Juvenile Court Mental Health Advocacy Project

Final Report

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Prepared for

Health Law Advocates

by

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EXECUTIVE SUMMARY

This report presents evaluation findings of the Juvenile Court Mental Health Advocacy Project (J-MHAP) for the analysis period of February 1, 2015 to December 31, 2016. During this period, J-MHAP served 152 youth, 8 of which had two separate appointments (160 cases). About one-third (n=52) of J-MHAP families participated in an in-depth evaluation. The report is organized into six main sections: (1) Family Profiles, (2) the Work of Mental Health Advocates (MHAs), (3) Evidence of Program Impacts, (4) Cost Analysis, (5) Stakeholder Perspectives, and (6) Recommendations and Considerations.

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. 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).

- The majority of youth in J-MHAP identified as male and White. The average age was 15 years old.
- 87% of youth were appointed a MHA on a Child Requiring Assistance (CRA) case, though 35% had court involvement at appointment in addition to the case on which the MHA was appointed. Of these youth, the most common pattern was of youth with an open delinquency case and MHA appointment on a CRA.
- 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.

Section 2. The Work of the MHAs: Includes goals set by MHAs and MHA recorded effort within systems.

- Cases averaged 6.9 months in length, with a minimum of 1.4 and maximum of 12.8 months.
- By case closure, 81% of goals had been completed. 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.
- The greatest proportion of MHA time allocation was in communication 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 analyses of effects on youth court involvement and youth and family functioning, and examples of individual youth trajectories.

- Court Involvement. MHAs successfully advocated to avoid or shorten pre-trial detention, avoid arraignment on delinquency charges, reduce sentences, and provide treatment instead of detention among the 36% of youth with delinquency involvement during the MHA appointment.
- Family Functioning. Statistically significant improvements in parent stress, parent-reported overall youth mental health, parent-perceived conflict with the youth, and parent-reported youth total difficulties and the impact of the youth's difficulties on the youth and family were observed based on measures administered at baseline and follow-up interviews with youth and families. A strong signal of improvement was found in four additional areas: parental depression, youth-perceived conflict with parent or guardian, overall parent mental health, and the youth-rated impact of youth's difficulties.
- Mental Health Service Use. Statistically significant reductions were found in use of emergency mental health services and hospitalizations.
- In-depth case examples for youth identified critical points of intervention and the work of MHAs.

Section 4. Economic Analysis: Includes analyses of the costs to run J-MHAP compared with the number of youth who received services, as well as potential costs averted.

- During 2016, the second year of the pilot, 123 youth received services at approximately $2,838/youth; and
- A combination of outcomes, such as prevention of two youth from three months of detention, ten youth from dropping out of high school, and five youth from mental health hospitalizations in one year would offset all of J-MHAP's annual operating costs.

Section 5. Stakeholder Perspectives: Includes analysis of data from qualitative interviews conducted with primary and secondary stakeholders, as well as key informants. As of January 24, 2017, qualitative interviews had been completed with 40 families in the evaluation subset and 30 stakeholders and key informants. Themes highlighted by stakeholders included:

- The challenges facing youth, families, and MHAs resulting from systemic gaps in the court, mental health, child welfare, and school systems;
- J-MHAP's capacity to shrink the gaps in services for youth and families and the necessary skills and competencies of the MHAs;
- Potential implicit biases affecting J-MHAP referrals and J-MHAP's ability to address inequities in the juvenile justice and mental health systems; and
- Stakeholder recommendations for program implementation, sustainability, and scale-up.

Section 6. Recommendations and Considerations: Includes guiding questions and associated metrics for evaluation, specific recommendations, and future considerations. Based on evaluation data to date, recommendations were developed for J-MHAP as it transitions to a new program design and begins work as the Mental Health Advocacy Project for Kids, or *MHAP for Kids*. Recommendations are organized into three topic areas: (1) referrals, outreach and buy-in; (2) need for MHAP for Kids and program effectiveness; and (3) implementation, sustainability, and scalability. Main recommendations include:

- Assessment of program efficacy through the use of guiding questions, data collection, and evaluation of measurable objectives;
- Continued use of formal processes for tracking metrics and activities of the MHAs (e.g. goals and contacts);
- Development and implementation of a Continuous Quality Improvement (CQI) process to support continued effectiveness, sustainability and replicability;
- Assessment of satisfaction of youth, families, and stakeholders by integrating procedures for feedback;
- Consideration of how best to outreach to and serve youth not integrated within service systems.

Summary

The analyses presented here 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. Statistically significant improvements were observed in family functioning during the period of MHA involvement. Stakeholders and key informants largely consider J-MHAP to play a crucial role filling gaps in service systems and suggest the need for further investigation into options for strengthening the service systems of which J-MHAP is a part. As J-MHAP transitions to the new program model, MHAP for Kids, it will shift its focus toward prevention of court involvement and earlier intervention to meet unmet mental health service needs. Recommendations developed based on evaluation findings suggest possible avenues to support continued effectiveness, sustainability and replicability.

INTRODUCTION

This report has been prepared for Health Law Advocates by the Boston University School of Public Health Evaluation Team to present findings of the evaluation of the Juvenile Court Mental Health Advocacy Project (J-MHAP). The data presented covers the 22-month period from February 1, 2015, when the J-MHAP pilot began, through December 31, 2016. The goal of the report is to present findings on the population served by J-MHAP, the work of the Mental Health Advocates (MHAs), evidence of program impacts, cost analysis, stakeholder perspectives, and recommendations. Multiple data sources were included in the analysis, including baseline and follow-up interviews with youth and families and interviews with stakeholders and key informants. The report is organized into five main sections: (1) Family Profiles, (2) the Work of MHAs, (3) Evidence of Program Impacts, (4) Cost Analysis, (5) Stakeholder Perspectives, and (6) Recommendations. The methods and data sources used to obtain the data are described in each section.

1. Family Profiles (pages 5 to 10). This section details demographic characteristics of J-MHAP youth and families, youth court involvement, use of school and mental health services, and family mental health related risk. 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?
- What are the mental health risk profiles of families in J-MHAP? To what extent are youth receiving school and mental health services at the start of their involvement with J-MHAP?

2. Work of Mental Health Advocates (pages 11-13). This section documents MHAs' work based on the types of goals established with families and completion of those goals as well as MHAs' recorded effort within different systems. Key questions addressed include:

- What types of goals do MHAs work on for youth? What proportion of goals are completed?
- How do MHAs invest their time? How much time do MHAs spend interacting with different systems?

3. Evidence of Program Impacts on Youth and Family Outcomes (pages 14-18). This section includes follow-up family risk measures and youth service use, 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?

4. Economic Analysis (pages 19-22). This section includes analysis of J-MHAP operating costs and potential costs averted. Key questions addressed include:

- What is the total operating cost for J-MHAP per year? What is the average cost to serve each youth?
- What are potential cost savings or costs averted due to J-MHAP? What does J-MHAP need to accomplish to be considered cost-saving?

5. Stakeholder Perspectives on Implementation and Sustainability of J-MHAP (pages 22-31). This section explores themes from interviews with stakeholders related to implementation of J-MHAP and includes stakeholders' recommendations for 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?
- What are stakeholder recommendations for increasing sustainability and scalability?

6. Recommendations and Considerations (pages 32-34). This section outlines recommendations and considerations for program planning and evaluation as J-MHAP transitions to the new MHAP for Kids program model. Key questions addressed include:

- What metrics can be used to track implementation and effectiveness?
- What changes might be made to integrate learning from evaluation results and stakeholder impressions into program design going forward?

SECTION 1. FAMILY PROFILES

Overview: Between February 1, 2015 and December 31, 2016, 152 youth were appointed a MHA in the Lowell and Salem Juvenile Courts (Lowell=74; Salem=78). Of these youth, eight had two separate appointments (i.e. MHA was re-appointed after initial appointment was vacated), resulting in a total of 160 cases. Of the 152 youth who received J-MHAP services, 52 families (i.e. parent and/or youth) participated in the evaluation as of December 31, 2016. This section will describe the family profiles of all youth in J-MHAP and/or the evaluation subset, including demographic characteristics, school and service use histories, and measures of parent and youth mental health related risk. Data on demographics and court involvement were available for all youth in J-MHAP. School and service use data and baseline risk measures are reported for the evaluation subset.

Methods: (1) Data on the demographics and court involvement of youth enrolled in J-MHAP were recorded by HLA and de-identified prior to analysis by the BU evaluation team. (2) 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=52) for in-depth interviews related to family functioning and their experiences with mental health and school services. Interviews were conducted one time near the beginning of their work with the MHA (baseline) (n=52) and at least one additional time a minimum of six months after baseline (follow-up). As of December 31, 2016, follow-up interviews were conducted with 31 families, an average of 8.2 months after baseline (min = 6, max = 17.5). Follow-up interviews and brief phone calls conducted quarterly also included qualitative questions about youth and family experiences in J-MHAP. Findings reported in tables are based on the data available. On average, missing data was 9% for items included within this section (range: 2% to 31%).

1A. DEMOGRAPHIC CHARACTERISTICS OF YOUTH

Most of the 152 youth who received J-MHAP services at time of the analysis were white, male, and English speaking. Latino/Hispanic and Black youth were 21% and 6% respectively. In total, 34% identified as Black, Latino/Hispanic, or other non-White race/ethnicity. Race/ethnicity, gender, and language spoken were similar by site. The ages of the youth ranged from 8 to 21 years, with an average of 15 years of age (both mean and median = 15 years). The 52 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=5) 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. There were no statistically significant differences between the subset of participants who withdrew and the participants who remained in the study in terms of youth race/ethnicity, gender, type of cases, and family mental health risk profiles.

Table 1. Youth Demographic Characteristics of All J-MHAP and the Evaluation Subset

Demographic	All J-MHAP (n=152)	Evaluation Subset (n=52)
Youth Race/Ethnicity	Number of Youth (%)	Number of Youth (%)*
White	66%	77%
Latino/Hispanic	21%	17%
Black	6%	12%
Other	7%†	12%‡
Household Primary Language		
English	93%	96%
Non-English	7%	4%§
Youth Gender		
Male	61%	69%
Female	39%	27%
Other	1%	4%

* Numbers do not sum to 100% because youth may report more than one race, ethnicity or language
† Biracial (n=7), Brazilian (n=2), Cape Verdean (n=1), Asian (n=1).
‡ Biracial White and Black/African American (n=4), Biracial White and Hispanic/Latino (n=1).
§ Primary language is Spanish

1B. YOUTH COURT INVOLVEMENT

Limited data on youth court involvement were available for all youth in J-MHAP. The vast majority of youth were appointed a MHA on a CRA case (87%). Approximately 6% of cases on which MHAs were appointed were Delinquency, 5% were Care and Protection, 1% were Permanency, and 1% were "other." However, almost one third of youth (30%) had court involvement in addition to the case for which the MHA was appointed at time of appointment.[i] Of youth with additional court involvement at any point during MHA involvement, the most common pattern was of youth who received a MHA on a CRA case but also had delinquency involvement, also referred to as dual-status youth (n=29). In total, about one-third of youth (38%, n=39) had some type of delinquency or criminal charges during the MHA appointment, 2 of whom had charges in adult court. Youth in the evaluation subset had MHAs appointed on similar types of cases to all youth in J-MHAP, with a slightly higher percentage having MHAs appointed on delinquency cases (10%).

The scope of the MHAs' work is defined by the judge when the appointment is made. **Table 2** details a breakdown of these scopes. Some youth (n=30) had only one scope selected, but most had two or more, with five youth having five scopes. Cases had an average of 2.3 scopes at the initial appointment.

Table 2. Percent of Cases Containing Category of Scopes*	
Begin or improve special education services	67%
Secure community-based mental health services	40%
Coordinate mental health services	38%
General education services	19%
Secure services from Department of Children and Families	17%
Become eligible for services from Department of Mental Health	14%
Other (defined by judge)	12%
Secure services from Department of Mental Health	11%
Become eligible for services from Department of Children and Families	8%
Assist with health insurance coverage	3%
Secure services from Department of Developmental Services	3%
Become eligible for services from Department of Developmental Services	1%

* All youth in J-MHAP

J-MHAP is designed with initial court appointments lasting up to six months. Appointments may be extended by a judge to allow for continued efforts. As of December 31, 2016, 103 cases had been closed with an average appointment time of 7 months. Among the cases that were closed at time of analysis, most had received an extension with the average extension being 12 weeks **(Table 3)**. Common reasons for case extensions beyond six months included that the 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**
6 months	23%
< 6 months	28%
> 6 months	56%

* All youth in J-MHAP

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

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

Data on youth use of school, mental health services was available for the evaluation subset and were obtained through interviews with families participating in the evaluation. To understand youth school engagement at baseline, data was obtained on school attendance, school services, grade retention, and disciplinary actions. At baseline, 17% of youth were not attending school and a total of 28% either didn't attend or missed almost every day. Another 33% missed more than one day each week. Grade retention and disciplinary actions were common. Almost one quarter (21%) of youth had repeated one grade in school and 9% had repeated two grades. In addition, 45% had received at least one suspension in the past year. **Table 4** summarizes these indicators of school risk.

The majority of youth had received additional school services or special placement in the year prior to MHA appointment. Almost 60% of youth had received some type of in-school counseling, just over one-third (38%) were placed in a special education classroom, and about one-quarter (29%) were placed in a special school for emotional or behavioral needs **(Table 5)**. Some youth (18%) 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, and life stress.

Table 4. Indicators of School Risk*	
Attendance in past 3 months	**% Youth**
Missed more than one day/week	33%
Didn't go at all or missed almost every day	28%
Attended almost every day	28%
Missed one or two days/month	13%
School suspensions in past year	**% Youth**
0	55%
1	15%
2-5	20%
More than 5	10%

* Evaluation subset

Table 5. Additional School Services*	
Type of Service / Placement	**% Youth**
In-school therapy or counseling	59%
Special classroom for learning, emotional or behavioral needs	38%
Special school for youth with emotional or behavioral needs	29%

* 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 assessed included seeing a provider, participating in a day program, using emergency or crisis services, or taking prescription medications. The majority (94%) of youth had seen an outpatient mental health provider (therapist or medication provider). Youth who used crisis services (in-home crisis services or emergency room) for mental health or substance use needs (63%) used these services an average of 5 times within the year, with a minimum of 1 and maximum of 45 times.

Overnight services used included inpatient hospital, residential treatment and drug and alcohol treatment. Almost half of youth (n=24) had at least one stay in an inpatient or residential facility during the year before baseline. Among youth who had an inpatient stay (hospital or drug or alcohol clinic) in the past year, the average length of stay was 30 days, with a minimum of 2 and maximum of 135 days (not always in succession). Some youth also had out of home placements in emergency shelters, group homes, detention centers, prisons, and jails during the year prior to baseline**.**

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, 11% said they went because they wanted to do it 53% said they went because someone else put pressure on them, and 32% said that both were true. Youth identified pressure from parents, school staff, mental health providers, judges or court personnel, and other providers.

Table 6. Mental Health Services Received*	
Type of Service	**% Youth**
Outpatient Services	
Mental Health Provider	94%
Crisis or Emergency Services (emergency room, in-home crisis services)	63%
Took medication for emotional, behavioral, or substance use reasons during past year (at least 1 week)†	88%
Day Treatment (Partial hospital or drug/alcohol clinic)	16%
Overnight Services	
Hospital	44%
Residential Treatment Facility	37%
Drug/Alcohol Treatment Unit	6%
Other Out of Home Placements	
Group Home	12%
Detention center/prison/jail	14%
Emergency Shelter	8%
Foster Home	2%

* Evaluation subset

† Missing data was 50% for this item and should be interpreted with caution

1D. FAMILY RISK CHARACTERISTICS

The overall risk profile of J-MHAP families was assessed during baseline interviews with 52 families, including parents (n=49) and/or youth (n=31). Family risk was assessed through standardized instruments of risk, as well as youth diagnoses, parent ratings of youth health, and family barriers to accessing services.

Standardized Measures

Nine standardized instruments were used to assess family risk across three domains: family functioning, parent mental health, and youth functioning. Adult measures assessed overall health, general stress, family conflict, youth strengths and difficulties, and depression symptoms. Youth answered questions about quality of life, strengths and difficulties, family conflict, and trauma symptoms. 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." Scores are reported 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 (worse) on almost every measure of risk compared to the norms, suggesting a significantly elevated risk profile among participants. **Table 7** presents the number of standard deviations between J-MHAP evaluation participants' scores and the norms. 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 1.06 (youth) to 3.46 (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 2.40 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 4.31 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 1.24 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, 60.4% 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, 41% had scores that indicate major depression (score >27) which is associated with impaired functioning. For full details of baseline and comparison scores see **Appendix A, Table 1.**

Additional youth measures assessed overall quality of life and trauma symptoms. 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 14% lower than a sample of youth with no condition (70.9 vs. 82.2) and 6% lower than a sample of youth with ADHD (70.9 vs. 75.2)[6].

The Los Angeles Symptom Checklist PTSD subscale was used to measure 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 scored 0.68 standard deviations higher (worse) than a comparison sample of youth enrolled in continuation or alternative schools.[7] J-MHAP youth's average score of 19.5 was slightly lower than that of a published sample of incarcerated youth, with a difference of about 0.18 standard deviations.[8]

Table 7. Family Risk at Baseline*

Domain	Measure	Number of standard deviations from norm
Family Functioning	Parent perceived conflict	+ 3.46
	Youth perceived conflict	+ 1.06
Parent Mental Health	Parental stress	+ 1.21
	Parental depression	+ 1.24
	Overall mental health	+ 0.63
	Overall physical health	- 0.67
Youth Functioning	Total difficulties (Parent on youth)	+ 2.40
	Impact of difficulties (Parent on youth)	+ 4.31
	Total difficulties (youth completed)	+ 1.06
	Impact of difficulties (youth completed)	+ 2.63
	Trauma Symptoms	+ 0.68
	Quality of life	+ 14%†

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

* Evaluation subset
† No standard deviation available

Additional Indicators of Risk

The risk profiles of youth were also assessed through analysis of formal diagnoses for youth, parent-rated youth mental and physical health, and barriers to accessing services for youth. Almost 85% (83.3%) of youth had more than one diagnosis or condition, with an average of 3.5 mental health related conditions. The most common conditions are listed in **Table 8**. In addition, parents and guardians were 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 mental health a four and physical health an eight at baseline.

Parents and guardians also reported barriers experienced when trying to access needed services for youth. Barriers were assessed using the Child and Adolescent Services Assessment (CASA).[9] **Table 9** lists the percent of parents who reported each type of barrier. Systems barriers were the most commonly reported type of barrier. The majority of parents and guardians (89%) reported experiencing systems barriers (challenges related to cost, time, transportation, bureaucratic delay, being denied services, language, or lack of beds) when accessing or engaging in services. Overall, 93% of parents/guardians said that services were affected by any of these barriers at baseline. For more detailed descriptions of each type of barrier, see **Appendix A, Table 2.**

Table 8. Youth Mental Health Conditions*†	
Condition	**% Youth**
Depression	62.5%
Anxiety Disorder	60.4%
ADHD	60.4%
Oppositional Defiant Disorder	29.2%
Learning Disability	27.1%
Bipolar or Psychotic Disorder	22.9%
Substance Use Disorder	20.8%
Self-injuring Behavior	18.8%
Autism Spectrum Disorder	16.7%
PTSD	12.5%
Obsessive Compulsive Disorder	10.4%
Eating Disorder	2.1%

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

Overall, scores of both parents/guardians and youth on the standardized measures suggest a substantially greater risk profile among participants compared to community populations and indicated a high level of family vulnerability and stress. Youth diagnoses, parent ratings of youth health, and barriers reported to accessing services suggest additional areas of risk. 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. Barriers to Accessing Services*†	
Type of barrier	**% Families who reported barrier**
Systems barriers	89%
Bureaucratic delay	63%
Transportation to treatment/services	38%
Incomplete information	37%
Time	46%
Service not available nearby	31%
Cost of treatment/services	37%
Refusal to treat	23%
Language	6%
Child or parent refuses treatment	42%
Quality of services	40%
Fear of consequences	38%
Stigma	29%

* 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 which was assigned a MHA required a tailored approach to meet the needs of the youth, family and scope as defined by the judge. The work of the MHAs was captured in two 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 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 six thematic categories based on the focus of each goal. Data was complete for 97% of indicators.

Results: Of the cases which ended by December 31, 2016, 81% of goals had been completed by case closure. The percentage of goals completed increased with length of time in the program, with 68% of goals completed for cases open beyond nine months. Cases had an average of 5 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 "not complete" on closed cases included goals for which substantial progress was made but there was no final determination of "complete." Proportions of goals met according to case status are shown in **Table 10.**

Table 10. Goal Progress by Case Status as of December 31, 2017*

Case status	Length of time in J-MHAP	Goals completed %	Goals in progress %	Goals not completed %
Case Closed (n=103)	**All closed cases** (range: 2 to 10 months)	81.0%	n/a	18.9%
Case Open (n=55)	**Up to 3 months**	21.9%	12.2%	65.9%
	3 to 6 months	22.7%	47.7%	29.6%
	6 to 9 months	47.8%	47.8%	4.4%
	9 to 12 months	67.5%	15.0%	17.3%

* All youth in J-MHAP

The categories of goals and completion status by category are found in **Table 11.** 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 11. Goal Progress by Type of Goal Open and Closed Cases*				
Type of goal	Type of goal (as % of all goals)	Goal completion status		
		Goals completed %	Goals in progress %	Goals not completed %
School Placement/Issues	32.9%	68.7%	9.4%	21.9%
Access to Appropriate Mental Health Services	25.3%	72.6%	7.3%	20.1%
Case Coordination	14.5%	73.8%	1.9%	24.3%
Case Assessment and Planning	14.1%	75.0%	9.0%	16.0%
Access or Coordinate Evaluation for Youth	7.9%	73.2%	1.8%	23.2%
Access to Other Services†	2.7%	47.4%	10.5%	42.1%
Court/Juvenile Justice Issues	2.5%	72.2%	5.6%	22.2%

* All youth in J-MHAP

† Other services included services such as housing and health insurance

2B. MHA Effort within Various Systems

Overview: In order to achieve the goals represented above and respond to 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: At the time of this analysis, 56 cases remain open. Of those that are closed, the average amount of time spent on a case was 24.3 hours with a minimum of 1.5 hours, a maximum of 108 hours and a median of 17.6 hours. 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.

Table 12. MHA Recorded Effort by System		
System	% Contact Events	% Time
Family	24.7%	23.3%
Court	22.6%	30.2%
School/Education	13.3%	13.3%
Dept. of Children and Families	12.0%	10.2%
Children's Behavioral Health Init.	11.0%	8.4%
Not Specified	4.3%	4.2%
Programs (Group Homes, Residential Treatment)	4.2%	4.7%
Outpatient Mental Health (non-CBHI)	3.8%	2.4%
Inpatient Mental Health or Substance Use (Hospital, CBAT)	1.2%	1.2%
Other Gov Agency	1.2%	0.8%
Dept. of Mental Health	1.0%	0.7%
Outpatient Substance Abuse	0.4%	0.2%
Inpatient Substance Abuse	0.2%	0.2%
Dept. of Youth Services	0.1%	0.1%

A breakdown of MHA effort may be found in **Table 12**.

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 9%. Court-related activities included working with attorneys, probation officers, and court officials as well as accompanying the youth to court appearances. Of these interactions, 68% 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. Perhaps the most interesting finding of this analysis is that the MHAs spent 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.

2C. MHA Support

Overview: Given the nature of their role, MHAs provide intensive, targeted advocacy for families in the midst of crises. Like providers working in similar capacities with families in crisis, MHAs face stresses that can put them at risk for compassion fatigue or vicarious trauma. This section describes the structures within J-MHAP that support MHAs and prevent these outcomes.

Methods: The evaluation team conducted quarterly phone interviews with MHAs and the J-MHAP Project Director. The interview guide was developed using the Consolidated Framework for Implementation Research, a widely used framework for assessing the various elements involved in program implementation.[10] Key themes related to the MHA role and supportive structures were coded and analyzed to identify areas for further consideration.

Results: MHAs discussed the challenges inherent to their role, which included building relationships with different parties while advocating aggressively for youth; working with parents or guardians who may be experiencing their own mental health or related challenges; navigating family dynamics and parents' varying levels of engagement; and the expectation that they can "put out fires at a moment's notice." They also faced systemic obstacles, educated other stakeholders about issues related to mental health, and advocated for trauma-informed services in order to "change the paradigm of how people look at these kids."

One MHA shared that the systemic failures and persistent barriers experienced by clients can be "draining" and "disheartening." Another highlighted the "weight of responsibility" of needing to be a "fixer" for "people in these really tough situations." MHAs discussed the necessity of striking a balance between a compassion for and connection with families versus ensuring a level of distance to avoid "getting emotionally weighed down."

Internal stakeholders explained that the program structure maintains a focus on sensitivity to the mental health of the MHAs as well as recognition of the emotional elements of the role. These stakeholders further discussed the importance of self-care as well as supportive supervision, consultation and ongoing training. MHAs reported that they attended monthly meetings with a psychologist from Lawyers Concerned for Lawyers to process the clients' trauma they encounter. The time MHAs spend engaging in these tasks are not included in the hours they log to record their work on cases, but reflects another group of responsibilities integral to the MHA role and program sustainability.

SECTION 3. EVIDENCE OF PROGRAM IMPACTS

The evaluation data collected to date was analyzed to assess program impacts. Three areas of analysis provide an overview of J-MHAP's impact: youth court involvement, youth and family functioning, and 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 to inform this analysis. Comprehensive court data is necessary to understand the complete impact of MHAs on youth court involvement.

Results: Of 36% of youth (n=37) with delinquency charges, MHAs advocated for reduced delinquency involvement. MHAs successfully advocated to avoid arraignment on delinquency charges for six youth by advocating for participation in a diversion program or by assisting youth at a clerk magistrate's hearing. MHAs successfully advocated to avoid or shorten pre-trial detention for 11 youth, for reduction in sentence for 4 youth, and for treatment instead of detention for 1 youth. MHAs were able to prevent Care and Protection cases by securing needed services for 10 youth. Among youth for whom MHAs avoided arraignment, all had MHAs appointed on a CRA case rather than a delinquency case.

3B. YOUTH AND FAMILY FUNCTIONING AT FOLLOW-UP

Overview: The trajectories of youth and family risk are dynamic and may change over time. By looking at trajectories of change surrounding the period of MHA appointment, we assessed the association between MHA involvement and improved youth and family outcomes.

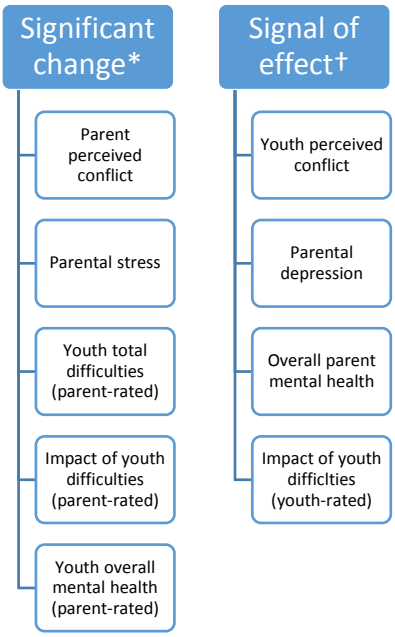
Methods: In order to understand whether there was any change in the overall risk profile of J-MHAP families during participation in the program, follow-up interviews were conducted with a subset of families (n=31), including youth (n=14) and/or their parents/guardians (n=29). (1) Scores on the measures of risk for youth and parents at follow-up were compared to scores at baseline to determine if there were any changes in risk over time. (2) Additional areas compared include youth school status, barriers to accessing care, parent ratings of youth health, and youth service use. Statistical analyses were conducted to compare baseline and follow-up data.

A paired t-test was used for continuous variables and a chi-square test was used for categorical variables. P-values reported for these tests were used to assess level of significance of the results. A p-value measures the likelihood that a change observed is due to chance.[11] We considered p-values less than or equal to 0.05 as statistically significant, meaning that the changes observed are not likely to be due to chance and rather reflect a true change over time. Due to the small sample size, the present study is underpowered to detect significant changes from baseline to follow-up. As a result, we also report on outcome measures for which the p-value exceeded 0.05 but was less than or equal to 0.10, which we consider a "signal of effect."

YOUTH AND FAMILY MENTAL HEALTH AND FUNCTIONING

Youth and family scores on standardized measures of risk showed notable changes from baseline to follow-up. Four areas were statistically significant and four others showed a signal of effect. **Figure 1** summarizes the measures based on degree of effect. All measures showed improvement (e.g. changes in mean scores) from baseline to follow-up. For full details on the change in scores see **Appendix A, Table 3**. In addition, parents' ratings of their children's mental health improved significantly (increased from a four out of ten at baseline to six at follow-up, P<.05).

Figure 1. Changes in Family Mental Health and Functioning



* Changes observed were statistically significant (not due to chance) (p≤.05)
† Changes observed showed a signal of effect (not likely due to chance) (p≤.10)

YOUTH SCHOOL AND MENTAL HEALTH SERVICE USE

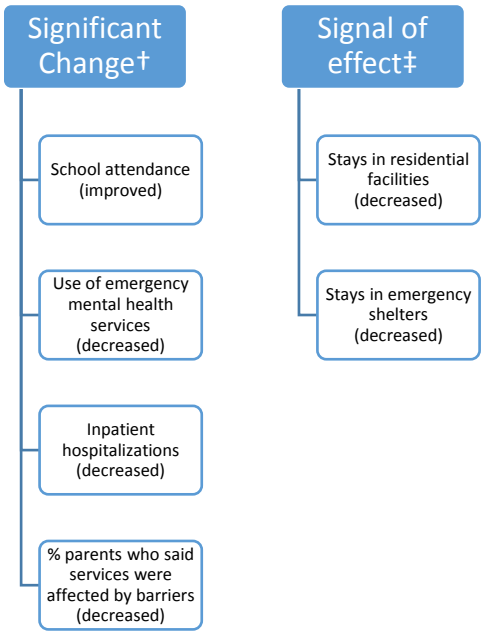
Additional aspects of youth and family functioning showed change at follow-up, as shown in **Figure 2** (For full details on change in service use and barriers reported, see **Appendix A, Tables 4 and 5)**. The distribution of youth school attendance shifted significantly between baseline and follow-up, reflecting improvements in attendance. The use of crisis and emergency room services and overnight hospitalizations showed statistically significant decreases. The proportion of youth with stays in residential facilities and emergency shelters decreased at a signal of effect level of significance. Participants' experiences of barriers to accessing services showed change over time in J-MHAP. Parents reported on both the existence of barriers and the impact of those barriers on receipt of services. At follow-up, significantly fewer parents reported that services were affected by barriers compared to baseline. In addition, the percent of parents reporting any systems barriers decreased, showing a signal of effect. Systems barriers included challenges related to time, bureaucratic delay, service denials, cost, transportation and more. When analyzed individually, time was the only systems barrier that showed a signal of effect, though all systems barriers decreased from baseline to follow-up. The percent of parents reporting that they or their child refused treatment decreased, but this decrease was not statistically significant. More data on changes in barriers can be found in **Appendix A, Table 5.** These data should be interpreted with caution due to differences in the duration of the look-back period for the service use questions (i.e. past 12 months (baseline) vs. since baseline interview (follow-up)).

There were increases in use of the three types of additional school services included in the evaluation, although no statistically significant change was observed. These services included common types of school services, but did not include all forms of special education services youth may have received. Thus, it is possible that there were changes in other types of school services that were not assessed. Youth use of services from outpatient mental health providers (e.g. therapist, medication provider), decreased from 94% to 87%, but this decrease was also not statistically significant. Increases in youth group home placements and decreases in youth stays in detention centers, prison, or jail were observed but were not statistically significant.

Discussion: Results suggest that families experienced improvements in multiple domains of functioning over time in J-MHAP. The nonrandomized study design does not allow us to assume causality; however, it is quite plausible to infer that the MHAs helped stabilize youth and/or families at high-risk. While It is possible that these changes

could have happened without the MHA or that CRA filing and court involvement may have put in place a series of events that led to such outcomes, the previous involvement that many youth had the court, DCF, or mental health services at the time of MHA appointment suggest that these interventions had not produced similar results. The nature of MHA activities and findings from qualitative interviews provide a mechanism to explain how the MHAs contributed to improved outcomes. The work of the MHAs in connecting youth with needed services, removing barriers to accessing services, and supporting families navigate complex systems may have allowed for youth to get needed treatment which supported their mental health and overall functioning. These activities, along with the support of MHA partnerships with families as they navigated complex systems, may have played a role in alleviating parental stress and related family dynamics. Such effects of MHAs' work were described in interviews with some parents and youth. As MHAs frequently worked closely with other providers, it is not possible to discern the change directly attributable to the MHAs' work. However, their role to promote care coordination appears to have served as a catalyst to advance the work carried out by youth's provider teams. The observed changes provide strong evidence that MHAs independent work or involvement in care teams contributed to positive changes in youth and family outcomes.

Figure 2. Changes in School and Mental Health and Service Use*



* Results should be interpreted with caution because of differences in the look-back period at baseline and follow-up
† Changes observed were statistically significant (not due to chance) (p≤.05)
‡ Changes observed showed a signal of effect (not likely due to chance) (p≤.10)

3C. INDIVIDUAL YOUTH TRAJECTORIES

Overview: The work of MHAs is targeted to the needs of each youth and family. Examples of MHA work on specific cases elucidate the role of the MHA's intervention and the youth change over time. Case examples draw on data from multiple sources to provide examples of MHA work.

Methods: Data for case examples includes MHAs' recorded contacts, case success and setbacks, and goals; baseline and six-month participant interviews; and school and medical records. Court Activity Record Information (CARI) records were available for a small number of youth. One case example is included below. See **Appendix B** for additional case examples.

Case 1: 17-year-old from the Lowell Court with CRA and Delinquency Cases

Summary

Demographics: 17-year-old Hispanic male youth.
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."

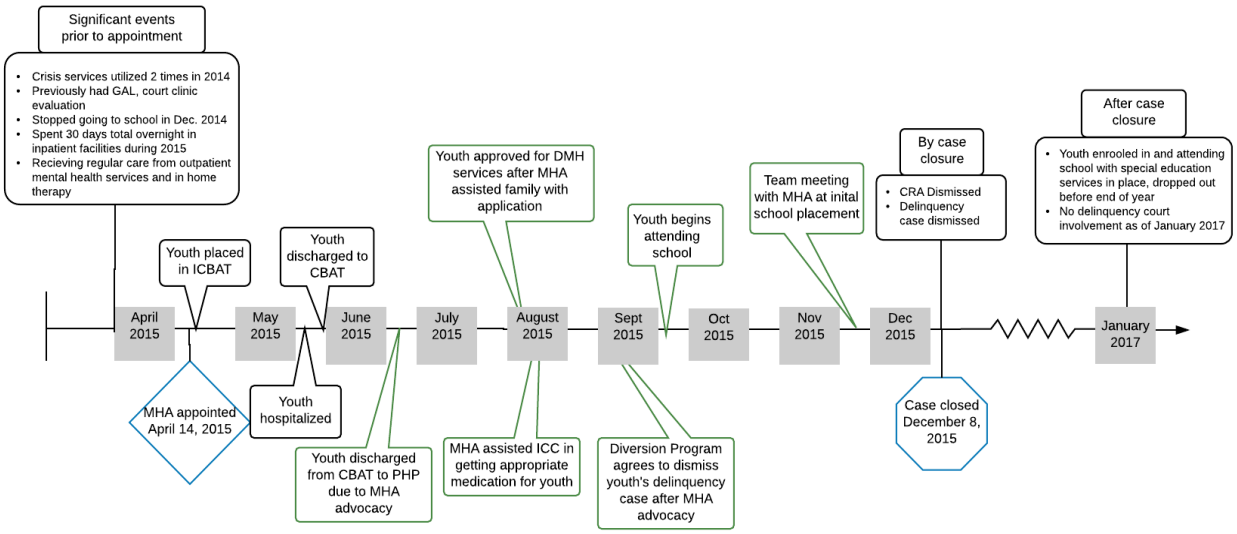
MHA Goals

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 substance exposure and diagnoses of Major Depressive Disorder, Anxiety Disorder, Bipolar Disorder, ODD, and ADHD. 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 used crisis services or the emergency room three times. In 2015 just before the MHA appointment, the youth was hospitalized for behavioral issues.

Case details: 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 on advocating to have the youth's delinquency case dismissed. She worked with the 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. Though 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. 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 in contact with the youth's CBHI providers. Substantial time was also devoted to working with non-CBHI therapist and inpatient providers.

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. The youth continued to be enrolled in school with an IEP through March 2016, despite continued difficulty with attendance, and dropped out of school before the end of the 2016 school year. The youth continued to experience difficulty with taking his medication and engaging in mental health services; however, as of November 2016 he had had no inpatient stays since the spring of 2015. The family reported continued difficulty accessing emergency mental health services, with calls to 911 not responded to. The youth's mother felt that the MHA helped her "a lot" by being "there with [her]." Specifically, she felt the MHA helped by attending treatment and school meetings, where she talked with clinicians and special education teachers; attending court hearings; helping to find "the right" medication; and navigating health insurance plans and advocating for extensions. The youth had no delinquency court involvement when Commissioner of the Probation Department provided the CARI in January 2017.

Key Learnings
This case demonstrates the MHA's potential role 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. This case also highlights the long-term challenges facing youth and families related to accessing services.

PROGRAM TRANSITION

Beginning in March 2017, J-MHAP will transition out of its location in the Salem and Lowell Juvenile Courts to its new setting in the Lynn and Lowell Family Resource Centers. In leaving the court system, services provided by J-MHAP will no longer be connected to court cases. Rather, the program will become community-based referral program, expanding to include youth at-risk for court involvement. Prevention of court involvement will remain the mission and focus of the program.[12] This broadened focus is reflected in the program's new name, the Mental Health Advocacy Project for Kids (*MHAP for Kids*). MHAP for Kids will continue J-MHAP's work addressing mental health and educational service needs for youth with unmet mental health needs.

The transition to MHAP for Kids marks changes to the program structure, referrals and staffing. Referrals for MHAP for Kids will continue to come through the court system, but youth may also be referred by outside sources, including schools and the Family Resource Centers (FRCs). MHAs will transition from their roles as *best interest* advocates for youth, in which advocacy is based on an independent assessment of youth needs rather than youth's expressed wishes. Moving forward, MHAs will serve as staff attorneys who represent families' requests and personal objectives using *zealous advocacy*. The case load for each MHA will increase from 25 to 30 youth. Staff Attorneys' primary responsibilities will be split between outreach in the courts and community and direct advocacy. The MHAP for Kids Project Director will supervise staff attorneys as well as manage program planning, implementation, and development. The transition to MHAP for Kids aims to build a program model which increases sustainability and replicability with the potential to expand statewide.[13]

SECTION 4. ECONOMIC ANAYLSIS

As J-MHAP transitions from a court-appointed model to a community-based referral model, the potential economic impact of the MHAs' work is important to consider. The first part of this section looks at the work of J-MHAP in relation to its yearly operating costs. This analysis explores the annual per-youth costs of J-MHAP and has implications for replication and scale-up. The second part of this section aims to provide information about potential costs to society that could be averted through J-MHAP successes. As with any economic analysis, the findings are limited to the data available to the evaluators. Suggestions for modeling a more thorough future economic analysis are included.

4.1 COSTS PER YOUTH

Overview: An evaluation of program costs relative to the number of youth who received MHA services provides insight into the costs to replicate or bring the model to scale.

Methods: Program costs were identified and compared with MHA allocation of time and enrollment data. Summary program costs were acquired from Health Law Advocates for the February 16, 2016 to February 17, 2017 time period. The figures were assessed for relevance to replication and costs were omitted if they were not likely to be needed in future years. For example, moneys for political action work and program evaluation are not anticipated to be direct costs in the future, so they were excluded. Remaining budgeted costs were then compared and adjusted to better reflect actual expenses, as they appeared in the general ledger. This yearly total was compared with the number of youth receiving services in that year.

Results: J-MHAP's annual program costs include salaries and fringe benefits for two full-time Mental Health Advocates, a full-time Project Manager, and 15% time for each an Executive Director and an Intake Coordinator. Additional direct costs included marketing materials, travel, meeting expenses, rental space, equipment, and facilities and administration for a total annual cost of $349,042.

The two MHAs had the capacity to work with a total of 50 youth at any given point in time, and the length of appointment varied based on individual need. As previously stated, the pilot provided services for 160 cases (152 youth) over the course of its 22 months in operation. Pro-rating the 2016 annual budget for those 22 months and dividing by the number of cases yields a per-youth cost of $3,999. However, it may be more accurate to look at the number of youth who received services during the second year of the pilot after any minor administrative or other issues related to start up were resolved. During 2016, the second full year of the pilot, 123 youth received MHA services. This number includes youth whose appointments started in 2015 and ended in 2016 for approximately $2,838/youth.

Holding all program costs the same but increasing capacity would bring this per-youth cost down. MHAs spent a significant proportion of their time interacting with court officials, likely due to their appointed role. It would be reasonable to assume that this time allocation would decrease in the new community-based model, which might result in freeing up time for other advocacy-related tasks, shortening the duration of cases allowing more cases per year, or perhaps increasing the MHA's capacity for more cases at a time.

It is difficult to predict the rate at which costs will vary going forward. For example, it is not known how many cases MHAs can sustain in their new setting, how many MHAs the Project Manager can supervise, or how much effort the Executive Director or Intake Coordinator will dedicate as the program grows to scale. This differentiation in variable costs would be crucial when determining future budgetary requests for replication and scale-up of the program. Until these variations are known caution should be used when using the per-youth cost for financial forecasting.

4.2 PARTIAL COST-SAVINGS THRESHOLD ANALYSIS

Overview: One option for replicating and disseminating the J-MHAP model would be to secure public funding; therefore, an economic analysis to understand societal costs is warranted. This analysis aims to better understand the potential for J-MHAP to alleviate some societal burdens of untreated mental health conditions among court-

involved youth. In economic evaluation, programs are often assessed in terms of their cost-savings. For example, if a program were to help avert outcomes that are more costly to society than the costs of the program itself, the program could be determined to be a savings to society. One way to understand this is to set the standard, or threshold, at which the program would become cost-saving. In other words, how many specific outcomes would have to be averted for the program to save the public money? This section details a partial cost-savings threshold analysis that seeks to define the standard at which J-MHAP would be cost-saving to society in a given year. This is not a complete analysis as only program operating costs are considered. As a result, the thresholds indicate the number of specific outcomes that would have to be avoided in order for the program to be considered cost-saving, in relation to the public money needed to run the program and does not consider the costs to society for the services acquired by the MHA for the youth. The outcomes selected reflect three domains of the larger evaluation: educational attainment, health service use, and court-involvement.

Methods: As described in the methods section above, J-MHAP cost data were reviewed from a 12 month summary budget for the February 16, 2016 to February 17, 2017 time period. The annual costs of running the program were determined to be $349,042. This yearly total was compared to annual costs of outcomes that may be averted by the work of the MHAs.

A literature review was conducted to determine the societal costs of burdensome outcomes within the identified domains. These outcomes include: school drop-out, youth psychiatric hospitalization, and Department of Youth Services detention. Each of these outcomes were determined to be realistic based on data collected during the pilot evaluation. Publicly available cost data were annualized and inflated to 2016 present dollars to match the HLA program budget using the Consumer Price Index through the U.S. Department of Labor.[14] Program and outcome costs were compared to develop thresholds within each of the three domains using the formula:

yearly program operating cost / yearly outcome cost to society = threshold

Results: The methods used represent a partial analysis that underestimates both societal costs of the program as well as costs of outcomes that may be averted. Program costs were limited to the annual project operating costs of $349,042 and do not consider the costs resulting from MHA activities (e.g., services or placements acquired on behalf of the youth). For example, at baseline 27% of youth participating in the evaluation received services through a special school for youth with emotional needs. This rose to 42% at follow-up, presumably due to the work of the MHAs. These specialized educational services come at an additional cost to society that are not factored into this analysis. Additionally, only a few outcome costs were identified and are intended to be illustrative of potential cost-savings from the pilot and are not exhaustive. Please note, the calculation of the threshold looks only at one outcome at a time and ignores other possible outcomes.

COSTS OF SCHOOL DROP-OUT

There are many educational outcomes that were likely impacted by the work of the MHAs. Among these, truancy is an important predictor of academic success and is often a symptom of a youth's unmet mental health needs.[15] Truancy is a status offense and may be the reason a CRA case is filed. At baseline, 28% of youth in the evaluation missed almost every day of school in the past three months. At follow-up, this was reduced significantly to only 4% ($P<.05$). Intervening and supporting truant youth may prevent the disengagement with school that leads to dropping out.[15]

Youth who drop-out before high school graduation will have many personal financial consequences including decreased earning potential throughout their lives. There are also measurable costs to society. This fiscal burden includes lost taxes, as well as additional health care, criminal justice and corrections, and social service expenses paid by taxpayers. The estimated lifetime lump sum burden (beginning at age 16) to taxpayers is approximately $275,000 in 2016 present dollars.[16] According to a 2012 national report, youth ages 16-24 years who are not enrolled in school and also not involved in the labor market, each pose a yearly burden on taxpayers at approximately $13,900 in 2011 dollars ($14,321 per year in 2016 dollars).[16] Using the formula described in the methods section, the cost-saving threshold for school drop-out is 24.37, meaning that MHAs would have to prevent at least 24 youth from dropping out of school in a given year for J-MHAP to be considered cost-saving.

This threshold, like all presented in this analysis, looks at this one outcome in isolation and does not consider J-MHAPs impact in other domains.

COSTS OF HOSPITALIZATION

When a youth is experiencing a mental health crisis, hospitalization may be necessary. At baseline, 44% of youth in the evaluation had experienced a hospitalization due to mental health issues in the previous year. The costs accrued are primarily shared by public or private insurance and out of pocket payments from the family. A 2009 study used the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project database to estimate the total costs for pediatric mental health disorder hospitalizations in the United States. The average charge for a stay lasting an average of seven days was $15,540, which is equal to $17,384 in 2016 dollars. The 2009 national sample also estimated that approximately 50% of the sample were covered with public monies (43% public insurance, 7% uninsured).[17] Therefore, for every youth hospitalization, the cost to society is approximately $8,692. J-MHAP would have to prevent a total of 40 hospitalizations in one year to be cost-saving.

Youth who have been hospitalized for a psychiatric condition are likely to experience hospitalization more than once in a year. Twenty-two J-MHAP youth participating in the evaluation had a psychiatric hospitalization in the year prior to receiving MHA services. Their average number of days in the hospital for a year was 26.6 days. Adjusting the costs of one stay to account for re-hospitalizations, the yearly estimate for one youth is $30,422 for this population. This means that J-MHAP would have to prevent 11.5 youth from experiencing psychiatric hospitalization in one year.

While inpatient treatment may be the desired outcome for some youth, preventing costly hospital stays through outpatient therapy may be the more frequent goal. At follow-up assessment, only 13% of J-MHAP youth (a significant decline from baseline, P<.05) had a hospitalization since beginning their work with the MHA, indicating the potential for J-MHAP to meaningfully impact costs for this outcome.

COSTS OF JUVENILE CONFINEMENT

While most of the youth receiving J-MHAP services were before the court on a CRA case at baseline, 14% of youth had stayed in a DYS facility in the past year. One of the goals of the program was to prevent youth from becoming more deeply involved in the court system, including prevention or diversion from delinquency proceedings. According to the Massachusetts Budget and Policy Center, the annual cost of youth detention was $109,500 in 2013, which is equivalent to $112,814 in 2016 dollars. **Table 13** shows the estimated annual costs (figures have been inflated) for the three levels of Department of Youth Services (DYS) placement and detention for Massachusetts youth. Please note that the figures presented are for one year.

Table 13. Annual Costs of Juvenile Community Placement or Detention in Massachusetts[18]

Department of Youth Services Program	Annual Costs (Inflated to 2016 dollars)
High Security	
Secure Detention	$112,814
Medium Security	
Staff-Secure Shelter	$98,223
Low Security	
Therapeutic Foster Care with Community Supervision	$58,781
Foster Care with Community Supervision	$32,457

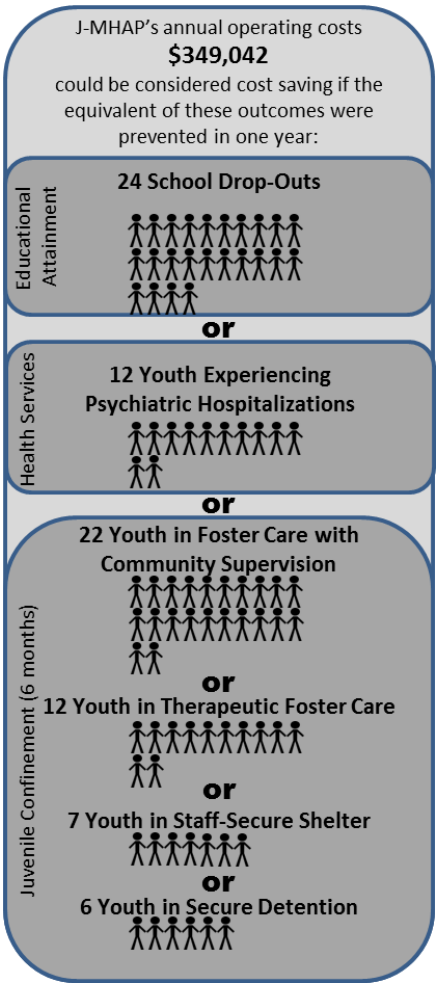
These annual costs may not reflect the average amount of time a youth would stay in a DYS facility. Prorating the costs for 6 month placements would yield thresholds of 6.2 for secure detention, 7.1 for staff-secure shelter, 11.8 for therapeutic foster care, and 21.5 for foster care with community supervision. These thresholds, like those presented above, are calculated in isolation. In other words, J-MHAP would only have to prevent at least 6 youth from experiencing 6 months of secure detention and no other outcomes at all in order to be considered cost-saving.

A future cost-saving analysis should prorate all figures based on the likely length of stay for each outcome for this population. Other additional costs should be considered like court costs. Diverting youth from court-involvement would alleviate time and resources financed by public dollars through the juvenile court and legal system, as well.

SUMMARY OF THRESHOLDS

Each threshold represents the number of outcomes that would need to be averted in a year due to J-MHAP in order for one year of the program to be considered cost-saving. **Appendix C** provides the thresholds by domain, using annual outcome costs to society. The thresholds are oversimplified due to lack of societal data on the costs of new services acquired for youth through MHAs' advocacy, but does highlight some important potential cost-savings of J-MHAP. It is important to note that these calculations are looking at each outcome in isolation; therefore each threshold assumes that outcome is the only impact of J-MHAP. In reality, the work of the MHAs is likely to have some impact across all domains and may even affect more than one outcome in the same youth, as is exemplified in the case examples in **Section 3 and Appendix B** of this report.

Figure 3. Cost-Saving Thresholds by Domain



Thresholds not only provide information regarding the point at which the program could be viewed as cost-saving but also to determine if being cost-saving is a reasonably attainable goal for the program. Providing secure detention is the most costly burden to society presented. The thresholds in **Appendix C** provide information based on detaining a youth for a full year, which may not be a likely outcome for J-MHAP youth. However, the threshold can be used to break down the costs of DYS custody for shorter durations, as well **(Figure 3)**. For example, if J-MHAP were able to prevent 12 youth from experiencing 3 months of detention each, or 6 youth from experiencing 6 months of detention, the public savings would essentially pay for J-MHAP's yearly operating costs. A combination of outcomes, like prevention of two youth from three months of detention, ten youth from dropping out of high school, and five youth from mental health hospitalizations during the year would similarly be cost-saving.

These thresholds should only be used as examples comparing J-MHAP's annual operating costs to these potential averted outcomes. A full threshold analysis would use all costs associated with the program including costs of new services which the MHA helped to obtain for the youth. For example, it may be a goal of the MHA and the family to move a youth to a therapeutic school, obtain substance use services or intensive community-based acute treatment, or be placed outside of the family home. These costs are more difficult to quantify using available literature and are difficult to predict as J-MHAP youth each have a complex set of individual needs requiring an array of services. A future analysis could acquire data from Massachusetts insurers, public agencies, and programs to better understand the private and public costs associated with these services to provide a more thorough analysis.

SECTION 5. 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.[19] 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 follow-up interview to learn about their experiences with the program. Interviews were also conducted with leaders at HLA and with the MHAs.

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, and those with the highest scores were contacted to participate in qualitative interviews. Additional stakeholders and key informants were selected based on specific areas of expertise. This systematic approach allowed for identification of a broad - yet high value - sample of stakeholders representing 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 with stakeholders and key informants. As with the MHA interviews, the interview guide for stakeholders and key informants was developed using the Consolidated Framework for Implementation Research (**Appendix E**). This comprehensive guide was adapted for each specific stakeholder to illicit the most relevant information. For example, those more versed in the day to day needs of court-involved youth were asked targeted questions regarding "client needs and resources," while others with expertise in the policy arena were asked about "policy considerations" and "relative priority" to other current initiatives. Interviews were transcribed and coded for key themes. The Consolidated Framework for Implementation Research was used to anchor these themes within an analysis based in implementation science.[10] The majority of stakeholder interviews were conducted prior to the decision to transition from J-MHAP to MHAP for Kids. More recent interviews highlighted information related to the new program design, as is reflected in the following sub-sections.

Results: As of January 24, 2017, interviews had been completed with 40 J-MHAP families and 30 stakeholders and key informants. **Table 14** provides a breakdown of interviews to date by agency or role of the interviewee.

Table 14. Completed Stakeholder Interviews as of January 24, 2017	
Agency or Role	**Number of stakeholders interviewed**
Primary Stakeholders	
J-MHAP Families	40
Secondary Stakeholders- Internal	
Health Law Advocates	5
Secondary Stakeholders- External	
Court-appointed Attorneys	5
Court Clinics	2
Department of Youth Services	1
Department of Mental Health	1
Department of Children and Families	1
District Attorney's Office	1
Juvenile Court Judges	2
Public School District Attorney	1
Probation Officers	2
Tower Foundation	1
Family Resource Centers	2
Key Informants	
Boston Children's Hospital	2
Massachusetts Advocates for Children	1
Mental Health Legal Advisors Committee	2
Parent / Professional Advocacy League	1

The findings from the key informant and stakeholder interviews are organized into two main domains and seven 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 referral process 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? Will the transition to the Family Resource Centers (FRCs) affect how J-MHAP meets these needs? What outcomes matter most to stakeholders?
6. How does program design affect sustainability and scalability? How does J-MHAP fit in with the broader systems with which it interacts?
7. What role can J-MHAP play to address potential inequities youth experience within the juvenile justice and mental health service systems?

6A. 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. Court system gaps included a lack of sufficient support or resources to meet the needs of youth and families. As one professional working within the court system explained "we can't get help…we need all the help we can get." Mental health system gaps included a 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 quality residential placements for youth in need. Other gaps included waiting lists for community services, a lack of services for youth with dual diagnoses, less access to support for transition-aged youth, and a lack of age-appropriate mental health resources. 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.

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 and problems identified included difficulty working with schools, substantial differences between school districts' resources and willingness to accommodate student needs, the criminalization of youth of color for behavioral or mental health related issues, and a need for quality vocational programming for youth receiving special education services.

Individual needs

Stakeholders explained that families in court are by definition "in crisis." Youth were discussed as facing 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, stakeholders explained that parents and guardians may have their own mental or physical health issues. Other parental challenges mentioned were related to "living perilously close to the economic edge" and related stress, lack of time or resources, working multiple jobs or experiencing unemployment, and accessing insurance. One stakeholder also noted that parents and families of youth with mental health needs tend to experience stigma, blame, and shame which could inhibit both willingness to seek treatment and quality of services received.

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 system as well as 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?*

Youth and families shared insights of their experiences during the interviews, including what they believed to be the MHAs' most important successes. A large part of these successes were accessing needed services that participants had been unable to achieve on their own. Services included group homes, drug treatment programs, residential placements, school evaluations and IEP services, DMH involvement, as well as therapists, counselors, and social workers.

Parents also stressed previous unsuccessful attempts to access these services on their own. For example, one parent noted that the MHA saved the family "thousands of dollars" they would have been charged for the youth to obtain a needed residential placement. Another parent, whose child had been on a waiting list for a neuropsychological evaluation for two years, described immediately receiving an appointment after their MHA spoke to a judge.

Securing or improving IEP services were also important accomplishments for participants. This included receiving psychological and academic testing youth needed to receive an IEP, new or additional IEP services being put in place, and schools being pressured to abide by youths' IEPs when they had not been doing so. IEP services were discussed as helping youth attend class more frequently, enjoy learning more often, and in at least one case, preventing a youth from being expelled by their school. One youth was convinced to attend their IEP meeting by the MHA, and school staff later said that without the youth's involvement, "it would have been a totally different outcome."

Youth and parents discussed additional achievements related to the MHAs' support. Youth's achievements attributed to MHA support included staying sober, avoiding DYS commitment, being placed in a new school, and successful matriculation into high school. 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.

MHA involvement was also described as helping alleviate the stress of navigating the court systems, school settings, and range of services available to the youth. Parents discussed MHAs' help communicating with service providers, gathering necessary documents for court dates, and presenting the mental health "piece" to judges in ways that parents did not feel that they could have done on their own. Support also 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. This support was also described as helping reduce stress for parents or youth. In discussing working with the MHA, one participant remarked, "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." Youth varied in the degree to which they were aware of the MHA's work. Youth who worked with the MHAs described their experiences and themes included feeling comfortable around the MHA and appreciating their presence and involvement.

When asked about youth's health over time, parents described changes in youth behavior during and after MHA involvement, including missing fewer days of school, abiding by school rules, and starting to enjoy going to school. For example, one youth was described as being "a totally different kid," no longer engaging in assaultive behavior following treatment the MHA helped the family to access. In another case, the family said that the youth had initially improved, but then later experienced behavioral difficulties again.

When asked about challenges related to working with the MHA, a small minority of families mentioned communication difficulties, especially during a transition from one MHA to another and at the end of the case. Additional themes included a sense that the MHA workloads were too large or that they could not devote enough time to each family. Occasionally parents described times when they did not feel that the MHA was able to get what they were hoping for, the MHA did not have sufficient power vis-à-vis lawyers or social workers, and that

things moved slowly due to bureaucracy. For example, families described not receiving hoped for services such as transportation to school, new school placements, or mentors. One parent recalled struggling with feeling like he didn't have any warning that the program was coming to an end.

When asked about what they would change about J-MHAP, families discussed themes such as lengthening the time of the MHA appointment; clarification about when the case would close; increasing contact between MHAs and families, including more in-person contact; and further dissemination to "make the community aware that there is such a position, a person, that does that kinda work," "so it's accessible to more people."

After the MHAs' work with the families ended, their involvement was often missed by parents and youths alike. 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 be aware that this program exists. Overall, families described feeling that it was helpful to have someone to advocate and provide support through the court process, school struggles, and difficulties in the home. One youth in particular said, concerning J-MHAP, "I feel like it could help anyone's problems" and a parent explained, "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."

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

Key elements of the MHAs' role described by stakeholders included assessing youth and family needs, setting goals in collaboration with families, 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, which is work that "changes the paradigm for how people look at these kids."

The move to MHAP for Kids will inevitably alter the role of the MHA. It removes the question of the importance of the MHAs' legal background, as the MHAs' legal background will be an inherent part of their role as staff attorneys within the new program model. As a result, as some stakeholders noted, the MHAs' power to take legal action in the new program model may give them additional leverage to secure needed services and placements for youth. Additionally, it has been expressed that the switch from best interest to zealous advocacy model may shift the dynamic of the MHAs' work. The MHA may no longer be seen as a neutral party, but will have additional tools to achieve successes and secure needed services.

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

In the J-MHAP model, a MHA could be recommended 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 relied 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. 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.

Stakeholders suggested that a small number of families in J-MHAP which had been appointed a MHA did not want MHA services or negatively associated the MHA's connection with the court. According to stakeholders, the voluntary nature of MHAP for Kids and the fact that it is no longer connected to the courts may encourage more "buy-in" from families.

In transitioning to the FRCs, MHAP for Kids will continue to accept referrals from the court system and serve youth who end up in court. However, the new program model will offer an opportunity for earlier intervention. For example, schools will be able to refer youth to the program prior to CRA involvement. One stakeholder suggested that this may result in a younger cohort of youth served. Another stakeholder expressed that a departure from the court system would provide the opportunity for a broader population to have access to MHA services.

6B. SUSTAINABILITY AND SCALE UP

5. To what extent is J-MHAP serving to meet key unmet needs? Will the transition to the Family Resource Centers affect how J-MHAP meets these needs? What outcomes matter most to stakeholders?

Stakeholders discussed needs and gaps that J-MHAP is working to fill or may be well positioned to address. These needs and gaps included educational advocacy, helping parents access information about programs or services, and coordination of systems and parties involved in a youth's care.

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. Stakeholders discussed the need for a comprehensive approach to coordinate systems and parties involved with youth, and the MHAs were seen as carrying out this role. 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.

Stakeholders felt that J-MHAP was working to meet family needs by making things easier for parents who may be struggling with their own needs and pushing systems to better serve "the most high-need" kids who have "nowhere else to turn after doing multiple other things." 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.

Those working regularly with J-MHAP through the court system, including judges, attorneys and probation officers, consistently described a strong need for J-MHAP within the court and felt it would be a loss if J-MHAP left the court. 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."

Stakeholders also discussed outcomes that mattered most in their assessment of J-MHAP's success and metrics for evaluating such outcomes. Outcomes discussed included youth staying out of court, matching youth with appropriate services, fostering agency cooperation, family satisfaction and support, keeping kids with families, school outcomes (e.g. attendance, dropout rates, grade promotion), court outcomes (e.g. future court involvement and arrests), youth ability to live in the community, and family self-sufficiency in accessing services.

Metrics suggested for evaluating the program's success included number of hospitalizations, family satisfaction, cost (e.g. cost relative to other programs, costs averted, cost per case for successful vs. unsuccessful cases). Another metric proposed was a "success rate" (i.e. cases in which J-MHAP was able to successfully get services vs. unsuccessful cases), although it remained unclear what a good or acceptable success rate would be.

In thinking about the new program model, stakeholders focused on the role of MHAP or Kids as a prevention program. Preventing youth from becoming involved with court or in DCF custody in the first place by working with families to put needed services in place and thereby preventing family dynamics that may lead to DCF involvement was considered an important step. Stakeholders also described the existing work of the FRCs in preventing CRAs, a need for which MHAP for Kids will be well positioned to address.

As one MHA noted, many youth served by J-MHAP would have benefited from earlier intervention due to the amount of time that passed during which their needs were not being met, and during which youth and families experienced failure and frustration as a result. Stakeholders similarly discussed the potential for MHAP for Kids to have a greater impact because of the ability to intervene earlier. The importance of the focus on diversion and prevention of court involvement was a common theme among stakeholders prior to and following the decision to transition to MHAP for Kids.

In addition, MHAs discussed challenges associated with the six-month term of appointments in J-MHAP. Often, school holidays and summer break led to stagnation for youth and families due to added stress, less structure, and difficulty of planning meetings and screenings. There was a noted tension between the frequent need for an extension of services and the needs to take on more appointments and remain goal-oriented. In moving to the FRCs, one stakeholder expressed the need to find this balance in the new program structure. This would potentially involve focusing less on the 6-month timeline and instead working within a more "objectives-based" model.

Stakeholders discussed J-MHAP's role in addressing both individual and systemic needs and proposed ideas for enhancing J-MHAP's impact on systemic gaps. These ideas may be transferable to MHAP for Kids. Ideas proposed included compiling a digest of services; engaging in direct policy advocacy related to systemic gaps; serving as a mechanism for system learning by aggregating lessons learned; identifying systemic barriers that youth and families face and making recommendations for system improvement; and investigating ongoing statewide initiatives and programs related to MHAP for Kids.

To advance the overall efficacy of the new program moving forward, one stakeholders suggested developing a formal process for Continuous Quality Improvement (CQI) in which cases are systematically reflected upon at case closure to assess what went well and what did not go well in order to generate learning for continual improvement. Another suggested creating a formal mechanism for parties involved in cases to provide feedback.

6. How does program design affect sustainability and scalability? How does J-MHAP fit in with the broader systems with which it interacts?

Sustainability and scalability reflect J-MHAP's fit within larger policy context and the systems with which J-MHAP interacts, including the school, court, and state and national mental health care systems. According to stakeholders within HLA, sustainability and scalability have been a focus of J-MHAP since its development. 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 provided a needed service 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.*

Themes related to scalability of J-MHAP revolved around program staffing related to potential expansion of MHA services. Ideas for staffing organization included supervising attorneys overseeing staff attorneys in different regions and a Project Director who would perform consultation and supervision. Concerns were raised around the need to maintain a high quality of services if the program expands. Ideas for additional program support included access to a prescriber to address medication questions, a clinical expert (e.g. in the case of conflicting recommendations from providers), and administrative support. To address this concern, one idea involved delineating exact criteria for each role, including what training would be necessary for new staff, and monitoring of staff. It was noted that the quality of MHAs is "essential" and that the program's successes are largely tied to quality of its staff.

Prior to the development of the new MHAP for Kids program model, stakeholders raised several concerns and offered thoughts about where J-MHAP might be better situated in order to enhance sustainability and scalability and to meet the greatest need for its services. A primary consideration involved the positioning of J-MHAP within the court system, which one stakeholder said does not "position J-MHAP well for replication and sustainability." A key informant explained that determining J-MHAP's target population would play a role in determining where to situate the program. Youth at risk of CRAs, for example, would likely be better served outside of and prior to court involvement. Alternative suggestions included situating J-MHAP within court clinics or Accountable Care Organizations (ACOs) where they could qualify for reimbursement through value-based payment systems. Within an ACO, one key informant explained, J-MHAP would be situated within a system that would offer added evaluation support and in which the "wave of change is happening."

Several stakeholders suggested advantages to positioning a program like J-MHAP within Family Resource Centers (FRCs). The transition to MHAP for Kids was seen as supporting sustainability and as allowing the program to serve a broader demographic. According to stakeholders, political will and funding opportunities may be greater for

MHAP for Kids due to its focus on diversion, which would contribute to its financial sustainability, scalability, and overall longevity.

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

Stakeholders discussed 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 equitable access to MHA services.

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 and criminalization of youth of color might also be introduced by school officials' responses to youth behavioral issues, in that these youth may be more likely to experience arrest as opposed to having a CRA filed. Stakeholders also discussed potential disparities in 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.

Stakeholders suggested that parents and guardians may also differ in terms of level of expectation of fair treatment by the court system and acknowledgement of youth mental health needs. Some stakeholders 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.

The question raised by stakeholders about which youth are accessing services based on race/ethnicity and mental health status is further complicated by a lack of available data. Currently, data is limited to mostly anecdotal or speculative evidence of bias. Stakeholders acknowledged wanting to know more in regard to population served versus the demographics of the surrounding communities. Recommendations for monitoring and evaluation related to this theme are discussed in the next section.

SECTION 6. RECOMMENDATIONS & CONSIDERATIONS

The evaluation findings provide important information to guide implementation and assessment of MHAP for Kids. Recommendations for better understanding the implementation and effectiveness of MHAP for Kids were developed by the evaluation team, drawing on published literature and the analysis of program data. Recommendations are grouped by theme and include guiding questions to address for continued evaluation, metrics for data collection which may help address these questions, and recommendations which may support the transition to MHAP for Kids.

Referral Patterns, Outreach, and Buy-in

GUIDING QUESTIONS

1. How successful is MHAP for Kids in *identifying* youth at risk before a CRA is filed?
2. Does MHAP for Kids serve a similar demographic to J-MHAP? Are youth from certain backgrounds referred more/less to the program?
3. Who is targeted by outreach and who is harder to reach?
4. What are best practices for outreach? What methods are effective for advertising services so that appropriate referrals are made?

METRICS

- Demographics of youth and families referred*
- Youth court involvement*
- Screening for youth and parent mental health with validated measures (e.g. parental depression, parent stress, family conflict, youth strengths and difficulties)
- Youth history of service use
- Referral sources*

RECOMMENDATIONS

- Develop standard outreach and referral process to support replication, including methods for counteracting potential implicit bias in referrals'
- Integrate diverse methods for outreach to reach all populations to support equity in referrals;
- Establish direct outreach to schools and identify point person at each school in catchment areas;
- Create plan for ensuring access to MHAP for Kids services for non-English speaking families and families with other access barriers; and
- Screen for parent and youth mental health and functioning using standardized measures at intake.

CONSIDERATIONS

- Referrals to MHAP for Kids are likely to be affected by similar implicit biases that some stakeholders felt may have affected referrals within the court system. Tracking youth characteristics by referrals source may help determine whether, for example, schools tend to refer youth with certain characteristics more than others and help identify approaches to address disparities through system advocacy or other means.
- At least one family referred to J-MHAP was able to afford a private educational advocate who, despite the economic burden to the family, was able to help the family access services before the MHA was fully on board. Going forward, MHAP for Kids may consider measures to ensure that the program has capacity to serve those otherwise unable to secure support.
- Alternative methods may be needed to reach transition-age youth and any other populations of youth who may not be enrolled in schools or integrated into existing service systems.

Need for MHAP for Kids and Program Effectiveness

GUIDING QUESTIONS

1. How large is the need for MHAP for Kids?
2. What are the main systemic gaps families served by MHAP for Kids have experienced?
3. How many youth does the program prevent from going deeper into the court system?
4. By intervening earlier in complex cases, does MHAP for Kids help to alleviate overall strain on limited intensive mental health resources?

METRICS

1. Quantity of referrals
2. Demand for services (e.g. waitlist)
3. Requests for consultation from other providers
4. Duration of cases
5. Number of referrals accepted as cases vs. denied
6. Reasons for denial or postponement of services

RECOMMENDATIONS

- Develop procedures for providing regular updates to families about MHA progress toward goals;
- Develop specific criteria for closing cases;
- Standardize procedures for preparing and supporting families for transition at the end of the appointment;
- Develop a well-defined plan to ensure that the population served is consulted regularly regarding perceived effectiveness and cultural relevance.[20] For example, brief follow-up surveys to families after case closure may provide insight into families' experiences in the program and the degree to which the program met each family's needs; and
- Incorporate quality assurance practices to support intervention integrity,[20] such as ensuring MHAP for Kids maintains J-MHAP's focus on recruiting and supporting high-quality attorneys. Develop specific training process for new staff attorneys if program expands, including training related to cultural relevance, and for ongoing support for staff post-training.

CONSIDERATIONS

- As MHAP for Kids is actively considering, an objectives-based model may provide structure and flexibility and avoid abrupt endings due to limitations on case length. Due to the wide-ranging magnitude of challenges faced by different families and complex bureaucratic barriers, a program structure that allows for staff attorneys to stay on cases long enough to meet goals may support continued effectiveness.
- Families in J-MHAP faced challenges in addition to youth mental health needs, including parent mental health, housing instability and homelessness, and domestic violence. The partnership with the FRCs presents an opportunity to establish processes for working with families to address these additional needs.

Implementation, Sustainability and Scalability

GUIDING QUESTIONS

1. How is implementation carried out at different FRC sites? Are there differences between implementation in the Lynn and Lowell FRCs?
2. Are there barriers to implementation? If so, are there best practices MHAP for Kids can identify for addressing these barriers if the program expands?
3. Which individuals or parties are most supportive of implementation? Are there parties whose support is critical for successful implementation?
4. Are different types of stakeholders more or less receptive to the program?

METRICS

1. Satisfaction of youth, families, and stakeholders
2. Timeline of implementation milestones (e.g. moving into FRC, receiving referrals, filling caseloads, beginning advocacy)
3. Activities of the MHAs (e.g. goals and contacts)

RECOMMENDATIONS

- Develop a formal process for Continuous Quality Improvement (CQI);
- As part of CQI process, continue to use data systems and develop any additional systems as needed to track metrics; and
- Implement a process for soliciting feedback from families and other providers involved in cases.

CONSIDERATIONS

- Establishment of formal processes as described above may support development of MHAP for Kids as a replicable mental health advocacy model which can be implemented statewide across FRCs.
- Continuous monitoring of qualitative and quantitative metrics in a continued evaluative process will be important not only for evaluating MHAP for Kids' efficacy, but also for developing an evidence base for other programs like MHAP for Kids.[20]

* In existing MHAP for Kids Protocols

SUMMARY

Analyses of baseline, follow-up, process, and stakeholder data indicate that the MHAs have been largely successful in their work thus far and have filled a needed role for families and 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 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. These 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. Statistically significant changes in risk profile measures were observed from baseline to follow up. Four areas showed statistically significant improvement and four others showed a signal of effect, suggesting 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.

APPENDIX A

Table 1. Baseline Family Risk Scores*				
Domain	**Baseline**	**Published norm**	**Standard deviations from norm**	**Interpretation**
	Mean (SD) Or %	**Mean (SD) Or %**		
Family Functioning				
Parent perceived conflict ➢ Conflict Behavior Questionnaire (CBQ)	12.1 (5.8)	2.4 (2.8)[1]	+ 3.46	Higher scores indicate more negative perceptions.
Youth perceived conflict ➢ Conflict Behavior Questionnaire (CBQ)	5.3 (4.9)	2 (3.1)[1]	+1.06	Higher scores indicate more negative perceptions.
Parent Mental Health				
Parent Stress ➢ Perceived Stress Scale	20.7(6.3)	13.02 (6.35)[21]	+1.21	Higher scores indicate more stress.
Parental Depression ➢ Center for Epidemiological Studies Depression Scale (CES-D)	19.9 (12.8)	9.25 (8.58)[5]	+1.24	Higher scores indicate greater depression symptoms.
At least mild depression (CES-D ≥ 16)	60.4%	19%[5]	n/a	≥ 16 indicates any depression.
Overall Mental Health ➢ VR-12	42.8 (14.0)	50.08 (11.49)[22]	+0.63	Higher scores indicate better health.
Overall Physical Health ➢ VR-12	48.1 (11.3)	39.82 (12.29)[22]	-0.67	Higher scores indicate better health.
Youth Functioning				
Total Difficulties (Parent on youth) ➢ Strengths and Difficulties Questionnaire	20.8 (6.2)	7.1 (5.7)[2]	+2.40	Higher scores indicate more difficulties.
Impact of Difficulties (Parent on youth) ➢ Strengths and Difficulties Questionnaire	6.0 (2.9)	0.4 (1.3)[2]	+4.31	Higher scores indicate greater impact.
Total Difficulties (Youth Completed) ➢ Strengths and Difficulties Questionnaire	15.8 (6.4)	10.3 (5.2)[23]	+1.06	Higher score scores indicate more difficulties.
Impact of Difficulties (Youth completed) ➢ Strengths and Difficulties Questionnaire	2.3 (1.8)	0.2 (0.8)[23]	+2.63	Higher scores indicate greater impact.
Youth Quality of Life ➢ Youth Quality of Life Scale (Y-QOL)	70.9 (15.8)	82.20 (1.14)[6]*	n/a	Higher scores indicate greater QOL.
Trauma ➢ Los Angeles Symptom Checklist	19.5 (13.4)[†]	12.29 (10.63)[7‡]	+ 0.68	Higher scores related to more extensive trauma exposure.[24]

* Evaluation subset

Table 2. Description of Barriers from Child and Adolescent Services Assessment[9]	
Barrier	**Description**
Systems 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.

Table 3. Comparison of Baseline and Follow-up Family Risk Scores*			
	Baseline	**Follow-up**	
Domain	**Mean (SD)**	**Mean (SD)**	**p-value (paired T-test)**
Family Functioning			
Parent perceived conflict ➢ Conflict Behavior Questionnaire (CBQ)	12.1 (5.8)	9.3 (6.1)	.05
Youth perceived conflict ➢ Conflict Behavior Questionnaire (CBQ)	5.3 (4.9)	4.2 (4.7)	.10
Parent Mental Health			
Parent Stress ➢ Perceived Stress Scale	20.7 (6.3)	16.9 (7.2)	.03
Parental Depression ➢ Center for Epidemiological Studies Depression Scale (CES-D)	19.9 (12.8)	16.1 (13.6)	.06
Overall Mental Health ➢ VR-12	42.8 (14.0)	46.6 (15.0)	.07
Overall Physical Health ➢ VR-12	48.1 (11.3)	49.7 (10.5)	.51
Youth Functioning			
Total Difficulties (Parent on youth) ➢ Strengths and Difficulties Questionnaire	20.8 (6.2)	18.5 (8.4)	.05
Impact of Difficulties (Parent on youth) ➢ Strengths and Difficulties Questionnaire	6.0 (2.9)	3.4 (3.3)	<.01
Total Difficulties (Youth Completed) ➢ Strengths and Difficulties Questionnaire	15.8 (6.4)	14.6 (7.5)	.20
Impact of Difficulties (Youth completed) ➢ Strengths and Difficulties Questionnaire	2.3 (1.8)	1.1 (1.6)	.07
Youth Quality of Life ➢ Youth Quality of Life Scale (Y-QOL)	70.9 (15.8)	73.6 (16.7)	.27

* Evaluation subset

Table 4. School and Service Use Baseline and Follow-Up Comparison*			
	Baseline %	**Follow-up %**	**p-value**
School Engagement			
Attendance in past 3 months			<.01
Missed more than one day/week	33%	4%	
Didn't go at all or missed almost every day	28%	4%	
Attended almost every day	28%	48%	
Missed one or two days/month	13%	22%	
Missed one day/week	0%	22%	
School Suspensions (past year/since baseline)†			.43
0	55%	62%	
1	15%	15%	
2 to 5	20%	23%	
More than 5	10%	0%	
Type of Service/Placement†			
In-school therapy or counseling	59%	67%	.53
Special classroom for learning, emotional or behavioral needs	38%	48%	.72
Special school for youth with emotional or behavioral needs	29%	41%	.31
Mental Health Services Received†			
Outpatient Services:			
Mental Health Provider	94%	87%	.30
Crisis or Emergency Services (emergency room, in-home crisis services)	63%	23%	<.01
Took medication for emotional, behavioral, or substance use reasons during past year (at least 1 week)‡	88%	n/a§	n/a
Overnight Services:			
Hospital	44%	13%	<.01
Residential Treatment Facility	37%	21%	.14
Drug/Alcohol Treatment Unit	6%	7%	.91
Other Out-of-Home Placement:			
Group Home	12%	23%	.18
Detention center/prison/jail	14%	7%	.30
Emergency Shelter	8%	0%	.10
Foster Home	2%	3%	.76

* Evaluation subset

† Results should be interpreted with caution due to discrepancy in look-back period between baseline and follow-up

‡ Missing data was 50% for this item and should be interpreted with caution

§ No data available

Table 5. Barriers to Accessing Services Baseline and Follow-Up Comparison *†‡			
Type of barrier	**Baseline**	**Follow-up**	**p-value**
	% Families reported barrier	**% Families reported barrier**	
Systems barriers	89%	74%	.09
Bureaucratic delay	63%	55%	.44
Transportation to treatment/services	38%	35%	.79
Incomplete information	37%	32%	.69
Time	46%	26%	.07
Service not available nearby	31%	26%	.63
Cost of treatment/services	37%	32%	.69
Refusal to treat	23%	16%	.45
Language	6%	3%	.60
Child or parent refuses treatment	42%	26%	.13
Quality of services	40%	42%	.89
Fear of consequences	38%	42%	.75
Stigma	29%	42%	.22

* Evaluation subset

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

‡ Results should be interpreted with caution due to discrepancy in look-back period between baseline and follow-up

APPENDIX B

Case 2: 13-year-old from the Lowell Court with a CRA

Summary

Demographics: 13-year-old White male youth.
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.

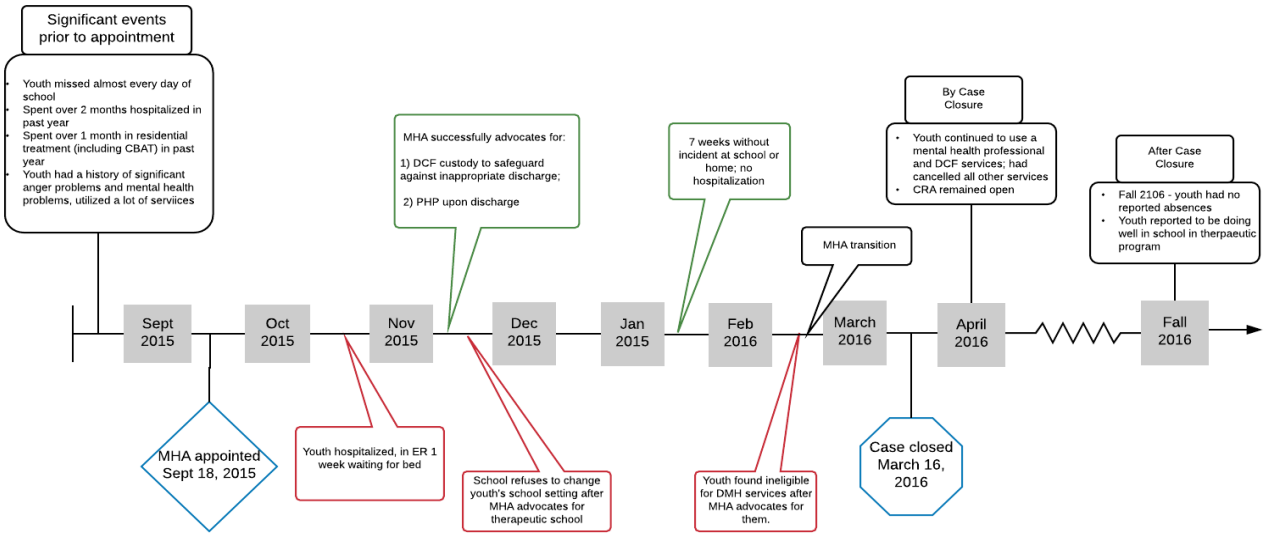
MHA Goals

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 "support family through the Bureau of Special Education Appeals process," and "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 was experiencing difficulties in school and at home. He had formal diagnoses of Autism Spectrum Disorder (ASD), Oppositional Defiant Disorder (ODD), Attention Deficit Hyperactivity Disorder (ADHD), learning disability, anxiety, and Bipolar Disorder. Behavior and symptoms included anger, aggressive and impulsive behavior, and destruction of property, resulting in repeated hospitalizations and crisis service use over the previous two years. He was in a therapeutic class at school, but missed almost every day.

He had some services provided through CBHI and DCF, including a therapeutic mentor and Intensive Case Coordination, among others. Despite these services, he continued to experience behavioral difficulties.

Case details: The MHA's goals spanned multiple service systems including DMH, DCF, the school system, and the mental health system. According to the youth's mother, the MHA primarily worked on securing a new school placement. Over the six-month appointment, the MHA spent the most time working within the legal system with attorneys and the youth's probation officer, as well as in court. Communicating with family members and mental health services consumed a substantial amount of time as well, and the MHA spent her remaining time interacting directly with the school system, DMH and DCF.

At the start of the appointment, the youth spent three days in the emergency room due to behavioral issues, used in-home crisis services within a week of discharge, and then stayed at a Community Based Acute Treatment Center (CBAT) for one week. Within one month after appointment, the youth spent a week 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 and tried to facilitate his placement in a therapeutic school. In November, there was a case setback when the MHA learned that the school district refused to change the youth's school placement despite MHA advocacy and clinical recommendations t

In January, the MHA began advocating for DCF and DMH services. Although the youth was not expected to be eligible for DMH services since he was already receiving DCF services, the MHA's advocacy was aimed at identifying the youth to DMH so that he would be known by the department when he becomes an adult. In February, DMH determined that the youth was not eligible for services, as expected. 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 MHA appointment was vacated on March 16, 2016, 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. During the fall of 2016, the youth had no reported absences and was reported to be doing well in a therapeutic class at school.

Key Learnings

This case illustrates the 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 3: 18-year-old from the Salem Court with a Care and Protection case

Summary

Demographics: 18-year-old White male youth.
Case type: Care & Protection, amended to Permanency
MHA court appointment: 3/6/15-12/2/15

Scope: The judge set three scopes for this case: secure services from DCF, secure Services from DDS, and secure services from DMH. The Judge also commented on the need for "appropriate placement and services and planning for past 18" and that the youth "may need a team meeting to figure out agency responsibilities."

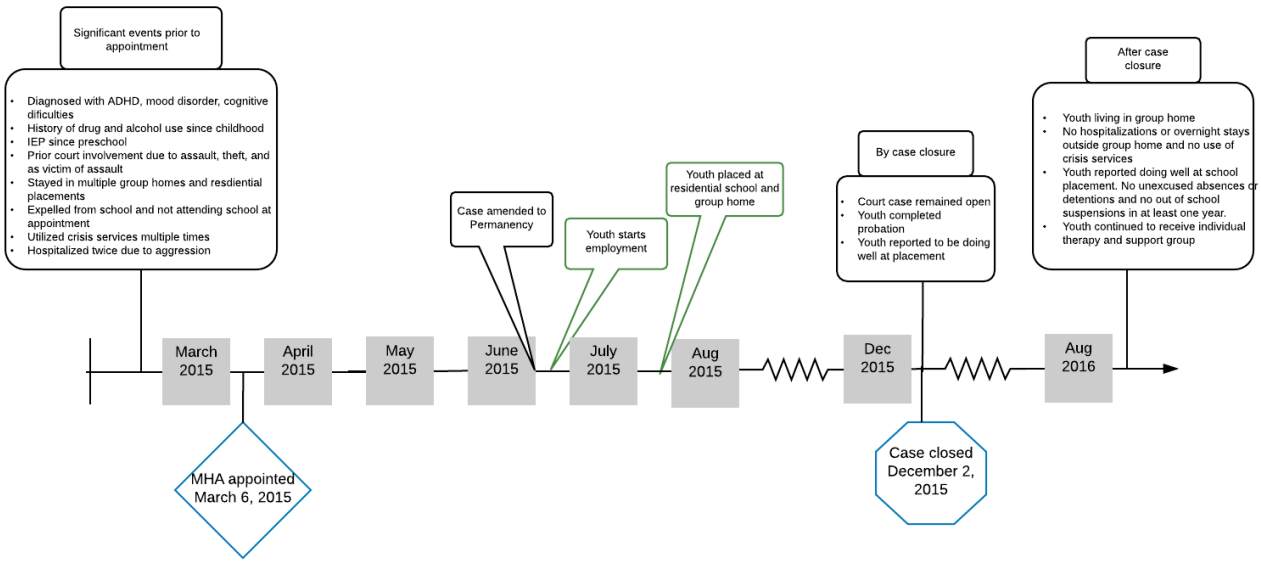
MHA Goals

The MHA outlined four specific case goals:

1. Improve team communication
2. Assist with/expedite placement process
3. Support 18 year old with placement and ensure appropriate services are in place
4. Address adult agency services issue (was denied for DDS)

Outcomes: The case was extended for 16 weeks because the time of year made it difficult to ensure school services would be in place. By case closure, the MHA had completed 3 out of 4 goals. The goal that remained incomplete was "support 18 year-old with placement and ensure appropriate services are in place," however substantial progress had been documented on this goal. The court case remained open at the end of the MHA appointment.

Timeline



Detailed Case Timeline

History: Prior to the MHA appointment, the youth was living in a group home and was receiving tutoring while he waited for a new school placement after being expelled from his previous school. He was also on probation due to a prior delinquency case. The youth had been diagnosed with ADHD, mood disorder, and cognitive difficulties, and had a history of polysubstance abuse and impulsive behavior. He experienced two prior hospitalizations and several residential or group home placements and mobile crisis evaluations. He also had a history of prior court involvement and previously had a Guardian ad Litem.

Case Details: The MHA was appointed in March 2015, and spent her time working with many different parties. The largest proportion of her time was spent working directly with the youth and his family. The MHA also spent time interacting with residential and group home placements, the youth's school, DCF, and the legal system including the youth's attorney and judge. The MHA also spent time working on tasks such as motions and reports for the court. A small fraction of the MHA's time consisted of communicating with other government agencies and other providers.

During the first few months of the case, the MHA worked on improving communication among the youth's team and working on securing an appropriate placement for the youth. The youth was due to switch placements when he turned 18 and aged out of his current group home. The MHA was concerned about his risk for violating probation and worked on securing a placement where he would have structure and support to return to school and stay out of trouble. At the time, DCF was planning to send youth to a program in a nearby city. The MHA researched the potential placement and, after speaking with the Clinical Director, determined the placement would not sufficiently support the youth's needs due to a lack of clinical support on site and might put him at risk for violating probation.
In June, the case was amended to a Permanency case. The MHA appointment was extended to assist with ongoing DCF placement issues and because the time of year made it difficult to ensure that school services would be in place at the time the appointment was set to end. The youth also began working part-time in June.

In July, the MHA advocated successfully for the youth to attend a therapeutic residential school outside of the city. The youth was not initially on board with this decision, and the MHA and youth worked together to help him adapt to the new placement. The MHA also communicated with the youth's clinician at the program to assess his progress. Despite some behavioral incidents, the youth was reported to be doing well at his placement through the date the case was closed.

After Case Closure: The MHA appointment was vacated in December 2015, though the court case remained open. The youth successfully completed probation. Eight months after the case was closed, the youth reported no hospitalizations or use of emergency or crisis services in the past year. The youth continued seeing a therapist and attending support groups. He had no reported unexcused absences or suspensions during the school year ending six months following case closure. He noted that the MHA helped him out "the most, more than anyone" because she knew how to talk to him and helped his parents. The youth reported that the MHA was on his side in court when "everybody would be against [him]." Looking back, he reported getting into his current school as a success that occurred during this work with the MHA, something he and the MHA wanted.

Key Learnings
As this case demonstrates, older youth may face unique challenges as they move toward adulthood, such as connecting with service systems that serve adults, completing school and/or starting work, in addition to any ongoing mental health and/or substance use needs. In this case, the MHA worked to help navigate these challenges and put appropriate services in place to serve the youth going forward. In this case, MHA's comprehensive understanding of youth and family needs served as a foundation for advocacy work. While DCF supported placing the youth in a specific program, the MHA's assessment and knowledge of the youth led her to believe this placement was not a good fit. This case also highlights the importance of the support provided by the MHA in addition to the concrete advocacy work. The youth described a very positive relationship with the MHA and appreciated the support of the MHA in addition to the specific achievements.

Case 4: 15-year-old from the Salem Court with a Delinquency/CRA case

Summary

Demographics: 15-year old biracial male youth.
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."

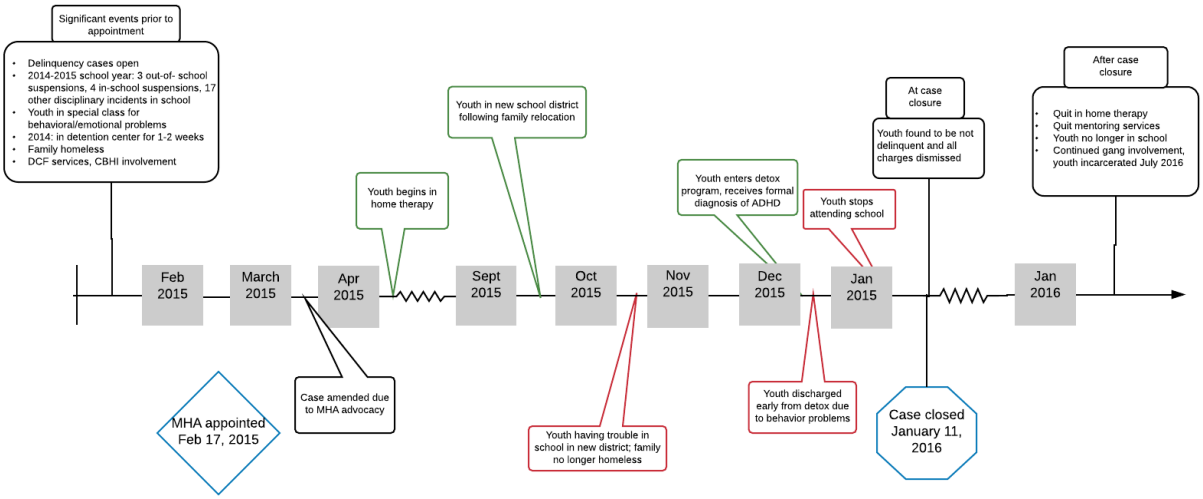
MHA Goals

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 living in a shelter. Medically, he had formal diagnoses of ODD and substance use disorder. 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. 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; however, he was discharged after one week due to behavioral problems. The MHA worked on setting up outpatient substance use treatment. 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 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 had difficult experiences working 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 difficult conditions. 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 5: 17-year-old from the Lowell Court with a CRA Case

Summary

Demographics: 17-year-old White genderqueer youth.
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."

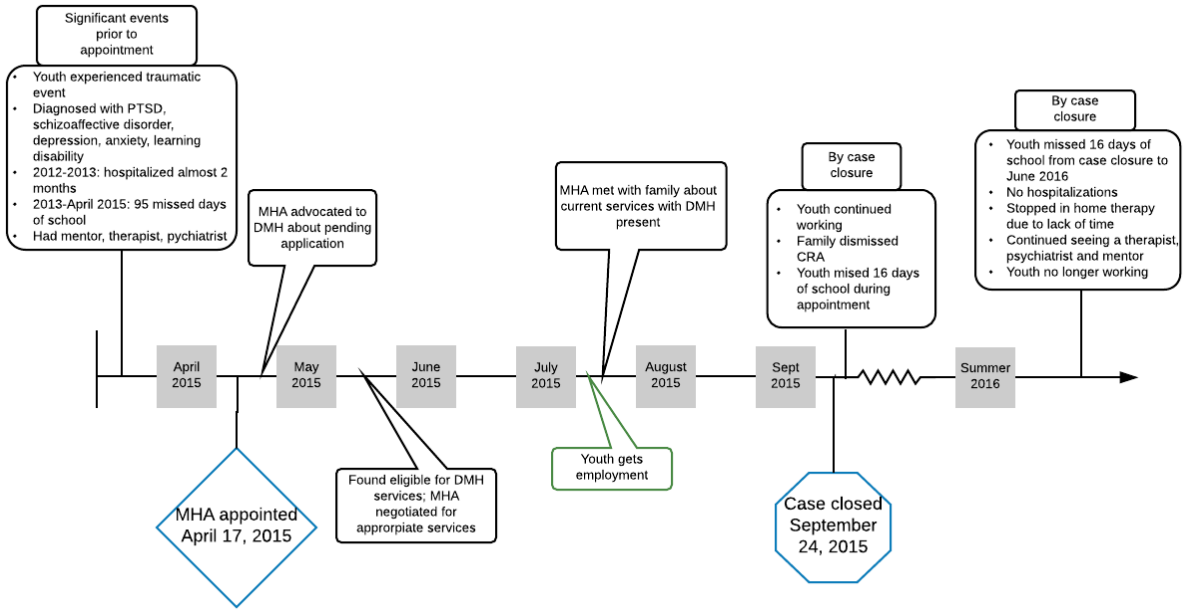
MHA Goals

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 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 early 2013 to the MHA appointment in April 2015, the youth missed 95 days of school. In the 2013-2014 school year, the youth 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. The youth 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.

Case Details: The MHA was appointed in April 2015. Over half 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 and DMH.

The MHA worked on advocating to DMH regarding services for the youth in the first month of the case. The youth was found eligible for DMH. From June to August, the MHA interacted with CBHI providers almost exclusively, specifically an Intensive Care Coordinator and in-home therapy clinicians. In July, the youth successfully obtained a job. During most months of the MHA appointment (April – September), the youth missed sixteen 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 her job. The youth missed about 16 days of school from September 2015 to June 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 work advocating to DMH to secure services for the youth illustrates the ability of the MHA to navigate across multiple systems.

Case 6: 15-year-old from the Salem Court with a Delinquency case

Summary

Demographics: 15-year-old White male youth.
Case type: Delinquency
MHA Appointment: 5/5/15 – 1/12/16

Scope: The judge set two scopes for this case: coordinate mental health services and general school/education advocacy. The Judge also commented on the need to help youth "with obtaining mental health services as well as assistance with his upcoming exclusion hearing at school."

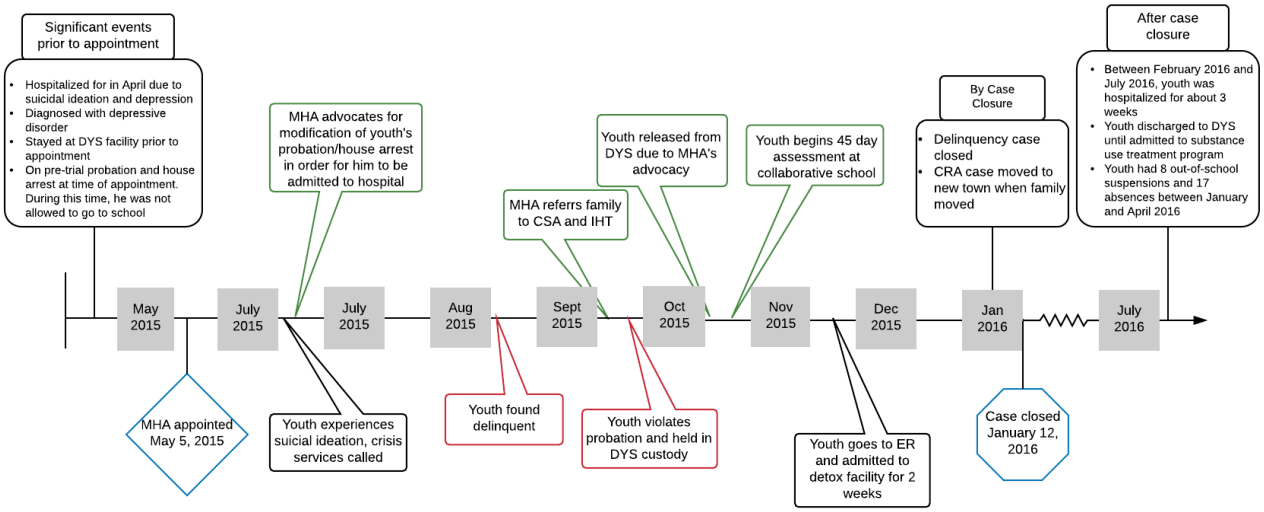
MHA Goals

The MHA set the following four goals for the case:

1. Assist with school discipline issues
2. Determine other appropriate mental health services
3. Ensure mental health referrals go through and services begin
4. Monitor placement at new special education program

Outcomes: The case was open for eight months. By case closure the MHA completed two out of the four goals. The two goals which remained open were: "assist with school discipline issues" and "monitor placement at new special education program," but goals had progress documented. The MHA successfully advocated for and put into place therapeutic mentoring and CSA services for the youth and helped him to continue treatment instead of DYS commitment.

Timeline



Detailed Case Timeline

History: Prior to the MHA appointment, the youth had spent one week at a DYS facility, and was on pre-trial probation and house arrest. He received a DCF worker and a therapist. The youth was also frequently refusing to do schoolwork or attend school. Within two weeks of the MHA appointment, he was hospitalized for about a week due to depression. The youth had an educational tutor and an IEP at school, but was not allowed to attend school while on house arrest.

Case details: The MHA was appointed in May 2015. Over the eight-month appointment, she was in contact with many various parties. Around half of the MHA's time was spent communicating with court officials such as the judge, probation officer, and the youth's attorney. The youth's family and the MHA were also in close contact for a large proportion of the MHA's appointment. She spent a smaller amount of time communicating with different providers, programs, and school officials.

The youth struggled with suicidal ideation and substance abuse while awaiting trial. Early in July, the MHA attended court for motions on the youth's delinquency matters. She successfully advocated to modify the youth's probation and house arrest in order for him to engage in treatment. Around this time, the MHA also worked on getting a therapeutic mentor for the youth and securing a detox bed for the youth. He was screened by crisis services in July and it was determined that he needed to be admitted to the hospital due to suicidal ideation, but faced barriers due to his insurance and ankle bracelet. The MHA worked with the youth's father to facilitate the youth's admission by advocating to the youth's insurance company and probation department, as well as to crisis services to ensure that he met level of care.

Multiple providers and the judge recommended that the youth attend a PHP following hospitalization. The youth's father was living in another town and unable to transport the youth to and from the program. The MHA worked on coordinating among multiple parties and insurance and successfully advocated for the youth to be placed at a STARR program so that he could attend the PHP during the day. Around this time, the MHA also worked to get the family connected with CSA services, but the youth's father felt overwhelmed with parties involved and stopped these services at that time.

In August, the youth was found delinquent and was at risk of being committed to DYS. The MHA and CRA attorney successfully advocated for probation instead of commitment so that he could return to the community in order to participate in therapeutic services.

Throughout the month of August, the MHA coordinated with the Department of Child and Families (DCF) to enroll the youth in a new school district when the youth's family moved. He was enrolled in a charter school, but struggled at this placement. At the end of September, an incident at the youth's school in which he violated pre-trial probation resulted in the youth being held in DYS custody. The MHA worked with the youth's DCF worker and advocated for the youth to be released in order to complete a 45 day assessment at a collaborative school and continue to work with supports that were in place. The youth was released from DYS custody and began the 45 day assessment at a collaborative school in October.

In the beginning of November, the youth went to the emergency room due to depression and substance use, which led to him staying at a detox facility for two weeks. The MHA continued to communicate among his treatment team at this time.

In December, the MHA worked to get CSA services in place again, and the family continued with this service. The MHA also advocated for in-home therapy (IHT), which was also put into place, but the family ultimately decided not to go through with IHT. They felt that things were going well and felt overwhelmed by the other services.

Also in December, the MHA spoke with a clinician at the collaborative special education program about the youth's progress. It was also noted that the youth's discipline had not been an issue. At the beginning of January 2016, the youth continued to struggle with mental health symptoms and utilized crisis services. The MHA appointment was vacated once the extension ran out, the CRA was moved to a new town when the family moved, and the youth's delinquency case had closed.

After case closure: The appointed closed in mid-January 2016. Over the six-month period after case closure, the youth was admitted to the psychiatric emergency room for two days and had an inpatient hospital stay for three weeks. The youth had 8 out-of-school suspensions and 17 absences between January and April 2016. Following the hospital stay, he was discharged to DYS until he could be admitted to a substance use treatment program. By July 2016, the youth's father reported that there had been nothing resembling the violation that had initially gotten him into trouble. He felt that while the experience with the youth's court involvement was traumatic for the family, the MHA provided stability during this time but said he would have wished to have extended her involvement in the case. He credited the MHA with keeping the youth out of DYS commitment which "allowed him to be in a therapeutic setting instead of punitive one."

Key Learnings

This case highlights the multifaceted role of the MHA in resolving mental health care crises involving multiple systems, working closely with family members, and addressing educational issues. This case also reflects the challenges of MHA support being tied to a court case. Despite the amount of work the MHA put into this case, once the court cases ended, the MHA was not able to follow the youth to ensure all needed services were in place and working well. As the MHA noted, she would have kept this case open longer if possible, as the youth continued to experience mental health crises at the time the case closed. This case also highlights the stress of the court process for families, which the father referred to as "traumatic", and the potential of the MHA role in diverting youth from the juvenile justice system in order to engage in treatment. In this case, the youth's father felt that keeping his son out of detention was critical as it allowed him to continue in school and with treatment.

APPENDIX C

Table 6. 2016 Annual Outcome-Specific Cost-Saving Thresholds for the J-MHAP Program		
Domain/Outcome	**Annual Outcome Costs to Society**	**Threshold* (# of cases that would need to be averted)**
Educational Attainment		
School Drop-Out	$14,321	24.37
Health Service Use		
Hospitalizations	$30,422	11.47
Court Involvement		
Secure Detention	$112,814	3.09
Staff-Secure Shelter	$98,223	3.55
Therapeutic Foster Care with Community Supervision	$58,781	5.94
Foster Care with Community Supervision	$32,457	10.75

*Calculated using the formula Annual J-MHAP Operating Costs/ Annual Outcome Costs to Society = Threshold
Each threshold should be considered in isolation as if the program only impacted that one outcome, not the sum of all outcomes.

APPENDIX D

Table 7. 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?

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