Advocating for the Educational and Health Needs of Court-Involved Youth

Patricia Elliott, DrPH, Patrice Basada, Neena Schultz, MSW, MPH, Emily Feinberg, ScD, CPNP
Learning Objectives

- **Learning Objective 1:**
  - Describe the unique circumstances and family profiles of court-involved youth in need of mental health services

- **Learning Objective 2:**
  - Identify opportunities for improving youth’s access to mental health services and overall health through advocacy and care coordination between school, health providers, and community-based organizations

- **Learning Objective 3:**
  - Discuss various strategies to improve independent advocacy and care coordination for court-involved youth
Agenda

- Describe the J-MHAP pilot
- Overview of the evaluation
- Family Risk Profiles
- Impact of the Program
  - Families
  - Health and School Services
  - Court Involvement
  - Case Examples
- Public Health Implications
J-MHAP

- Juvenile Mental Health Advocate Project (J-MHAP)
- Developed by Health Law Advocates
- Goal to improve access to Mental Health Services for court-involved youth
- Pilot in the juvenile courts in two MA counties from Feb 2015-Feb 2017
J-MHAP

Youth is Involved in the Court

Judge Appoints an Advocate with a Scope of Work

Mental Health Advocate (MHA) Works with Family and Youth

MHA Appears in Court with Updates

MHA Appointment Ends

87% Child Requiring Assistance
6% Delinquency
5% Care and Protection
1% Permanency
1% Other

36% of cases youth had additional court involvement in addition to case MHA appointed on
Youth is Involved in the Court

Judge Appoints an Advocate with a Scope of Work

Mental Health Advocate (MHA) Works with Family and Youth

MHA Appears in Court with Updates

MHA Appointment Ends

February 2015-February 2017: 152 Youth appointed an MHA; 160 cases (8 youth with 2 cases)
J-MHAP

Youth is Involved in the Court

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MHA Appointment Ends

<table>
<thead>
<tr>
<th>Type of goal</th>
<th>Type of goal as % of all goals</th>
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<tbody>
<tr>
<td>Access to Appropriate Mental Health Services</td>
<td>25.8%</td>
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<tr>
<td>Assessment and Planning</td>
<td>25.8%</td>
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<tr>
<td>School Placement/Educational Issues</td>
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<tr>
<td>Care Coordination</td>
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Youth is Involved in the Court

Judge Appoints an Advocate with a Scope of Work

Mental Health Advocate (MHA) Works with Family and Youth

MHA Appears in Court with Updates

MHA Appointment Ends

46% Cases MHA requests an extension beyond 6 months
Youth is Involved in the Court

Judge Appoints an Advocate with a Scope of Work

Mental Health Advocate (MHA) Works with Family and Youth

MHA Appears in Court with Updates

MHA Appointment Ends

As of February 2017:
160 cases; 152 youth served
Average appointment of 7 months
Key Evaluation Questions

- Outcomes Question
  - What is J-MHAP’s impact on access to, and engagement in:
    - Mental health services;
    - Youth functioning at home and in school; and
    - Involvement in the judicial and emergency mental health systems?

- Implementation/Replication Questions
  - How was J-MHAP implemented?
  - How was J-MHAP perceived by key stakeholders?

- Sustainability Question
  - What are the potential cost-savings (e.g. estimation of costs of providing advocacy services and estimated costs averted) of J-MHAP?
Key Evaluation Questions

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  - What is J-MHAP’s impact on access to, and engagement in:
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- **Implementation/Replication Questions**
  - How was J-MHAP implemented?
  - How was J-MHAP perceived by key stakeholders?

- **Sustainability Question**
  - What are the potential cost-savings (e.g. estimation of costs of providing advocacy services and estimated costs averted) of J-MHAP?
Evaluation Design

J-MHAP

Youth Records 2 yr prior

MHA Appointment

Youth Records

MHA Process Data

Evaluation

Baseline Interviews

Follow Up Interviews

Average 8 months after baseline
Instruments:
Conflict Behavior Questionnaire
Perceived Stress Scale
Center for Epidemiological Studies Depression Scale
VR-12
Youth Quality of Life Scale
Los Angeles Symptom Checklist
Evaluation Survey
Demographics of Youth Assigned a MHA

- Majority male (61%)
- Race/ethnicity
  - 66% white
  - 20% Hispanic
  - 6% Black
  - 7% other
  - 5% unreported
- Majority were English speaking (93%)
- Average age 16 (range 8-22)
### Baseline Family Risk

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<th>Measure</th>
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<td>Parent perceived conflict</td>
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<td>Youth perceived conflict</td>
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<td><strong>Parent Mental Health</strong></td>
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<td>Parental depression</td>
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<td>Overall mental health</td>
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<td>Overall physical health</td>
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<td><strong>Youth Functioning</strong></td>
<td>Total difficulties (Parent on youth)</td>
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<td>Impact of difficulties (Parent on youth)</td>
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<td>Total difficulties (youth completed)</td>
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<td></td>
<td>Impact of difficulties (youth completed)</td>
<td>+ 2.63</td>
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<td></td>
<td>Trauma Symptoms</td>
<td>+ 0.61</td>
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Parental Depression

(CES-D)

60% of J-MHAP parents and guardians had symptoms of depression, compared to only 19% in the published community data.¹

Of these, 40% had scores that indicate major depression (score > 27) compared to:

- 16.2% national prevalence of Major Depressive Disorder²
- 23% in an urban community sample³

High unmet mental health needs of the adults in the household
- Association with child/youth functioning
Baseline School Engagement

In year prior to baseline:

- **Attendance in past 3 months**
  - Missed more than one day per week on average - 57%
  - Nearly half of these youth didn’t go or missed almost every day (26%)

- **Discipline in past year**
  - Received at least 1 out-of-school suspension - 46%
  - Received 5 or more suspensions - 13%

- **School Services in past year**
  - Received counseling or therapy in school - 72%
  - Special education classroom part or full day - 49%
  - Alternative school placement – 31%
Baseline Mental Health Services

- **Outpatient Provider** - 92%
- **Crisis Services** - 70%
  - In-home Crisis
  - Emergency Department
- **Overnight Services** - 63%
  - Hospital
  - Residential Treatment
- **Out of Home Placements**
  - Group Home – 14%
  - Detention Center/Jail - 14%
  - Emergency Shelter - 10%
  - Foster Home - 4%
Evidence of Program Impacts

1. Family Profiles

2. Service use outcomes
   1. Mental health services
   2. Other overnight placements
   3. School services and engagement
   4. Barriers to accessing services

3. Effects on court involvement
Family Risk

**Significant Decrease**
- Parent perceived conflict ($p=0.05$)
- Youth perceived conflict ($p=0.05$)
- Parent stress ($p=0.02$)
- Parental depression ($p=0.04$)
- Youth total difficulties - parent rated ($p=0.03$)
- Impact of youth difficulties - parent rated ($p<0.01$)
- Youth overall mental health - parent rated ($p=0.04$)

**Signal of Effect Decrease**
- Impact of youth difficulties - youth rated ($p=0.07$)

**Non-significant Decrease**
- Parent physical health ($p=0.60$)
- Youth total difficulties ($p=0.43$)
- Youth quality of life ($p=0.31$)
Mental Health Services

**Significant Decrease**
- Emergency room and in-home crisis services (p=<.01)
- Inpatient hospitalizations (p<.01)
- Prescriptions for medication for mental health (p=.05)
- Any inpatient facility (hospital, drug or alcohol treatment unit, or residential placement) (p=<.01)

**Signal of Effect Decrease**
- Residential placements (p=.146)

**Non-significant Decrease**
- Partial Hospital Program or Drug or Alcohol Clinic (p=.50)
- Mental Health Professional (e.g. community mental health center, mental health professional, counselor or family preservation worker) (p=.60)
- Regular use of prescription medication for mental health (for at least 1 week) (p=.52)
Additional Overnight Placements

**Significant Decrease**
- Emergency Shelter ($p = .05$)

**Non-significant**
- **Decrease**
  - Detention Center, Prison, or Jail ($p = .23$)
- **Increase**
  - Group homes ($p = .42$)
  - Foster homes ($p = .75$)
School Engagement/Services

**Significant Change**
- Significant shift in distribution of attendance showing improvement (p<.01)

**Signal of Effect Change**
- Decrease in use of school therapy (p=.12)

**Non-significant Change**
- Decreases in suspensions (p=.23)
- Slight Increase in special classroom placements (p=.93)
- Decrease in special school placements (p=.39)
Barriers to Services

**Significant Change**
- ↓ % parents reporting any systems barriers (e.g. time, cost) (p=.02)
- ↓ % parents reporting services were affected by any barriers (p=.02)
- ↓ % parents reporting barrier: Parent or child refusal of treatment (p=0.05)

**Signal of Effect Change**
- ↓ % parents reporting time as a barrier (p=0.06)
- ↓ % parents reporting refusal to treat as a barrier (p=.148)

**Non-significant Change**
- % parents reporting barriers: bureaucratic delay, transportation, incomplete information, service not available nearby, language, fear of consequences & stigma
Effects on Court Involvement

- MHAs avoided arraignment on delinquency charges - 6 youth
- MHAs prevented Care and Protection cases by securing needed services - 12 youth
- Among 34% of youth (n=55) with delinquency involvement, MHAs successfully advocated for:
  - Avoid or shorten pre-trial detention - 16 youth
  - Avoid adjudication due to competency concerns – 5 youth
  - Reduction in sentence - 3 youth
  - Substance use or mental health treatment instead of detention - 1 youth
How Families Felt

- Parents described specific accomplishments and general support;

- MHAs seen as providing important support in court meetings and hearings, enabled parents to understand terms and services;

- MHA often described as dedicated and communicated frequently with family; and

- MHA seen as taking stress off parent and explained concepts so they can make informed decisions.
What families said

- “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”

- “They know how to fight for what it is that the family wants for their child”
What a school staffer said

After supporting a youth to attend an IEP meeting a parent said a school staffer noted positively that without the youth’s involvement in the process...

“it would have been a totally different outcome”
Families on MHA impact

- Parents described fewer missed days of school, abiding by school rules, and even enjoying going to school again.
- No longer engaging in assaultive behavior.
- It’s like “a totally different kid.”
Challenges for families

- Some parents would like more communication with MHA or between MHA and youth;

- Staffing transition disruptive for families with immediate needs; and

- Wish MHA was still involved due to ongoing needs.
Demographics: 17 year old Hispanic male referred to J-MHAP from Lowell court

Case type: Child Requiring Assistance, additional delinquency case

MHA Court appointment: 4/14/2015 – 12/08/2015

Scope defined under judge’s appointment: coordinate MH services; obtain special education services

MHA Goals: 8 identified goals fell within the following domains: access to mental health services, school placement/issues, assess/identify youth’s mental health needs, care coordination, legal advocacy

Outcome: CRA and delinquency cases dismissed, all 8 goals completed by end of case
Case Examples: Case 1

Summary of case:

- Prior to MHA appointment, youth removed from public school due to behavioral issues and sent to non-therapeutic alternative school. Youth used ER and crisis services, had one inpatient stay, and had previous GAL and court clinic evaluation. Youth was hospitalized twice shortly before MHA appointment.

- At start of the appointment, youth was not attending school due to mental health issues and lacked coordinated services. MHA reported that the youth was often seen by providers as a “bad kid” rather than a youth struggling with unmet mental health needs.

- Within 1 day of the initial appointment, youth entered an Intensive Community Based Acute Treatment (ICBAT) facility and was set to be discharged at the end of the month despite continued symptoms. The MHA successfully advocated to extend youth's stay.

- In early May, the youth was placed in inpatient facility due to worsening symptoms. The MHA was concerned that youth’s apparent psychotic symptoms were being overlooked. The MHA advocated to hospital clinicians around this issue; they agreed and changed youth’s medication.

- The youth was discharged to CBAT facility, which intended to discharge him without a step-down. MHA advocated successfully for PHP upon discharge.

- MHA successfully advocated to have Diversion Program terms waived due to concern the youth could not complete program requirements, potentially resulting in a criminal record. The delinquency case was dismissed in August.

- MHA assisted family to secure DMH services as youth was close to 18 and transitioning out of youth services.

- Lastly, MHA worked with school attorneys to allow youth to return to initial school placement and secure educational testing to ensure appropriate school services.

- The CRA was dismissed by the youth’s parent in December. The youth was reported to be making progress in school and continued to be enrolled in school with an IEP despite continued difficulty with attendance.
Case Examples: Case 1

Significant events prior to appointment:
- Crisis services utilized 2 times in 2014
- Previously had GAL, court clinic evaluation
- Stopped going to school in Dec. 2014
- Spent 30 days total overnight in inpatient facilities during 2015
- Receiving regular care from outpatient mental health services and in home therapy

- Youth placed in ICBAT
- Youth discharged to CBAT
- Youth discharged from CBAT to Partial Hospitalization Program after MHA advocated for PHP
- MHA assisted ICC in getting appropriate medication for youth
- ADA diversion program agrees to dismiss youth’s delinquency case after MHA advocacy
- Youth begins attending school
- Team meeting with MHA at initial school placement
- Case closed December 8, 2015

After case closure:
- CRA Dismissed
- Delinquency Case dismissed

MHA appointed April 14, 2015
Key Learnings Case 1

- This case highlights key functions of the MHA that supported positive changes for this youth:
  - in-depth case assessment, coordination, and planning;
  - advocacy across court, school, and mental health systems;
  - use of legal expertise to advocate for youth in court and school settings to prevent further court involvement and access needed services;
  - ability to focus attention on unmet mental health needs and “reframe” youth’s behavior; and
  - focus on addressing immediate needs and planning for long-term needs.

- Dynamic nature of the MHA’s work and the need to continually reassess and prioritize the focus of their efforts.
Case Example: Background Case 2

- **Demographics:** 17 year old White genderqueer individual referred to J-MHAP from Lowell court
- **Case type:** Child Requiring Assistance
- **MHA Court appointment:** 4/17/2015 – 9/24/2015
- **Scope defined under judge’s appointment:** become eligible for DMH services
- **MHA Goals:** 3 identified goals fell within the following domains: access to mental health services and care coordination
- **Outcome:** CRA case dismissed by family prior to fact finding hearing, secured DMH services.
Case Examples: Case 2

Summary of case:

- Prior to MHA appointment, youth was attending a therapeutic school, had diagnoses of schizoaffective disorder and PTSD, a history of inpatient hospitalizations, and had long-term outpatient services in place. Despite services, the youth continued to experience difficulty with school attendance and behavior and was unable to obtain DMH services.
- The MHA worked to collaborate with providers to ensure necessary information for DMH and to obtain DMH services for the youth.
- The youth was found eligible for DMH services. The MHA then worked to negotiate for specific DMH services for the youth to ensure they were receiving services they were eligible for. DMH responded by providing a letter about available services for the youth.
- The youth’s family dismissed the CRA prior to the fact finding hearing due to the quick work of the MHA in obtaining DMH services.
- By the summer after the case closed, the youth’s DMH services were stopped but the family was unclear why this happened. The youth’s parent thinks this might have been because they were unable to use some services due to transportation issues, but is hoping to receive DMH services again.
- The youth’s parent reported feeling that the MHA was very helpful and provided important support through the court process. They wished the MHA was still involved due to youth’s ongoing court involvement as a victim in a case.
Case Examples: Case 2

Significant events prior to appointment:
- Youth experienced traumatic event
- Diagnosed with PTSD, schizoaffective disorder, depression, anxiety, learning disability
- 2012-2013: 54 total days hospitalized
- 2013-April 2015: 95 missed days of school
- Had mentor, therapist, psychiatrist

April 2015: Missed 1 day of school
MHA appointed April 17, 2015

May 2015: Missed 1 day of school

June 2015: Missed 2 days of school
Found eligible for DMH services; MHA negotiated for appropriate services

July 2015: Missed 1 day of school
Youth gets employment

August 2015: Missed 11 days of school
MHA met with family about current services with DMH present

Sept 2015: Missed 1 day of school

After case closure:
- Youth missed 11 days of school from case closure to 2/8/16
- No hospitalizations
- Stopped in home therapy due to lack of time
- Continued seeing a therapist and psychiatrist as well as mentor
- No longer working
- Family dismissed CRA

Case closed September 24, 2015
Key Learnings

- This case highlights key elements of the MHA role:
  - ability to work quickly and effectively to obtain concrete service needs while providing support to the youth and family in navigating the court system;
  - collaboration with providers and aggregation of information to make a solid case for needed services.

- The MHA could focus narrowly on state mental health services and achieve quick results for the youth and family, resulting in no further need for court involvement.

- This case also highlights the ongoing needs of many youth which, whether or not directly related to mental health, may continue to impact the youth’s mental health.
Limitations

- Very small sample (n=54) & loss to follow up (n=13)
- No comparison group
- Non-randomized study design
Conclusions

- Results suggest that J-MHAP families experienced improvements in accessing needed services for youth.

- The nonrandomized study design does not allow us to assume causality; however, it is plausible to infer that 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.
Public Health Impact

- These results highlight the potential for independent advocacy work or involvement in care teams to improve youth access to mental health services and measurable improvement in overall functioning.

- Programs targeting court-involved youth and youth at risk for becoming court-involved can help families successfully navigate a complex system to acquire needed care.
Acknowledgements

- Emily Feinberg, ScD, CPNP
- Management Team:
  - Neena Schultz, MSW, MPH
  - Kelley Devlin, MPH
- Field Team
- The Tower Foundation
- Health Law Advocates
Thank You!

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Essex County
Middlesex
The Work of the Mental Health Advocates

1. MHA Goals
2. MHA Effort by System
MHA Goals

- MHAs worked with families to create specific goals that responded to the scope of work defined by the judge.
  - Average of 5 goals per case

- Most common types of goals related to accessing appropriate mental health services, case assessment and planning, and school placement issues.

- The analysis of goals revealed that 74% of identified goals were completed by case closure

- The proportion of goals completed increased with length of time in J-MHAP
# MHA Goals

## Goal Progress by Type of Goal*

<table>
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<tr>
<th>Type of goal</th>
<th>Type of goal (as % of all goals)</th>
<th>Goal completion status</th>
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<tr>
<td></td>
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<td>Goals completed %</td>
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<tr>
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<td>Goals in progress %</td>
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* All youth in J-MHAP
† Other services included services such as housing and health insurance
## MHA Goals

### Goal Progress by Case Length*

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<th>Length of time in J-MHAP</th>
<th>Goals completed %</th>
<th>Goals in progress %</th>
<th>Goals not completed %</th>
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<td>All cases (range: 2 to 15 months)</td>
<td>73.8</td>
<td>21.5</td>
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<td>Up to 3 months</td>
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<td>3 to 6 months</td>
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<td>6 to 9 months</td>
<td>82.4</td>
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<td>9 to 12 months</td>
<td>77.4</td>
<td>19.3</td>
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* All youth in J-MHAP
## MHA Effort by System

### MHA Recorded Effort by System

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<th>System</th>
<th>% Contact Events</th>
<th>% Time</th>
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<td>Family</td>
<td>24.9</td>
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<td>Court</td>
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Case Examples

- 1 from Essex Juvenile Court
- 3 from Middlesex Juvenile Court
Case Example: Background Case 1

- **Demographics:** 13-year-old White male referred to J-MHAP from the Lowell court
- **Case type:** Child Requiring Assistance
- **MHA court appointment:** 9/18/15-3/16/16
- **Scope defined under judge’s appointment:** improve access to community based mental health services; secure appropriate or improved Department of Children and Family (DCF) services, secure Department of Mental Health (DMH) services
- **MHA Goals:** 8 identified goals fell within the following domains: school placement/issues, accessing mental health services, assess/identify youth’s mental health needs, and care coordination.
- **Outcome:** CRA closed at end of appointment
Case Examples: Case 1

Summary of case:

- Prior to MHA appointment, youth had history of behavioral issues resulting in repeated hospitalizations and residential placements, missed almost everyday of school.
- At start of appointment, youth spent 3 nights in ER, then used crisis services followed by stay at a CBAT. Within a month, stayed a week in ER followed by inpatient hospitalization.
- Initial MHA work focused on ensuring appropriate discharge planning to avoid further court involvement as recommended by hospital, successfully advocated for partial hospital program (PHP).
- In October and November, the MHA advocated for therapeutic school placement, which was refused despite clinical recommendations. MHA worked on addressing fractured outpatient care to ensure youth was receiving appropriate services and that services were coordinated with the youth’s family.
- By January, the youth had gone 7 weeks without hospitalization, and had no school incidents during the case.
- In January, the MHA began advocating for DCF and DMH services. As expected, DMH services were denied due to existing DCF services but MHA succeeded in “identifying” youth to DMH.
- In February, a MHA transition resulted in family working with new MHA.
- At case closure, the youth continued to receive mental health services, though some were closed by the family. Youth’s school engagement and attendance continued to improve.
**Case Examples: Case 1**

**Significant events prior to appointment**
- Youth missed almost every day of school
- Spent over 2 months hospitalized in past year
- Spent over 1 month in residential treatment (including CBAT) in past year
- Youth had a history of significant anger problems and mental health problems, utilized a lot of services

**Sept 2015**
- 4 days of school missed

**Oct 2015**
- 16 days of school missed
- Oct 20: Youth hospitalized, in ER 6 days waiting for bed
- MHA appointed Sept 18, 2015

**Nov 2015**
- 14 days of school missed
- Nov 21: School refuses to change youth's school setting after MHA advocates for therapeutic school

**Dec 2015**
- 1 day of school missed

**Jan 2015**
- no school missed

**Dec 2015**
- Jan 12: Youth 7 weeks without incident at school or home; no hospitalization
- MHA successfully advocates for: 1) DCF custody to safeguard against inappropriate discharge; 2) partial hospital program upon discharge

**Feb 2016**
- 1 day of school missed
- Feb 9: Youth found ineligible for DMH services after MHA advocates for them.

**March 2016**
- no school missed

**April 2016**
- no school missed

**MHA transition**

**Case closed March 16, 2016**

**After Case Closure**
- Youth continued to use a mental health professional and DCF services; had cancelled all other services
- CRA dismissed
Key Learnings

- This case highlights key functions of the MHA that supported positive outcomes for this youth:
  - coordination of services across multiple systems;
  - ability to respond quickly to setbacks and mobilize stakeholders to set new plans in place;
  - capacity to achieve concrete goals in a timely manner;
  - relationship building and working closely with family to build support; and
  - consideration and planning around youth's long term needs.
Case Example: Background Case 3

- **Demographics:** 15 year old Biracial (White and African American) male referred to J-MHAP from Salem court
- **Case type:** Delinquency, amended to CRA
- **MHA Court appointment:** 2/17/2015 – 1/11/2016
- **Scope defined under judge’s appointment:** obtain community based services, obtain special education services, and possibly a medical evaluation for medications.
- **MHA Goals:** 6 identified goals fell within the following domains: secure/coordinate assessment for youth, access to mental health services, school placement/issues, care coordination, legal advocacy
- **Outcome:** Case extended due to family moving, MHA successfully advocated to avoid pre-trial detention, delinquency cases dismissed.
Case Examples: Case 3

Summary of case:

- Prior to appointment youth had history of trauma, substance use, gang involvement, and formal diagnosis of Oppositional Defiant Disorder.
- At time of appointment, youth had open delinquency cases and several instances of school discipline, family experiencing homelessness and living in a shelter. Youth was receiving CBHI services.
- Following initial appointment, MHA successfully advocated for the judge to delay sentencing and avoid pre-trial detention. The case was amended to a CRA one month after appointment.
- During the first 4 months of the appointment, the MHA worked with CBHI to ensure that the youth continued to receive support through the CSA.
- In June, the family secured housing and moved to a new town. The MHA worked with the new school district to ensure the youth had evaluations and special education services in the new school.
- After transitioning to the new school, youth continued to have difficulty with attendance. In November, the MHA helped the youth to enter a detox program, where he was diagnosed with ADHD.
- The youth was discharged after 1 week due to behavioral problems. The MHA worked on setting up outpatient substance use treatment for the youth. The youth was reported to be staying out of trouble and more stable, so the cases were dismissed.
- After the case was closed, the youth missed educational testing appointments and dropped out of school in January. The youth had continued gang involvement and was incarcerated again after case closure.
Case Examples: Case 3

Significant events prior to appointment:
- Delinquency cases open
- 2014-2015 school year: 3 out-of-school suspensions, 4 in-school suspensions, 17 other disciplinary incidents in school
- Youth in special class for behavioral/emotional problems
- 2014: in detention center for 1-2 weeks
- Family homelessness
- DCF services, CBHI involvement

Significant events:
- Feb 2015: NHA appointed
  - MHA appointed Feb 17, 2015
- March 2015: Case amended due to MHA advocacy
- March 24: Youth having trouble in school in new district; family no longer homeless
- April 2015: Youth in new school district following family relocation
- Sept 2015: Youth missed 8 days of school
- Oct 2015: Youth missed 6 days of school
- Nov 2015: Youth missed 5 days of school
- Dec 2015: Youth enters detox program, receives formal diagnosis of ADHD
- Youth discharged early from detox due to behavior problems
- Youth stops attending school
- Jan 2016: Case closed January 11, 2016

After case closure:
- Youth not found delinquent and all charges dismissed because of MHA effort
- Quit in-home therapy
- Quit mentoring services
- Youth no longer in school
- Continued gang involvement, youth incarcerated July 2015
Key Learnings

- This case highlights key elements of the MHA role:
  - advocacy for treatment rather than detention;
  - ability to intervene quickly and adapt goals based on immediate youth and family needs;
  - building alliances with families and working closely with families who may have negative experiences with service systems.

- Other key elements of this case:
  - limitations of current systems to address the needs of youth with complex needs, such as dual substance use and mental health needs;
  - positive work by the MHA may be limited by term of appointments for youth with complex needs and limited histories of support.
Stakeholder Interviews

Methods

- Interviews conducted with youth, families, internal and external stakeholders and key informants.

- 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 comprehensive list of individuals using a set of identification questions focused around expectations, goals and responsibilities.
  - Individuals were then ranked based on the individual’s (1) power and (2) interest. Priority scores were generated using a sum of these scores. Potential stakeholders and key informants were ranked and those with the highest rank were contacted to participate in qualitative interviews.
  - Additional key informants were selected based on specific areas of expertise.

- Semi-structured in-person or telephone interviews lasted 20 minutes to 1 hour. The interview guide was developed using the Consolidated Framework for Implementation Research (CFIR).

- Interviews transcribed and coded for key themes.

- Analyses of these data will continue as more stakeholder data are collected. The results presented here are preliminary.
Stakeholder Interviews

Table 14. Completed Stakeholder Interviews

<table>
<thead>
<tr>
<th>Agency or Role</th>
<th>Number of stakeholders interviewed</th>
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<tbody>
<tr>
<td><strong>Primary Stakeholders</strong></td>
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<tr>
<td>J-MHAP Families</td>
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<td><strong>Secondary Stakeholders- Internal</strong></td>
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<td>Health Law Advocates</td>
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<tr>
<td><strong>Secondary Stakeholders- External</strong></td>
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<td>Department of Mental Health</td>
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<td>Department of Children and Families</td>
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<td>District Attorney’s Office</td>
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<td>Public School District Attorney</td>
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<td>Probation Officers</td>
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<td>Family Resource Centers</td>
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<tr>
<td><strong>Key Informants</strong></td>
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<tr>
<td>Mental Health Legal Advisors Committee</td>
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<tr>
<td>Parent / Professional Advocacy League</td>
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</table>

- Interviews with J-MHAP families: 45
- Interviews with stakeholders and key informants: 30
Stakeholder Domains

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

- **Sustainability and Scale Up**
  5. To what extent is J-MHAP serving to meet key unmet needs?
  6. How does program design affect sustainability and scalability? What changes would support these aims? Are there opportunities that HLA can leverage in identifying where J-MHAP can be situated?
  7. What role can J-MHAP play to address potential inequities in youth experience within the juvenile justice and mental health service systems?
Question 1: Common Themes

What are the main gaps within the juvenile court and children’s mental health systems?

- **Systemic Gaps**
  - Court system: Overall lack of sufficient support and resources.
  - Mental health system: Lack of inpatient beds, poor quality of some residential placements, “holding patterns” and “revolving door” in placements, fractured care even with CBHI ICC. Lack of services for youth with substance use and mental health needs.
  - State agencies: Overburdened, denying responsibility for youth or “throwing” youth back and forth.
  - School system: difficulty working with schools, differences between school district resources, criminalization of youth of color for behavioral or mental health issues.

- **Individual Needs**
  - Families in court are in crisis;
  - Transition-age youth – gaps in systems;
  - Parents may have own mental or physical health needs;
  - Resistance re: accepting mental health or special education labels; and
  - Difficulty navigating the court, school, and social service systems.
What are necessary skills and competencies a MHA must have? How are MHAs different from other providers?

- In addition to case-specific goals, the MHA role was seen as specialized in:
  - Assessing youth and family needs;
  - coordinating care across agencies;
  - advocating for youth and family needs;
  - writing comprehensive reports for court and providing recommendations; and
  - supporting families to navigate systems.

- MHAs specialization seen as supported by more limited caseloads and ability to advocate for the best interests of youth.

- Skills seen as critical for MHAs:
  - expertise in court, mental health, and school systems; and
  - aggressive advocacy along with diplomacy and relationship building with agencies and families.
How does the process for appointing MHAs work? Is this process effective for targeting youth with the highest level of needs?

- MHA can be recommended by probation, family, or youth’s attorney; final decision made by judge.
- Relies on “triage” and judgement to prioritize highest need cases. Some stakeholders discussed the difficulty of determining which youth’s needs are more critical.
- Some concerns were raised about potential for implicit bias in referrals.
- Lack of formal waitlist for MHA involvement seen as resulting in lack of clarity and difficulty triaging cases.
- Recommendations included: a system for identifying MHAs’ current cases, implementation of initial assessment in every case, and more MHAs available to meet needs.
To what extent is J-MHAP serving to meet key unmet needs?

- Stakeholders discussed the need for a comprehensive approach to coordinate court, mental health, and school needs, including advocacy, strong communication, and service coordination.
- MHAs seen as a “hub” bringing parties together and preventing duplication
- Stakeholders working in the court system consistently described a strong need for J-MHAP.
  - “We can’t get the proper supports for kids on a lot of cases without their help.”
  - “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 and key informants in more administrative roles or who worked less directly with the program tended to see J-MHAP as important but in need of restructuring or re-organization to better meet system-level needs or enhance sustainability.

The need for J-MHAP was also discussed as a function of its role addressing individual or systemic needs.

- Stakeholders consistently described J-MHAP as working to fill individual needs facing youth and families, especially those resulting from systemic gaps. Stakeholders and key informants differed in the degree to which they felt J-MHAP addresses system-level problems.
How does program design affect sustainability and scalability? What changes would support these aims? Are there opportunities that HLA can leverage in identifying where J-MHAP can be situated?

- Some stakeholders discussed need for further consideration of where J-MHAP fits within the broader system and shared concerns about sustainability and scalability as currently designed
  - Idea of having attorneys provide leadership and supervision for a larger cohort of “extenders”

- Many stakeholders, especially those working within the court system, said that they did not think any changes were needed except for increasing J-MHAP’s capacity to take on cases.

- Location of J-MHAP in the court system
  - Alternatives proposed included locating program within ACOs, FRCs, and court clinics
  - Stakeholders working with court system discussed importance of J-MHAP being situated within court system due to needs for the program
What role can J-MHAP play to address potential inequities in youth experience within the juvenile justice and mental health service systems?

- Stakeholders discussed their perspectives related to differences in MHA appointments by case type, race and gender
  - The focus on CRA cases 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.
  - Some stakeholders did not see direct evidence of disparities by race or ethnicity; others suggested differences in MHA appointment might be due to implicit bias of individuals such as judges or probation officers.
  - Bias might also be introduced by school officials’ responses to youth behavioral issues (filing CRA vs. arrest) and the ability of families to gather resources necessary to file CRAs.
  - Mental health needs of white youth, and white males in particular, are more readily acknowledged and identified.
  - Parent and guardians may also differ by race and ethnicity in terms of level of trust of the court system and familiarity with mental health services.
References


