be the focus of J-MHAP.

Stakeholders working within the court system discussed themes related to the location of J-MHAP within the court system and a desire to have more MHA services available. For example, one stakeholder discussed the importance of having J-MHAP situated within the court because they felt it provides a needed service in the court. Another

stakeholder proposed situating J-MHAP within court clinics to centralize mental health related services in the court. Stakeholders working closely with J-MHAP shared concerns about what would happen if the MHAs were no longer involved. For example, one stakeholder said, "I would be really distraught if we didn't have [MHA] in our court. As I think other people, other people have come to me saying, 'We can't lose this person.'… And I really think the population, particularly the mental health population that we're dealing with, would really suffer a huge loss. I think families would lose out."

7. What role can J-MHAP play to address potential inequities in youth experience within the juvenile justice and mental health service systems?

Stakeholders discussed their perspectives related to differences in MHA appointments by case type, race and gender. As described above, the majority of youth were appointed a MHA on a CRA case, and the majority of youth were identified as white and male. Though further analysis is needed to determine whether these are proportional within the areas served, many stakeholders shared concerns and interest related to this issue.

The focus on CRA cases was seen as a function of District Attorney involvement in delinquency cases and the need for attorneys to keep information confidential to avoid repercussions for youth. Potential reasons for predominance of white youth receiving MHAs were not well understood. Some stakeholders did not see direct evidence of disparities by race or ethnicity, while others suggested that differences in MHA appointment might be due to implicit and unintentional bias of individuals such as judges or probation officers. Stakeholders suggested that bias might also be introduced by school officials' responses to youth behavioral issues (filing CRA vs. arrest) and the ability of families to gather resources necessary to file CRAs.

Stakeholder responses suggested that mental health needs of white youth, and white males in particular, are more readily acknowledged and identified. The decision to appoint a MHA, made by a judge, relies on someone identifying a youth as having unmet mental health needs. Given that the identification of mental health needs is necessary for MHA appointment, such disparities in identification could translate into inequities in MHA appointments.

Parent and guardians may also differ by race and ethnicity in terms of level of trust of the court system and acknowledgement of youth mental health needs. One key informant suggested that parent or youth race or ethnicity may affect how likely they are to approach the court for assistance and shape expectations of whether their children would be well served by this system. Some stakeholders also suggested that families who come to the United States from other countries may be less familiar with the mental health system or feel reluctant to share information related to mental health.

SUMMARY

These interim analyses of baseline, six-month, process, and stakeholder data indicate that the MHAs have been largely successful in their work thus far and fill a needed role within the court system. Overall, J-MHAP has appeared to accomplish stated goals in a timely manner while dealing with very complex cases and families with high mental health risk profiles. There is preliminary evidence to suggest that the uniqueness of the MHAs' legal training has been utilized in their advocacy work to meet the needs of both the youth and the court in a timely manner. Interim findings demonstrated MHAs' impact on court involvement for youth with delinquency cases, even when the MHA was appointed on a CRA case, by preventing a subset of youth from further court involvement. Case examples and court involvement data point to the role of MHAs in steering youth from the delinquency system toward treatment for mental health needs. Change in risk profile measures from baseline to six-month follow up was minimal as expected; however, three areas showed change in this preliminary analysis, suggesting a possible improvement in risk characteristics over time in the program. These findings reflect key areas

of program impact. Recommendations by stakeholders and key informants suggest avenues of further investigation to strengthen the service system infrastructure of which J-MHAP is a part. Future analyses of complete data, once they become available, will provide the information necessary for a full evaluation of the impact of J-MHAP on the youth and families involved and the systems in which MHAs operate.

APPENDIX A

Table 17. Baseline Family Risk Scores			
Domain	**Baseline**	**Published norm**	**Interpretation**
Family	**Mean (SD) Or %**	**Mean (SD) Or %**	
Parent perceived conflict ➢ Conflict Behavior Questionnaire (CBQ)	12.2 (5.9)	2.4 (2.8)[1]	Higher scores indicate more negative perceptions.
Youth perceived conflict ➢ Conflict Behavior Questionnaire (CBQ)	5.4 (5.2)	2 (3.1)[1]	Higher scores indicate more negative perceptions.
Parent			
Parent Stress ➢ Perceived Stress Scale	21 (6.0)	13.02 (6.35)[11]	Higher scores indicate more stress.
Parental Depression ➢ Center for Epidemiological Studies Depression Scale (CES-D)	21.2 (13.1)	9.25 (8.58)[5]	Higher scores indicate greater depression symptoms.
At least mild depression (CES-D ≥ 16)	63.4%	19%[5]	≥ 16 indicates any depression.
Overall Mental Health ➢ VR-12	42.0 (14.7)	50.08 (11.49)[12]	Higher scores indicate better health.
Overall Physical Health ➢ VR-12	47.8 (11.4)	39.82 (12.29)[12]	Higher scores indicate better health.
Youth			
Total Difficulties (Parent on youth) ➢ Strengths and Difficulties Questionnaire	21.1 (6.0)	7.1 (5.7)[2]	Higher scores indicate more difficulties.
Impact of Difficulties (Parent on youth) ➢ Strengths and Difficulties Questionnaire	6.2 (2.7)	0.4 (1.3)[2]	Higher scores indicate greater impact.
Total Difficulties (Youth Completed) ➢ Strengths and Difficulties Questionnaire	16.1 (6.4)	10.3 (5.2)[13]	Higher score scores indicate more difficulties.
Impact of Difficulties (Youth completed) ➢ Strengths and Difficulties Questionnaire	2.4 (1.9)	0.2 (0.8)[13]	Higher scores indicate greater impact.
Youth Quality of Life ➢ Youth Quality of Life Scale (Y-QOL)	70.2 (14.2)	86.85 (1.58)**[14]	Higher scores indicate greater QOL.
Trauma ➢ Los Angeles Symptom Checklist	22.7 (15.1) *6-month interview	21.39 (10.63)[6]*	Higher scores related to more extensive trauma exposure.[15]

* Scores are for incarcerated youth

** Estimated marginal mean (Standard Error)

APPENDIX B

Table 18. Description of Barriers from Child and Adolescent Services Assessment[8]	
Barrier	**Description**
Structural barriers	
Bureaucratic delay	Bureaucratic hurdles such as excessive pre-visit paperwork or authorizations, difficulty getting an appointment in a timely fashion or being put on a waiting list, or offices where the phone is not answered or calls are not returned.
Transportation to treatment/services	Reluctance to use services caused by difficulty getting to treatment site.
Incomplete information	Difficulty in getting services caused by lack of information about where to get services or how to arrange them.
Time	Reluctance to use services caused by lack of time to get treatment or to make arrangements for treatment.
Service not available	Non-availability of a particular service desired by a subject (such as counseling or drug rehab) because it does not exist in the area where the subject lives.
Cost of treatment/services	Inability to use services or underutilization of services caused by perception that services could not be afforded or paid for; insurance would not cover cost
Refusal to treat	Being refused by the service for various reasons: lack of space/beds, problematic history of subject, fear of liability, etc.
Fear of consequences	1. Reluctance to use services caused by fear that subject's children might be at greater risk of out-of-home placement; or 2. Reluctance to use services caused by fear that subject might be seen as an unfit parent and lose parental rights.
Child or parent refuses treatment	1. Youth refused to go for treatment; or 2. Parent refused to allow the youth's participation.
Quality of services	1. Concern or discomfort with using services caused by subject's fear, dislike, or distrust of talking with professionals; or 2. Concern or discomfort with using services caused by subject's previous negative experience with professional(s).
Stigma	1. Reluctance to use services caused by self-consciousness about admitting having a problem or about seeking help for it. Also inability to talk with anyone about such sensitive issues; or 2. Reluctance to use services caused by anticipation of a negative reaction from family, friends, or others to seeking treatment for an emotional or mental problem.

APPENDIX C

Table 19. Follow-up Family Risk Scores			
Domain	**Baseline**	**6-month**	**Effect Size (Cohens' d)**
Family	**Mean (SD)**	**Mean (SD)**	
Parent perceived conflict ➢ Conflict Behavior Questionnaire (CBQ)	12.2 (5.9)	10.2 (5.9)	.34
Youth perceived conflict ➢ Conflict Behavior Questionnaire (CBQ)	5.4 (5.2)	3.4 (3.9)	.44
Parent			
Parent Stress ➢ Perceived Stress Scale	21.0 (6.0)	19.1 (8.2)	.26
Parental Depression ➢ Center for Epidemiological Studies Depression Scale (CES-D)	21.2 (13.1)	20.7 (15.3)	.04
Overall Mental Health ➢ VR-12	42.0 (14.7)	42.1 (17.2)	.006
Overall Physical Health ➢ VR-12	47.8 (11.4)	51.3 (7.6)	.36
Youth			
Total Difficulties (Parent on youth) ➢ Strengths and Difficulties Questionnaire	21.1 (6.0)	18.9 (7.7)	.32
Impact of Difficulties (Parent on youth) ➢ Strengths and Difficulties Questionnaire	6.2 (2.7)	3.3 (3.2)	.98
Total Difficulties (Youth Completed) ➢ Strengths and Difficulties Questionnaire	16.1 (6.4)	14.5 (8.6)	.21
Impact of Difficulties (Youth completed) ➢ Strengths and Difficulties Questionnaire	2.4 (1.9)	1.1 (1.7)	.72
Youth Quality of Life ➢ Youth Quality of Life Scale (Y-QOL)	70.2 (14.2)	75.4 (19.2)	.31

APPENDIX D

Table 20. Stakeholder and Key Informant Identification Questions [6]
Who might have expectations?
Who might experience negative effects?
Who might be forced to make changes?
Who might have to change behavior?
Who has goals that align with these goals?
Who has goals that conflict with these goals?
Who has responsibility for action or decision?
Who has resources or skills that are important to this issue?
Who has expectations for this issue or action?

APPENDIX E

J-MHAP Evaluation
Stakeholder Meeting Guide

Thank you for agreeing to meet with us to help us and Health Law Advocates learn more about the Juvenile Court Mental Health Advocacy Program (J-MHAP) from your perspective. I have some questions that will guide our discussion today, but they are just a guide.

If it is ok with you, I would like to record our meeting so that I can be sure to maintain the integrity of the information you are sharing. I will also be taking notes. Our team will use the recording and notes to categorize and summarize your information along with that collected from other stakeholders and key informants.

Your name will not be associated with the information we share with Health Law Advocates and would not be included in any publications or presentations that may result from our work. If there are any questions you would rather not answer we can skip them and move on.

1) Can you tell me about your role at _____?

2) How do you and/or your organization interface with youth involved in the court system?

Knowledge & Beliefs

1) How familiar are you with J-MHAP and its implementation so far?

Tension for Change and Relative Advantage/Competition

1) Based on your experience, what do you see as the major unmet needs for youth related to mental health, school, and court involvement?
    a. What about needs within family systems?

2) Is there a strong need for J-MHAP? Why or why not?
    a. Do others see a need for J-MHAP?

3) Does J-MHAP meet any unmet needs?

4) How does J-MHAP compare to existing programs in your setting?
    a. What advantages does it have compared to existing programs?
    b. What disadvantages does it have compared to existing programs?

5) How do MHAs compare to other providers?
    a. Are there things MHAs are able to do that others aren't?
    b. Is the legal background of the MHAs important? Why or why not?

6) Does J-MHAP replace or compliment a current program or process? In what ways?

7) If you could implement any intervention to address unmet needs of these youth, what would it be?

8) Do you think that there are disparities that affect who is served by a program like J-MHAP? Why or why not?
    a. Can you imagine why a program like J-MHAP might be involved more with CRAs?
    b. Based on your experience, what is happening with mental health of youth with delinquency cases?

Relative Priority

1) To what extent might the implementation of J-MHAP take a backseat to other high-priority initiatives going on now?

2) Is there any opportunity cost or downside to implementing J-MHAP?

Evidence Strength/Quality and Leadership Engagement

1) How does J-MHAP impact your work?

2) What outcomes do you expect as a result of J-MHAP?

3) How would you judge if this program is successful? What outcomes matter most?

4) Do you think it is or will be effective in your setting? Why or why not?

5) What do administrative or other leaders think of the intervention? Do you think your opinions are similar to others in similar roles?

6) What kind of supporting evidence or proof is needed about the effectiveness of the intervention to get staff and leaders on board?

Compatibility and Complexity

1) How well does J-MHAP fit with existing work processes and practices in your setting?

2) Are there complexities or difficulties related to J-MHAP that have arisen or that you anticipate? That affect receptivity to the program? How so?

3) How does or will J-MHAP impact your work or the work of your organization?
    a. Does it help you achieve certain outcomes?
    b. Does it make anything more difficult?

Client Needs & Resources

1) To what extent are J-MHAP staff aware of the needs and preferences of the individuals or families being served by your organization?
    a. How well do you think J-MHAP meets these needs?

2) How do you think the individuals served by your organization are responding or will respond to J-MHAP?
    a. Have you heard stories about the experiences of participants?

External Policies & Incentives

1) How will J-MHAP affect your organization's ability to meet local, state, or national measures, policies, regulations, or guidelines?

2) Are there financial or other incentives or burdens involved with implementing J-MHAP in your setting?

INNER SETTING

Structural Characteristics

1) What kinds of infrastructure changes will be needed to accommodate J-MHAP if it expands to a larger scale?
    a. Changes in scope of practice?
    b. Changes in formal policies?

c. Changes in information systems or electronic records systems?
d. Other?

Culture

1) Do you think your organization's culture (general beliefs, values, assumptions that people embrace) will affect collaboration with J-MHAP?
    a. Can you describe an example that highlights this?

Implementation Climate

1) What is the general level of receptivity in your setting to implementing J-MHAP?

Sustainability

1) What do you see as the likelihood of J-MHAP becoming a permanent program within the Juvenile Court?

2) If J-MHAP were expanded and turned into a permanent program, what changes, if any, would need to be made? Where do you think J-MHAP would best be situated to best meet the needs of youth?

Organizational Incentives & Rewards

1) What is your motivation, if any, for wanting to help ensure J-MHAP is successful?

Access to Knowledge & Information

1) Who do you ask if you have questions about the J-MHAP? How available are these individuals?

Adaptability

1) What kinds of changes or alterations do you think you will need to be made to J-MHAP so it will work effectively in your setting?

2) Are there components that should not be altered?

Learning Climate

1) Can you describe the climate around quality improvement and implementation of new programs in your setting?

Conclusion

1) Is there anything additional that you'd like to share based on your experience with J-MHAP to date?

2) Would it be ok to reach out to you in the future if, as we hear from more people and notice common themes, any additional questions arise?

REFERENCES

1. Robin AL, Foster SL. Questionnaire and Observational Assessment. Negotiating Parent-Adolescent Conflict: A behavioral-family systems approach. New York, NY: Guilford Press; 1989. p. 77-308.
2. Youthinmind. Normative SDQ data from the USA 2004 [Available from: http://www.sdqinfo.org/norms/USNorm.html.
3. National Research Council (U.S.). Committee on Depression Parenting Practices and the Healthy Development of Children. Depression in parents, parenting, and children : opportunities to improve identification, treatment, and prevention. Washington, D.C.: National Academies Press; 2009. xvii, 470 p. p.
4. Beardslee W, Wright E, Gladstone T, Forbes P. Long-term effects from a randomized trial of two public health preventive interventions for parental depression. J Family Psychol. 2008;21:703-13.
5. Radloff LS. The CES-D Scale: A Self-Report Depression Scale for Research in the General Population. Applied Psychological Measurement. 1977;1(3):385-401.
6. Burton D, Foy D, Bwanausi C, Johnson J, Moore L. The relationship between traumatic exposure, family dysfunction, and post-traumatic stress symptoms in male juvenile offenders. J Trauma Stress. 1994;7(1):83-93.
7. Guevara M. Exposure to Gang Violence and the Development of Posttraumatic Stress Disorder in Continuation School Youth. Ann Arbor, MI: Fuller Theological Seminary; 1992.
8. BJ B, A A, K M-H, EJ C, MKS P. The Child and Adolescent Services Assessment (CASA) Duke University Medical Center, Program DE, Sciences DoPaB; 2008.
9. Tague N. The Quality Toolbox. Hytinen A, O'Mara P, editors. Milwaukee: ASQ Quality Press; 2005.
10. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implement Sci. 2009;4:50.
11. Cohen S, Williamson GM. Perceived Stress in a Probability Sample of the United States. In: Spacapan S, Oskamp S, editors. The Social Psychology of Health. Newbury Park, CA: Sage; 1988. p. 31-67.
12. Selim AJ, Rogers W, Fleishman JA, Qian SX, Fincke BG, Rothendler JA, et al. Updated U.S. population standard for the Veterans RAND 12-item Health Survey (VR-12). Qual Life Res. 2009;18:43-52.
13. Youthinmind. SDQ: Normative school-age SDQ data from Britain 2001 [Available from: http://www.sdqinfo.org/norms/UKSchoolNorm.html.
14. Patrick DL, Edwards TC, Topolski TD. Adolescent quality of life, part II: initial validation of a new instrument. J Adolesc. 2002;25(3):287-300.
15. Wevodau A. Review of trauma screening tools for children and adolescents. In: School UoMM, editor. 2016.