Massachusetts Health Passport Project Evaluation
Final Report

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EXECUTIVE SUMMARY

This executive summary highlights the key findings to emerge from the Massachusetts Health Passport Project (MHPP) Evaluation, a multi-year study—with data collection spanning from November 2005 through December 2008—of MHPP. This executive summary includes a brief description of the program and the evaluation and summarizes key findings relevant to the program’s operations and attainment of goals.

Massachusetts Health Passport Project Services and Goals

The MHPP began in April 2004, as a pilot program of the Juvenile Rights Advocacy Project at Boston College Law School under the direction of Francine Sherman, Esq. The program was originally called the Girls’ Health Passport Project (GHPP) and was designed to address the unmet health needs and gaps in health care services for girls committed to the Massachusetts Department of Youth Services (DYS) and re-entering their communities from DYS assessment and treatment facilities. An advisory board of health, juvenile justice, philanthropy, and evaluation professionals assisted the program in its early development.

The original GHPP theory of change stated that, “Better health care access coupled with system change will yield better health for system involved girls” (Massachusetts Health Passport Project Planning Grant proposal to the Jacob and Valeria Langeloth Foundation, 2005). Four key program goals emerged from this program theory:

- Improve health care access for enrolled youth;
- Create changes in relevant systems;
- Improve social supports for enrolled youth; and
- Improve health status for enrolled youth.

Beginning in March 2007, the program expanded from serving DYS-committed girls in Boston to serving DYS-committed boys in Boston. Subsequently, the program expanded to Worcester, first to girls in November 2007 and then to boys in October 2008. Evaluation data indicate that the program served approximately 173 youth (109 girls, 64 boys), though this figure does not take into account youth who may have been served by the program informally or indirectly.

Until 2008, MHPP was intentionally staffed by nurses who could offer direct medical consultation to youth, access medical records, and educate youth and DYS staff about health issues and community health care services. In February 2008, the MHPP boys’ program in Boston was staffed by an HIV prevention counselor who had previously worked within DYS facilities. The program has partnered with two community health centers in Boston, first Codman Square Health Center (CSHC) in Dorchester and then Sidney Borum, Jr. Health Center (SBHC) in Boston and one in Worcester, Great Brook Valley Health Center (GBVHC). The MHPP services have varied from site to site, though they have generally included the MHPP
health advocates conducting health assessments, referring youth to health care providers and services in their communities, offering individual and group health education, and communicating with DYS and Community Re-entry Center (CRC) staff about clients and program operations.

Massachusetts Health Passport Project Evaluation

In November 2005, Sherman awarded a six-month planning grant to an evaluation team at Tufts University, headed by Professor Francine Jacobs of the Eliot-Pearson Department of Child Development and the Department of Urban and Environmental Policy and Planning.

The MHPP evaluation design is based on Jacobs’s Five-Tiered Approach (FTA) to evaluation.\(^1\) The FTA is developmental in nature, organizing research activities at five levels. The first tiers are process, or operations, oriented, and the fourth and fifth tiers are focused on measuring or determining outcomes. The assumption inherent in this model is that outcome evaluation is built on the data collected at earlier stages.

The MHPP Evaluation was designed as both a process-oriented and an outcome-oriented evaluation. The research questions were as follows:

- What are the core needs and preferences for health care among system-involved girls? How do these needs and preferences compare to those articulated by system-involved boys?
- What are the processes by which the MHPP is implemented in its current sites? Who is the MHPP serving (numbers, demographics of youth served) and what are the ways in which these youth are being served by the program?
- How do changes in the program’s staffing and partnering health centers affect, if at all, the way the program is delivered and received?
- What does it mean for MHPP to be “gender-specific” or “gender-responsive”? Are there similarities and/or differences between how the MHPP is delivered to girls and how it is delivered to boys?
- What are the perceived roles that parents/guardians play in their child’s health care? What are the perceived roles that parents/guardians play in the MHPP?
- What efforts, if any, has the MHPP made to involve parents?
- What are the perceived outcomes of parent involvement (or lack thereof) in the

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1 Jacobs, 1988; Jacobs, 2003; Jacobs & Kapuscik, 2000
What do program staff, partners, and youth participants perceive to be the effects, if any, of the MHPP to date?²

What changes, if any, in the DYS’s approach to health care have occurred since the MHPP’s inception? What is the perceived role of the MHPP in facilitating these changes in the system?

Methodology

Sample Size

The data collected and analyzed over the course of the MHPP evaluation include interviews and focus groups with senior DYS officials, DYS health care and direct service workers, MHPP staff, community health center partners, and funders (N = 94), as well as interviews and focus groups with system-involved girls and boys (N = 41), a pilot health survey administered to a group of DYS-committed boys (N = 20) and interviews with individuals outside of DYS with expertise in providing health and/or support services to adolescents (N = 4).

It should be noted that it was difficult for the evaluation team to gain access to youth due to their frequent movement in and out of the community, the consent requirements of the Tufts Institutional Review Board, and the assistance with recruitment of youth and getting consent forms signed by youth and parents that the evaluators relied on from already overextended MHPP and DYS staff.

In total, we collected data from 61 youth (22 girls and 39 boys) through interviews, focus groups, and surveys. A portion of these youth were involved in MHPP and a portion of these youth were not. In their subgroups (e.g., the six girls interviewed for the parent study), the numbers are undoubtedly too small on which to base program initiatives. However, even these small numbers of youth raise provocative issues that program developers might consider. Further, aggregated across subgroups (e.g., girls interviewed for the needs assessment, boys participating in the health pilot survey, and girls interviewed for the parent study) and about a particular topic, for example, their health concerns, or their desire for parents to be involved in their health care, their perspectives take on additional weight.

Data Sources

The data sources for the MHPP evaluation include the following:

- Key informant interviews and focus groups with adults;

² It was the initial intention of this evaluation to assess both MHPP program processes and its observed outcomes. However, due to an unexpected drop in the census of girls at the participating CRCs, and a smaller research budget than anticipated, the assessment of program outcomes is, rather, at the level of perceived effects, or those program effects as perceived and reported, but not “observed,” by key informants.
Key informant interviews and focus groups with youth;
- MHPP and DYS databases;
- MHPP health advocates’ monthly reports;
- Notes from CRC site visits;
- Meeting notes;
- Program documents (e.g., proposals for funding, logic model);
- DYS documents (e.g., annual reports); and
- Review of relevant literature.

Data Analysis

Our interview and focus group transcripts were coded using a qualitative data analysis software package, ATLAS.ti. Codes were generated directly from the data and organized thematically. We used cross-case analysis (Miles & Huberman, 1994) to examine perceptions of systems change shared across the interviews. Analysis of the MHPP database and health utilization surveys involved using a quantitative data analysis program, SPSS, in which a variety of statistical analyses were employed (e.g., descriptives, chi squares, correlations).

Major Findings

The evaluation produced scores of findings with relevance to MHPP operations and the attainment of its goals. The findings noted here are considered the most consequential for policymakers and program designers.

- **MHPP is an example of a promising private/public partnership in health care.** Collaborations of this sort generally are difficult to establish and maintain; Sherman’s considerable skills in this area, combined with DYS’s and the partnering health centers’ willingness to join the effort, represent a core strength of this program. This is an essential element of any attempt to innovate in health care services for youth in the juvenile justice system.

- **MHPP appears to have influenced DYS’s approach to providing for the health needs of youth under its supervision, as well as the partnering health centers’ level of attention to, and interest in addressing, those needs.** The MHPP’s focus on the health of system-involved youth, and the imperative to have good quality health care available when they return to their neighborhoods and communities, was reported by many to have affected the institutional behaviors of both systems. In this sense, MHPP appears to have made significant progress toward achieving its desired outcome of system change. On the other hand, MHPP, in its current form, has not been fully adopted by either system, and is unlikely to be in the near future.

- **The principles that undergird MHPP have found broad resonance among the evaluation’s informants, and across the relevant theoretical, empirical, and practice-oriented literatures.** These principles pertain both to the desired outcomes for health-related interventions for system-
involved youth, and to the approaches to be used to achieve them. They include, for example, the goal of improved health access, and ultimately health status, of system-involved youth; the promotion of gender-responsive programming; the investment in developing and sustaining professional collaborations; and the belief that building supportive and nurturing relationships with youth is the cornerstone to achieving these goals.

- **While the full MHPP model may not be sustainable or replicable, there are specific elements of the model which seem eminently exportable.** The MHPP model in its current form, with its emphasis on independent health professionals managing youth’s health care at community re-entry centers, appears not to be sustainable within this state’s juvenile justice system. In addition, other contextual factors such as the reliance on private funding, a relatively health resource-rich state that provides health insurance coverage to all youth committed to DYS, and a relatively progressive juvenile justice system make the model less exportable to other states without such an infrastructure in place. However, certain programmatic components—for example, connecting youth to a community health provider, providing youth with health education, and building relationships between community agencies in the interest of serving youth’s health needs—are likely generalizable to other contexts.

- **The MHPP goals were overly ambitious for a program of its scale, supported by “soft” funding, and dependent on the active support and participation of the agencies and individuals involved.** However energetic the program’s director and staff, there are limits on the ability of a modest program such as MHPP to have the effects—on health access, health practices, health status, social supports, etc.—it intended. At a minimum, this is an issue of “dosage”—too little intervention to comprehensively address the health care needs of system-involved youth. Further, factors on the individual, family, community, and system levels (e.g., the transience and fluctuating census of committed youth, lack of long-term investment in the program from the partnering systems) likely moderated the program’s ability to achieve its goals.

- **It is difficult to estimate the reach or “penetration” of MHPP into the population of DYS-involved youth needing its attention.** The program database includes ~116 youth, across the sites, over the five years of MHPP’s operations; a percentage of these youth were seen more than once, some on numerous occasions. In addition, MHPP health advocates interacted informally with other youth who are not represented in the database. The MHPP staff work limited hours, and spent a percentage of their time providing indirect or collateral services for their clients—consulting to DYS and CRC personnel on specific health problems, working through health insurance matters, etc. Since the program did not set target figures for the number of clients to serve, and indeed, the census at CRCs fluctuates sufficiently to make that hard to do anyway, we cannot judge the effectiveness of MHPP’s outreach efforts. There was, however, a large drop-off in Boston girls served which warrants further investigation.
While MHPP did not develop a formal health “passport” document, it did demonstrate—with individual youth—the possibility of providing continuous care and executing appropriate transfer of medical records. The process of developing and implementing a specific passport was more complicated than initially expected, due in large part to issues of confidentiality and practicality. However, examples from this study suggest that the program’s aim to provide continuous care to youth was attainable. Our evaluation documented cases of prerelease health planning for youth, communications, follow-up, and transfer of medical records among facility and community providers facilitated by MHPP health advocates. In at least one case, MHPP staff successfully advocated for a participating youth recently reconfined to a DYS facility, to receive uninterrupted care from a community health provider.

The program’s visibility faded over the period of the evaluation. During the early phase of this evaluation, the program enjoyed relatively high visibility, related to some degree, to the several advisory committee meetings that occurred during that time and to the first health advocate’s regular communications with DYS staff in facilities and in the CRCs. As the program proceeded, this initial level of communication among program partners was not sustained, which might account, in part, for the decrease in visibility. For example, during our final set of interviews, several informants indicated that numbers of youth, parents, and DYS staff were unaware of the program, or had heard of it, but were unsure of the services offered. This appears different than what was the case earlier on.

Many system-involved youth who participated in MHPP reported having primary health care providers. Nonetheless, health advocates reported that many were also responsive to, and appeared to need, MHPP services. Adult informants during the needs assessment phase of this evaluation frequently reported that system-involved girls often did not have primary health care providers; these concerns were expressed about boys as well. While this is likely true for a proportion of this population, both girls and boys, our findings suggest that youth may well be more connected to care than some expect. What remains unclear, however, is the extent to which these system-involved youth have a true health care “home” (as opposed to a primary care physician)—an entity that, similar to the MHPP model, coordinates care (including mental health services), follows up on referrals, advocates for the clients in dealings with other institutions, etc. This might be a better indicator of health care coverage for this population, and we suspect that such a gap still exists for numbers of these youth.

Many of the health concerns expressed by youth, and by others on their behalf, are shared by girls and boys. Issues that affected both girls and boys included those related to sexual health; hygiene, nutrition and exercise; and mental health; however, these issues appear to affect girls and boys in different ways. Thus, a gender-responsive orientation to discerning effective ways of addressing these topics with system-involved youth remains a useful approach to programming.
It appears that youth’s parents are more involved in their health care than was initially assumed. The MHPP model does not include parents or other family members in a central way. The origins of this decision are not clear, but they likely reflect the desire to protect youths’ confidentiality in these matters, and also perhaps the assumption that the relationships between youth and their parents are often strained, that parents would not choose to be involved or would be unable to maintain involvement, and that the youth would just as soon negotiate these issues themselves. In our view, this choice should remain the youth’s to make, however, MHPP might profitably research this issue, with the possibility of including parents and families in some planful way.

Both the nurse health advocates, and the HIV prevention counselor (non-nurse) health advocate, offered thoughtful, generally well-received, programming. This might suggest that the specific credentials of the health advocates are less important than their ability to build relationships with youth and staff and to implement services that are based on sound judgments about what their potential clients want and need, and that fit their own expertise. This evaluation, however, could not ascertain whether, by whatever approach, the goals of the program were met, so the necessity of using medical personnel remains an open question.

In general, MHPP’s constituencies appreciated its intentions and the efforts of its director and staff. Across the evaluation, key informants we interviewed reported positive impacts of MHPP on specific individuals involved in the program and conveyed a sense that the program has strong potential over the long-term. Some of the promising elements they noted were in the areas of increased connections to health care, continuity of health care, and increased awareness of preventive care.

Although the evaluation did not analyze data to establish “observed effects,” individual examples of the desired results were repeatedly brought to our attention—a promising if not conclusive, finding. The following adapted case, based on interview data from the current Boston-based health advocate, serves as one such example:

…Two nights ago there was a young man who is involved in the program who was shot in his neck...he’s still in the hospital and undergoing surgery...his caseworker contacted me because when he got to the hospital his heart rate was very low, so the nurses were asking if there were any medical records or if there were issues with his heart rate before, blood pressure or anything like that...so she contacted me and I called Dr. Veters immediately the next morning...and then contacted “Laura” the nurse over at DYS who had dealt with him for a couple years. Information was exchanged between “Laura” and Dr. Veters, which went over to the hospital. They were able to give the history because he had just had his physical with Dr. Veters and had special blood work done because of his high blood pressure...Dr. Veters is going to the hospital to see how he is doing and kind of check in with him because they had started to create a relationship...when he gets released from the hospital, Dr. Veters can continue with his after care and follow up with him on everything....
Recommendations

The purpose of this set of recommendations is two-fold, first to guide MHPP staff and collaborators in their thinking about how to export core elements of the program to other settings, and second to highlight areas for further research pertinent to the development and potential adaptation of a program such as MHPP.

Program-specific Recommendations

There are several MHPP program elements that emerge from this study that appear critical for any program such as MHPP, serving the health needs of system-involved youth. These include establishing interagency collaboration, building relationships at all levels, facilitating continuous care through transfer of medical information and records, and connecting youth to community health providers committed to them. The following recommendations speak to these program elements:

- **Concentrate efforts on developing and maintaining strong interagency relationships.** System-involved youth appear to be best served when multiple agencies collaborate to meet their needs. These interagency relationships often develop from relationships on the individual level, e.g., between program staff and youth, between their caseworkers and their health care providers, between youth and their health care providers, and so forth. In order to maintain the active engagement of partnering organizations, regular opportunities for developing these individual relationships as well as for collaborators to meet and exchange ideas is critical.

- **Hire program staff with experience, expertise, and/or a vested interest in building relationships with system-involved youth and staff; provide training and supervision for that dimension of the job.** Developing strong relationships with youth and those who work with them inside and outside the system is essential to serving them well. Given their often complex relationships to authority figures and other adults in their lives, system-involved youth require time and a variety of methods to build trusting relationships with those attempting to assist them. In addition, caseworkers and other juvenile justice and community health care staff need opportunities to develop strong working relationships with those outside the system.

- **Use these strong relationships to facilitate transfer of medical information and records.** Given that system-involved youth often confront serious medical conditions and that they experience many interruptions to their health care due to their system involvement, and at times, transient lives, the facilitation of medical information and records is critical.

- **Connect youth to community health providers, or preferably, to a health care “home,” invested in building long-term relationships with youth.** System-involved youth, like all youth, need continuous, consistent, integrated health care services. This type of care is found in the health care “home” model, in which individuals are connected to a variety of health care
services, receive follow up on referrals, and have the opportunity to develop long-term relationships with providers. Ideally, the connection to this care is coordinated prior to youth re-entering their communities. In communities where there are health centers that are invested in, cater to, or have interest in and knowledge of serving system-involved youth, a health care professional on staff could perform outreach to youth and serve as the interface between youth and juvenile justice staff and other community health services. This health center professional could also consult to or train juvenile justice staff in helping youth to manage their health care upon community re-entry.

- Establish a facilitative, working relationship between the “inside” providers of health care (when youth are detained) and the youth’s “outside” providers (primary care physicians, or health care homes, in the community). These outside providers should include the MHPP health advocate, or the person in that role. Quality health care for these youth requires continuity between these two providers. The obligation to develop this relationship is equally the community provider’s, who should be available to consult while the youth is detained, and to participate in pre-release planning related to health care.

- Integrate health education into pre- and post-release services for system-involved youth. Similar to most adolescents, system-involved youth are in need of assistance managing their health care. Integrating the type of health education that addresses how to get medical records, how to make a doctor’s appointment, how to know when to seek urgent care versus routine care, would greatly benefit youth. Ideally, such education would occur prior to and following youth’s community re-entry, during which youth are assisted in establishing a long-term health care plan.

Research-based Recommendations

A central premise of this evaluation is that good data are critical to good decisions about programs. For that reason we offer here recommendations for the direction that further research should take. These recommendations are organized into two broad categories: The first contains activities to help understand, validate, and/or challenge the theoretical assumptions undergirding a program such as MHPP—for example, the extent to which system-involved girls and boys differ in their preferred mode of health care. The second set relates to specific program components, and are meant to clarify aspects of MHPP’s actual operations—for example, the calculation of the “coverage” (percentage served) that MHPP achieves among eligible youth—and to determine program effects. The FTA\(^3\) considers both types of research activities as essential components of a comprehensive evaluation strategy.

Establishing the Program’s Theoretical Base

In this country, most public programs are initiated to fill the gap between the current

\(^3\) Jacobs, 1988; Jacobs, 2003; Jacobs & Kapuscik, 2000
circumstances for a particular population, on the one hand, and what is considered an acceptable circumstance for those individuals, on the other.

- **Program architects should be able to support their call for a new or modified program with evidence that such a gap or problem actually exists, and with data that detail the nature and magnitude of that problem.** These are the core elements of a needs assessment. The problem needs to be defined precisely, but at least initially, without the preferred solution tucked into that definition. For example, with reference to a program such as MHPP, one might focus, first, on the disparity in health status between system-involved youth and other youth in comparable communities, rather than on data confirming the relatively low percentage of these youth who have a primary care physician. It may end up that increasing the percentage of youth with primary care physicians is the best strategy toward improving their health status, but other possible programmatic options that may be more immediately achievable, or more reasonable given the particular community, are obscured if the needs assessment is organized around data with an implied solution.

Analysis of the problem includes presenting the data in meaningful subgroups for comparison—by gender, place of residence, age, family configuration, etc., as well as by health concern or condition. (The data from MHPP confirm that understanding the differences and similarities of the health problems of girls and boys is particularly critical to designing promising health support programs.) It could be, for example, that youth in certain communities are more affected by particular conditions (e.g., urban neighborhoods and asthma) than others; these data are critical to establishing the dimensions of a problem. There are several public sources of these kinds of data; in addition, a survey of current system-involved youth would help define the range of health problems to be addressed.

Occasionally, at the end of this phase it is determined that the identified problem does not exist, or exists only in a limited fashion, not warranting a new intervention. This is one appropriate conclusion to a needs assessment.

- **A thorough review of extant data on the implementation and outcome results of programs designed to address similar problems should be undertaken.** There are many potential sources of data for this review, ranging from evaluation studies reported in academic and professional journals, and on reputable public agency websites, to detailed “best practices” reports available from professional membership and/or advocacy organizations. The weight given to the evidence should reflect the rigor of the research design employed; nonetheless, all these materials help array the options for programming in a broad manner, so that considered choices can be made.

- **Programs should be designed in a way that credits the views, and preferences for service modality, expressed by all stakeholders, but in particular, by their potential consumers;** the process of collecting and analyzing these data is called a demand assessment. Too often
Programs are initiated without input from the people to be served by them. In our view it is imperative to collect, analyze, and make use of data that describe how these individuals define their problems, and how they would like to receive help to ameliorate them. In the case of MHPP, for example, participants extolled the virtues of health care professionals (including MHPP advocates), who worked to establish relationships with them, respected their opinions (even though they did not always agree), treated them as real people. Indeed, sometimes it seemed to us that the content of any given interaction was less consequential, from the youth’s perspective, than the feeling he/she had that someone interpersonally trustworthy was available to them. If this is the case, then the training of health advocates should entail at least as much attention to this aspect of the program than to the equally necessary other, more knowledge-based training subjects. Youth’s preferences for the degree of parent involvement in these services, and the type of service (e.g., group discussion of health education topics vs. accompanying youth to medical appointments and chatting on the way) to be offered, for example, should be reflected in the program’s design. Knowing this information as a program is being developed (by surveying youth in DYS custody, for example) is a wise way to proceed.

- Programs should be designed to reflect their particular contexts—the opportunities and constraints—that existing policies and already established institutions present to implementing a successful program. At a community level, this activity is called an environmental scan. Not only should programs be responsive to the various stakeholders’ ideas of how services should be provided, and be knowledgeable about what the research literature recommends. Their design should also be based, empirically, on knowledge of what resources to solve the identified problem already exist in that locality; and the strengths and limitations of, and possibilities in, those institutions in playing the desired service role. An excellent health center that is located in a neighborhood that youth do not feel comfortable visiting is not the best choice for a health care partner; a service model that relies on health professionals who are in great demand, and therefore are expensive to employ and difficult to keep, might likewise be a less promising choice in a particular economy than it might be at another time. Infrastructural issues—transportation, building accessibility, manpower availability—must be considered as well.

Recommendations for Research on Program Operations

This evaluation assumes a continuous demand for program-based research—in essence, evaluation—to maintain a nimble, well-functioning program, best able to achieve the desired results. The following recommendations are offered in that spirit:

- To begin, a juvenile justice system must have the technical capability to generate data about its youth, the conditions of their system involvement, their family and community relationships, and their health status and health care utilization. This participant data system must be flexible, relatively easy to use, and accessible to juvenile justice personnel both inside detention facilities and in the community. Periodic aggregated reports that include the health status
of youth in individual facilities, and those reporting to individual CRCs, should be generated to allow for contemporaneous comparisons across sites, and comparisons across time within individual sites. In this way, particular needs (for example, for primary health care coverage) within particular geographical locations, or evidenced by particular subpopulations, can be identified and possibly addressed. To the extent possible, in the context of confidentiality requirements, data on individual youth might be shared with community-based health care personnel, to facilitate the re-entry of youth to their communities.

- **Health centers, for their parts, should use their extant databases to better understand the health needs of youth in their caseloads.** Presumably, community health centers maintain considerable patient databases. Again, within the parameters of confidentiality requirements, they could anonymize, and then analyze, aggregated data to help plan health services for all youth, including those in the juvenile justice system.

- **The environmental scan proposed for the design phase should be periodically updated to reflect changes in community resources, new opportunities or necessities for collaboration.** Since any program dedicated to improving the health status and health care access and utilization of youth depends on resources outside the juvenile justice system, continuous attention to that larger context is warranted. Systematic tracking of these resources within communities, and across states for that matter, keep programs alert, and facilitate possible partnerships, for example, in securing grant funding for innovations.

- **A schedule of periodic data collection from stakeholders in any health-focused initiative should be developed and implemented.** Program consumers have critical information to share—not at a single moment in time, but as they continue to use (or cease using) services, as programs change their offerings or their personnel, and as, in this case, they mature and their concerns or requirements change. The perspectives of other stakeholders—program staff, parents, agency personnel, community providers, for example—also likely change over time, and should be considered periodically as well. Among the topics to include in these data collection activities are the following:
  
  - Satisfaction with/perceived effects of particular program components (location, personnel, specific activities); probe for gender, regional, age differences (youth);
  - Satisfaction with/perceived effects of program, program components; by affiliation, professional discipline, geography, familiarity with program (other stakeholders);
  - Topics to include in health education components (youth, other stakeholders); and
  - Extent to which parents should be involved in programming (youth, parents, other stakeholders).
A series of in-depth studies of particular service-related issues that might affect program design in the future should be initiated. Several of these topics surfaced during this evaluation that could not be addressed sufficiently, and exemplify the type of issue that might warrant further attention. These include the influences that parents, families, and cultural communities have on youth’s health practices and beliefs; the nature of the health advocate/youth relationship; perceptions of these youth by community health care professionals; parenting among youth in custody, to name a few.

At the appropriate time, an outcome study to measure program results—to answer the “does it work?” question, should be undertaken. Ultimately, programs should be held accountable to the standards for effects they set for themselves in their stated goals and objectives. Data collected for this purpose should be “observed” (objectively reported), in addition to “perceived” (reported as having occurred, without external confirmation), and the research design should include a comparison group so that differences in effects can be plausibly attributed to the program. This outcome study would answer the following questions:

- What dosage (how much service, of what kinds) is needed to achieve a positive result?
- Which issues of concern related to health status, access to health care, individual health practices, are the most amenable to intervention?
- In what ways do individual and community characteristics moderate the effects of programs?
- Which aspects of programs, or which program in their entirety, are more cost-effective and/or cost-beneficial?

Program-based research should be a standard component of program operations. Given the complexity of the issues being addressed here, and the “constancy of change” in our current social and economic environment, program-based research seems a virtual necessity for any intervention of this nature. While some portion of this work requires independent contractors, much of it can be done “in-house,” with relatively modest amounts of training and support, strategically scheduled.
References


MASSACHUSETTS HEALTH PASSPORT PROJECT: PROGRAM AND EVALUATION

In this section, we introduce the Massachusetts Health Passport Project (MHPP), briefly detailing its history, goals and objectives, and current activities. We then provide a summary of the design of the evaluation, including a description of the framework that guides it (the Five-Tiered Approach to evaluation, or the FTA), the major research questions we sought to answer, and the methods used in this study. The section concludes with a “roadmap” of this report.
THE MASSACHUSETTS HEALTH PASSPORT PROJECT:
PROGRAM AND EVALUATION OVERVIEW

The MHPP began in April 2004, as a pilot program of the Juvenile Rights Advocacy Project at Boston College Law School under the direction of Francine Sherman, Esq., a veteran juvenile rights advocate with expertise in juvenile justice system reform. Sherman launched the program, then called the Girls’ Health Passport Project (GHPP) in response to what she and others working with system-involved girls saw as the unmet health needs and gaps in health care services to girls re-entering their communities from Massachusetts Department of Youth Services (DYS) assessment and treatment facilities. In particular, Sherman believed there was a need for improved, gender-responsive health care services for DYS-committed girls, as well as a need for “continuity of care,” or care that was consistent and uninterrupted through the many transitions girls experienced during their commitment to the juvenile justice system.

The original GHPP theory of change stated that, “Better health care access coupled with system change will yield better health for system involved girls” (MHPP Planning Grant proposal to the Jacob and Valeria Langeloth Foundation, 2005). Four key program goals emerged from this program theory:

- Improve health care access for enrolled youth;
- Create changes in relevant systems;
- Improve social supports for enrolled youth; and
- Improve health status for enrolled youth.

Sherman created a program logic model to outline the intended program activities and outputs necessary for the achievement of these program goals and convened an advisory board of health, juvenile justice, philanthropy, and evaluation professionals to assist in the program’s early development.

In May 2004, Sherman hired a nurse practitioner to deliver program services to girls in Boston, and developed a partnership with Dotwell (a collaborative of Codman Square Health Center and Dorchester House Multi-Service Center) to have Dotwell employ the nurse practitioner. This nurse practitioner, referred to as the program’s first Boston girls’ health advocate worked with DYS-committed girls reporting to the Still We Rise Community Re-entry Center (SWR) in Dorchester from June 2004 until August 2007. When the census of DYS-committed girls decreased in the summer of 2006, the health advocate extended MHPP services to boys.

Following the first Boston girls’ health advocate’s tenure with the program, Sherman developed a subsequent partnership with Justice Resource Institute, which manages the Sidney Borum, Jr. Health Center (SBHC), and subcontracted with SBHC to hire two nurses from Boston College School of Nursing (BCSN). One of these nurses was employed by SBHC and staffed the Boston girls’ program from November 2007 until June 2008. The other nurse was hired by the
program’s partnering health center in Worcester, Great Brook Valley Health Center (GBVHC), and staffed the Worcester girls’ program from November, 2007 until the present, and extended her services to boys in Worcester in October 2008. In February 2008, Sherman subcontracted again with SBHC to hire an HIV-prevention counselor working with youth in DYS facilities, to serve as the MHPP Boston boys’ advocate. This advocate worked with a few girls at the Still We Rise CRC from July – September 2008, and has worked with boys from February 2008 until the present. The MHPP health advocates at all the sites have provided a range of services to participating youth, including direct medical care and consultation, referrals to health services, appointment assistance and accompaniment, and health education.

MHPP health advocates reported working with a total of 173 youth (109 girls and 64 boys) from June 2004 until the close of the evaluation data collection phase in December 2008.\(^4\) It is possible that MHPP served more than this number of youth, given that the program often served youth informally or indirectly. For example, MHPP advocates spoke to youth about their health in informal settings, such as while playing pool with them, and some advocates educated parents and DYS staff about youth’s health care needs, which resulted in indirectly serving these youth.

Participating youth have presented a range of health issues to MHPP advocates, including sexually transmitted diseases (STDs), pregnancy, need for dental work, and concerns about weight and hygiene. The MHPP health advocates report that a handful of participating youth have had chronic illnesses or serious medical conditions, as well as serious injuries (e.g., stab and gunshot wounds). Our data reveal that the majority of girls in Boston and Worcester and most of the boys in Worcester already have established relationships with primary care physicians and most have been responsive to MHPP services.

MHPP was initially supported by the Jessie B. Cox Trust and has received funding from multiple sources over the years, including the Florence V. Burden Foundation, Partners HealthCare, Blue Cross Blue Shield, the Jacob and Valeria Langeloth Foundation, and The Boston Foundation.

**MHPP Evaluation**

In November 2005, Sherman awarded a six-month planning grant to an evaluation team at Tufts University, headed by Professor Francine Jacobs of the Eliot-Pearson Department of Child Development and the Department of Urban and Environmental Policy and Planning. Prior to November 2005, Sherman invited Jacobs and evaluation researchers Rachel Oliveri and Ila Deshmukh Towery to attend the MHPP advisory board meetings as consultants. Once the planning grant was awarded, Oliveri and Deshmukh Towery became the project co-managers and primary research analysts. Tufts University graduate students in Child Development and Urban and Environmental Policy and Planning have served as research assistants and analysts.

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\(^4\) These figures are calculated from reports by the MHPP health advocates in the MHPP database and in monthly evaluation interviews. They do not include youth who may have been served by the program informally or indirectly.
on the MHPP evaluation team over the years; they include Abby Copeman, Kathryn Rollins, Claudia Miranda-Julian, Leah Jacobs, Caroline Campbell, and Jessica Greenstone. Former Tufts graduate students Everett Dickerson and Christian Mitchell helped to facilitate youth focus groups and consulted on issues related to system-involved youth, respectively. In addition, several Tufts graduate and undergraduate students, including Siobhan O’Riordan, Shea Sullivan, and Charlene Mantia, provided interview transcription and research assistance.

From the fall of 2005 through the fall of 2006, the evaluation team conducted a needs assessment for the program’s expansion to additional sites for girls and to serving boys for the first time. From the fall of 2006 to the spring of 2007, the evaluation team conducted its first phase of program implementation documentation, conducted an analysis of program collaboration, and documented lessons learned to date. In the final phase of the evaluation, from the spring of 2007 to the winter of 2008, the evaluation team developed and facilitated the administration of a health utilization survey to system-involved youth in DYS facilities, conducted the second phase of program implementation documentation, conducted substudies on system change, gender-responsive service delivery, and parent influence on youth’s health beliefs and practices, and assessed perceived program effects.

The MHPP evaluation design is based on Jacobs’s Five-Tiered Approach (FTA) to evaluation. As illustrated in Table 1, The FTA is developmental in nature, organizing research activities at five levels, “moving from generating descriptive and process-oriented information at the earlier stages [of a program’s development] to determining the effects of programs later [on].” At the same time as it focuses on the evaluation posed by clients, the FTA is also responsive to program-specific variations, for example, its age and developmental stage, its evaluation resources and capacity, and the context in which the program operates. The FTA then matches evaluation activities appropriately. The first tiers are process-, or operations-, oriented, and the fourth and fifth tiers are focused on measuring or determining outcomes. The assumption inherent in this model is that outcome evaluation is built on the data collected at earlier stages.

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5 Jacobs, 1988; Jacobs, 2003; Jacobs & Kapuscik, 2000
6 Jacobs & Kapuscik, 2000, p. 37
7 Jacobs, 1988
Table 1: Description of Evaluation Activities for the Five-Tiered Approach

<table>
<thead>
<tr>
<th>Tier</th>
<th>Purposes of Evaluation</th>
<th>Types of Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIER 1: NEEDS ASSESSMENT</td>
<td>♦ To document the size and nature of a public problem</td>
<td>♦ Review existing community, county, and state data</td>
</tr>
<tr>
<td></td>
<td>♦ To determine unmet need for services in a community</td>
<td>♦ Determine additional data needed to describe problem and potential service users</td>
</tr>
<tr>
<td></td>
<td>♦ To propose program and policy options to meet needs</td>
<td>♦ Conduct “environmental scan” of available resources</td>
</tr>
<tr>
<td></td>
<td>♦ To set a data baseline from which later progress can be measured</td>
<td>♦ Identify resource gaps and unmet need</td>
</tr>
<tr>
<td></td>
<td>♦ To broaden the base of support for a proposed program</td>
<td>♦ Set goals and objectives for intervention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>♦ Recommend one program model from range of options</td>
</tr>
<tr>
<td>TIER 2: MONITORING AND</td>
<td>♦ To monitor program performance</td>
<td>♦ Determine needs and capacities for data collection and management</td>
</tr>
<tr>
<td>ACCOUNTABILITY</td>
<td>♦ To meet demands for accountability</td>
<td>♦ Develop clear and consistent procedures for collecting essential data elements</td>
</tr>
<tr>
<td></td>
<td>♦ To build a constituency</td>
<td>♦ Gather and analyze data to describe program along dimensions of clients, services, staff, and costs</td>
</tr>
<tr>
<td></td>
<td>♦ To aid in program planning and decision making</td>
<td></td>
</tr>
<tr>
<td></td>
<td>♦ To provide a groundwork for later evaluation activities</td>
<td></td>
</tr>
<tr>
<td>TIER 3: QUALITY REVIEW AND</td>
<td>♦ To develop a more detailed picture of the program as it is being implemented</td>
<td>♦ Review monitoring data</td>
</tr>
<tr>
<td>PROGRAM CLARIFICATION</td>
<td>♦ To assess the quality and consistency of the intervention</td>
<td>♦ Expand on program description using information about participants’ views</td>
</tr>
<tr>
<td></td>
<td>♦ To provide information to staff for program improvement</td>
<td>♦ Compare program with standards and expectations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>♦ Examine participants’ perceptions about effects of program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>♦ Clarify program goals and design</td>
</tr>
<tr>
<td>TIER 4: ACHIEVING OUTCOMES</td>
<td>♦ To determine what changes, if any, have occurred among beneficiaries</td>
<td>♦ Choose short term objectives to be examined</td>
</tr>
<tr>
<td></td>
<td>♦ To attribute changes to the program</td>
<td>♦ Choose appropriate research design, given constraints and capacities</td>
</tr>
<tr>
<td></td>
<td>♦ To provide information to staff for program improvement</td>
<td>♦ Determine measurable indicators of success for outcome objectives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>♦ Collect and analyze information about effects on beneficiaries</td>
</tr>
</tbody>
</table>
TIER 5: ESTABLISHING IMPACT

♦ To contribute to knowledge development in the field
♦ To produce evidence of differential effectiveness of treatments
♦ To identify models worthy of replication

♦ Decide on impact objectives based on results of Tier 4 evaluations efforts
♦ Choose appropriately rigorous research design and comparison groups
♦ Identify techniques and tools to measure effects in treatment and comparison groups
♦ Analyze information to identify program impacts

At Tier One, data are collected and analyzed to determine the unmet need for services in the target population and to propose program options to meet those needs. Activities at the first tier consist of reviewing existing relevant data, determining additional data needed to describe the problem and potential service users, and recommending a program model from a range of options.

At Tier Two, data are collected and analyzed to satisfy basic demands for service monitoring and accountability. Activities at the second tier focus on comprehensively and accurately describing program inputs, or elements—primarily participants, services, staff, and costs. The systematic collection of information about program operations is critical to all subsequent evaluation efforts. All programs should be able to answer the questions, “How, with whom, by whom, at what costs, is the program being implemented?”

At Tier Three, evaluation activities are undertaken in order to develop a more in-depth picture of the program, to assess program quality with respect to performance standards, and to provide information to staff and participants for program improvement.

Tier Four activities focus on measuring the attainment of shorter term objectives (proximal outcomes), and examine whether the program achieved the effects as intended.

Tier Five activities involve rigorous experimental research to assess long-term program impact.

MHPP Evaluation Questions

The MHPP evaluation was designed as both a process-oriented and an outcome-oriented evaluation. Because of the age of MHPP at the start of the evaluation and the expected duration of the evaluation, a Tier Four investigation was considered the appropriate approach. Activities at Tiers One to Four were proposed to answer the following questions:

Tier One: Needs Assessment

- What are the core needs and preferences for health care among system-involved girls? How do these needs and preferences compare to those articulated by system-involved boys?
Tier Two: Monitoring and Accountability

- What are the processes by which MHPP is implemented in its current sites? Who is MHPP serving (numbers, demographics of youth served), and what are the ways in which these youth are being served by the program?

Tier Three: Quality Review and Program Clarification

- How do changes in the program’s staffing and partnering health centers affect, if at all, the way the program is delivered and received?

- What does it mean for MHPP to be “gender-specific” or “gender-responsive”? Are there similarities and/or differences between how MHPP is delivered to girls and how it is delivered to boys?

- What are the perceived roles that parents/guardians play in their child’s health care? What are the perceived roles that parents/guardians play in MHPP? What efforts, if any, has MHPP made to involve parents? What are the perceived outcomes of parent involvement (or lack thereof) in the program?

Tier Four: Documenting Outcomes

- What do program staff, partners, and youth participants perceive to be the effects, if any, of MHPP to date?

- What changes, if any, in DYS’s approach to health care have occurred since MHPP’s inception? What is the perceived role of MHPP in facilitating these changes in the system?

Methodology

Sample Size

As illustrated in Table 2, the data collected and analyzed over the course of the MHPP evaluation include interviews and focus groups with senior DYS officials, DYS health care and direct service workers, MHPP staff, community health center partners, and funders (N = 94), as well as interviews and focus groups with system-involved girls and boys (N = 41), a pilot health survey administered to a group of DYS-committed boys (N = 20) and interviews with individuals outside of DYS with expertise in providing health and/or support services to adolescents (N = 4).

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8 It was the initial intention of this evaluation to assess both MHPP program processes and its observed outcomes. However, due to an unexpected drop in the census of girls at the participating CRCs, and a smaller research budget than anticipated, the assessment of program outcomes is, rather, at the level of perceived effects, or those program effects as perceived and reported, but not “observed,” by key informants.
Table 2: MHPP Evaluation Sample Size (December 2005 – January 2009)

<table>
<thead>
<tr>
<th></th>
<th>Number of Interviews/Focus Groups/Surveys</th>
<th>Number of Interviewees/Focus Group attendees/Survey respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHPP director</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>MHPP health advocates</td>
<td>35</td>
<td>4</td>
</tr>
<tr>
<td>DYS senior officials</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>DYS facility staff (e.g., health care staff, administrators)</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>DYS district managers, caseworkers, program coordinators, community monitors</td>
<td>8</td>
<td>64</td>
</tr>
<tr>
<td>CRC managers</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Girls</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>Boys</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>Boys-Pilot Health Survey</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Non-DYS girls’ and boys’ needs assessment informants</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Funders</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Health center partners</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>118</td>
<td>159</td>
</tr>
</tbody>
</table>

Note: MHPP = The Massachusetts Health Passport Project; DYS = The Massachusetts Department of Youth Services; CRC = Community Re-entry Center.

It should be noted that it was difficult for the evaluation team to gain access to youth due to their frequent movement in and out of the community, the consent requirements of the Tufts Institutional Review Board, and the assistance with recruitment of youth and getting consent forms signed by youth and parents that the evaluators needed from already overextended MHPP and DYS staff.
In total, we collected data from 61 youth (22 girls and 39 boys) through interviews, focus groups, and surveys. A portion of these youth were involved in MHPP and a portion of these youth were not. In their subgroups (e.g., the six girls interviewed for the parent study), the numbers are undoubtedly too small on which to base program initiatives. However, even these small numbers of youth raise provocative issues that program developers might consider. Further, aggregated across subgroups (e.g., girls interviewed for the needs assessment, boys participating in the health pilot survey, and girls interviewed for the parent study) and about a particular topic, for example, their health concerns, or their desire for parents to be involved in their health care, their perspectives take on additional weight.

**Data Sources**

The data sources for the MHPP evaluation include the following:

- Key informant interviews and focus groups with adults;
- Key informant interviews and focus groups with youth;
- Pilot Health Survey with youth;
- MHPP and DYS databases;
- MHPP health advocates’ monthly reports;
- Notes from CRC site visits;
- Meeting notes;
- Program documents (e.g., proposals for funding, logic model);
- DYS documents (e.g., annual reports); and
- Review of relevant literature.

**Data Analysis**

Our interview and focus group transcripts were coded using a qualitative data analysis software package, ATLAS.ti. Codes were generated directly from the data and organized thematically. We used cross-case analysis (Miles & Huberman, 1994) to examine perceptions of system change shared across the interviews. Analysis of the MHPP database and health utilization surveys involved using a quantitative data analysis program, SPSS, in which a variety of statistical analyses were employed (e.g., descriptives, chi squares, correlations).

**MHPP Final Evaluation Report**

In this report, we detail our evaluation findings within each tier of Jacobs’s FTA. In the first section, Tier One: Needs-Demand Assessment, we briefly summarize findings from the planning phase needs assessment initiated in December 2005 and present a review of the literature on the health and health care needs of system-involved youth. We then describe the second needs assessment study, which culminated in the development of the health utilization survey administered to youth in DYS facilities in January 2009, and we present our preliminary analysis of the survey results.
In the second section, Tier Two: Monitoring and Accountability, we describe MHPP program implementation from June 2004 through December 2008, along the dimensions of staff, participants, and services, detailing who the program has served, what services were delivered, and by whom the services were delivered. We also introduce the locations of service delivery (e.g., CRCs and partnering community health centers) in this section.

In the third section, Tier Three: Quality Review and Program Clarification, we examine the MHPP program theory, logic model, goals, and key components as a conceptual framework that has shifted over time and we discuss the implications of those shifts. We also examine the program implementation in greater depth, exploring how and why services were delivered the way they were and detailing the inherent strengths and challenges. This third section includes the substudy on gender-responsive service delivery and the substudy on parental influence on youth’s health beliefs and practices.9

In the fourth section, Tier Four: Achieving Outcomes, we present the substudy on system change and our investigation of perceived program effects. In the final section, we synthesize lessons learned and recommendations integrated throughout the report that have emerged from our four-year study of MHPP. Finally, in Section Five, we present major findings and recommendations.

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9 Given that the MHPP evaluation team documented program services, participants, and staff during the first MHPP advocate’s tenure in great detail in several previous evaluation reports, the program implementation analysis in this third section is based on data collection from the subsequent period of program implementation (November 2007–December 2008). Similarly, the substudy on gender responsive service delivery in this section was initiated following the first MHPP health advocate’s tenure and thus is based primarily on data collection from this latter period.
References


SECTION ONE: NEEDS-DEMAND ASSESSMENT

The process of determining the nature and extent of a problem requiring intervention is called a “needs assessment” (Tier One of the Five-Tiered Approach [FTA]). It is generally conducted by collecting data from knowledgeable individuals, often professionals and researchers. We have expanded that notion here to include elements of “demand assessment” as well—how clients and potential clients view their needs, and how they would like to see those needs met. The first component is a needs-demand assessment, based on data collected through interviews and focus groups; it begins with a review of the relevant research literature. The second component presents an analysis of pilot-test data from the Massachusetts Health Passport Project (MHPP) Youth Health Survey.
TIER ONE: MHPP NEEDS-DEMAND ASSESSMENT

According to the FTA, in order for a program like MHPP to determine unmet need for the services it intends to bring to its target population and to set a baseline from which later progress can be measured, conducting a needs assessment is a necessary first step. Thus, a needs assessment was among the first evaluation activities the Tufts team engaged in as part of assisting MHPP in planning for its expansion.

From December 2005 – April 2006, the Tufts evaluation team collected and analyzed data from interviews and focus groups with adult and youth key informants to assess the health care needs and preferences of girls in Boston, and in the two potential expansion sites, Worcester and Brockton. The Tufts evaluation team also conducted a review of the literature on health issues for girls in the juvenile justice system, reviewed extant program data, and collected information on the community resources available in the possible expansion sites that could be marshaled on behalf of participating girls. In May 2006, following the needs assessment specific to serving girls, the Tufts evaluation team conducted a similar needs assessment, this time for the program’s expansion of services to boys.\(^\text{10}\)

In this section, we present an abridged and updated review of the literature on health issues for system-involved girls and boys\(^\text{11}\), highlight findings from both the girls’ and boys’ program needs assessments conducted from December 2005 – December 2007, and discuss the relevance of these findings to the evaluation and program’s development.

Literature Review

A large body of research indicates that juvenile offenders have extensive psychosocial and physical health needs; an estimated 50-60% of this population suffers from psychological and emotional problems requiring mental health care, compared to approximately 15-20% of young people in the general US population (Shelton, 2002; Soler, 2002). Studies also indicate disproportionately high rates of physical health problems among juvenile offenders (Acoca, 2000), many of which are closely linked with disruptive or risky behaviors and detrimental environmental factors (Acoca, 2000; Atkins et al., 1999; Kroneman, Loeber, & Hipwell, 2004). Moreover, these youth typically do not receive the necessary care during and after their...


involvement with the juvenile justice system, despite their complex mental and physical health needs (Shelton, 2002; Soler, 2002).

Literature on the health needs of adolescents involved in the juvenile justice system consistently report high rates of dental, respiratory, orthopedic, hearing, and dermatological problems, sexually transmitted infections (STIs), alcohol and substance abuse, trauma, and mental illness, as well as high rates of accidents/injuries and hospital admissions (Anderson, Vostanis, & Spencer, 2004; Bolin & Jones, 2005; Golzari, 2006; Sege & Licenziato, 2004). Moreover, research has identified the low rate of preventive health care use among this population (Anderson et al., 2004). The literature also identifies the high prevalence of risk behaviors among these youth, and connects their participation in these behaviors to an increased risk for the development of health issues (Juczczak & Cooper, 2002). The following section will briefly detail the physical and mental health needs of the juvenile justice population and aim to identify health disparities between males and females involved in the juvenile justice system.

Sexual Risk Behaviors

Studies on the risk-taking behaviors of juvenile offenders find that both boys and girls in the juvenile justice system report higher rates of voluntary and forced sexual activity, including sexual abuse, when compared to community samples. Moreover, these teens also report having a greater number of sexual partners and lower rates of contraception use, particularly lower rates of condom use, therefore putting them at a higher risk for contracting sexually transmitted diseases (STIs). Studies have found recently arrested adolescents to be at high risk of STIs (Belenko, S., Dembo, R., Weiland, D., Rollie, M., Salvatore, C., Hanlon, A., et al., 2008) and other studies have reported elevated rates of many STIs, especially gonorrhea and chlamydia, among delinquent girls (American Academy of Pediatrics, 2001). The Centers for Disease Control report higher rates of sexually transmitted diseases in teen girls entering juvenile correction facilities than the rates of girls in the general population. In addition, teen girls in the general population have higher rates of infection than women in other age groups. Further, recent studies indicate that girls and boys have different patterns of STI risk and transmission and thus suggest the need for gender-specific interventions (Romero, Teplin, McClelland, Abram, Welty, & Washburn, 2007).

Most concerning are the significantly younger ages of these youth at the onset of sexual risk behaviors when compared to the general youth population (Golzari, 2006; Morris et al., 1995; Sege & Licenziato, 2004). Being of younger age when initiating sexual activity has been linked to an increased likelihood of engaging in sex while under the influence of drugs or alcohol, being involved in a pregnancy, having multiple partners, and having forced a partner to have sex (O'Donnell, O'Donnell, & Stueve, 2001). Therefore, this behavior—initiating sexual activity at a young age—along with being incarcerated, appear to put youth at a greater risk for involvement in sexual risk behaviors.

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12 CDC, 2004 STD Surveillance Report
Sege and Licenziato (2004) also report that incarcerated youth are at risk for sexual victimization by inmates and staff. The authors attribute this risk to overcrowding in detention facilities and poor supervision or behavioral management. As the literature indicates, not only do incarcerated youth have higher rates of sexual victimization than the general population prior to detention, but they are also at risk for further victimization upon incarceration.

Parenting

Literature on the health outcomes and risk behaviors of juvenile offenders indicates that these youth participate in multiple sexual risk behaviors, and also experience higher rates of STI infection than the general population of youth (Golzari, 2006; Juszczak & Cooper, 2002; Morris et al., 1995; Sege & Licenziato, 2004). Although involvement in these risk behaviors has been documented, there exists a paucity in the literature investigating the incidence of parenting among detained youth, particularly among the male population. Some studies have shown that detained male youth who are involved in gangs or who have numerous incarcerations, also known as recidivists, appear to have higher impregnation rates than other detained male youth (Golzari, 2006; Morris et al., 1995). Research also indicates that early delinquency is a major risk factor for early parenthood among male juvenile offenders (Thornberry, Wei, Stouthamer-Loeber, & Van Dyke, 2000). Despite the high prevalence of sexual risk behaviors among young male offenders, research suggests that even when they do receive routine care from health providers, few receive services specific to reproductive and sexual health (Juszczak & Cooper, 2002). There is also scant mention in the literature of explicit support, guidance, or counseling being offered to these young men in their parenting roles.

Substance and Alcohol Use

Alcohol and illicit substance use is also higher among juvenile offenders of both sexes than in the general youth population (Anderson et al., 2004). Of adolescents detained for criminal offending in 2000, 56% of boys and 40% of girls tested positive for drug use (Chassin, 2008, p. 166). In a study of 1700 detainees, Morris and colleagues (1995) found that 75% of the participants had some involvement with alcohol, and that well over 50% had participated in at least one episode of binge drinking one month prior to detention. They also found that 40% of the sample reported at least 40 episodes of marijuana use in their lifetime. These youth also engage in illicit substance use at a younger age compared to the general youth population (Morris et al., 1995).

Research also indicates that youth who use drugs are at greater risk of becoming the perpetrators and victims of assault when compared to the general youth population (Morris et al., 1995) and are more likely to have continued involvement with the juvenile justice system (Chassin, 2008). Heavy use of alcohol and drugs was also associated with a greater incidence of suicide planning among incarcerated youth.
Although overall drug and alcohol use among detained youth is greater when compared to the general population, research indicates that incarcerated female youth use drugs more frequently and also use a greater variety of drugs than incarcerated male youth (Kim & Fendrich, 2002; Morris et al., 1995). In addition, studies indicate that female youth with substance use disorders are more likely than male youth to have co-occurring mental health disorders (Chassin, 2008, p. 167). Findings are conflicted as to sex differences in first time drug use. Some studies report that girls start using drugs at an earlier age than boys, whereas other studies indicate no sex differences in first time drug use (Kim & Fendrich, 2002; Morris et al., 1995).

In their study of 4,644 detained youth, Kim and Fendrich (2002) found that although females tended to report more drug involvement, male detainees reported higher rates of current drug use than females. Kim and Fendrich (2002) also found that males reported less drug dependence and need for treatment than most females, with the exception of females who reported more current and frequent drug use. These findings may imply that males are not seeking out help for their drug use because they do not perceive their use as a problem, a perception that further increases their involvement in health risk behaviors. Studies suggest a need for more substance use interventions and treatment models that integrate community-based approaches during and after youth’s justice system involvement.

Violence

Research also indicates that youth involved in the juvenile justice system engage in more violent interactions and are more at risk for intentional injuries than youth outside of the justice system (Morris et al., 1995; Sege & Licenziato, 2004). In a study of 1,700 detainees, Morris et al. (1995) found that 70% of youth involved in the juvenile justice system had experienced some form of interpersonal violence in the year preceding incarceration compared to only 42% of a community youth sample. They also found that at least three quarters of these confrontations involved the use of a weapon. Involvement in violent interactions did not appear to significantly vary between detained boys and girls. However, boys appeared to use more weapons in these fights than did girls, putting these young men at greater risk for serious injury (Morris et al., 1995). Premature morbidity is also a major issue for detained males. In the general youth population, males have higher morbidity rates than girls. Reasons for morbidity include vehicular accidents, homicide, suicide, and intentional injuries (JuszczaK & Cooper, 2002). As found in the general youth population, morbidity rates of detained male youth are greater than that of detained female youth.

Gang Involvement

Youth in the juvenile justice system are more likely to be involved in a gang when compared to the general youth population (about half of detained youth compared to 20% of the general youth) (Morris et al., 1995). Rates of gang involvement among female versus male detainees did
not appear to differ significantly. However, when health outcomes of gang involved youth are compared to non-gang-involved youth in the system, the former appear to be doing worse.

Gang involvement serves as a compounding risk for lengthier incarceration times, increased violence rates, increased weapon use, and increased drug and alcohol use. Gang membership also appears to be related to younger age at sexual debut, less use of contraception, more STI diagnoses, and more reported rates of pregnancy or impregnation (Morris et al., 1995).

**Recidivism**

Another factor associated with increased rates of high risk behaviors is recidivism. For example, Golzari, Hunt, and Anoshiravani (2006) found that young men who were incarcerated more than once report less condom use, younger age at sexual debut, more than eight lifetime partners, having exchanged drugs or money for sex, and also report higher rates of impregnation.

In a study of 75 incarcerated youth, Wierson and Forehand (1995) found that recidivism was most associated with age at detention and severity of crime. They found that participants who were first detained at an earlier age than most other detainees and who committed more severe crimes were more likely to have been arrested multiple times. They also found that a diagnosis of Conduct Disorder and substance abuse was a successful predictor of recidivism among white male youths while a diagnosis of Attention Deficit Hyperactivity Disorder, number of severe crimes committed, younger age at first conviction, and less likelihood of presence of depressive symptomatology was a successful predictor of recidivism among African-American male youths.

**Mental Health Needs**

Detained youth suffer from a vast array of mental health issues. Prevalence rates of psychological disorders in delinquent girls are higher than those of both adolescent girls in general, and of the juvenile justice population as a whole. According to one study, the estimated prevalence of mental illness for delinquent boys was 27%, compared with 84% for delinquent girls (Timmons-Mitchell et al., 1997). Like all adolescent girls, delinquent female youth are more likely than their male counterparts to suffer from internalizing disorders such as depression (Keenan & Hipwell, 2005).

In addition, for girls in the justice system, a significant correlation exists between violent or criminal behavior and mental health problems. Correlates of violent and criminal behavior in delinquent girls have been found to include anti-social attitudes, low self-esteem, and negative family experiences (Holsinger & Holsinger, 2005). However, the strongest correlate of delinquent behavior in girls is victimization, in the form of abuse or assault (AddHealth, 2000). A study of California’s juvenile justice system found that 93% of female detainees had experienced some form of victimization; 88% had been emotionally abused, 81% had been
physically abused, and 56% had been sexually assaulted (Acoca, 2000). While all adolescents in the juvenile justice system are disproportionately more likely to have experienced maltreatment at some point in their lives, rates of sexual abuse are about four times higher among girls than boys in this population (Acoca, 2000).

Exposure to such trauma is a predictor of delinquent behavior in both girls and boys, but girls are significantly more likely to develop mental health issues, as well, as a result (Kessler, Sonnega, Bromet, & Hughes, 1995); in particular, they are six times more likely to develop post-traumatic stress disorder (PTSD) (Cauffman, Feldman, Waterman, & Steiner, 1998). Thus, it has been suggested that “increases in female delinquency may be a consequence of females’ greater susceptibility to the traumatic events they experience in the increasingly violent settings of modern urban neighborhoods, and that, as a result, we should view female delinquency as a symptom rather than the problem itself” (Cauffman, Feldman, Waterman, & Steiner, 1998, p. 1210).

Compared to about one-fifth of the general youth population, well over two thirds of detained youth suffer from a serious psychiatric disorder (Golzari et al., 2006; Shelton, 2002; Soler, 2003). Psychiatric disorders suffered by this population include depression, anxiety, attention-deficit and hyperactivity disorder, conduct disorder, substance abuse, psychosis, and PTSD (Atkins et al., 1999; Golzari et al., 2006; Sege & Licenziaito, 2004). However, these disorders are not mutually exclusive. Studies of mental health illness among incarcerated youth have found that many of these young men and women meet the diagnosis for two or more psychiatric disorders (see Anderson et al., 2004; Atkins et al., 1999; Sege & Licenziaito, 2004). Although prevalent among detained youths, comorbidity of mental health disorders appears to be found among more female detainees than male detainees (Hussey, Drinkard, Falletta, & Flannery, 2008). High comorbidity rates among this population indicate the need for increased mental health services for these youth during incarceration as well as following their release.

Suicidality has been found to be related to involvement in high risk behaviors among the general population of youth (Hallfors et al., 2004). Although researchers indicate that the rate of suicidal ideation between general population youth and incarcerated youth does not differ (Golzari et al., 2006), serious suicidal planning, attempts, injuries and completion are higher among detained youth than the general population (Golzari et al., 2006; Morris et al., 1995; Sege & Licenziaito, 2004).

Incarcerated youth have also been found to employ more violent methods of attempted suicide than the general population (Sege & Licenziaito, 2004), and their suicide injury rate is twice as high among incarcerated males than males in the general population (Morris et al., 1995). Researchers have also found that, when compared to female detainees, male detainees have higher rates of suicide completion (Rohde, Mace, & Seeley, 1997). While few longitudinal studies exist that investigate the health trajectories of detained youth, a study of Canadian detainees found that an estimated 15% of detained youth will attempt suicide at some point following their release (Corneau & Lancot, 2004).
Although multiple studies indicate that the health outcomes of detained females are worse than those of detained males, both detained male youth populations and general male youth populations suffer from higher mortality rates (Juszczak & Cooper, 2002). Overall, incarcerated youth have more health care problems and are involved in more health risk behaviors than youth in the general population. In fact, a Maryland study of male youth detainees found that almost 70% of detained boys were considered to have worse health outcomes when compared to an age-matched school sample. Of these detained youth, only 6% were considered to be in excellent health compared to a third of the age-matched school sample (Golzari et al., 2006).

**Access to Health Care and Health Care Utilization**

In recent years, scholars have turned their attention to describing not only the health and mental health needs of youth in the juvenile justice system, but also to examining the possible barriers and facilitators to receiving care and treatment that address these needs. Given the overrepresentation of mental health disorders in the juvenile justice population, much of this research has focused on access to mental health services in particular.

Findings from studies of youth in the general population suggest that boys are less willing to access care or utilize mental health services than girls (Chandra & Minkovitz, 2006). Studies on gender differences in service utilization among youth in the juvenile justice system suggest similar patterns of service utilization. In their study of detection and treatment of mental disorders in 1829 detained youth, Teplin, Abram, McClelland, Washburn, and Pikus (2005), found that significantly more girls than boys were both detected with and received treatment for mental disorders at some point during their involvement in the system, and that African-American boys in particular “had the lowest rate of service provision” (p. 1778). Caufmann (2004) reported a similar finding that White youth were more likely to receive treatment than were non-White youth. In their qualitative study analyzing depression and help seeking among African-American boys, Lindsey et al. (2006) note that African-American boys, while at high risk for poor mental health, often do not receive treatment when necessary. Similarly, in their review of research on service utilization by adolescent boys, Juszczak and Cooper (2002) note that fewer males than females use health services. In particular, they note that though non-White boys are more likely to be in poorer health than White boys, they are less likely than White boys to see doctors. The authors attribute this, in part, to these boys’ lack of positive attitude to health care.

Researchers identify a number of possible reasons for these race and gender related differences. Chandra and Minkovitz (2006) found that stigma and parental attitudes towards boys’ receiving help from a mental health professional largely explained gender differences in willingness to receive help in their sample of 274 eighth graders. Lindsey et. al. (2006) also cite studies that claim non-White youth are more likely to be skeptical of mental health services than White youth, and that stigma, reinforced by peer networks, contribute to non-White boys’ underutilization of services. In addition to stigma and skepticism, the authors found that
African-American boys often rely on informal help from parents or friends rather than on professional help, highlighting the importance of social support networks in accessing, monitoring, maintaining, and facilitating care.

Some scholars view juvenile offenders’ difficulty accessing health care as symptomatic of the system’s orientation toward punishment rather than treatment or rehabilitation (Acoca, 2000; Shelton, 2002). Citing Grinfield, Shelton (2002) notes that this tendency of the juvenile justice system to minimize the costs of rehabilitation can lead to a “vicious cycle, where untreated behavioral symptoms will, sooner or later, come to law enforcement’s attention. They will eventually deteriorate even further in youth authority facilities, at which point they are released and abandoned, destined to commit even more offenses” (p. 279). Advocates of better health and mental health care for system-involved youth assert that such care will likely enhance their quality of life and decrease recidivism, reducing further costly system involvement (Pumariega et al., 1999; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Further, Golzari, Hunt, and Chamberlain (2008) argue that the time of committed youth’s release from the juvenile detention system provides a “critical opportunity” for connecting them to the medical system. They make a case for paying special attention to ensuring youth confined to correctional facilities are connected to a “medical home” prior to release, as articulated in a 2001 policy statement of the American Academy of Pediatrics (AAP). The concept of a “medical home” involves “health care delivered or directed by a physician who provides preventive, acute, and chronic care that is accessible, continuous, comprehensive, compassionate, and coordinated with specialized services such as mental health provided by community agencies” (Golzari, Hunt, & Chamberlain, 2008, p. e397).

The literature reviewed here indicates that system-involved boys and girls participate in many high risk behaviors that have serious health-related consequences. Despite these documented needs, research on health care provision and health service utilization suggest that many of these youth are not provided the necessary medical care for these issues or do not adequately utilize the services that are available to them. System-involved girls and boys have unique pathways to delinquency, and their distinctive health and mental health needs speak to the need for specialized services, like those offered by MHPP, that seek to address these needs and improve youth’s access and utilization of health care.

Summary of Findings from the 2005 – 2006 Girls’ Program Needs-Demand Assessment

Our interviews and focus groups with adults and girls indicated the following as major health concerns for DYS-committed girls in Boston and Worcester:

- Pregnancy;
- Sexually transmitted diseases (HIV);
- Sexual abuse and involvement in prostitution;
- Nutrition/exercise;
- Hygiene;
Lack of regular, routine care;
- Multiple medications/inconsistent use of medications;
- Waiting until health problem is an emergency;
- Mental health; and
- Substance abuse.

Our interviews and focus groups with adults and girls indicated the following as major health care needs for DYS-committed girls in Boston and Worcester:

- Regular check-ups;
- Pap smears;
- Birth control;
- STD testing;
- Pregnancy testing/prenatal care;
- Mental health services;
- Health education;
- Hygiene care;
- Dental care;
- Monitoring of medications; and
- Complete medical records (currently unavailable).

Health Care Utilization

While adult interviewees noted that girls rely largely on the emergency room for care and do not utilize the drop-in hours that some community clinics offer, the girls we interviewed reported having their “own” doctor, and several reported visiting their doctors or clinics for regular medical check-ups (every three or six months), and for mental health services.

Community Health Resources

Our interviews with key informants as well as our research of available community health resources indicated that both Boston and Worcester have an extensive network of community health centers and clinics, in addition to major medical centers (e.g., Children’s Hospital, Boston and University of Massachusetts Memorial Medical Center) with adolescent clinics. Both sites also have extensive public transportation systems, facilitating youth’s access to these health centers.

Program Recommendations

Our girls’ program needs assessment generated the following recommendations for the Boston girls’ program:
Key Program Components

- Team approach: caseworker, nurse/practitioner, girls collaborate on treatment plan—a long-term process as opposed to a quick-fix “crisis intervention” style;
- Partnering with existing resources in the community;
- Parental/family involvement;
- Professionalism in interactions with girls and among adults serving girls;
- Professional development to train providers (DYS and MHPP) on collaborative model;
- Linking health care services to other facets of girls’ lives, in particular, their education (getting girls to go to school is a major challenge);
- Listening to girls, understanding where they are coming from, responding to their needs;

Type of Provider

- Professional medical provider;
- Person who can do a lot of “hand holding” and modeling of good health habits;
- Person who has connections with health centers and can facilitate appointment making;
- Person who can form a stable, long-term relationship with girls;

Service Delivery

- Location associated with family services or events for families to bring parents in; and
- Partnering with a major health provider in the area.

Our girls’ program needs assessment generated the following recommendations for the Worcester girls’ program:

Key Components

- Updated medical records for girls that follow them through transitions;
- Training for DYS staff regarding health care issues for girls;
- Parental/family involvement;
- Health education (e.g., addressing body image, self-esteem, dating violence, nutrition, hygiene, physical activity);
- Birth control (mentioned specifically by girls);
- Drug counseling (mentioned specifically by girls);
- Consistent communication about girls’ health care through all their transitions (e.g., among providers in detention, at the CRC, in the community, etc.);
- Integrated mental health services;
- Adequate funding;

Type of Provider

- One person in charge who is outside DYS or Spectrum;
- Person familiar with the community & existing resources;
• Person familiar with medical transcription;
• “Medical Case Manager” (e.g., a case worker trained to understand health care issues);
• Person who can help girls see health care as important and normative;
• Person who can provide reassurance and address girls’ preconceived notions and fears about health care;

**Service Delivery**

• In-house at the CRC;
• Home visits to girls who do not report to the CRC;
• Proactive, preventive approach to health care;
• Management of medications; and
• Regular physicals.

**Relevance of Girls’ Program Needs-Demand Assessment Findings**

The findings from the girls’ program needs assessment guided the evaluation’s research and the program’s development over its tenure. For example, given that key informants identified parent and family involvement as a key program component, during monthly implementation documentation interviews, evaluators asked MHPP health advocates about their contact, if any, with parents and the perceived effects of those parent contacts. In addition, the evaluation team conducted a substudy on the influence of parents on youth’s health beliefs and practices. These findings also influenced program development, as the program implemented various program components that emerged from the recommendations, such as the team approach to care, integrating health education into program services, and efforts to build relationships between the MHPP advocates and the girls. As described in Section Three of this report, various shifts in thinking and practice over the years has made some of these recommendations not as viable. For example, it has been determined that a medical professional is not necessarily the most optimal or most cost-effective model of service delivery and that teaching youth how to manage their care independently is more in keeping with the program’s goals of improving health care access than “a lot of hand holding.”

**Summary of Findings from the 2006 – 2007 Boys’ Program Needs-Demand Assessment**

Our interviews and focus groups with adults and boys indicated the following as major health concerns for DYS-committed boys in Boston and Worcester:

• STDs;
• Violence-related injuries (e.g., gunshot wounds);
• Sports-related injuries;
• Letting injuries go untreated;
• Lack of regular, routine care (have not seen primary care physician “in years”);
• Delaying care until health problem is an emergency;
• Mental health (trauma, depression);
• Substance abuse;
• Nutrition/exercise;
• Hygiene/skin (acne);
• Vision; and
• Experiences of trauma/abuse/violence.

Our interviews and focus groups with adults and boys indicated the following as major health care needs for DYS-committed boys in Boston and Worcester:

• Regular check-ups (annual physicals);
• STD testing;
• Treatment of injuries;
• Mental health services and medications;
• Health education;
• Hygiene care;
• Dental care;
• Vision care;
• Monitoring and maintenance of medications; and
• Complete medical records.

Health Care Utilization

Adult interviewees described boys’ health care upon community re-entry as irregular to nonexistent. They said that many of the boys they work with do not have a primary care physician and have not seen a doctor in years. They also noted that many boys rely on the emergency room for care to address an “immediate crisis.” While a couple of the boys we interviewed reported having a primary care provider, most of the boys described obstacles to seeking care, including having to wait too long for care, having to fill out complicated forms, and experiencing discrimination based on their DYS status when receiving health care in the community. In addition, these youth expressed reluctance to seek care for one of their most common health issues, for example, violence-related injuries, for fear of apprehension.

Program Recommendations

Our boys’ program needs assessment generated the following recommendations for the Boston and Worcester boys’ program:

Type of Provider
• Preference for female provider;
• Person who can tap into existing social supports and resources for system-involved boys;
• Person who can ensure privacy of health information and independence from DYS in order to gain trust from system-involved boys;
• Person who can educate system-involved boys and their families about the importance of a preventative approach to health care as well as about their health care rights;

Service Delivery
• Adults said the CRC was the best place for MHPP service delivery; boys preferred not to meet at the CRC; and
• Services that acknowledge the ways boys can and do take care of themselves and that integrate these strengths and skills into the model for delivering care to them.

Relevance of Boys’ Program Needs-Demand Assessment Findings

The findings from the boys’ program needs assessment have also guided the evaluation’s research and the program’s development over its tenure. For example, given that key informants spoke of boys’ lack of routine health care and challenges to health care utilization, during monthly implementation documentation interviews, evaluators asked the Boston boys’ advocate about the health care utilization of the boys with whom she was working, and assessed the role, if any, MHPP was playing in facilitating their access to care. In addition, the evaluation team developed a health utilization survey, described later in this section, in an effort to further examine the utilization patterns of system-involved youth. The boys’ program needs-assessment findings also influenced program development, as the program implemented various program components that emerged from the recommendations, such as hiring a female provider who has knowledge of existing social supports and resources for system-involved boys. In addition, the service delivery model acknowledges the ability and desire of system-involved boys to “take care of themselves,” by the fact that participating youth can contact the MHPP advocate on her project cell phone, and as illustrated in the way the MHPP advocate prioritizes independent health care education.

Gender Comparison

Tables 1.1 and 1.2 offer a gender comparison of findings from our girls’ and boys’ needs assessments. Table 1.1 illustrates areas of overlap between girls’ and boys’ health concerns and health care needs. Table 1.2 illustrates the shared preferences of girls’ and boys’ needs assessment informants for the type of provider and service delivery components of MHPP.

This gender comparison reveals that the health concerns and health care needs of system-involved girls and boys are quite similar, with the primary exceptions being reproductive health issues and violence related injuries. Both girls’ and boys’ needs assessment informants shared preferences for MHPP to be staffed by providers with knowledge of existing community health resources, to emphasize a preventative approach to health care, and to involve parents and families. Adult informants shared preferences for the CRCs as the location of service delivery, while youth informants preferred that either the MHPP provider or site be outside of DYS.
Table 1.1: Needs-Demand Assessment Comparison by Gender

<table>
<thead>
<tr>
<th>Health Concerns</th>
<th>Girls</th>
<th>Boys</th>
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</thead>
<tbody>
<tr>
<td>Delaying care until health problem is an emergency *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Exposure to trauma/abuse/violence *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hygiene *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lack of regular, routine care *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Letting injuries go untreated *</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Mental health (trauma, depression) *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Multiple medications/inconsistent use of medications *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nutrition/exercise *</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Pregnancy *</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sexual abuse and involvement in prostitution *</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Skin (acne) *</td>
<td>X</td>
<td></td>
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<tr>
<td>Sports related injuries *</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>STDs (HIV) *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Substance abuse *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Violence related injuries (e.g., gunshot wounds) *</td>
<td>X</td>
<td></td>
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<tr>
<td>Vision *</td>
<td>X</td>
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<table>
<thead>
<tr>
<th>Health Care Needs</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth control *</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Complete medical records *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Dental care *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Health education *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hygiene care *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mental health services and medications *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Monitoring of medications *</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Pap smears *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy testing/prenatal care *</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Regular check-ups (annual physicals) *</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regular, routine care *</td>
<td>X</td>
<td>X</td>
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<tr>
<td>STD testing *</td>
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<td>X</td>
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<tr>
<td>Treatment of injuries *</td>
<td>X</td>
<td></td>
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<tr>
<td>Vision care *</td>
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</tbody>
</table>

*Youth mentioned only; *Adults mentioned only; *Both youth and adults mentioned
### Table 1.2: Needs Assessment Comparison by Site and Gender

<table>
<thead>
<tr>
<th>Key Components</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bost.</td>
<td>Worc.</td>
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<tr>
<td>Team approach—long-term collaborations rather than quick-fix “crisis</td>
<td></td>
<td></td>
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<tr>
<td>intervention” style&lt;sup&gt;1&lt;/sup&gt;</td>
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<tr>
<td>Partnering with major health provider and/or existing resources in the</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>community&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
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<tr>
<td>Parental/family involvement&lt;sup&gt;1&lt;/sup&gt;</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Professionalism in interactions with girls and among providers&lt;sup&gt;1&lt;/sup&gt;</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Training of providers (DYS and MHPP) on collaborative model and health</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>care issues&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linking health care services to other facets of girls’ lives, in particular,</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>their education&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listening to girls, understanding where they are coming from, responding</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>to their needs&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Updated medical records for girls that follow them through transitions&lt;sup&gt;1&lt;/sup&gt;</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Consistent communication about girls’ health care through DYS transitions&lt;sup&gt;1&lt;/sup&gt;</td>
<td>X</td>
<td></td>
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<tr>
<td>Integrated mental health services&lt;sup&gt;1&lt;/sup&gt;</td>
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</tr>
<tr>
<td>Strength-based services that acknowledge ways in which boys can do take</td>
<td></td>
<td></td>
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<tr>
<td>care of themselves&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
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<tr>
<td>Adequate funding&lt;sup&gt;1&lt;/sup&gt;</td>
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<table>
<thead>
<tr>
<th>Type of Provider/Service Delivery</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bost.</td>
<td>Worc.</td>
</tr>
<tr>
<td>Professional medical provider&lt;sup&gt;1&lt;/sup&gt;</td>
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<td></td>
</tr>
<tr>
<td>Person who can do a lot of “hand holding” and modeling of good health habits&lt;sup&gt;1&lt;/sup&gt;</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Person who is connected with health centers, other resources, and can</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>facilitate appointment making&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person who can form a respectful, stable, long-term relationship with girls&lt;sup&gt;1&lt;/sup&gt;</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>One person, outside DYS or Spectrum (someone who can ensure privacy of health information)&lt;sup&gt;1&lt;/sup&gt;</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Person familiar with medical transcription&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>“Medical Case Manager” (e.g., caseworker trained to understand health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>issues)&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person who can help girls see health care as normative/address girls’ fears</td>
<td></td>
<td></td>
</tr>
<tr>
<td>about health care&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preference for female provider&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Provider located in a center/agency associated with family services or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>events for families&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider located in-house at the CRC&lt;sup&gt;1&lt;/sup&gt;</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Provider who is &lt;i&gt;not&lt;/i&gt; based at the CRC&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home visits to girls who do not report to CRC&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person who can educate youth and their families about the importance of a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>preventative approach to health care as well as about their health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>rights&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup>Youth mention only; <sup>A</sup>Adults mention only; <sup>YA</sup>Both youth and adults mention
References


Pumariega, A.J., Atkins, D.L., Rogers, K., Montgomery, L., Nybro, C., Caesar, R., and


MHPP PILOT HEALTH SURVEY

In response to interests expressed by the Massachusetts Health Passport Project (MHPP) director and MHPP collaborators and partners in systematically assessing the health knowledge, utilization, and social supports of youth served by MHPP, the evaluation team created a survey that would have the capacity to gather data on health-related variables in the Massachusetts juvenile justice population. The evaluation team researched existing national and statewide standardized measures which assess health utilization, access, and knowledge. The resulting MHPP health survey instruments emerged from a combination of questions primarily from the Center for Disease Control’s (CDC’s) National Health Interview Survey and the CDC’s National Survey of Children’s Health, with some questions from the Massachusetts Department of Health and Human Services’ Behavioral Risk Factor Survey Questionnaire included as well. Most of the questions taken from these measures were adapted to make them appropriate for the targeted population. In addition, evaluation team members created supplementary questions.

The survey was developed to measure two areas related to MHPP’s goals: health care access and utilization (including approach to care, social supports, obstacles to care, and quality of care); and health and health care knowledge, and to be administered to youth in two parts, as follows:

- Nurse-administered baseline interview (NABI): To be administered, face-to-face, by a health care professional,
- Youth-administered baseline survey (YABS): To be completed, in written form, by youth themselves.

Data collected through these surveys are intended to contribute to our understanding of past and current health and health care utilization-related patterns in this population and provide useful health data for the MHPP director and health advocates so that they can then target services accordingly to the population served by MHPP (e.g., try to reduce ER use, reconnect youth to past providers in the community). The following sections describe survey development and pretesting procedures, sample recruitment and characteristics, and survey results.

Development of the MHPP Health Survey

Because the content of the MHPP Health Survey and its implementation protocols required input and endorsement from several different entities (e.g., The Massachusetts Department of Youth Services [DYS], MHPP, program partners and collaborators, human subjects institutional
review boards) the process of arriving at a final draft of the document was a long one—from November 2007 to December 2008.

Conventional pretesting of surveys generally involves several administrators field testing the instrument with a small number of participants and then sharing their experiences, going through each question on the instrument and reviewing problems. Another method for pretesting involves an observer noting deviations from the instrument during administration.\textsuperscript{13} A combination of these methods was used to test the MHPP Health Survey instrument. Survey administrators were provided with an administrator notes page, and were asked to note on that page, for each survey they administered, any challenges participants had in understanding a question, instances where participants asked for clarification, and questions for which the administrator altered the wording they used in delivering a question. In addition, a member of the MHPP evaluation team observed two survey administration sessions and took notes on challenges and deviations. Finally, a member of the MHPP evaluation team was in regular contact with the survey administrators to discuss and keep notes on challenges and trends observed in participants’ responses to the surveys. The observations made during each of these pretesting methods were used to modify and finalize the MHPP Health Survey.

Administrators also noted the length of time it took each participant to complete both components. This information will be useful to individuals who would like to utilize the survey in the future.

\textbf{Sample Recruitment and Survey Administration}

The MHPP Health Surveys were administered between January and March 2009. Youth who were committed to DYS, and who would be reporting to the Boston and Worcester CRCs in which MHPP is located when they return to the community, were recruited to participate in the pilot study sample. These youth were in custody in treatment facilities in two of DYS’s regions, the Metro Region and the Central Region. DYS staff, including regional staff, facility directors and facility health care staff, assisted in the identification of youth who were eligible to be included in the pilot survey sample. Participation of youth was completely voluntary. Eligible youth were informed about the survey and given the option to sign a consent form indicating their interest in participating. Youth who were under 18 years of age were not permitted to participate until their parent’s or guardian’s consent was also obtained. The pilot surveys were administered by the MHPP advocates from the Boston boys’ site and the Worcester girls’ site. Respondents who completed the surveys were given a gift card for their participation.

While the intention of the evaluation team was to have an approximately equal number of girls and boys participate in the pilot study, recruiting females for the pilot proved to be very challenging, leaving us with a total sample of 20, including 19 boys and one girl. This situation occurred for the following reasons: 1) due to conflict with another study taking place in DYS.

facilities, certain facilities, including one all-female facility, was not accessible to us during the pilot study period; 2) there were fewer females in custody in the facilities included in the pilot study who were 18 years old or older, and obtaining parent or guardian consent for the younger girls was extremely difficult; and 3) because the “launch” of the surveys was delayed, the window of time for data collection was narrow.

Sample Characteristics

A total of 20 DYS-committed youth completed the MHPP Pilot Health Survey. Nineteen of the respondents were boys. The mean age of respondents was 17.75, with a range from 15 to 20.

As shown in Table 1.3, the sample was racially and ethnically diverse, with a majority of participants self-identifying as African-American or Black.

Table 1.3: Respondents’ Self-identified Race and/or Ethnicity

<table>
<thead>
<tr>
<th>Respondent race/ethnicity</th>
<th>Percentage (number) of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American or Black</td>
<td>45 (9)</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>15 (3)</td>
</tr>
<tr>
<td>Caucasian or White</td>
<td>15 (3)</td>
</tr>
<tr>
<td>Black and Puerto Rican</td>
<td>5 (1)</td>
</tr>
<tr>
<td>Asian/Cambodian</td>
<td>5 (1)</td>
</tr>
<tr>
<td>Guianese and Haitian</td>
<td>5 (1)</td>
</tr>
<tr>
<td>Cape Verdean</td>
<td>5 (1)</td>
</tr>
<tr>
<td>Caucasian, Portuguese/Spanish</td>
<td>5 (1)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100% (20)</strong></td>
</tr>
</tbody>
</table>

Eight survey respondents were in treatment facilities in DYS’s Central Region, and twelve in the Metro Region. Youth respondents in the Central Region resided in the following towns when they were committed to DYS: Worcester (n = 3), Fitchburg (n = 1), New Bedford (n = 1), Lowell (n = 1), Shrewsbury (n = 1), and Pittsfield (n = 1). Youth respondents in the Metro Region resided in the following towns when they were committed to DYS: Dorchester (n = 5), Roxbury (n = 3), Hyde Park (n = 2), Mattapan (n = 1), and Charlestown (n = 1).

At the time of their survey completion 11 youth were completing treatment, 8 youth were serving for a violation, and 1 youth was in detention, awaiting a court hearing.

Findings from the MHPP Pilot Health Survey

The survey asks questions about DYS-involved youth’s health care access and utilization (including approach to care, social supports, obstacles to care, and quality of care); and health and health care knowledge. The section on health care access and utilization documents where youth seek health care, how often, and for what reasons. Included here are dental and mental health
care, and for female respondents, one question about health care specific to girls and women. It also gathers information on what prevents youth from seeking care, how youth experience the health care they receive, and includes a few questions for youth who are parents. Finally, there are questions in this section pertaining to the sources on which youth rely for help in accessing health care services. The section on health and health care knowledge focuses on youth’s knowledge of health resources in their community, the sources from which youth learn about health and health care issues, and the health topics youth would like to learn more about. It also addresses youth’s knowledge of how to obtain their medical records and make health care appointments.

These surveys were designed to provide baseline data on youth who might become MHPP participants once they re-enter the community. Thus, most questions on the survey ask youth about their health care-related experiences prior to their involvement in DYS, that is, before their DYS commitment.

**Health Care Access and Utilization**

*Approaches to Care*

The survey includes a series of questions intended to assess how youth approached health care prior to their involvement in DYS, including where or from whom they would usually seek care, variations in care-seeking approaches in cases of illness versus routine or preventive health needs, frequency of care-seeking, and reasons for care-seeking. The existence of individuals who assist youth with their health care, and in what ways, was also investigated.

*Types of care received. The majority of the sample (80%) reported having regular well check-ups prior to their DYS involvement.* Three youth reported only having had a few well check-ups ever, and one youth did not know how often he had received them.

Youth were asked when they had last seen a dentist (a category including dentists, dental hygienists, orthodontists, oral surgeons, and all other dental specialists), prior to their DYS involvement. Figure 1.1 depicts their responses.
Half of survey respondents had seen a dentist within 6 to 12 months prior to their DYS involvement, 3 youth had seen one within 6 months prior to their involvement, 1 youth had seen a dentist within 18 to 24 months, 2 youth had not seen a dentist for more than 2 years prior to their DYS involvement, and 4 youth did not know when they had last seen a dentist. These figures are not necessarily a reflection of respondents’ regular dental care patterns; they only capture respondents’ most recent dental visit prior to their DYS involvement.

Youth were asked whether they had seen or talked to a health care professional who specializes in mental health, or dealing with emotional or psychological problems (including a psychologist, psychiatrist, psychiatric nurse, or clinical social worker), prior to their DYS involvement. Twelve youth (60%) reported having seen such a mental health professional.

**Primary sources of care.** When asked what type of health place they went to most often when they were sick, seven respondents said a clinic or health center, five said a doctor’s office or HMO, four said a hospital outpatient department, one said a hospital emergency department, and two reported that they had not sought health services for illness, prior to their involvement in DYS. Taken together, 16 youth, or 80% of the sample, reported seeking care for illness from a nonurgent health care provider. Fifteen of those youth also said they usually received routine or preventive care from the same health place as they go to when they are ill. The respondent who went to the hospital emergency department when ill, and one of the respondents who reported not having sought care for illness, reported going to a doctor’s office to receive routine or
preventive care. Four youth in the sample reported never having gone to a hospital emergency department regarding a health concern.

Respondents were asked to give examples of reasons they have gone to either a hospital emergency department or a doctor’s office or clinic in the past. The responses are organized below by categories of health care. Youth often gave several reasons that fell into more than one category. Table 1.4 shows the number of youth who provided examples that fell into each of the response categories for going to either an emergency department or a doctor’s office or clinic.

Table 1.4: Examples of Respondents’ Reasons for Seeking Care from an Urgent Versus Non-urgent Health Care Provider

<table>
<thead>
<tr>
<th>Hospital Emergency Department</th>
<th>Number of youth who sought care for this reason</th>
<th>Examples of youth responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness/Health condition</td>
<td>9</td>
<td>Flu; Asthma (attack and needed medication); Ear infection</td>
</tr>
<tr>
<td>Injury/Accident</td>
<td>13</td>
<td>Broken bones; Was shot; Fell and needed stitches</td>
</tr>
<tr>
<td>Mental health</td>
<td>1</td>
<td>Suicidal ideation</td>
</tr>
<tr>
<td>Routine/preventive</td>
<td>1</td>
<td>Immunizations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doctor’s Office or Clinic</th>
<th>Number of youth who sought care for this reason</th>
<th>Examples of youth responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness/Health condition</td>
<td>9</td>
<td>Vomiting for over a week; Asthma; High fever; Strep throat</td>
</tr>
<tr>
<td>Injury/Accident</td>
<td>1</td>
<td>Stepped on a rusty nail</td>
</tr>
<tr>
<td>Mental health</td>
<td>1</td>
<td>Suicidal ideation</td>
</tr>
<tr>
<td>Routine/preventive</td>
<td>19</td>
<td>Well check-ups; Immunizations; Braces</td>
</tr>
<tr>
<td>Lab work/Tests</td>
<td>3</td>
<td>STD testing</td>
</tr>
</tbody>
</table>

As Table 1.4 above summarizes, the most common reason youth have sought care from an urgent care provider was injury or accident, followed by illness or health condition. Table 1.4 also shows that some youth have sought care at a hospital emergency department for illnesses or health conditions that would not be considered urgent.

All but one youth in the sample reported receiving routine and preventive care, such as regular physical examinations or immunizations, from a doctor’s office or clinic. The fact that a number of youth in the sample reported going to a hospital emergency department for illness but to a doctor’s office or clinic for routine and preventive care suggests that their reason for going to an emergency department when they are ill was not lack of knowledge of a doctor’s office or clinic that is accessible to them. The reasons these youth did not go to a doctor’s office or clinic for illness or a health condition should be investigated further, and could involve family factors, health care
knowledge or attitudes, the nature of relationships with nonurgent care providers, or health insurance issues, to name a few possible factors involved in this choice.

Reasons for seeking care. In order to investigate youth’s perceptions of when it is appropriate or necessary to seek care from providers, respondents were provided with categories of health issues and asked whether they would see a doctor or nurse to seek care for a health need in each category. Responses are presented in Figure 1.2.

Figure 1.2

![Number of Youth who Would/Would Not See a Doctor or Nurse for Categories of Health Issues](image)

Reasons for Seeing a Doctor or Nurse

As can be seen, while the majority of youth said that they would seek care from a doctor or nurse if they needed a regular check-up, were ill, or had an injury, the majority of youth said that they would not seek care from a doctor or nurse if they were experiencing emotional problems, alcohol or drug addiction, or physical or sexual abuse. In the category of emotional problems, it is interesting to note that twelve youth in the sample reported having already seen a mental health professional prior to their DYS involvement, however only four youth responded to this question that they would go to a doctor or nurse if they were experiencing emotional problems. It is possible that youth think of mental health professionals as specialists, and think of doctors and nurses as “generalists,” and so did not view a doctor or nurse as the appropriate choice if they were to be seeking care for emotional problems. Another possible explanation is that youth who had seen a mental health professional prior to their DYS involvement continue to have a relationship with that individual, or with another mental health professional, and therefore
would not perceive a need to seek mental health care from someone else. The data collected in the pilot survey cannot confirm these explanations.

As another way to assess what types of health concerns prompt youth in this population to seek care from various types of providers, youth were asked to provide health problems that would lead them to seek care from various types of health professionals or places (either by going to the health resource or contacting them), including: a school nurse, a pharmacy or drug store, the nurse located in the DYS facility, a doctor, a hospital emergency department, a community health clinic, and a friend or family member. Youth were also given the option to respond that they would not seek care from these resources for any reason.

All respondents provided health reasons which would lead them to seek care from resources in three categories: the nurse located in the DYS facility, a hospital emergency department, and a friend or family member. For the resources school nurse, pharmacy or drug store, and community health clinic, only one youth in each category reported that they would not seek care from these resources for any reason. Two youth reported that they would not seek care from a doctor for any reason.14

The specific health reasons provided by youth were grouped into 8 categories: illness/health condition, injury/accident, mental health, routine/preventive, lab work/tests, help for another person, other (could not be categorized; examples include lip balm, restraint, and pain), and unspecified (e.g., “anything that’s bothering me”). Table 1.5 shows the number of respondents whose reasons for seeking care from each health person or place fell into each of these eight categories. Youth sometimes provided multiple health reasons that would prompt them to seek care from each type of health care resource.

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14 This option on the survey was worded: “call a doctor.” It is possible that youth took this phrase literally, that is, to ask whether they would call a doctor (as opposed to going to see a doctor). In fact, it was reported by the health professionals who administered the surveys that some youth revealed interpreting the question in this way.
Illness or a health condition was the most common reason provided by youth for potentially seeking health assistance or care from a school nurse, a pharmacy or drug store, the DYS facility nurse, a doctor, and a friend or family member. Injury or accident was the most common reason provided by respondents for going to a hospital emergency department. Routine or preventive care was the most common reason provided for going to a community health clinic. By separating doctor’s office and clinic in this question, we can see possible evidence of a distinction in youth’s perceptions of doctor’s offices versus health clinics. In this sample, more youth view a doctor as an appropriate provider to seek care from in the case of illness or health condition (n = 10) than in the case of routine or preventive care (n = 4). Twelve youth view a community health clinic as an appropriate source of routine or preventive care, while only one views it as the health resource of choice for illness or a health condition. This finding underscores the need for further inquiry into youth’s perceptions of the function, capacity, and quality of doctor’s offices and community health clinics, and into the factors that youth consider when deciding where and from whom to seek care.

Two additional themes were evident in these data. It was observed that in many cases, youth would indicate the level of severity of a health problem that would lead them to seek care from these health resources, and that in many cases they would mention the outcome they would desire if they were to seek care from these resources.

Figure 1.3 illustrates the number of youth who noted severity as a factor in the reasons they would seek care from various types of health resources, or who provided examples of health

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Table 1.5: Types of Health Care Concerns Leading Youth to Seek Care from Various Health Resources.

<table>
<thead>
<tr>
<th>Health Resource</th>
<th>Illness/Health condition</th>
<th>Injury/Accident</th>
<th>Mental Health</th>
<th>Routine/preventive</th>
<th>Lab work/Tests</th>
<th>Help for another person</th>
<th>Other</th>
<th>Unspecified (anything)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School nurse</td>
<td>15</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy/drug store</td>
<td>18</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse in DYS facility</td>
<td>13</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital emergency department</td>
<td>3</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community health clinic</td>
<td>1</td>
<td></td>
<td>12</td>
<td>5</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friend/family member</td>
<td>13</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Note: DYS = The Massachusetts Department of Youth Services.
reasons that would be considered severe or acute.

**Figure 1.3**

![Number of Respondents who Noted Severity as Factor in Decision to Seek Care from Various Health Resources](image)

Note: DYS = The Massachusetts Department of Youth Services.

Not surprisingly, severity was a theme was noted most frequently in the category of hospital emergency department. Examples of youth responses which were categorized in this way are: “really bad cough,” “excruciating headache,” “STDs,” “If I had a seizure or heart attack,” broken bone, and being shot or stabbed. This finding suggests that youth understand that the hospital emergency department is intended for urgent care needs. However, as noted earlier, almost half of youth in the sample have sought care at a hospital emergency department for nonurgent illness and health conditions. Thus, there may be a disparity between youth’s understanding of the purpose of a hospital emergency department and their utilization of this health care resource.

The finding that only one youth’s reason for going to a community health clinic included the element of severity is consistent with the finding in Table 1.5 above that youth’s reasons for seeking care from a clinic primarily fell into the categories routine and preventive care and lab work (which in some cases may be routine or preventive).

Although a significant number of youth reported that they would see a school nurse or the nurse in the DYS facility for illness or a health condition, which sometimes could be severe, only
one youth noted severity as a factor in going to the school nurse, and two youth noted severity as a factor in going to the DYS facility nurse. This first finding may have to do with youth’s perceptions of convenience; if youth are attending school they likely perceive this health professional as being readily available to them (and are probably told that this is the case). If youth are living in a DYS treatment facility, the facility health care staff acts as their primary care providers, and thus during that time they are not in a position to make a decision about the appropriate provider to meet their health care needs. In both cases, the severity of a health concern may not be relevant in their assessment of where to seek care. While there is no indication of this in our data, it is also possible that cost is a factor in youth’s consideration of severity in their decision to seek care from various types of providers. Youth would not incur any cost if they sought care from either the school nurse or the DYS facility nurse.

Figure 1.4 illustrates the number of youth who noted a particular goal or outcome in the reasons they provided for potentially seeking care from these health resources.

**Figure 1.4**

**Number of Youth who Noted Outcome or Goal in Reasons for Seeking Care from Various Types of Health Resources**

<table>
<thead>
<tr>
<th>Type of Health Resource</th>
<th>Youth (frequency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School nurse</td>
<td>4</td>
</tr>
<tr>
<td>Pharmacy/drug store</td>
<td>14</td>
</tr>
<tr>
<td>Nurse in DYS facility</td>
<td>4</td>
</tr>
<tr>
<td>Doctor</td>
<td>4</td>
</tr>
<tr>
<td>Hospital emergency department</td>
<td>2</td>
</tr>
<tr>
<td>Community health clinic</td>
<td>18</td>
</tr>
<tr>
<td>Friend/family member</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: DYS = The Massachusetts Department of Youth Services.

Seventeen youth in the sample noted an outcome or goal in their reasons for potentially going to a community health clinic to seek care. The outcomes noted here were in three categories: STD testing, well check-ups, or to pick up condoms. Predictably, half of youth noted a desired outcome in the reasons they provided for going to a pharmacy or drug store; all outcomes in
this category were related to picking up prescription or over-the-counter medications. Examples of goals or outcomes noted in the other health resource categories include: having blood pressure checked, asking questions about medication for emotional problems, well check-ups, and to receive support and help. Again, a notable difference emerged here between the categories of doctor and community health clinic, with many fewer youth noting desired outcomes in their reasons for seeking care from a doctor compared with a health clinic. Further investigation into youth’s perceptions of these two types of providers is certainly warranted.

Health care support. Respondents were asked whether there is a friend or relative who usually helps them with their health care. Seventeen youth named an individual. Thirteen of those named their mother, one youth named both parents, one named his father, one named an aunt, and one named the MHPP health advocate at his site. That is, 15 (75%) noted that a parent would provide this health care-related support. Since the majority of the people named are parents, this set of findings suggests that these youth have a parent that they feel is supportive in matters related to health. Youth were provided a list of ways that people who support their health care might help. Figure 1.5 depicts their responses.

Figure 1.5

Types of Help Provided by Respondents' Health Care Support Person

Note: Appts. = appointments; HC = health care.
The majority of youth who reported having a health care support person indicated that this person assists them in all of the ways listed. All but one youth in this group said that their health care support person schedules appointments for them.

The relationships among types of help provided by respondents’ health care support person were investigated using Pearson product-moment correlation coefficient. A number of significant correlations were found. Respondents who said that their health care support person scheduled doctors appointments for them were more likely to say that this person also ensured that they receive the health care they need ($r = .54, p < .05$), and assists with their health insurance and necessities related to it ($r = .54, p < .05$). Respondents who receive assistance with health insurance and related matters from their health care support person were also likely to report that this person answers questions that they have about health problems or concerns ($r = .72, p < .01$), makes sure that they get the health care they need ($r = .60, p < .05$). Respondents whose health care support person makes sure that they receive the health care they need are also likely to provide them with care when they are sick ($r = .84, p < .01$), and to answer questions they have about health problems or concerns ($r = .72, p < .01$). Finally, if respondents’ health care support person provides them with care when they are sick, they are also likely to answer questions that they have about health problems or concerns ($r = .56, p < .05$).

**Obstacles to Care**

One section of the survey was designed to assess whether any barriers exist to youth in this population receiving health care, seeking health care, or having all of their health care needs met. Themes investigated in this section include whether youth have delayed receiving health care and if so, for what reasons; youth’s experiences when receiving health care in the past, their comfort level with providers, the characteristics they prefer their providers to have, and whether they have delayed health care and if so, for what reasons.

**Youth who had delayed health care.** Youth were asked if they had ever delayed getting health care they needed, or did not get all of the health care they needed, prior to their involvement in DYS. Seven youth responded that they had. These youth were provided with seventeen reasons why people might delay getting health care or not get all of their health care needs met. Their responses are illustrated in Figure 1.6.
Figure 1.6

Reasons for Delaying Health Care or Not Getting All Health Care Needs Met

Refusal to go to receive care was the most common reason given (n = 5) in the group of youth who reported having delayed health care or not receiving all of the care they needed in the past. This reason was followed by a health plan problem, dissatisfaction with doctor, and other reasons (n = 4). For “other reasons,” youth reported the following: “didn’t think it was serious enough,” “don’t have time,” “laziness,” and being “on the run from the police.”

Possible other reasons for delaying health care. In order to investigate possible reasons youth in this population may have delayed seeking or receiving health care in the past, all respondents were asked whether, in their experiences receiving health care prior to their DYS involvement, they ever felt that their race or ethnicity affected the health care they received. All twenty respondents answered “no” to this question.

Youth were also asked if they felt that other characteristics (age, having MassHealth for their insurance, gender, accent/English not being first language, sexual orientation, being a parent) affected the way that health care providers treated them in the past. None of the respondents answered affirmatively to feeling that they were treated differently due to their accent/English not being their first language, sexual orientation, or being a parent. One respondent answered affirmatively to MassHealth affecting treatment by providers, explaining that her family could not find anyone in her area who accepted MassHealth to cover braces, and when they did, the insurance only covered half of the
cost of the braces. One respondent answered affirmatively to being treated unfairly due to his age and gender. He explained that he feels he is sometimes treated differently because he is a young boy.

Experiences when receiving health care. Respondents were asked about their experience of receiving health care from a medical provider. \textit{Nineteen respondents said that in general, when they are receiving care from a doctor or nurse, they feel comfortable when the provider asks them questions about their health.} Seventeen respondents said that in general, when they are receiving care from a doctor or nurse, they feel comfortable asking that person questions about their health and/or the treatment the provider is recommending. Although this finding is encouraging, it is unclear whether youth feel comfortable asking questions of, and being asked questions by, their health care providers applies to all health-related topics. More specific inquiry into whether youth feel comfortable discussing all health topics with their providers would be informative.\textsuperscript{15}

The relationship between respondents’ comfort when being asked questions by a provider and comfort asking a provider questions about their health or the provider’s recommended treatment was explored using Pearson product-moment correlation coefficient, and the relationship was found to be strong ($r = .55$, $p < .05$). Respondents who feel comfortable when providers ask them questions are also likely to be comfortable asking health-related questions of that provider.

Desired provider characteristics. Youth were also asked the characteristics of a provider from whom they would feel most comfortable receiving health care. Specifically, they were asked about the importance of providers being of the same gender, being of a particular age, being the same race or ethnicity, and having a certain type of medical training.

Twelve youth (60\%) felt that it was not at all important that the health care provider they saw was of the same gender as them, two felt that it was a little important, four felt that it was somewhat important, and two felt that it was extremely important that their health care provider be of the same gender as them. \textit{The majority of youth ($n = 17$) felt that the age of their health care provider was not at all important in their comfort level with that person.} One youth felt that age was a little important, one felt that it was somewhat important, and one felt that it was extremely important. The three youth who reported that provider age was a little, somewhat, or extremely important said that they would like the provider to be at least in their thirties or forties. \textit{No respondents in the sample felt that it was at all important for their provider to be of the same race or ethnicity as them.} Eighteen youth reported that it was extremely important for the health care provider with whom they would feel most comfortable to have a certain type of medical training, and one youth said it was somewhat important (one youth did not respond to this

\textsuperscript{15} A study of females in juvenile diversion programs, ages 12-18, found that only half of participants were comfortable discussing sex, birth control, STDs, and substance abuse with their health care providers. Guthrie, B.J., Hoey, E., Ravoiria, L., & Kintner, E. (2002). Girls in the juvenile justice system: Leave no girl’s health un-addressed. \textit{Journal of Pediatric Nursing}, 17(6), 414-423.
question). When asked what type of training, youth said either medical school, the highest training possible, or experience.

Youth were asked if there was anything else they look for in a health care provider that helps them feel comfortable with him or her. Here are their responses:

- Experience; how they talk to you; their tone of voice;
- Good to talk to—they don’t just ramble stuff off at you; good relationship; easy to understand;
- I’ve had female doctors all my life so I’m a little more comfortable with a female;
- As long as they talk to me respectfully;
- If they are respectful and take their time, don’t rush;
- Patience; nice; respectful;
- Smart; easy to talk to;
- Clean—need to be clean; people can’t be dirty and place can’t be dirty;
- I’d like it if they were female doctors;
- They have experience and know what they are doing;
- I want them to be a female; they gotta be a female;
- They have to be nice; and
- They just gotta be a female; I don’t want a man doctor.

Some themes in these examples from respondents related to characteristics they look for in health care providers are gender, how they feel they are being treated, comfort level with their provider, and experience.

Quality of care. Respondents were asked two questions about how their past health care experiences made them feel, in order to assess their perceptions of the quality of the health care they have received. This information may relate to youth’s health care utilization.

Figure 1.7 depicts youth’s feelings about how often they felt that health care providers they received care from prior to their DYS involvement spent enough time with them during appointments.
Twelve youth (60% of the sample) reported that providers usually or always spent enough time with them. Six youth felt that this had been the case sometimes, and one youth felt that this was never the case.

Figure 1.8 depicts youth’s responses to the question, “How often did the doctors or nurses you saw explain things so that you understood what they were explaining?”
Figure 1.8

How Often Did Provider Explain Things in a Way That You Understood?

Fifteen youth (75% of the sample) felt that the doctors or nurses they received care from prior to their DYS involvement usually or always explained things in a way that they could understand. Two youth sometimes felt this way, one youth never felt this way, and two youth said that they did not know.

There was a strong correlation found between youth’s responses to these two questions ($r = .68$, $p < .01$). Youth who felt that their health providers spent enough time with them were also likely to feel that their providers explain things in a way they understood.

Youth Who Are Parenting

The survey includes several questions for youth who are parents. These questions relate to the health care of the children of respondents who are parents.

Six of the respondents in the pilot sample were parents, and two were going to be parents soon. The ages of the children of respondents who are parents, at the time they completed the survey, were three months, four months, six months, twelve months, sixteen months, and two years. Of the six respondents who were parents, four reported not having any awareness of the health care his child receives. Each youth provided an unsolicited explanation or comment regarding their level of awareness about their child’s health care to the survey administrator. The explanations they provided include the following:
• Respondent said he would like to be more involved in his child’s health care, that he needs to work on that.
• Respondent stated that he does not know about his child’s health care because he is incarcerated.
• Respondent said that he hates that he does not know about his child’s health care, and would like help when he is released to make sure that his child is up to date on all health appointments. He added, “I’ve been slacking on that.”

The respondent who said that he is aware of his child’s health care reported that his child does have a regular pediatrician, and that his child receives regular well-child check-ups.

Health and Health Care Knowledge

Youth were asked a series of questions regarding their knowledge of health resources in the community, how they get this information, and their perception of resources available to them once they are released from DYS custody. It also assesses skills related to health care management, and health topics youth would like to learn more about.

Utilization and Sources of Knowledge of Health Resources

Youth were provided with a list of health resources and asked whether they had ever gone to the place listed.\(^\text{16,17}\) If they had gone to the place, they were then asked to select from a list of people and organizations how they learned about the place. If they had not gone to the place, they were asked to select from a list of reasons why they had not gone. Youth sometimes selected more than one response. Table 1.6 summarizes these responses.\(^\text{18}\) Figures 1.9 and 1.10 provide graphic representations of the sources of information about health resources reported by youth who had used these health resources in the past, and the reasons given by youth who had not used these health resources in the past.

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\(^{16}\) One of the health places provided was Mobile medical van. The survey administrators reported that none of the youth they surveyed had heard of a Mobile medical van, so this place is not included in the analysis.

\(^{17}\) This series of questions asked youth whether they had been to these health places \textit{any time}, not only prior to their DYS involvement.

\(^{18}\) One survey respondent was removed from the analysis of the section of the survey which youth completed on their own. He was removed because he provided identical answers to each of the options provided in this particular series of questions, and it was assumed that the data he provided on this section of the survey was thus not reliable.
Table 1.6: Community Health-related Resources that Respondents Have Used in the Past, and Reasons for Use or Lack of Use (n = 19)

<table>
<thead>
<tr>
<th>Place</th>
<th>Number who have been to this health place</th>
<th>For those who have been to this place, how did they learn about it? (Frequency)</th>
<th>Number who have not been to this health place</th>
<th>For those who have not been to this place, why have they not gone? (Frequency)</th>
</tr>
</thead>
</table>
| Hospital         | 18                                       | - Parents/family: 17  
-Friends: 8  
-DYS Nurse/health educator: 3  
-Doctor/nurse outside of DYS: 2  
-DYS caseworker: 1  
-School: 7  
-DSS social worker: 2  
-Community health organization: 2  
-Saw it (walked or drove by it): 4 | 1 | -Never needed to go: 1 |
| Doctor’s office  | 16                                       | - Parents/family: 15  
-Friends: 4  
-DYS Nurse/health educator: 2  
-Doctor/nurse outside of DYS: 4  
-DYS caseworker: 1  
-School: 4  
-DSS social worker: 2  
-Internet/printed materials: 1  
-Saw it (walked or drove by it): 1 | 3 | -Never needed to go: 2  
-Had/have no time go: 1 |
| Health clinic    | 16                                       | - Parents/family: 13  
-Friends: 3  
-DYS Nurse/health educator: 3  
-Doctor/nurse outside of DYS: 2  
-DYS caseworker: 4  
-School: 2  
-DSS social worker: 1  
-Community health organization: 2  
-Internet/printed materials: 1  
-Saw it (walked or drove by it): 1 | 3 | -As far as I know, there is no place like this in the area where I live: 2  
-Never needed to go: 2 |
<table>
<thead>
<tr>
<th>Place</th>
<th>Number who have been to this health place</th>
<th>For those who have been to this place, how did they learn about it? (Frequency)</th>
<th>Number who have not been to this health place</th>
<th>For those who have not been to this place, why have they not gone? (Frequency)</th>
</tr>
</thead>
</table>
| Sexual/Reproductive health center | 1                                        | -DYS Nurse/health educator: 1                                                  | 18                                            | -As far as I know, there is no place like this in the area where I live: 4  
- Never needed to go: 14  
- Had/have no time go: 1  
- Other reason: 1 (unspecified) |
| Substance abuse clinic            | 4                                        | -Parents/family: 1  
- DYS caseworker: 3  
- Court/judge/probation officer: 1  
- DSS social worker: 1                                                  | 15                                            | -As far as I know, there is no place like this in the area where I live: 3  
- Never needed to go: 13  
- Located in area that I don’t feel safe going to: 1  
- Had/have no time go: 2 |
| Counseling center\(^\text{19}\)   | 12                                       | -Parents/family: 9  
- Friends: 2  
- DYS Nurse/health educator: 1  
- DYS caseworker: 6  
- Court/judge/probation officer: 5  
- School: 3  
- DSS social worker: 3  
- Community health organization: 1  
- Internet/printed materials: 1  
- Saw it (walked or drove by it): 1  
- Other: 1 (unspecified) | 6                                             | -Never needed to go: 5  
- Had/have no time go: 1 |
| Dental clinic                     | 19                                       | -Parents/family: 18  
- Friends: 3  
- DYS Nurse/health educator: 3  
- Doctor/nurse outside of DYS: 4  
- DYS caseworker: 3  
- School: 4  
- DSS social worker: 3                                                  | 0                                             | N/A |

\(^{19}\) One response was eliminated from the analysis of “counseling center” because the respondent’s answers contradicted one another.
<table>
<thead>
<tr>
<th>Place</th>
<th>Number who have been to this health place</th>
<th>For those who have been to this place, how did they learn about it? (Frequency)</th>
<th>Number who have not been to this health place</th>
<th>For those who have not gone to this place, why have they not gone? (Frequency)</th>
</tr>
</thead>
</table>
| Domestic violence safe house | 0                                        | -Community health organization: 1  
-Internet/printed materials: 1  
-Saw it (walked or drove by it): 1  
-Other: 1 (unspecified) | N/A                                    | -As far as I know, there is no place like this in the area where I live: 4  
-Never needed to go: 17  
-Other reason: 2 (unspecified; “never knew there was one”) |
| Shelter                     | 1                                        | -Parents/family: 1  
-DYS Nurse/health educator: 1 | 18                                    | -As far as I know, there is no place like this in the area where I live: 2  
-Never needed to go: 16  
-Other reason: 1 (unspecified) |
| WIC                         | 2                                        | -Parents/family: 1  
-DYS Nurse/health educator: 1 | 17                                    | -As far as I know, there is no place like this in the area where I live: 2  
-Never needed to go: 15  
-Other reason: 2 (unspecified; “I don’t know”) |

Note: DYS = The Massachusetts Department of Youth Services; DSS = The Massachusetts Department of Social Services; WIC = Women, Infants, and Children.
Figure 1.9

Source of Information About Health Resources

Health Resources

- Parents/family
- Friends
- DYS Nurse/health educator
- Doctor/nurse outside of DYS
- DYS caseworker
- Court/judge/probation officer
- School
- DSS social worker
- Community health organization
- Internet/printed materials
- Saw it (walked or drove by it)
- Other
Figure 1.10

Reasons Youth Did Not Use Health Resources

<table>
<thead>
<tr>
<th>Health Resources</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>1</td>
</tr>
<tr>
<td>Doctor's office</td>
<td>0</td>
</tr>
<tr>
<td>Health clinic</td>
<td>0</td>
</tr>
<tr>
<td>Sexual/reproductive health center</td>
<td>2</td>
</tr>
<tr>
<td>Substance abuse clinic</td>
<td>1</td>
</tr>
<tr>
<td>Counseling center</td>
<td>3</td>
</tr>
<tr>
<td>Domestic violence safe house</td>
<td>17</td>
</tr>
<tr>
<td>Shelter</td>
<td>17</td>
</tr>
<tr>
<td>WIC</td>
<td>1</td>
</tr>
</tbody>
</table>

Legend:
- □ There is no place like this where I live
- ■ Never needed to go
- □ Located in area that I don’t feel safe going to
- □ Had/Have no time go
- □ Other
As illustrated in Figure 1.9, parents and family are the most common source of respondents’ information about health-related resources. The majority of youth who had been to a hospital, doctor’s office, health clinic, counseling center, and dental clinic, said that they learned about that place from parents or family members, suggesting that for the majority of survey respondents, at least one individual from their families is involved in their health care. This is corroborated by the finding reported earlier that sixteen out of twenty survey respondents named a family member as someone who usually helps them with their health care. Of the six youth who had been to a substance abuse clinic, five had learned about the clinic from someone in a state agency (a DYS caseworker, a judge or probation officer, or a DSS social worker).

While it may initially seem troubling that only one youth reported having gone to a sexual or reproductive health center, this does not necessarily mean that respondents’ sexual and reproductive health needs are not being met. It is possible that respondents receive this type of care from primary care physicians, health clinics, or a nurse or doctor in their DYS facility.

As Figure 1.10 shows, the most common reason given by respondents for not using health resources was that they did not need to use them. This response can be anticipated for certain health resources, including sexual/reproductive health center, substance abuse clinic, counseling center, domestic violence safe house, shelter, and WIC, but seems more unusual for hospital, doctor’s office, and clinic. Some youth also indicated lack of knowledge about the existence of some of the health resources, which is a concern that could be addressed through programming.

Resources to Support Good Health

Nineteen youth reported that it is extremely important to them to stay in good health in the future, and one youth reported that it is somewhat important to do so. Nineteen out of twenty youth also reported that they feel they have enough resources available to help them manage physical illness and injury when they return to the community.

Youth were also asked about whether they have sufficient information and resources available to help them manage stress, depression, and problems with emotions when they return to the community. Seventeen youth said that they do, two youth said that they do not, and one youth said that they do not have these problems. One of the youth who reported not having sufficient information and resources in this area explained, “Not right now. I know about the suicide hotline but I want someone to talk to help me out of depression. I would talk to my mom and DMH.”

Health Care Management Skills

Respondents were asked two questions about their skills related to health care management. Ten youth (53%) reported that they knew how to get copies of their medical records if they wanted to do so, and nine youth said that they did not know how to do this. Fifteen youth (79%) reported that they knew how to call a health provider to make an appointment if they needed care, and four youth said that they did not know how to do this. Youth who responded affirmatively to these questions
were asked to indicate (on a list provided) where or from whom they learned these skills.

Figure 1.11 depicts the number of youth who reported that their knowledge of how to obtain copies of their medical records came from each of the sources shown.

**Figure 1.11**

![Source of Knowledge: How to Obtain Copies of Medical Records](image)

Note: DYS = The Massachusetts Department of Youth Services; DSS = The Massachusetts Department of Social Services.

Seven of the ten youth who had this skill reported learning it from their a parent or family member, four youth said they learned it from a doctor or nurse outside of DYS, three youth said they learned it from a DYS nurse or health educator, three youth from school, three youth from a DSS social worker, and three said they learned how to do this by figuring it out on their own. Two youth said they learned it from a community health organization (Planned Parenthood was the example of a community health organization provided on the survey).

Figure 1.12 depicts the number of youth who reported that their knowledge of how to call a health provider and make an appointment came from each of the sources shown.
Figure 1.12

Sources of Knowledge: How to Make an Appointment with a Health Provider

Note: DYS = The Massachusetts Department of Youth Services

Again, parents and family were the most common source of this knowledge; it was the response selected by thirteen of the fifteen youth (87%) who reported having this skill. Three youth said they learned how to do this from a DYS nurse or health educator, three from a doctor or nurse outside of DYS, and three indicated that they figured out how to do it on their own. One youth said they learned how to do this from school, and one youth said they learned how to do this from a community health organization. It is apparent from both Figures 1.11 and 1.12 that youth report having learned these two skills related to health management from multiple sources.

Youth were also asked how comfortable they feel calling a health care provider and making an appointment to receive care. Of the fourteen youth who responded to this question, nine said that they feel “pretty comfortable,” and five said that they feel “very comfortable” doing that.

Desire for Additional Health Information

Finally, respondents were asked what additional information or resources they would like in order to support their health. This question was asked in two ways. First respondents were provided with a list of health-related topics and asked to check those which they would like to learn more about. Figure 1.13 represents the number of youth who selected each topic.
Figure 1.13

Which Health Topics Would You Like to Learn More about?

The most common response was parenting, with eight youth selecting it. Seven youth selected sexual health/safe sex/STDs, nutrition, exercise, and stress; six youth selected MassHealth/health insurance and dental health; three weight loss and learning how to make appointments; and one, mental health.

Second, they were asked for open-ended responses to the question, “What additional information would you like in order to stay in good health in the future.” Here is a sampling of their responses:

- Counseling;
- Education to avoid getting sick, or to avoid sickness from getting worse. Someone who has that information that I could call;
- I don’t know yet;
- Gym membership; martial arts; swimming in a pool;
- Maybe more information on working out and healthy stuff I should be eating;
- I need condoms;
- I’ll take anything I can get;
- I want to learn how to be a good parent; how to treat my baby’s mother right;
- I need to get my health insurance because I’m turning 21 soon;
- Counseling—I have anger problems; and
- I need to make sure I have health insurance once I get out. I also need to stop smoking.
Topics that were mentioned more than once include counseling, exercise and nutrition, and health insurance.

Clearly, the survey respondents have a desire for additional health information in numerous areas.

Conclusions

Several findings from the pilot survey are particularly salient in the context of this current evaluation:

- While most respondents reported relying primarily on nonurgent care providers when seeking care for an illness, a number of respondents have also utilized a hospital emergency department for nonurgent care needs. Most youth seem to understand, nonetheless, that a hospital emergency department is a health resource intended for use in urgent or severe health situations. Since respondents were reporting on care-seeking experiences prior to their DYS involvement, these experiences could have occurred when they were children, dependent on their caretakers to make decisions related to their health care. Factors that affected care-seeking from urgent care providers in nonurgent health situations may thus be related to family economic factors, lack of health care, attitudes about care-seeking, health and health care knowledge, and so forth. To address this issue effectively with this population, these reasons must be better understood.

- Youth’s families, especially mothers, figure prominently as supports for good health and obtaining health care. Family members were reported to play a role in helping youth receive the health care they need, teaching youth about the existence of health resources in the community, and imparting to youth certain health care management skills. Promoting ongoing family involvement in youth’s health care may be a worthy area of focus for a health intervention program for this population.

- Youth reported having different reasons for potentially seeking care from a doctor’s office versus a health clinic. Youth in this sample evidently, for the most part, view community health clinics as places to receive routine or preventive care, and/or lab work and medical testing. Only one youth reported that he would go to a community health clinic for an illness or health condition, and none reported that they would go to a clinic for an injury or accident. In comparison, more than half of youth in the sample said that they would go to a doctor’s office for an illness or health condition, and several others said they would go to a doctor’s office for an injury or accident. The reasons influencing youth’s disparate views of doctor’s offices and health clinics begs further study.

- Seven youth, or 35% of the sample, reported having delayed receipt of health care, or not
having received all of the health care they needed. The most common reason given was, simply, the refusal to go. This response, as well as some of the open-ended responses provided, relate to health care attitudes that might impede the maintenance of good health. They suggest that some youth are in need of health care education about, or assistance in, seeking and obtaining health care.

- Sixty percent of youth in the sample reported having seen a mental health professional in the past. Mental health services may have been mandated to youth by the court, or it could be the case that, as is the case in the general juvenile justice population, many youth in this sample have mental health problems. This survey did not investigate the nature of youth’s mental health needs, nor their reasons for seeking care from a mental health professional. Nonetheless, these youth, as a group, are not unfamiliar with mental health services. Further research into the perceived quality of these services, and inducements to use them, would be useful.

- On the whole, youth in this pilot study reported having a good deal of knowledge about certain community health resources that are available to them, and to have utilized these resources. Resources in this category include doctors’ offices, clinics, hospitals, counseling centers, and dental clinics. Although one cannot assume that this finding is generally true, since these respondents live in relatively resource-rich communities, this level of awareness indicates some sophistication in this matter.

- While many youth reported having certain basic health care management skills, the depth of their understanding of these skills is unclear, as is whether or not they actually use these skills. Almost all respondents also reported having the health resources they need to manage their physical and mental health. A deeper investigation of these issues would certainly be useful to gaining a better understanding of the health care needs of this population. This pilot survey did clearly reveal the desire for additional resources related to health care management to help them manage their health care, and for information about a range of health topics, as well the high value participants apparently place on their future health.

This pilot study served two functions: It offered preliminary information, some of it quite provocative, on what youth think about their health and health care. Secondly, it tested instruments, and a protocol, for collecting data from youth in the system that appears to have worked quite well. With minor revisions to the survey, DYS might consider collecting these data, routinely, from a larger sample of their youth. Because of the small sample overall (N = 20), the lack of gender distribution, and the concentration of respondents geographically, one cannot consider this, in any way, a representative study; programming decisions cannot be made on the basis of what has been learned here. Nonetheless, the study does point out areas for further research, and provides a mechanism for undertaking a portion of it.
SECTION TWO: DESCRIBING THE PROGRAM

Before one can determine whether a program is achieving its goals, an accounting of how, exactly, the program is operating is in order. This documentation is the first step in process or implementation evaluation (Tier Two: Monitoring and Accounting of the Five-Tiered Approach [FTA]). In this section, we detail the core elements of the Massachusetts Health Passport Project (MHPP)—its participants, services, and staff. MHPP services are analyzed using a variant of a time-motion study, and participant profiles are offered to “humanize” the statistical data.
TIER TWO: DETAILING MHPP STAFF, SERVICES, AND PARTICIPANTS

The documentation of a program’s inputs—primarily participants, staff, and services—is the focus of evaluation activities at Tier Two in the FTA. The following documentation of MHPP implementation spans from the program’s initiation in June 2004 until the end of the evaluation’s data collection period in December 2008. This description of MHPP participants, staff, and services explicates who has been served by the program, by whom they have been served, and what services were offered. The Program Model and Implementation Analysis that follows expands on these dimensions, examining how and why the program was conceptualized and implemented as it was. Sources of data for this section include the MHPP program timeline, program database, interviews with MHPP health advocates, and monthly reports from the health advocates.

Boston Girls’ Program

The MHPP Boston Girls’ Program, originally named the Girls’ Health Passport Project (GHPP) began in June 2004. The program was initially supported by the Jessie B. Cox Trust and received funding from multiple sources over the years, most substantially from the Jacob and Valeria Langeloth Foundation. The first Boston girls’ health advocate, a nurse practitioner, worked approximately twenty hours per week at the Still We Rise girls’ resource center (SWR) in Dorchester that eventually became a Massachusetts Department of Youth Services (DYS) reporting center for girls. Still We Rise was run by Roxbury Youth Works, Inc (RYI), a multi-service community-based organization. Descriptions of the first Boston girls’ health advocate’s role on the project and the services she provided are detailed in previous evaluation reports.

In the summer of 2005, Sherman developed a relationship with Dotwell, a collaborative of Codman Square Health Center and Dorchester House Multi-Service Center, and they formalized the collaboration by having Dotwell employ the Boston girls’ advocate. This collaboration allowed the advocate to initiate on-site pregnancy tests and direct medical consultation, and link the girls to Dotwell’s providers and resources.

In the summer of 2006, the number of DYS-committed girls in Boston dropped, SWR underwent structural and staffing changes, and Sherman and the Boston girls’ advocate discussed plans to expand the program to serve DYS-committed boys. In March 2007, the girls’ health advocate extended her services to boys (one day a week) at the boys’ Community Re-entry Center (CRC)

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21 See Table 1.1 for a graphic representation of MHPP Implementation Documentation.
in Dorchester.

In May 2007, the girls’ health advocate announced she would be leaving the program by the end of the summer, and she worked with Sherman and staff from SWR and D/CSHC to plan for the transition. Sherman explored several options for staffing the Boston girls’ program. She spoke with representatives of D/CSHC about the possibility of the health center hiring a nurse who would be based at the health center, visit the girls’ and boys’ CRCs to meet youth, and then link them to the health center for their ongoing care. She also spoke with DYS officials about the possibility of extending the services of health care providers in DYS facilities to youth in the CRCs. When discussions with key individuals within D/CSHC and DYS indicated that these options were not viable, Sherman looked into other possibilities. She learned that medical staff at Sidney Borum, Jr. Health Center (SBHC) had been doing some outreach to system-involved boys at the boys’ CRC in Roxbury, and that they had an established relationship with the Boston College School of Nursing (BCSN). In September 2007, Sherman engaged in conversations with representatives of the health center, and by October 2007, the collaboration with SBHC was formalized and two nursing students from BCSN were hired to staff the Boston girls’ and Worcester girls’ programs respectively.

This second Boston girls’ advocate, a registered nurse (RN), worked approximately twelve hours per week at SWR until June 2008, when she completed training for her nurse practitioner degree. She was employed by the Justice Resource Institute, which manages SBHC, and she was supervised by Dr. Ralph Vetters at SBHC.

Sherman’s conversations with DYS officials about health care staff extending their services to youth in the community resulted in her hiring an HIV-prevention counselor, in March 2008, who was providing sexually transmitted disease (STD) education, counseling, and testing for youth in DYS facilities. This prevention counselor worked for both DYS and MHPP for five months before she left DYS to enroll in a social work graduate program. She then transitioned to working just for MHPP. From July – September 2008, she met with four girls with serious medical conditions reporting to SWR. Since that time, she has worked only with boys.

Following is a more detailed examination of the Boston girls’ program, specifically in terms of its participants, staff, and services.

**Participants**

The first Boston girls’ advocate reported serving approximately 53 girls from June 2004 – August 2007. From September 2007 – June 2008, the second Boston girls’ advocate reported serving approximately 20 girls, some of whom had also been served by the first advocate. From July – August 2008, the Boston boys’ advocate reported serving five girls and had not

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23 These figures are calculated from reports by the MHPP health advocates in the MHPP database and in monthly evaluation interviews. They do not include youth who may have been served by the program informally or indirectly.
served any other girls as of the end of our data collection phase in December 2008.

Table 2.1 is based on a review of MHPP databases and monthly evaluation interviews with MHPP health advocates at each site. All data are thus reported from the advocates’ perspective and have not been validated by another party such as the youth, their parents, or another medical provider. Thus, it cannot be seen as more than individual accountings of youth descriptives and program delivery.

MHPP database records indicate that the Boston boys’ advocate worked with two girls, but in an interview with the advocate in July 2008, she described meeting with a total of five girls.
Table 2.1: MHPP Program Implementation

<table>
<thead>
<tr>
<th></th>
<th>Boston Girls</th>
<th>Boston Boys</th>
<th>Worcester Girls</th>
<th>Worcester Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Year</strong></td>
<td>Year 1–3</td>
<td>Years 3–4</td>
<td>Year 3</td>
<td>Years 4–5</td>
</tr>
<tr>
<td><strong>Staff credentials</strong></td>
<td>NP</td>
<td>RN</td>
<td>Health educator</td>
<td>RN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Health educator</td>
<td>RN</td>
</tr>
<tr>
<td><strong>Total # of youth served (one or more interaction with MHPP advocate)</strong></td>
<td>approx 53</td>
<td>approx 20</td>
<td>approx 5</td>
<td>approx 33</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>approx 11</td>
<td>approx 31</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>approx 33</td>
<td>approx 20</td>
</tr>
<tr>
<td><strong>Sites</strong></td>
<td>SWR</td>
<td>SWR</td>
<td>Dorchester CRC</td>
<td>Worcester CRC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CRCs</td>
<td>CRC</td>
</tr>
<tr>
<td><strong>Partnering health centers</strong></td>
<td>Dotwell/CSHC</td>
<td>SBHC</td>
<td>Dotwell/CSHC</td>
<td>Great Brook Valley Health Center</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Great Brook Valley Health Center</td>
</tr>
<tr>
<td><strong>Funders</strong></td>
<td>Cox/Burden/Partners/Blue Cross Blue Shield/Langeloth</td>
<td>Langeloth</td>
<td>Langeloth</td>
<td>The Boston Foundation</td>
</tr>
<tr>
<td><strong>Program features and services</strong></td>
<td>Acoca screening measure/formal health assessment</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td><strong>Database</strong></td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td>Boston Girls</td>
<td>Boston Boys</td>
<td>Worcester Girls</td>
<td>Worcester Boys</td>
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<tr>
<td>--------------------------------</td>
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<tr>
<td>Direct medical care or consultation</td>
<td>***</td>
<td>***</td>
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<td>***</td>
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<tr>
<td>Appointment or pharmacy accompaniment</td>
<td>***</td>
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<td>***</td>
<td>***</td>
</tr>
<tr>
<td>Parent involvement</td>
<td>**</td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health education/health care education: group setting</td>
<td>**</td>
<td>**</td>
<td></td>
<td></td>
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<tr>
<td>Health education/health care education: one-to-one</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>Communication with DYS or CRC staff</td>
<td>***</td>
<td>***</td>
<td>**</td>
<td>***</td>
</tr>
<tr>
<td>Medical supervision</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>Program supervision</td>
<td>***</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
</tbody>
</table>

Key: blank=never; * = one time; ** = sometimes; *** = most of the time

Note: NP = nurse practitioner; RN = registered nurse; SWR = Still We Rise Community Re-entry Center; CRC = Community Re-entry Center; CSHC = Codman Square Health Center; SBHC = Sidney Borum, Jr. Health Center; DYS = Massachusetts Department of Youth Services.
As illustrated in Table 2.1, there is variation in the degree to which program services and features were implemented by the MHPP advocates during the program’s tenure. For example, the first Boston girls’ advocate accompanied girls to appointments to a greater extent than the second Boston girls’ advocate. Both utilized the Girls’ Health Resources Screen Protocol prepared for GHPP by Leslie Acoca and documented encounters with girls through the program database.

Demographic summaries and profiles of girls served by the first Boston girls’ advocate are detailed in previous evaluation reports. The second Boston girls’ advocate submitted a monthly report in February 2008, which provided a snapshot of 12 of the girls she worked with at that time. Of these 12 girls, 67% (N = 8) were identified by the Boston girls’ advocate as African American, 25% (3) as “more than one race,” and one as “other.” The girls’ advocate noted her encounters with these girls as involving initial assessments, requests for pregnancy tests, cold symptoms, acute injuries (sprains), allergy symptoms, clinic visits, scheduling physical exams, and acute exams. In addition, the two girls whose data in the MHPP database fulfill consent requirements of the Tufts Institutional Review Board participated in the program during the tenure of this second Boston girls’ health advocate. Health concerns raised by these two girls included a possible pregnancy, a history of sexual abuse and self-harming behaviors, and current relationship violence involving one girl residing in a shelter with her baby. The Boston girls’ health advocate referred one of these girls to Harvard Vanguard and the other to Martha Elliot Health Center, though in the latter case, the girl did not attend the appointment.

In our monthly interviews with the MHPP health advocates, they have provided rich stories of the youth they have worked with that illustrate the complex needs of these youth and how the health advocates have helped these youth in addressing their needs. The following vignette emerged from our interviews with the first Boston girls’ advocate:

“Carla”

DYS staff informed the nurse advocate that “Carla,” a pregnant 14-year-old, would soon be released from detention. In an effort to establish rapport, the nurse advocate agreed to meet Carla while still in detention. During this meeting the nurse advocate and Carla had a conversation about the pregnancy. At this time the nurse discovered that Carla had become pregnant while under the influence of alcohol. The nurse also learned that initially Carla did not want to be pregnant but while in lock-up she received special recognition for her being pregnant, and as a result she now wanted to keep the baby. Based on the belief that Carla wanted to keep her baby, the nurse advocate began to develop a plan with Carla for prenatal care, which she would follow up on upon Carla’s re-entry into the community.

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After visiting Carla in the facility, the nurse advocate contacted Carla’s primary care provider as well as Healthy Families (a pregnancy support program for teen mothers). However, upon re-entry into the community, Carla changed her mind about keeping the baby. The primary reason for this change was the negative reactions Carla was getting from people regarding her pregnancy, particularly from her mother. Carla’s mother made it very clear that she was too busy to help Carla raise the baby. At this point, the nurse advocate and Carla explored options available to her. Carla eventually chose to terminate the pregnancy. The nurse advocate met with Carla for some counseling, based on the fact that Carla mentioned feeling both sad and relieved about her decision. Along with meeting regularly for counseling, the nurse advocate also made sure that Carla followed up with her primary care provider. The nurse advocate strongly felt that connecting with Carla while she was still in lock-up made a difference. As the nurse advocate noted, “When they are locked up, they are a little more open, maybe because they are more scared. They are more receptive to people on the outside, maybe because they want to be on the outside.”

This vignette, as well as the one included in the Boston Boys’ Program section below, underscores the complexity of the health needs, both physical and mental, that system-involved youth experience. Both vignettes illustrate how participation in MHPP can link youth to an advocate from whom they can receive ongoing support, positive reinforcement and encouragement around their health care choices and actions, and increased connections to health care providers in their communities.

Staff

The first Boston girls’ advocate was a women’s health nurse practitioner (NP), with a master’s degree in maternal/child health nursing, and certification as a lactation counselor. She brought to the project 30 years of experience working with high-risk, underserved women and families in Boston. Her areas of expertise included reproductive health, adolescent health, and breastfeeding. The second Boston girls’ advocate was an RN in her last year of training at BCSN for her nurse practitioner degree. Her training focused on women’s reproductive health and, in addition to MHPP, she worked in several other community health settings. A profile of the Boston boys’ advocate who worked with five girls at the Boston site is included in the Boston boys’ program section below.

Services

For a snapshot of services provided to girls by the first Boston girls’ advocate, see the time-motion log and analysis included in the Evaluation and Planning Period Report (Jacobs, Deshmukh Towery, Oliveri, Copeman, & Rollins, 2006). For a detailed description and analysis of services delivered by the subsequent three health advocates, see the time-motion analysis included at the end of this section.
Boston Boys’ Program

In January 2007, Sherman and the first Boston girls’ health advocate met with representatives of Dotwell and the Dorchester boys’ reporting center to discuss expanding MHPP to serve boys at the site. Over the next two months, the girls’ health advocate met with staff and youth at the site to introduce the program. In March 2007, the advocate began visiting the site to meet with boys once a week. She reported meeting with approximately 11 boys from March – June 2007, when she ended her tenure with the program.\(^{26}\)

As noted above, Sherman’s conversations in September 2007 with DYS officials about health care staff extending their services to youth in the community resulted in her hiring an HIV-prevention counselor who worked with youth in DYS facilities to continue to staff MHPP in Boston. Justice Resource Institute officially employed this new Boston boys’ advocate in February 2008, and she was supervised by Dr. Ralph Vetter at SBHC. She was given an office at the Roxbury boys’ CRC, and in March 2008, she began meeting with boys from the Roxbury and Dorchester CRCs. From March 2008 until the end of our data collection period in December 2008, she reported serving approximately 33 boys.\(^{27}\)

Participants

The MHPP database documents the demographics, presenting health problems, and MHPP services provided to 44 boys served by the program from March 2007 – December 2008 (11 by the first Boston girls’ health advocate and 33 by the Boston boys’ advocate).\(^ {28}\) Of these 44 database records, 14 meet the Tufts Institutional Review Board’s consent requirements. The average age at intake for these 14 boys was 18.7 years. The majority, 77% (N = 11) were identified as African American, one as African American/Jamaican, one as Hispanic, and one as Caucasian. Presenting health problems included STI-related (N = 6), in need of physical exam (N = 4), dental (N = 2), acute illness (N = 1), stabbed (N = 2), hit by car (N = 1; this youth also stabbed), and wounded by gun violence (N = 1).

The Boston boys’ advocate referred over half the boys (N = 8) to a primary care physician at the MHPP partnering health center, SBHC, and records indicate that seven of those boys attended the referral appointment. The Boston boys’ advocate also referred one boy to a nutritionist and another to a dermatologist at SBHC. In addition to SBHC, the only other health center to which the Boston boys’ advocate referred one boy was the South End Community Health Center.

The following vignette emerged from the MHPP database records and our interviews with the

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\(^{26}\) These figures are calculated from reports by the MHPP health advocates in the MHPP database and in monthly evaluation interviews. They do not include youth who may have been served by the program informally or indirectly.

\(^{27}\) ibid.

\(^{28}\) ibid.
Boston boys’ advocate:

“Ray”

Ray first met the Boston boys’ advocate when he attended her sexual health classes at a DYS facility. Ray was in DYS custody for almost four years and was 20 years of age at MHPP intake. When he re-entered the community, he frequently called the MHPP advocate about “different things,” mainly to just let her know how he was doing. The last time Ray had seen a primary care provider was in elementary school, and he admitted a physical exam was “long overdue.” The MHPP advocate referred him to Dr. Vetters at SBHC and followed up with him about appointments Dr. Vetters had advised Ray to make with a nutritionist and for cholesterol testing. The MHPP advocate created a folder with Ray’s test results as well as all contact information for his PCP, nutritionist, and other specialists, so that he would have them when he turned 21 and would age out of DYS custody.

After five months of meeting with Ray, the MHPP advocate learned he had been stabbed one evening and was undergoing surgery at a local hospital. She called Ray to check on him, and he told her that he had called Dr. Vetters on his own to tell him about the stabbing incident. He also asked the advocate to set him up with a dentist. Subsequently, Ray was “pulled back into custody” to remain there until he aged out. He called the advocate from the DYS facility to let her know and asked her for paperwork about his health insurance and discussed his need to see a dentist and receive follow-up care for the stabbing incident.

The advocate met with Ray at the DYS facility, assisted him with setting up a dentist appointment and getting information about his health insurance and she arranged to take him to his appointments at SBHC. Soon after Ray aged out of DYS custody, the MHPP advocate learned he had been hit by a car and had suffered a serious facial injury. She notified Dr. Vetters, who met with Ray at the hospital and arranged for his aftercare.

Staff

The MHPP Boston boys’ advocate worked for close to three years as an HIV-prevention counselor for DYS prior to entering a graduate program in social work and joining the MHPP. As an HIV-prevention counselor for DYS, she provided one-to-one counseling, and STD education and testing to system-involved youth in facilities. She has a bachelor’s degree in psychology and rehabilitation, and received training through the Massachusetts Department of Public Health for HIV-risk assessment, risk reduction, and counseling and testing. She also received sexual health education training from Planned Parenthood.

Services

For a detailed description and analysis of services delivered by the Boston boys’ advocate, see the time allocation analysis included at the end of this section.
Worcester Girls’ Program

In September 2006, Sherman began meeting with representatives of Great Brook Valley Health Center (GBVHC) in Worcester to plan for the program’s expansion to include services for girls. From February 2007 through August 2007, three separate candidates were offered the position, but each decided against accepting it. As noted previously, in October 2007, the collaboration with SBHC was formalized, and two nursing students from BCSN were hired to staff the Boston girls’ and Worcester girls’ programs respectively. The Worcester girls’ health advocate, training for her RN and then NP licensure, began serving girls reporting to the Worcester girls’ CRC in November 2007. Through the end of the evaluation data collection period in December 2008, the Worcester girls’ advocate worked 10-14 hours per week and reported meeting with a total of approximately 31 girls. She received office equipment, supplies, and monthly programmatic supervision from administrators at GBVHC.

Participants

Of the 31 database records of Worcester girls participating in MHPP, 15 meet the Tufts Institutional Review Board’s consent requirements. The average age at intake for these 15 girls was 16.5 years. Race/ethnicity was identified for only eight of the 15 girls as follows: Hispanic (N = 3), Caucasian (N = 2), African American (N = 2), and Puerto Rican (N = 1). Presenting health needs included STI-related health needs (N = 7), pregnancy-related health issues (N = 6), acute illness or injury (N = 4), chronic illness (N = 3), allergic reaction (N = 3), in need of physical exam (N = 2), dental (N = 2), relationship violence (N = 2), and hit by car (N = 1). The Worcester girls’ advocate referred over half the girls (N = 9) to a pediatrician or primary care physician, and it appears that these were preexisting providers for at least five of these girls. The Worcester girls’ advocate referred three of the girls to the MHPP partnering health center, GBVHC, but the records do not indicate whether or not the girls attended the appointments there. In addition to GBVHC, other health centers to which the Worcester girls’ advocate referred girls included University of Massachusetts Memorial Medical Center, St. Vincent Hospital at Worcester Medical Center, Worcester Pediatrics, and Family Health Center of Worcester. These records reveal that seven girls did not always attend their appointments.

Staff

The Worcester girls’ advocate earned her RN licensure in September 2008, and continued with family NP training at BCSN. Prior to MHPP, she worked as a camp nurse responsible for the health and safety of 150 campers and staff. She also volunteered at a health clinic for more than three years, which served an immigrant population of all ages.

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20 These figures are calculated from reports by the MHPP health advocates in the MHPP database and in monthly evaluation interviews. They do not include youth who may have been served by the program informally or indirectly.
Services

For a detailed description and analysis of services delivered by the Boston boys’ advocate, see the time allocation analysis included at the end of this section.

Worcester Boys’ Program

In October 2008, the Worcester girls’ advocate extended her MHPP services to Worcester boys through a group meeting in which prospective enrollees were identified. She met with them one afternoon a week and from October – December 2008 served a total of approximately 20 boys, five of whom she met more than once. At the close of our evaluation data collection period in December 2008, intake of boys was stopped by DYS Worcester Region administration until written permission for the program was received.30

Participants

There are no database records of the boys served in Worcester, but our conversations with the Worcester girls’ advocate who extended her services to boys indicate that nearly all the boys she met with could identify a primary care physician; two were unsure of who to go to for care, but said their mother would make any appointments they needed. The advocate indicated that a “good portion” of the boys said they preferred to see a male health care provider (Personal Interview).

Services

Our conversations with the Worcester girls’ advocate indicate that she facilitated two scheduled meetings with a group of boys at the Worcester boys’ CRC and then met individually with boys on a weekly basis. In the scheduled group meetings, food and free condoms were offered, and she discussed the importance of primary care coverage, how to access care, how she can help them to access care, and what it means to be healthy (e.g., healthy lifestyle—diet, exercise, safe sex). In her individual meetings, she talked with boys about when they had a last physical and asked them who helps them with their health care (Personal Interviews).

Staff

See the profile of the Worcester health advocate in the previous section.

A Time Allocation Analysis: A Snapshot of How MHPP Health Advocates Spend their Time

As one way of documenting the services provided by each of the health advocates at the three

30 Conversations with MHPP program staff indicate that written permission was submitted to Worcester Region administration and the program was resumed in March 2009.
program sites, the health advocates were asked to keep a daily log of their MHPP activities over a consecutive three-week period. The total number of days, and thus hours, worked by each of the advocates over a three-week period varied. The logs depict how the MHPP health advocates’ time is allocated during the three-week period documented.

Tables 2.4 - 2.6 have been color coded to distinguish five broad categories of activity engaged in by the health advocates at their respective program sites: client contacts, meetings and communications with adults about clients, administration related to clients, general administrative activities, and evaluation activities. Within the first three of these broad categories, each activity or task reported by the health advocates has been labeled with a more specific subcategory (in bold in front of each activity description). These subcategories can be organized into two types of activities, those activities that pertain directly to program participants, and those that pertain to program level operations. Some subcategories apply to both types of activities.

Activities with or for Program Participants

These activities are intended to further the program’s goals of a) linking clients with health care, b) assisting in the maintenance or improvement of clients’ health, or c) providing clients with tools to help them manage their health care. While not all of these activity subcategories involve direct provision of these services, they each contribute to the advocates’ abilities to provide services aimed at addressing the program’s goals. The activities in this grouping include the following:

- Recruitment of youth;
- Relationship building with youth;
- Case management;
- Direct medical care or consultation;
- Appointment or pharmacy accompaniment;
- Parent involvement;
- Information gathering;
- Health education;
- Communication with DYS or CRC staff; and
- Medical supervision.

Activities Related to the Program

These activities pertaining to program level operations involve a) program development (e.g., relationship building with program partners, identification of local services, enrollment of participants); b) supervision of health advocates pertaining to program operations; and c) program administration. These activities include the following:

- Recruitment of youth;
Communication with DYS or CRC staff;
Medical supervision;
Program supervision; and
Information gathering.

Table 2.2 is a key of activity subcategories, including brief descriptions of the activity subcategories, and abbreviations used to denote them in the log.
Table 2.2: Time Allocation Log Key: Activity Subcategories

<table>
<thead>
<tr>
<th>Activity Subcategory</th>
<th>Description</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment of youth</td>
<td>Efforts to enroll youth in MHPP</td>
<td>Recruitment</td>
</tr>
<tr>
<td>Relationship building with youth</td>
<td>Informal interactions with youth; lead to recruitment or engagement in program</td>
<td>Relationship building</td>
</tr>
<tr>
<td>Case management</td>
<td>All activities related to managing a client’s health care, including assessment, referrals, care and consultation, accompaniment to medical services, parent involvement, information gathering related to health or health care, and health education</td>
<td>Case mngt</td>
</tr>
<tr>
<td>Direct medical care or consultation</td>
<td>Assessment, and provision of health care or health-related advice to client</td>
<td>Med care or Med consult</td>
</tr>
<tr>
<td>Appointment or pharmacy accompaniment</td>
<td>Health advocate accompanies client to a medical appointment or to the pharmacy to receive health services</td>
<td>Appt accompaniment or Pharm accompaniment</td>
</tr>
<tr>
<td>Parent involvement</td>
<td>Contact with parent related to client</td>
<td>Parent involv</td>
</tr>
<tr>
<td>Information gathering</td>
<td>Collecting of information pertaining to client needs or program development</td>
<td>Info gathering</td>
</tr>
<tr>
<td>Health education</td>
<td>Provision of education to youth about health or health care, in group setting or one-to-one</td>
<td>Health edu</td>
</tr>
<tr>
<td>Communication with DYS or CRC staff</td>
<td>Formal and informal interactions with DYS or CRC staff about clients or program operations</td>
<td>Comm w/ DYS or Comm w/ CRC</td>
</tr>
<tr>
<td>Medical or program supervision</td>
<td>Interactions and meetings with medical supervisor from partnering health center regarding health-related issues or program operations issues, or with program director regarding program operations issues</td>
<td>Med supervision or Prog supervision</td>
</tr>
</tbody>
</table>

Note: MHPP = Massachusetts Health Passport Project; DYS = Massachusetts Department of Youth Services; CRC = Community Re-entry Center.

Figure 2.1 shows a comparison in the percentage of time advocates across the three program sites devoted to each of the five broad categories of activity used to organize the time allocation.
As illustrated in Figure 2.1, the Boston boys’ advocate spent nearly half of her time during the time period included in her log in direct communication with clients. The Boston girls’ advocate spent 20% of her time, and the Worcester girls’ advocate 27% of her time in direct communication with clients, during the time period logged. A closer look at the activity subcategories engaged in by the advocates under the broad category of client contacts explains this variation: The Boston boys’ advocate spent large blocks of time accompanying youth to appointments or the pharmacy, and in activity that neither of the other advocates practiced at their sites during the period of time logged. In fact, this activity was a major area of focus for the Boston boys’ advocate, and a minor one for the other advocates, throughout their respective tenures as MHPP advocates. Other factors to consider in understanding the variation across the sites in time engaged directly with youth include the youth census at each CRC, the reporting requirements for youth at each CRC, and whether the advocates had preexisting relationships with youth.

During the time period included in the time allocation log, the Boston boys’ advocate spent the least amount of time (21%) of the advocates engaged in communication with adults (such as

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31 Three hours of time included in the log submitted by the Boston boys’ advocate were not specified according to the type of activity. These hours were thus not categorized by us, and were not included in the calculations for this table.
DYS or CRC staff, the medical or program supervisor, or health professionals in the community) about clients. The Boston girls’ advocate was engaged in this type of activity 38% of her time, and the Worcester girls’ advocate 34% of her time, during the periods of time logged. The Boston boys’ advocate spent most of her time in this activity area in communication with DYS staff, and very little time communicating with CRC staff. In contrast, both of the girls’ advocates spent a significant amount of time communicating with CRC staff regarding clients’ health and clients’ DYS-related case updates, as well as in discussions dealing with health education. The Worcester advocate also had frequent communication with DYS staff regarding girls’ reporting schedules, and integrating MHPP into the CRC structure. The Boston girls’ advocate met regularly with DYS nurses in treatment facilities, whereas neither of the other advocates had this relationship.

In the area of administration related to clients, the Boston girls’ and Worcester girls’ advocates spent similar proportions of their time in this area (22% and 26%, respectively), compared with 11% for the Boston boys’ advocate, during the time periods logged. The Boston girls’ advocate’s time in this area of activity was primarily divided between documentation of client cases, and appointment scheduling or reminders for clients. Other activities comprising this area of activity for the Boston girls’ advocate include administrative work to obtain clients’ medical history information, ordering of health supplies, and information gathering related to MassHealth. The Worcester girls’ advocate spent the majority of her time in this area engaging in information gathering related to health education. The rest of her activity in this area related to the CRC or MHPP youth census, or various activities related to client case management. The Boston boys’ advocate spent most her time in this area either traveling to pick up clients in order to accompany them to medical appointments, or doing work related to referrals for clients.

No significant variations across sites are notable in the area of general administration. The advocates spent similar proportions of their time (Boston girls’ advocate 12%, Boston boys’ advocate 8%, and Worcester girls’ advocate 9%) engaged in similar general administrative activities during the time periods logged. In the area of evaluation activities during the periods logged, the Boston girls’ advocate was engaged in such activities 8% of her time, the Boston boys’ advocate 11% of her time, and the Worcester girls’ advocate 4% of her time. Generally, the activities engaged in by the advocates were similar, and included monthly evaluation interviews. Because the Boston boys’ advocate completed her log toward the end of her tenure, her evaluation interviews were longer (i.e., they included “exit interviews”). During the period in which she completed her log, the Boston boys’ advocate was also engaged in collecting data for the MHPP health survey, which involved going to meet with youth in DYS facilities. The amount of time she dedicated to evaluation activities during this period was thus not representative of the amount of time she would normally be engaged in evaluation activities.
Table 2.3: Distribution of Program Activity Subcategory Units across Three Program Sites

<table>
<thead>
<tr>
<th>Activity Subcategories</th>
<th>Recruitment</th>
<th>Relationship building with youth</th>
<th>Case management</th>
<th>Direct medical care or consultation</th>
<th>Appointment/Pharmacy accompaniment</th>
<th>Health education</th>
<th>Information gathering</th>
<th>Parent involvement</th>
<th>Communication with DYS or CRC staff</th>
<th>Supervision</th>
<th>General admin.</th>
<th>Evaluation activities</th>
<th>Total # of program activity units</th>
<th>Total # of days covered in log</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston Girls' site</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>67.5</td>
<td>14</td>
</tr>
<tr>
<td># of units spent on each activity</td>
<td>3.5</td>
<td>7</td>
<td>13.5</td>
<td>1.5</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>21</td>
<td>4.5</td>
<td>7</td>
<td>6.5</td>
<td>6.5</td>
<td>14</td>
</tr>
<tr>
<td>Proportion of total units dedicated to each activity subcategory</td>
<td>5%</td>
<td>10%</td>
<td>20%</td>
<td>2%</td>
<td>0%</td>
<td>3%</td>
<td>1%</td>
<td>0%</td>
<td>31%</td>
<td>7%</td>
<td>10%</td>
<td>10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boston Boys' site</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>85</td>
<td>14</td>
</tr>
<tr>
<td># of units spent on each activity</td>
<td>11.75</td>
<td>7.5</td>
<td>29</td>
<td>0</td>
<td>9</td>
<td>7</td>
<td>1.75</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Proportion of total units dedicated to each activity subcategory</td>
<td>14%</td>
<td>9%</td>
<td>34%</td>
<td>0%</td>
<td>11%</td>
<td>8%</td>
<td>2%</td>
<td>0%</td>
<td>11%</td>
<td>0%</td>
<td>5%</td>
<td>7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worcester Girls' site</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>53</td>
<td>7</td>
</tr>
<tr>
<td># of units spent on each activity</td>
<td>1.5</td>
<td>1.5</td>
<td>13.75</td>
<td>6</td>
<td>0</td>
<td>9</td>
<td>5</td>
<td>1.5</td>
<td>10.25</td>
<td>0</td>
<td>3</td>
<td>1.5</td>
<td>1.5</td>
<td>7</td>
</tr>
<tr>
<td>Proportion of total units dedicated to each activity subcategory</td>
<td>3%</td>
<td>3%</td>
<td>26%</td>
<td>11%</td>
<td>0%</td>
<td>17%</td>
<td>9%</td>
<td>3%</td>
<td>19%</td>
<td>0%</td>
<td>6%</td>
<td>3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Many of the activities reported by the health advocates fall into more than one of the activity subcategories. In these cases, multiple subcategories have been assigned to the activity descriptions. In addition, multiple activities often took place within a given time block. Thus, rather than examining the advocates’ engagement in each activity subcategory in terms of hours, we have examined it in terms of units of effort in each activity subcategory. Table 2.3 summarizes the distribution of units of effort engaged in by the three health advocates in each of the activity subcategories. It should be noted that during the three-week period captured in the logs, the advocates at each site did not work the same number of days and hours.

As illustrated in Table 2.3, there are notable variations in the advocates’ proportion of engagement in each of the activity subcategories. The Boston girls’ advocate spent the largest proportion of her efforts during the three-week period represented in the log in communications with DYS or CRC staff, followed by case management, and relationship building with youth. The Boston boys’ advocate spent the largest proportion of her efforts during the three-week period on case management, followed by recruitment, and then appointment or pharmacy accompaniment and communication with DYS or CRC staff. The Worcester girls’ advocate spent the largest proportion of her efforts during the three-week period on case management, followed by communication with DYS or CRC staff, and health education. Each of the advocates is thus dedicating a large proportion of her efforts to case management. Each is also dedicating a large proportion of their efforts to communication with DYS or CRC staff; however, the Boston girls’ advocate is dedicating a significantly greater proportion to this activity than the other advocates.

There are clear disparities in the types of activities engaged in by the advocates, and in the units of effort spent engaged in each activity. For example, only the Boston boys’ advocate accompanied participants to appointments or pharmacies during the periods logged, and 11% of her efforts were spent on this activity. Similarly, the Worcester girls’ advocate involved parents in her program activities somewhat (3% of the time during the period logged), while neither of the other advocates involved parents. While the Worcester girls’ advocate spent 11% of her effort providing medical care or consultation to participants, the Boston girls’ advocate spent only 2% of her efforts providing it, and the Boston boys’ advocate did not provide any. Likewise, the Boston boys’ advocate dedicated a much larger proportion of her efforts recruiting youth (14%), than the Boston girls’ advocate (5%) and the Worcester girls’ advocate (3%). Health education was an activity engaged in by the Worcester girls’ advocate relatively frequently (17% of effort) in comparison with the Boston boys’ advocate (8%) and the Boston girls’ advocate (3%). The Worcester girls’ advocate dedicated 9% of her efforts to information gathering, compared with only 2% and 1% for the Boston boys’ advocate and Boston girls’ advocate, respectively. Finally, only the Boston girls’ advocate received either medical or program supervision during the time period logged.

Figures 2.2, 2.3, and 2.4 provide illustrations of the data from Table 2.3.
Figure 2.2

Boston Girls’ Site: Proportion of Total Units Dedicated to Each Activity Subcategory
Figure 2.3

Boston Boys' Site: Proportion of Total Units Dedicated to Each Activity Subcategory
Refer to Section Three for a more detailed description of the activities represented in these time allocation logs, Tables 2.4, 2.5, and 2.6. That latter analysis offers a contextualized picture of the program activities and services provided at each of the three program sites, including an examination of the factors that contribute to variations in the types of activities engaged in by the advocates at their program sites, and to the distribution of their time among these activities.
<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:30</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:00</td>
<td></td>
<td></td>
<td><strong>Comm w/ CRC staff:</strong> Attended client review meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:30</td>
<td><strong>Comm w/ DYS staff; Recruitment:</strong> Weekly meeting with DYS nurse – review of health issues of girls in custody and health updates on girls reporting to CRC</td>
<td><strong>Comm w/ DYS staff; Recruitment:</strong> Weekly meeting with DYS nurse – review of health issues of girls in custody and health updates on girls reporting to CRC</td>
<td><strong>Letter:</strong> Review of email</td>
<td><strong>Med supervision:</strong> Meeting with Dr. Vettes at SBHC; discussed new client assessments, clients' health issues, addressing nutrition at the</td>
<td><strong>Comm w/ DYS:</strong> Went to DYS facility for weekly meeting w/nurse; nurse not in</td>
<td></td>
</tr>
<tr>
<td>1:00</td>
<td><strong>Comm w/ DYS staff; Recruitment:</strong> Weekly meeting with DYS nurse – review of health issues of girls in custody and health updates on girls reporting to CRC</td>
<td><strong>Comm w/ DYS staff; Recruitment:</strong> Weekly meeting with DYS nurse – review of health issues of girls in custody and health updates on girls reporting to CRC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:30</td>
<td>Monthly evaluation interview</td>
<td><strong>Comm w/ DYS:</strong> Informal exchange with DYS clinician and program</td>
<td><strong>Comm w/ CRC staff:</strong> Received updates from CRC director re: girls' reporting</td>
<td><strong>Comm w/ CRC staff:</strong> Watched video on HIV with CRC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2.4: Time Allocation Log: Boston Girls’ CRC, April and May 2008 (Days 1-7)
<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:00</td>
<td><strong>Comm w/ DYS:</strong> Caseworker notified H.A. of client appt and need for another appt</td>
<td><strong>Case mngt:</strong> Scheduled 2 appts for 1 client; wrote reminder note for her of all appts; gave caseworker info too</td>
<td><strong>Prog supervision:</strong> Correspondence with program director re: enrollment and consents</td>
<td><strong>Updated client database</strong></td>
<td><strong>Updated client database; Case mngt:</strong> Wrote out appt reminder note for client</td>
<td><strong>CRC, research on health edu topics</strong></td>
<td><strong>director</strong></td>
</tr>
<tr>
<td>Time</td>
<td>Day 1</td>
<td>Day 2</td>
<td>Day 3</td>
<td>Day 4</td>
<td>Day 5</td>
<td>Day 6</td>
<td>Day 7</td>
</tr>
<tr>
<td>-------</td>
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<td>-------</td>
<td>-------</td>
<td>-------</td>
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<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>4:00</td>
<td>Comm w/ CRC staff: Talked with CRC director re: health edu issue and small number of girls reporting</td>
<td>Relationship building: Informal talk w/ client about community service dinner she is preparing</td>
<td>Comm w/ CRC staff: Informal discussion w/ CRC director re: non health-related issues that came up with girls</td>
<td>Documentation: updated database with client health information and encounters with H.A.</td>
<td>Case mngt: Case mngt: Wrote appt reminders for 2 clients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4:30</td>
<td>Comm w/ DYS: Spoke w/ caseworker about a client (not health related)</td>
<td>Comm w/ DYS: Spoke with clinician about girl who was aging out</td>
<td></td>
<td></td>
<td>Case mngt: Case mngt: Identified home health centers for girls participating in summer program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5:00</td>
<td>Case mngt; med consult: Spoke w/ client about sexual health concerns; scheduling OBGYN appt; client requested condoms</td>
<td>Documentation: updated database with client health information and encounters with H.A.</td>
<td></td>
<td></td>
<td>Case mngt: Case mngt: Completed release of information form for client to be used for summer program application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Case mngt: Case mngt: Requested release of information form from client’s health center to be used for summer program application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 1</td>
<td>Day 2</td>
<td>Day 3</td>
<td>Day 4</td>
<td>Day 5</td>
<td>Day 6</td>
<td>Day 7</td>
<td></td>
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<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>6:00</td>
<td>Case mngt:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Case mngt:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Allowed client to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Communication w/ health center - client made her own health appointment!</td>
<td></td>
</tr>
<tr>
<td></td>
<td>use H.A.'s office</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>telephone to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>make arrangements to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>get to a med appt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meetings/Communications with adults about clients</td>
</tr>
<tr>
<td>Administration related to clients</td>
</tr>
<tr>
<td>General administrative activities</td>
</tr>
<tr>
<td>Evaluation activities</td>
</tr>
</tbody>
</table>
Table 2.4 (cont.): Time Allocation Log: Boston Girls’ CRC, April and May 2008 (Days 8-14)

<table>
<thead>
<tr>
<th>Day 8</th>
<th>Day 9</th>
<th>Day 10</th>
<th>Day 11</th>
<th>Day 12</th>
<th>Day 13</th>
<th>Day 14</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Health edu: Replenished health supplies (condoms, dental dams, pamphlets on birth control and HIV)</td>
<td></td>
<td></td>
<td>Review of email</td>
</tr>
<tr>
<td>11:30</td>
<td></td>
<td></td>
<td>Comm w/ CRC staff: Attended client review meeting</td>
<td></td>
<td></td>
<td>Comm w/ CRC staff: Re: client medical forms for summer job referral; Med supervision: emailed question re: med testing</td>
</tr>
<tr>
<td>12:00</td>
<td></td>
<td></td>
<td>Case mngt: Called client with appt reminder; gave her dr.'s contact info if she was going to be late</td>
<td></td>
<td>Comm w/ CRC staff: Attended client review meeting</td>
<td></td>
</tr>
<tr>
<td>12:30</td>
<td>Correspondence with evaluation team member about scheduling</td>
<td>Phone calls and emails to: DYS facility nurse, program director, evaluation team member</td>
<td></td>
<td></td>
<td>Case mngt: Contacted clients’ health centers to obtain medical records</td>
<td></td>
</tr>
<tr>
<td>Day 8</td>
<td>Day 9</td>
<td>Day 10</td>
<td>Day 11</td>
<td>Day 12</td>
<td>Day 13</td>
<td>Day 14</td>
</tr>
<tr>
<td>-------</td>
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<td>--------</td>
<td>--------</td>
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<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>1:00</td>
<td><strong>Case mngt:</strong> Called client with appt reminder</td>
<td>Client seeking sanitary napkins, none available. Contacted partnering health center to order them.</td>
<td><strong>Review of email</strong></td>
<td><strong>Prog supervision:</strong> Meeting with program director</td>
<td></td>
<td><strong>Organized data for evaluation</strong></td>
</tr>
<tr>
<td>1:30</td>
<td><strong>Case mngt:</strong> Arranged for appt at clinic for client</td>
<td><strong>Comm w/ DYS staff:</strong> Recruitment: Weekly meeting with DYS nurse – review of health issues of girls in custody and health updates on girls reporting to CRC</td>
<td></td>
<td></td>
<td><strong>Case mngt:</strong> Appt scheduling for 2 clients at respective health centers</td>
<td></td>
</tr>
<tr>
<td>2:00</td>
<td><strong>Comm w/ DYS staff:</strong> Talked about medical release forms for clients</td>
<td><strong>Correspondence about data for evaluation</strong></td>
<td></td>
<td><strong>Comm w/ CRC staff:</strong> Meeting with CRC director re: H.A.’s services provided to CRC youth; director needed info for report</td>
<td><strong>Prepared final report for program director</strong></td>
<td></td>
</tr>
<tr>
<td>2:30</td>
<td><strong>Comm w/ CRC staff:</strong> Update from CRC director about clients who will be aging out this month</td>
<td><strong>Comm w/ CRC staff:</strong> Case mngt: Talked to commun. monitor re: client’s med appt attendance; &amp; clinician re: client’s meds</td>
<td><strong>Comm w/ DYS; Case mngt:</strong></td>
<td></td>
<td><strong>Relationship building:</strong> Spent time with girls in common area of CRC</td>
<td></td>
</tr>
<tr>
<td>3:00</td>
<td><strong>Comm w/ CRC staff:</strong> Talked with staff of ”A Way Back” program re: client's need for medical care</td>
<td><strong>Relationship building:</strong> Hanging out with girls in common area of CRC</td>
<td><strong>Relationship building:</strong> Spent time with girls in common area of CRC</td>
<td><strong>Review of email</strong></td>
<td></td>
<td><strong>Case mngt:</strong> Discussed missed appt and need for rescheduling with a client; Conducted initial</td>
</tr>
<tr>
<td>Day 8</td>
<td>Day 9</td>
<td>Day 10</td>
<td>Day 11</td>
<td>Day 12</td>
<td>Day 13</td>
<td>Day 14</td>
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<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>3:30</td>
<td></td>
<td><strong>Relationship building:</strong> Hanging out with girls and CRC staff in common area of CRC</td>
<td>Review of email</td>
<td><strong>Comm w/ CRC staff:</strong> Checked in with CRC director for any updates</td>
<td><strong>Relationship building:</strong> Accompanied girls to required off-site community service activity; informal discussions about cooking at home, prom;</td>
<td>Case mngt: Scheduled appointments (new appt for 1 client; rescheduled appt for 2nd client due to no-show)</td>
</tr>
<tr>
<td>4:00</td>
<td></td>
<td>*<strong>Info gathering:</strong> Research on MassHealth enrollment upon aging out</td>
<td></td>
<td><strong>Documentaion:</strong> Updated database with client health information and encounters with H.A.</td>
<td><strong>Case mngt:</strong> Reminded 2 clients to return release of information forms for summer program</td>
<td><strong>Case mngt:</strong> Reminded 2 clients about appointments over phone; gave 2 clients their appt times</td>
</tr>
<tr>
<td>4:30</td>
<td></td>
<td></td>
<td></td>
<td><strong>Evaluation interview</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5:00</td>
<td></td>
<td><strong>Case mngt:</strong> Comm w/ DYS: Reminded client of appt; notified community monitor about appt</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Day</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>5:30 Med consult: Talked w/ client about concerns following unprotected sex and birth control options</td>
</tr>
<tr>
<td>9</td>
<td>6:00 Med consult: Meeting with Dr. Veters at SBHC</td>
</tr>
<tr>
<td>10</td>
<td>6:30 Prepared final report for program director</td>
</tr>
<tr>
<td>11</td>
<td>Med supervision: Written notes to summer program stating clients will have necessary medical forms soon</td>
</tr>
<tr>
<td>12</td>
<td>Prepared final report for program director</td>
</tr>
<tr>
<td>13</td>
<td>Talking w/ client about concerns following unprotected sex and birth control options</td>
</tr>
<tr>
<td>14</td>
<td>Case mgt: Wrote notes to summer program stating clients will have necessary medical forms soon</td>
</tr>
</tbody>
</table>

Note: CRC = Community Re-entry Center, DYS = The Massachusetts Department of Youth Services, SBHC = Sidney Borum, Jr. Health Center, H.A. = Health advocate, MHPP = The Massachusetts Health Passport Project.
### Table 2.5: Time Allocation Log: Boston Boys’ CRC, March and April 2009 (Days 1-7)

<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Paperwork: Timesheet and expense report</td>
<td></td>
<td>Case mngt; Comm with DYS; Needed 2 clients’ MassHealth cards to be faxed; Recruitment: 2 youth referrals from caseworkers</td>
</tr>
<tr>
<td>1:30</td>
<td></td>
<td>Case mngt and Communication with DYS and CRC staff: with caseworker at West Roxbury CRC about health care and counseling services for 2 clients; Planned meeting with director</td>
<td>Comm w/ CRC and Recruitment: Meeting with director of West Roxbury CRC about new referrals and updates on clients</td>
<td>Case mngt: Looked up client information related to specialist referrals</td>
<td></td>
<td>Comm w/ DYS: Arranged future meeting with caseworker and client who is in custody</td>
<td></td>
</tr>
<tr>
<td>2:00</td>
<td></td>
<td></td>
<td></td>
<td>Case mngt: Gave client his new eye glasses and help scheduled dental apt</td>
<td></td>
<td></td>
<td>Info gathering: Meeting with representative of neighborhood health net to come up with system of collaboration/referral</td>
</tr>
<tr>
<td>2:30</td>
<td>Info gathering: Meeting with representative from health net at Roxbury CRC</td>
<td>Case Mngt: Confirmed appt and made transportation arrangements with client</td>
<td>Appt accompaniment; Case mngt; Drove client from CRC to appt</td>
<td></td>
<td>Paperwork: Completed expense report</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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32 All activities in this log took place at the Roxbury Boys’ CRC unless otherwise noted.
<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:00</td>
<td>Recruitment: Spoke with newly released client at Roxbury CRC about MHPP</td>
<td>Relationship building; Recruitment; Case mngt: Met with clients at West Roxbury; Completed paperwork with 1 client</td>
<td>Relationship building; Recruitment; Case mngt; Health edu: Client well check-up at SBHC</td>
<td>Appt accompaniment; Case mngt; Pharmac accompaniment and Case mngt and Health edu: Took client to fill 2 prescriptions</td>
<td>Case mngt; Paperwork related to client referrals to specialists by Dr. Vetters</td>
<td>Time allocation log</td>
<td>Relationship building; Recruitment: Spent time in recreation area of CRC to meet new clients and talk about MHPP services</td>
</tr>
<tr>
<td>3:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Case mngt; Paperwork related to client referrals</td>
<td></td>
<td></td>
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<tr>
<td>4:00</td>
<td>Case mngt: Completed paperwork with client and prepared for his appt</td>
<td></td>
<td></td>
<td></td>
<td>Relationship building; Recruitment; Informal interactions with youth at Dorchester CRC</td>
<td></td>
<td>Appt accompaniment; Case mngt: Travel time to meet client and drive him to medical appt</td>
</tr>
<tr>
<td>4:30</td>
<td>Case mngt: Picked up eyeglasses for client from DYS nurse</td>
<td></td>
<td></td>
<td>Pharm accompaniment and Case mngt and Health edu: Took client to fill 2 prescriptions</td>
<td></td>
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<tr>
<td>5:00</td>
<td>Case mngt and Comm w/ DYS; Client's medical records faxed from DYS to Dr. Vetters</td>
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<tr>
<td>5:30</td>
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<td></td>
<td></td>
<td></td>
<td>Case mngt: Documentation</td>
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<tr>
<td>Time</td>
<td>Day 1</td>
<td>Day 2</td>
<td>Day 3</td>
<td>Day 4</td>
<td>Day 5</td>
<td>Day 6</td>
<td>Day 7</td>
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<td>6:00</td>
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<td>6:30</td>
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</tbody>
</table>

- **Client Contacts**
- Meetings/Communications with adults about clients
- Administration related to clients
- General administrative activities
- Evaluation activities
<table>
<thead>
<tr>
<th>Day 8</th>
<th>Day 9</th>
<th>Day 10</th>
<th>Day 11</th>
<th>Day 12</th>
<th>Day 13</th>
<th>Day 14</th>
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</thead>
<tbody>
<tr>
<td>9:00</td>
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<td>9:30</td>
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</tr>
<tr>
<td>10:00</td>
<td>Paperwork and Review of Email</td>
<td>Time allocation log</td>
<td>Activity related to MHPP Pilot Survey</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30</td>
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</tr>
<tr>
<td>11:00</td>
<td>Appt accompaniment; Case mgmt: Travel time to pick up client for appt</td>
<td>Case mgmt: Updating client files</td>
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</tbody>
</table>

All activities in this log took place at the Roxbury Boys’ CRC unless otherwise noted.
Day 8 | Day 9 | Day 10 | Day 11 | Day 12 | Day 13 | Day 14
---|---|---|---|---|---|---
11:30 | Appt accompaniment; Case mngt: Client appt at SBHC | | | Case mngt: Tried to get in touch with a previous doctor for client's medical records | | |
12:00 | Comm w/ DYS and Recruitment: Discussed possible client referrals with a few caseworkers | Activity related to MHPP Pilot Health Survey | | Activity related to MHPP Pilot Survey | | |
12:30 | Appt accompaniment; Case mngt: Brought client back home | | | | | |
1:00 | At CRC, unspecified | | Case mngt: Met with client for update on appt and future appts | | | Case mngt: Met with client who is aging out of DYS to enroll in health insurance
1:30 | | | | Review of email | | |
2:00 | Communication with DYS and Recruitment: Discussed client's case w/ caseworker; Received referral | | | | Comm w/ DYS: Talked to several caseworkers about MHPP services | |
<table>
<thead>
<tr>
<th>Time</th>
<th>Day 8</th>
<th>Day 9</th>
<th>Day 10</th>
<th>Day 11</th>
<th>Day 12</th>
<th>Day 13</th>
<th>Day 14</th>
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</thead>
<tbody>
<tr>
<td>2:30</td>
<td><strong>Case mngt:</strong> Completed initial assessment and made appt for client at SBHC</td>
<td></td>
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<td></td>
<td></td>
<td><strong>Appt accompaniment; Case mngt:</strong> Travel time to pick up client for appt with specialist</td>
<td></td>
</tr>
<tr>
<td>3:00</td>
<td></td>
<td></td>
<td><strong>Comm w/ DYS and Recruitment:</strong> Meeting with nurse and caseworker in treatment facility about referred client</td>
<td></td>
<td></td>
<td><strong>Appt accompaniment; Case mngt; Health edu:</strong> Took client to Beth Israel to have wrist films done; Travel time to drop off client</td>
<td></td>
</tr>
<tr>
<td>3:30</td>
<td><strong>Activities related to MHPP Pilot Health Survey</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Relationship building; Recruitment; Talked with clients at the CRC</strong></td>
</tr>
<tr>
<td>4:00</td>
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<td></td>
<td></td>
<td></td>
<td><strong>Case mngt:</strong> Phone call to client with appt reminder</td>
<td></td>
</tr>
<tr>
<td>4:30</td>
<td><strong>Health edu and Case Mngt:</strong> Discussed preparation for next day medical appt. and issues related to clientele served by SBHC</td>
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</tbody>
</table>

**Note:** DYS = The Massachusetts Department of Youth Services; CRC = Community Re-entry Center; SBHC = Sidney Borum, Jr. Health Center; MHPP = The Massachusetts Health Passport Project.
<table>
<thead>
<tr>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Contacts</td>
</tr>
<tr>
<td>Meetings/Communications with adults about clients</td>
</tr>
<tr>
<td>Administration related to clients</td>
</tr>
<tr>
<td>General administrative activities</td>
</tr>
<tr>
<td>Evaluation activities</td>
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</tbody>
</table>
Table 2.6: Time Allocation Log: Worcester Girls’ CRC, May and June 2008 (Days 1-7)

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:00</td>
<td>Comm w/DYS staff: Facilitated DYS nurse contact with client for delivery of medical test results</td>
<td>Comm w/DYS staff; Case mngt: Coordination of care for client’s child; inquiry re: acquiring health info on client from DYS</td>
<td>Documentation</td>
<td>Voicemail; Schedule</td>
<td>Review Schedule</td>
<td>Voicemail</td>
</tr>
<tr>
<td>11:30</td>
<td>Comm. w/DYS staff; Case mngt: Coordination of care for client’s child; inquiry re: acquiring health info on client from DYS</td>
<td>Case mngt; Med consult: Talked w/ client about health and encouraged her to make med appt.</td>
<td>Case mngt; Med consult: Talked w/ client about health and encouraged her to make med appt.</td>
<td>Case mngt: Tried to engage client in follow-up discussion about previously discussed health concerns</td>
<td>Case mngt: With 1 client about nutrition and making dietary changes</td>
<td>Case mngt: Health edu; Med consult; Case mngt: With 1 client about nutrition and making dietary changes</td>
</tr>
<tr>
<td>12:00</td>
<td>Case mngt; Health edu; Info gathering: Literature search on adolescent diabetes for client care and group education</td>
<td>Comm w/DYS: Talked with caseworkers about 4 girls' cases (e.g., suicidal ideation when in custody; visits w/ child)</td>
<td>Case mngt: Review MHPP enrollment list</td>
<td>Comm w/DYS staff: Caseworker approached H.A. re: health of client &amp; lack of family support</td>
<td>Comm w/DYS staff: Caseworker approached H.A. re: health of client &amp; lack of family support</td>
<td>Comm w/DYS staff: Caseworker approached H.A. re: health of client &amp; lack of family support</td>
</tr>
<tr>
<td>12:30</td>
<td>Communication w/DYS staff; Health edu: Discussed exercise, diet,</td>
<td>Case mngt: Review DYS privilege status for 18 girls in the CRC</td>
<td>Case mngt: Scheduled an appt for client to obtain prescription</td>
<td>Info gathering; Case mngt: Health edu: Retrieved info on healthy teen</td>
<td>Case mngt: Health edu: Talked w/ clients in CRC common area about health</td>
<td>Case mngt: Met with client, discussed living situation, health</td>
</tr>
<tr>
<td></td>
<td>Monthly evaluation interview</td>
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</table>

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>and BMI recommendation s for teens with case workers</td>
<td>Health edu: Talked to CRC staff about junk food given to clients</td>
<td>Case mngt: Mapped out routes to clinics for clients</td>
<td>Case mngt: Scheduled appt; &amp; replenished condoms</td>
<td>Health edu; Info-gathering: Printed weight mgnt. info for clients; created food journals for distribution</td>
<td>Info gathering: Reviewed email re: health advisories; posted notices in CRC common area</td>
<td>Case mngt: Plans to follow-up w/ client to be returning to custody</td>
</tr>
<tr>
<td>1:00 Comm w/ DYS staff; Recruitment: Referrals from HIV educator for girls soon to be released; Meeting with few girls in custody</td>
<td>Case mngt: Mapped out routes to clinics for clients</td>
<td>Health edu: With 1 client regarding condom use</td>
<td>Health edu; Info-gathering: With 1 client re: health needs</td>
<td>Info gathering: Reviewed email re: health advisories; posted notices in CRC common area</td>
<td>Documentation</td>
<td></td>
</tr>
<tr>
<td>1:30 Recruitment; Med consult: Spoke with 2 girls in custody over the phone about health needs</td>
<td>Med consult: Looked at client's black eye</td>
<td>Case mngt: Mapped out routes to clinics for clients</td>
<td>Health Edu: With 1 client re: parenting; Case mngt: client wouldn't meet w/ H.A.</td>
<td>Parent involv: Re: assistance w/ daughter's healthy eating &amp; weight management</td>
<td>Documentation and Prep for Health edu</td>
<td>Comm w/ DYS staff: Contacted DYS nurses and caseworker re: client's contact info; need to communicate health care info to client</td>
</tr>
<tr>
<td>2:00 Review of email; Documentation</td>
<td>Case mngt: Documentation of encounter w/ 2 girls; Review of program activities (number of participants and</td>
<td>Case mngt: Documentation of encounter w/ 2 girls</td>
<td>Relationship building w/ youth; Health edu: H.A. present in common area of CRC to make herself available</td>
<td>Health edu; Case mngt: Urged client to go to a scheduled appt.; discussed importance of keeping appts.</td>
<td>Preparation of monthly nursing report for program supervisor</td>
<td>Med consult: Talked w/ client about daily activities, feeling tired</td>
</tr>
<tr>
<td>Comm w/ DYS: Spoke w/ caseworker re: 2 girls; coord. of care</td>
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<td>Day 1</td>
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<tr>
<td>2:30</td>
<td>Comm w/ DYS; Case mngt:</td>
<td>Medical consult; Case mngt: Met w/ client re: prescription need</td>
<td>to youth; Case mngt: Med consult; Case mngt: Met w/ client re: prescription need</td>
<td>Health edu: Created display of healthy weight loss and weight mgmt. info for CRC common area</td>
<td></td>
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<tr>
<td></td>
<td>obtained med records for DYS for client educ. placement, Requested records from DYS for client request; Info gathering: Research on MassHealth enrollment upon aging out</td>
<td>3:00</td>
<td>Health edu; Case mngt: Compet w/ client re: planning ahead for prescription refills; Attempted to make appt. for the client</td>
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<tr>
<td></td>
<td>Case mngt:</td>
<td>Case mngt:</td>
<td></td>
<td>Health Edu; Case mngt; Med consult: Spoke with 1 client about food journal and weight loss (client had expressed desire to H.A.)</td>
<td>Comm w/ DYS: Received client case updates</td>
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<td>H.A. contacted, concern re: client's missed appt.</td>
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<td>Documentation</td>
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<td>Case mngt: Recruitment:</td>
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<td>Case mngt:</td>
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<thead>
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<th>Day 1</th>
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<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:00</td>
<td><strong>Comm w/ DYS:</strong> Note to caseworker about talk with client's mother, plans for fam counseling</td>
<td>Preparation of monthly nursing report for program supervisor</td>
<td><strong>Med consult; Comm w/ CRC:</strong> Discussed dating violence with CRC staff member; provided hotline info</td>
<td><strong>Comm w/ CRC staff:</strong> Discussed use of food journal</td>
<td><strong>Comm w/ DYS staff:</strong> Attended community picnic with DYS staff; <strong>Info gathering:</strong> Received information on health services</td>
<td></td>
</tr>
<tr>
<td>4:30</td>
<td><strong>Comm w/ CRC staff:</strong> Spoke about girls not checking into CRC</td>
<td><strong>Parent involv:</strong> Called parent w/ appt reminder</td>
<td><strong>Case mngt:</strong> Reviewed clients' upcoming appts</td>
<td><strong>Comm w/ DYS staff:</strong> Discussed upcoming schedule and clients' cases with caseworkers</td>
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</tbody>
</table>

**Note:** DYS = The Massachusetts Department of Youth Services; H.A. = Health advocate; BMI = Body Mass Index; CRC = Community Re-entry Center.

<table>
<thead>
<tr>
<th>Color</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Client Contacts</td>
</tr>
<tr>
<td>Yellow</td>
<td>Meetings/Communications with adults about clients</td>
</tr>
<tr>
<td>Red</td>
<td>Administration related to clients</td>
</tr>
<tr>
<td>Gray</td>
<td>General administrative activities</td>
</tr>
<tr>
<td>Orange</td>
<td>Evaluation activities</td>
</tr>
</tbody>
</table>
SECTION THREE: QUALITY REVIEW

Once the details of program operations have been presented, a critical analysis of those data comprise the second phase of process or implementation evaluation (Tier Three: Quality Review and Program Clarification of the Five-Tiered Approach [FTA]). Often these analyses determine “fidelity to the model,” or the extent to which the program, as it is actually operating on the ground, resembles the program as it was designed. Tier Three analyses can also provide a more in-depth picture of an aspect of the program that warrants further investigation. This section begins with the former—a program model and implementation analysis—and concludes with two examples of the latter: one substudy of MHPP as a gender-responsive program, and another of the influence of parents and families on youth health practices and beliefs. These topics surfaced repeatedly in our data as important to understand in order to properly assess the Massachusetts Health Passport (MHPP) model.
TIER THREE: PROGRAM MODEL AND IMPLEMENTATION ANALYSIS

According to the FTA, the first, essential set of evaluation tasks is to document the program’s operations—what level and type of services is being offered, by whom, to whom, at what cost. There is, of course, more to learn about the delivery of a program than these “facts,” and the data collection and analysis necessary for a deeper understanding of the program—how staff are trained (not just whether or not they are), why eligible individuals enroll (not only the profile of those who do and do not), which factors account for variations in services, enrollment, or participant satisfaction across sites—constitute process evaluation activities at Tier Three in the Five-Tiered model. These data are critical for program improvement.

This present analysis represents a core component of Tier Three evaluation. Using the basic, unadorned picture of MHPP presented in the previous section as background, it delves into the “hows” and “whys” of the program’s implementation, first providing the conceptual framework that informs the program’s implementation (e.g., the program theory, logic model, goals, and key components), and then unpacking the service elements (e.g., what actually is the nature of that relationship between the health advocates and youth, so critical to MHPP’s success?) and detailing the processes by which the program came to be delivered as it was.

This analysis begins with a review of MHPP’s original goals, program theory, and logic model, and charts the development and change of these foundational program elements over time. Next, the discussion is organized into two superordinate categories: a) program structure and administration and b) direct program services. Program structure and administration refers to features of the program that deal with its design, philosophy, organization, operations, and management. Direct program services refers to key elements of service delivery, including what services are provided, in what ways they are provided, and by whom they are provided.

In each of these two sections, we first present a program model analysis, which details how the key program components were conceptualized, how they evolved over time, and the potential benefits and liabilities inherent in that evolution. These program components, which help to define the program and reflect its core philosophy, include the following:

- Gender-specific, gender-responsive programming;
- Medical professional service delivery;
- Locating service delivery in community reentry centers;
- Connecting youth to the program prior to community reentry;
- Partnering with community health centers;
- Collaboration with health, juvenile justice, philanthropy, and evaluation professionals;
- Parent and family involvement; and

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The program model analysis sections are based on extant data dating from the genesis of the Girls Health Passport Project (GHPP) in June 2004, through the initiation of the Tufts evaluation of its expansion—MHPP—in November 2005, and concluding in December 2008.

Following the program model analysis in each section, we present an in-depth analysis of program implementation based on data from the most recent phase of the evaluation, December 2007 through December 2008. The program implementation sections derive from an analysis of monthly interviews conducted with MHPP health advocates to track MHPP’s implementation in the program’s three core sites: the girls’ Community Re-entry Center (CRC) in Worcester, the girls’ CRC in Boston, and a boys’ CRC in Boston. Within the two superordinate categories of program structure and administration and direct services, we identify distinct variables that appear particularly influential to the course of MHPP’s implementation, and treat those in some depth. These variables include the following:

- Differences in CRC structures;
- Relationships between advocates and Massachusetts Department of Youth Services (DYS) and CRC staff;
- Supervision of MHPP health advocates;
- Transitioning into the health advocate position;
- Recruitment and engagement of youth in MHPP;
- Linking youth with health services and supports; and
- Providing youth with tools to manage their health care.

Brief summaries of the strengths and challenges that emerged within each aspect of implementation are included.

Finally, we conclude with a set of recommendations to facilitate future program delivery, reorganization, or replication.

**Program Theory, Logic Model, and Goals**

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35 These program components were largely an outgrowth of Sherman’s original vision for the program.
36 Analyses from earlier phases of the evaluation provided in-depth exploration of the initial phase of the program, which operated at the girls’ CRC in the Boston area. The present program implementation analysis focuses on a comparison of the three program sites in operation during this time period.
37 Although the intention of the MHPP program director was to have a single health advocate provide services to boys in three boys’ CRCs in the Boston area, and to girls reporting to the girls’ CRC in that area once the Boston girls’ advocate concluded her tenure with MHPP, due to time restrictions and other factors discussed in this analysis, the advocate provided services primarily at one of these CRCs, the Roxbury CRC, and provided services to a small number of boys at another, the Dorchester CRC. Throughout this analysis, the site at which the Boston boys’ advocate delivered the majority of her services will be referred to as the Boston boys’ CRC. During the period of focus in this analysis, she did not work with any youth reporting to the West Roxbury CRC. In addition, she worked with five female clients who were reporting to the girls’ CRC in the Boston area.
At the first MHPP Advisory Panel Meeting held at Boston College Law School on June 22, 2005, Sherman presented the MHPP program theory—the assumptions about how program activities and participant responses will result in desired outcomes. The theory for the program, then the Girls’ Health Passport Project (GHPP)—as it was originally conceptualized to serve only girls—was articulated in the Advisory Panel Briefing Book distributed at the June meeting as follows:

The theory behind the GHPP is that improved access to quality health care services, combined with improvements in the systems in which health care is delivered to these girls, will lead to improved health status for the girls, and this will lead to less restrictive involvement with the juvenile justice system in Massachusetts (p. 2).

This theory was detailed at length within the Briefing Book specifying a causal process that would lead to the desired effects:

If GHPP girls…connect with the GHPP nurse practitioner…then it is more likely that the girls will…agree to a personal “health care plan” they feel good about…and if those things occur, then it is more likely the girls will…go to regular medical and dental appointments…and if those things occur, then it is more likely that the girls will…experience improved health and experience less restrictive involvement in the juvenile justice system (p. 3).

As further explication of the program theory, Sherman also detailed a program theory model or logic model (e.g., the diagram or outline of intended program inputs, activities, and outcomes) which was originally framed by the overarching goals of improving health care access for girls in the juvenile justice system, creating change in the relevant systems, and helping girls attain personal health goals and experience less restrictive juvenile justice system involvement. Feedback from Advisory Panel members over the course of the three advisory board meetings led Sherman to revise the theory of change and logic model. The main revision was to remove the goal of less restrictive system involvement, as it was determined to be an unrealistic goal, with too many forces outside of improved health (e.g., race, gender, poverty, punitive juvenile justice policies) influencing system involvement. Sherman removed the goal of less restrictive system involvement from the program theory, but kept it in the logic model as one of the intended long-term project impacts.

Ultimately, Sherman revised the theory of change to read “Better health care access coupled with system change will yield better health for system involved girls” (Massachusetts Health Passport Project Planning Grant proposal to the Jacob and Valeria Langeloth Foundation, 2005).

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39 Ibid.
40 In the context of MHPP, system change refers to changes in thinking and/or practice around meeting the health care needs of system-involved youth within those systems (e.g., juvenile justice and health care) relevant to MHPP.
Her subsequent revision of the logic model emphasized “continuous health care access,” and she made a couple of other changes, adding improved social supports to the overarching program goals and integrating the development of personal health goals into the intended program activities. Thus, the program’s main goals were henceforth articulated as follows:

- Improve health care access for enrolled youth;
- Create changes in relevant systems;
- Improve social supports for enrolled youth; and
- Improve health status for enrolled youth.

An analysis of the program’s logic model and thus a measure of the extent to which the program achieved or progressed toward these overarching goals and its intended short-term, intermediate, and long-term impacts, is detailed in the Perceived Effects and System Change sections of this report and outlined graphically in Table 3.1.

As illustrated in Table 3.1, there is evidence to date that MHPP has achieved some of its intended short-term impacts (e.g., MHPP staff involvement in case meetings at CRCs and request for participation in prerelease planning at the facilities). Intermediate changes appear to be in progress (e.g., DYS seeks staff who address health issues in the community), and the long-term changes are, for the most part, yet to be achieved (e.g., Health is integrated into DYS re-entry services formally).
Table 3.1: MHPP Logic Model Analysis

<table>
<thead>
<tr>
<th>MHPP Logic Model</th>
<th>Evidence to date</th>
<th>In progress</th>
<th>No evidence to date</th>
<th>Project Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intended Project Activities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Design and implement site specific MHPP model, responsive to needs and demands of each community, collaboratively with JRAP, DYS, and local community health and CBOs, informed by evaluation data from Tufts University’s ongoing MHPP evaluation.</td>
<td>X</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve social supports; 4. improve health status</td>
</tr>
<tr>
<td>Place nurse advocate, employed by community health center, at safe, accessible community site and provide basic health care, develop health goals, link youth to community health care and traverse DYS internal health care and community health care.</td>
<td>X</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports; 3. improve health status</td>
</tr>
<tr>
<td>Enroll DYS youth as soon as possible after commitment to agency and plan health care (with DYS health care providers and case workers, and CBOs) throughout incarceration and community placement</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports; 3. improve health status</td>
</tr>
<tr>
<td>Include youth’s parents in health care planning and delivery, and outreach to family through family screening, health education and program referral</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports; 3. improve health status</td>
</tr>
<tr>
<td>MHPP Logic Model</td>
<td>Evidence to date</td>
<td>In progress</td>
<td>No evidence to date</td>
<td>Project Objectives</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Develop gender-responsive health access assessments for girls and boys as they move through the DYS system</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve health status</td>
</tr>
<tr>
<td>Develop ongoing database, medical records, and “passport” for youth</td>
<td>The MHPP, with consultation from evaluation staff, developed a program database.</td>
<td>MHPP advocates have access to some medical records through contact with DYS facilities.</td>
<td>“Passport” of health information for youth not developed to date.</td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve health status</td>
</tr>
<tr>
<td>Develop mechanisms for recovering of MHPP health services from public systems</td>
<td>Partnerships with Dotwell, Great Brook Valley, and Sidney Borum, Jr. Health Clinic, have facilitated public funding reimbursement for nursing services.</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve health status</td>
</tr>
<tr>
<td>Provide legal representation and health law education to facilitate improved health care access for enrolled youth</td>
<td>Representation of some girls on “as needed” basis; examined legal issues of access to tattoo removal services for DYS-committed girls under MassHealth; also “audited” out DYS girls' cases for health issues in an effort to explore the legal and medical implications.</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve social supports; 4. improve health status</td>
</tr>
<tr>
<td>MHPP Logic Model</td>
<td>Evidence to date</td>
<td>In progress</td>
<td>No evidence to date</td>
<td>Project Objectives</td>
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</tr>
<tr>
<td>Ongoing descriptive, process and outcome evaluation using FTA (Jacobs)</td>
<td>The Tufts evaluation of the MHPP was conducted from the fall of 2005-summer of 2009 using the Five-Tiered Approach.</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve social supports; 4. improve health status</td>
</tr>
<tr>
<td>Develop and disseminate Tool Box for implementation of MHPP (and like) models nationally</td>
<td>A Tool Box per say has not been developed, but the evaluation final report presents lessons learned and recommendations that can inform program replication.</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve health status</td>
</tr>
</tbody>
</table>

**Intended Project Outputs**

<p>| Youth are enrolled by MHPP nurse                  | X                     | 1. improve health care access; 2. improve health status |
| Youth are provided basic care by MHPP nurse        | X                     | 1. improve health care access; 2. improve health status |
| Youth develop ongoing relationships with community health care providers       | variable              | 1. improve health care access; 2. improve social supports; 3. improve health status |
| Youth are interviewed by MHPP using health access assessment            | variable: not always a formal assessment but advocates ask questions to assess access issues | 1. improve health care access; 2. improve health status |</p>
<table>
<thead>
<tr>
<th>MHPP Logic Model</th>
<th>Evidence to date</th>
<th>In progress</th>
<th>No evidence to date</th>
<th>Project Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth schedule own appointments</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports</td>
</tr>
<tr>
<td>Youth attend scheduled appointments</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports</td>
</tr>
<tr>
<td>Youth maintain ongoing relationships with MHPP nurse</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports</td>
</tr>
<tr>
<td>Parents agree for youth to enroll in MHPP</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports</td>
</tr>
<tr>
<td>Parents attend health planning meetings for their DYS committed children with MHPP staff</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports; 3. improve health status</td>
</tr>
<tr>
<td>Family members are screened, receive health education, or receive health care through MHPP connections</td>
<td></td>
<td></td>
<td>not assessed by our evaluation/unknown at this time</td>
<td>1. improve health care access; 2. improve social supports; 3. improve health status</td>
</tr>
<tr>
<td>Youth moving through detention, residential programs and community, maintain uninterrupted contact with MHPP or community health center staff</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve social supports; 4. improve health status</td>
</tr>
<tr>
<td>Youth are represented by JRAP attorneys</td>
<td>some representation has occurred</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve social supports; 4. improve health status</td>
</tr>
<tr>
<td>MHPP Logic Model</td>
<td>Evidence to date</td>
<td>In progress</td>
<td>No evidence to date</td>
<td>Project Objectives</td>
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<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>DYS and program staff are trained on health and health law issues for DYS youth</td>
<td>Communications between MHPP advocates and DYS staff, program consultation around case management, and the “Consent to medical treatment by minors in Massachusetts” (JRAP, 2006) offered elements of health and health law training and professional development to DYS and program staff.</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve health status</td>
</tr>
<tr>
<td>Guides to health law issues for MHPP population are distributed</td>
<td>“Consent to medical treatment by minors in Massachusetts” (JRAP, 2006). A second guide is forthcoming (JRAP, summer 2009) on access to medical records for youth in Massachusetts State systems.</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve health status</td>
</tr>
<tr>
<td>MassHealth and other public funding reimburses community health center for portion of nursing costs</td>
<td>First MHPP Boston site nurse able to bill Medicaid and ABCD (federal grant for reproductive health) for pregnancy tests and consultation (through Dotwell). Seeking MassHealth or other public funding is part of the strategic planning process as outlined by the program (Concept Letter to Smith)</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve health status</td>
</tr>
<tr>
<td>MHPP Logic Model</td>
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<td>Project Objectives</td>
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<td></td>
<td></td>
<td>Family Foundation, September 2008).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Database, continuous health record, and “passport” are available and used</td>
<td>Database used; Boston site nurses have had access to health records from DYS Harvard Street facility.</td>
<td>DYS central administrator communicated plans to create electronic health files to be transferred between residential and community health care providers (Interview, December 2008).</td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve health status</td>
</tr>
<tr>
<td>Protocols for communication between DYS and community health care providers</td>
<td>No evidence of formal protocols, but former MHPP Boston nurses communicated with DYS providers on a weekly basis. Current MHPP health educator in Boston continues this communication on a regular basis.</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems; 3. improve health status</td>
</tr>
<tr>
<td>MHPP Logic Model</td>
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<tr>
<td><strong>Intended Project Impacts</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Youth and/or parents agree to enroll in MHPP (S)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access</td>
</tr>
<tr>
<td>Youth and/or parents respond positively to MHPP nurse and begin to develop trust (S)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports</td>
</tr>
<tr>
<td>Youth and/or parents aware that they are covered by MassHealth (S)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access</td>
</tr>
<tr>
<td>Youth and/or parents are aware of health resources in their community (S)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve health status</td>
</tr>
<tr>
<td>Youth set personal health goals with MHPP nurse (S)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access</td>
</tr>
<tr>
<td>Youth agree to an ongoing “health care plan” (I)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access</td>
</tr>
<tr>
<td>Youth identify a primary care physician and health “home” and/or attend appointment (with MHPP Nurse) (S) (without MHPP Nurse) (I)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports; 3. improve health status</td>
</tr>
<tr>
<td>Youth identify and/or attend specialist care as needed (with MHPP Nurse) (S) (without MHPP Nurse) (I)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports; 3. improve health status</td>
</tr>
<tr>
<td>Youth agree to follow up appointment with PCP/NP or specialist (with MHPP Nurse) (S) (without MHPP Nurse) (I)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports</td>
</tr>
<tr>
<td>DYS and providers plan for youth’s health care with MHPP soon after commitment (S)</td>
<td>MHPP advocates have attended pre-release (90-60-30) meetings with youth and staff to discuss</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. create changes in relevant systems</td>
</tr>
<tr>
<td>MHPP Logic Model</td>
<td>Evidence to date</td>
<td>In progress</td>
<td>No evidence to date</td>
<td>Project Objectives</td>
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<tr>
<td>Youth establish relationships with a PCP, dentist and mental health professionals (I)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports; 3. improve health status</td>
</tr>
<tr>
<td>Youth satisfied with PCP, specialist physicians, dentist (and mental health professional, as needed) (I)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports; 3. improve health status</td>
</tr>
<tr>
<td>Youth's medical information is ongoing, updated, comprehensive, and accessible to the youth and health care providers (I)</td>
<td>efforts made by advocates to document medical information in program database and to facilitate flow of medical information between providers</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve health status</td>
</tr>
<tr>
<td>Communication and coordination between health professionals in DYS facilities, placements, community health providers, and CRCs to assist youth (I)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports; 3. improve health status</td>
</tr>
<tr>
<td>Youth, Program and DYS staff, and parents are aware of health and related rights and responsibilities (I)</td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td></td>
<td></td>
<td>1. improve health care access</td>
</tr>
<tr>
<td>MHPP Logic Model</td>
<td>Evidence to date</td>
<td>In progress</td>
<td>No evidence to date</td>
<td>Project Objectives</td>
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</tr>
<tr>
<td>Youth maintain relationship, for themselves and their children, with PCP, medical specialists, dentist (and mental health professional, as needed) (L)</td>
<td>variable</td>
<td></td>
<td></td>
<td>1. improve health care access; 2. improve social supports</td>
</tr>
<tr>
<td>Youth and their families have improved ability to access health care and other social supports (L)</td>
<td></td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td></td>
<td>1. improve health care access; 2. improve social supports</td>
</tr>
<tr>
<td>Youth take consistent responsibility for their physical and mental health (L)</td>
<td></td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td></td>
<td>1. improve health care access; 2. improve social supports</td>
</tr>
<tr>
<td>Youth experience improved health (for them and their children) (L)</td>
<td></td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td></td>
<td>1. improve health care access; 2. improve social supports</td>
</tr>
<tr>
<td>Youth have reduced restrictive involvement in the juvenile and criminal justice systems (L)</td>
<td></td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td></td>
<td>1. improve health care access; 2. improve social supports</td>
</tr>
<tr>
<td>DYS and program staff request involvement of MHPP nurse in pre-release discussions and planning (S)</td>
<td>MHPP nurses in Boston and Worcester have participated in pre-planning discussions with DYS staff in the facilities and community reentry centers.</td>
<td></td>
<td></td>
<td>1. create changes in relevant systems</td>
</tr>
<tr>
<td>MHPP Logic Model</td>
<td>Evidence to date</td>
<td>In progress</td>
<td>No evidence to date</td>
<td>Project Objectives</td>
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</tr>
<tr>
<td>Protocol developed and implemented to enroll DYS youth in MHPP prior to community re-entry (I)</td>
<td>No former protocols in place, but both Boston and Worcester nurses have met with youth prior to re-entry to introduce the program.</td>
<td></td>
<td></td>
<td>1. create changes in relevant systems</td>
</tr>
<tr>
<td>Routine and ad hoc multi-disciplinary case meetings at CRC, detention or program with MHPP nurse, DYS case worker, DYS health care staff and program staff (S)</td>
<td>In Boston, the original MHPP nurse participated in weekly &quot;case review&quot; meetings at the girls' CRC. In Worcester, the MHPP nurse communicates about cases on a regular basis with staff at the CRC and occasionally with DYS health care staff.</td>
<td></td>
<td></td>
<td>1. create changes in relevant systems</td>
</tr>
<tr>
<td>Parents involved with health and service planning meetings (S)</td>
<td>The first MHPP Boston site nurse reported some in-person and phone contact with parents. The current MHPP nurse in Worcester has reported phone contact with parents.</td>
<td></td>
<td></td>
<td>1. create changes in relevant systems</td>
</tr>
<tr>
<td>MassHealth reimbursement for MHPP nurse services at CRC (I)</td>
<td>X</td>
<td></td>
<td></td>
<td>1. create changes in relevant systems</td>
</tr>
<tr>
<td>MHPP Logic Model</td>
<td>Evidence to date</td>
<td>In progress</td>
<td>No evidence to date</td>
<td>Project Objectives</td>
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<td>---------------------------------------------------------------------------------</td>
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<td>----------------------------------------</td>
</tr>
<tr>
<td>Fiscal collaboration to formalize MHPP services for DYS youth (L)</td>
<td></td>
<td>The joint grant application from the MHPP, DYS, and the Sidney Borum, Jr. Health Center to SAMHSA was one attempt toward fiscal collaboration, as was the joint grant application from the MHPP and Sidney Borum to the Smith Family Foundation.</td>
<td></td>
<td>1. create changes in relevant systems</td>
</tr>
<tr>
<td>Database, continuous medical record and &quot;passport&quot; established (I)</td>
<td>Database used; Boston site nurses have had access to health records from DYS Harvard Street facility.</td>
<td>DYS central administrator communicated plans to create electronic health files to be transferred between residential and community health care providers (Interview, December 2008).</td>
<td></td>
<td>1. create changes in relevant systems</td>
</tr>
<tr>
<td>MHPP Logic Model</td>
<td>Evidence to date</td>
<td>In progress</td>
<td>No evidence to date</td>
<td>Project Objectives</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>MHPP experience and tools disseminated and used (I)</td>
<td>Evaluation report on Lessons Learned disseminated (May 2007); Sherman wrote an article entitled “Access to Community Healthcare for Youth in the Juvenile Justice System: Initial Lessons from the Massachusetts Health Passport Project” in the October/November 2007 issue of Women, Girls, and Criminal Justice.</td>
<td>Book contract with Wiley &amp; Sons Publishers on Health and Well Being in the Juvenile Justice System (Francine Sherman and Francine Jacobs, Eds., forthcoming 2010).</td>
<td>No evidence to date that MHPP experience/tools being used by others.</td>
<td>1. create changes in relevant systems</td>
</tr>
<tr>
<td>DYS seeks providers who address health issues comprehensively and in the community (I)</td>
<td>DYS agreed to allow two of their staff from the Metro facility (one nurse, one health educator) to work in the community with MHPP, the health educator became the MHPP advocate in Boston, though she no longer works for DYS.</td>
<td>Plans communicated by DYS administrator include training of caseworkers to address health issues in the community.</td>
<td></td>
<td>1. create changes in relevant systems</td>
</tr>
<tr>
<td>DYS providers address health issues comprehensively and in the community (L)</td>
<td></td>
<td>X</td>
<td></td>
<td>1. create changes in relevant systems</td>
</tr>
<tr>
<td>MHPP Logic Model</td>
<td>Evidence to date</td>
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<td>No evidence to date</td>
<td>Project Objectives</td>
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<td>---------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Health is integrated into DYS services formally (L)</td>
<td></td>
<td>DYS administrator communicated plans to create electronic health files to be transferred between residential and community health care providers and to train caseworkers to oversee health care of youth in the community.</td>
<td></td>
<td>1. create changes in relevant systems</td>
</tr>
<tr>
<td>Youth and parents are aware of and use health and other services and programs in their communities (I)</td>
<td></td>
<td></td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td>1. improve social supports</td>
</tr>
<tr>
<td>Youth feel agency by choosing and utilizing community resources (I)</td>
<td></td>
<td></td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td>1. improve social supports</td>
</tr>
<tr>
<td>Youth feel connection to their families and communities (I)</td>
<td></td>
<td></td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td>1. improve social supports</td>
</tr>
<tr>
<td>Low rates of chronic illness among enrolled youth (L)</td>
<td></td>
<td></td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td>1. improve health status</td>
</tr>
<tr>
<td>MHPP Logic Model</td>
<td>Evidence to date</td>
<td>In progress</td>
<td>No evidence to date</td>
<td>Project Objectives</td>
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<td>-------------------------------------------------------</td>
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</tr>
<tr>
<td>Low incidence of health complications among enrolled youth (L)</td>
<td></td>
<td></td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td>1. improve health status</td>
</tr>
<tr>
<td>Improved behavioral health among enrolled youth (L)</td>
<td></td>
<td></td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td>1. improve health status</td>
</tr>
<tr>
<td>Low rates of STIs among enrolled youth (L)</td>
<td></td>
<td></td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td>1. improve health status</td>
</tr>
<tr>
<td>Healthy outcomes of pregnancies among enrolled girls (L)</td>
<td></td>
<td></td>
<td>not assessed by our evaluation/ unknown at this time</td>
<td>1. improve health status</td>
</tr>
</tbody>
</table>

Note: MHPP = The Massachusetts Health Passport Project; JRAP = The Juvenile Rights Advocacy Project; DYS = The Massachusetts Department of Youth Services; CBO = Community-based organization; FTA = The Five-Tiered Approach to evaluation; PCP = Primary care provider; CRC = Community Re-entry Center.
In assessing achievement or progress toward program goals, it is essential to revisit the program theory and program implementation. If a program does not achieve certain goals, one can question whether it is due to a failure of program theory or a failure of program implementation (Weiss, 1998). A failure of program theory implies that the theory itself is based on faulty logic of cause and effect and thus would not be attainable even if all program activities were implemented as intended. A failure of program implementation indicates that the program was not implemented as planned and thus it cannot be expected that it would achieve its intended outcomes (ibid.).

One could argue that the MHPP program theory imagines a more cooperative, facilitative context for the provision of its services to youth than is actually the case. Indeed, each facet of the operational theory—the steps that would ultimately yield improved health care access and social support, system change, and improved health—necessitates the willingness of all those involved, across agencies and individuals, to actively support and participate in the intervention as intended. Thus, there are factors on the individual, family, community, and system levels (e.g., the transience and fluctuating census of committed youth, lack of financial support from the partnering systems) that could, and likely do, moderate the program’s positive influence on health care access, social support, and overall health, as well as on systems change. In addition, as we discuss in the Systems Change substudy and the Perceived Effects section, the theory may also suffer from a “dosage” miscalculation. That is, it may be that the pathways to achieve success are correct, but that MHPP would need more muscle—more funding, a greater number of health advocates, a larger enrollment of youth in the program—to meet its goals.

Further, it is not possible to “test” the program theory, given that the research design was necessarily nonexperimental and thus did not involve a comparison group or the collection of pre- and post-intervention health-related data (e.g., information about the health status and health care patterns of youth prior to and following their program participation). However, the data we did collect on program implementation confirm that not all assumed program activities and operational outputs were implemented (e.g., DYS and program staff are trained on health law issues for DYS youth), and many occurred to varying degrees (e.g., program includes youths’ parents in health care planning and delivery). In addition, participant responses to program activities were varied and thus did not always lead to the intended program outputs. For example, not all youth maintained ongoing relationships with MHPP advocates or attended scheduled medical appointments.

From our point of view, this deviation from the original, likely overly ambitious, set of goals was not unexpected, as the realities of the environment into which an enhanced MHPP was being situated became obvious. For example, to set as a program activity the development of a database, continuous medical records, and a “health passport” for youth requires a substantial commitment of time and resources on the part of the program director, health advocates, and DYS and community health center staff at all levels. While program staff in consultation with evaluation staff developed a program-specific database (e.g., a record of services provided to
participating youth), the program did not succeed in developing a continuous health record or “passport.” This part of the goal was arguably unrealistic given the small scale of MHPP and its limited funding to enable staff to facilitate and manage the collaborative efforts necessary to create such a continuous record and passport.

It should also be noted that the program theory, logic model, and goals were all created at a time when MHPP was planning to expand to three sites—Boston, Worcester, and Brockton—with potential for further expansion across the state, and with additional major funding, which the program did not receive. This no doubt contributed to the ambitious quality of the program model. In addition, program staff had expected that at some point the partnering systems (e.g., DYS, MassHealth, and community health centers) might fully absorb the program, thus enabling it to realize some of its long-term impacts, such as “DYS seeks providers who address health issues comprehensively and in the community” and “MassHealth reimbursement for MHPP nurse services at CRC.” However, the fact that the program did not fully expand as planned, did not receive the expected additional funding, and has not been fully absorbed by the relevant systems to date, speak to the need, going forward, for MHPP to reassess its goals and its overall program model.

**Program Structure and Administration**

The components of program structure and administration discussed in this section include the following:

**Program model analysis:**
- Gender-specific, gender-responsive programming;
- Collaboration with health, juvenile justice, philanthropy, and evaluation professionals;
- Locating service delivery in community re-entry centers;
- Connecting youth to the program prior to community reentry;
- Partnering with community health centers;

**Program implementation analysis:**
- Differences in CRC structures;
- Relationships between MHPP health advocates and DYS and CRC staff;
- Supervision of MHPP health advocates; and
- Transitioning into the MHPP health advocate position

**Program Model Analysis**

Several key program components relate to program structure and administration. These include gender-specific, gender-responsive programming; collaboration; locating service delivery in community re-entry centers; connecting youth to the program prior to community re-entry; and partnering with community health centers. Each of these components is discussed below, examining how it has changed over time and the implications of those changes.
Gender-specific, Gender-responsive Programming

The initial iteration of the program, the GHPP, was designed in the spring of 2004 to specifically serve girls in a way that was responsive to their particular health needs (Proposal Narrative to Jessie B. Cox Charitable Trust, 2004). When the census of DYS-committed girls in Boston dropped in the summer of 2006, Sherman began planning an expansion of the program to boys and seeking funding to support it. DYS partners were receptive to this, as they had long expressed the need for all DYS-committed youth to receive support in accessing health care upon community re-entry (Personal Interview, January 2006). The program first expanded to serving boys in Dorchester in the spring of 2007 and, due to changes in program staff and funding, was not in active operation again until the spring of 2008. Girls in Boston received MHPP services through the summer of 2008, but since that time, the health advocate in Boston has served only boys (Personal Interviews, 2008).

In Worcester, the girls’ program began in the fall of 2007. Over the course of that first year, the census of committed girls in Worcester decreased, as it had in Boston, and few girls were reporting to the CRC. The nurse advocate introduced the program to boys in November of 2008, though intake was halted in December and resumed again in March after written permission was provided by DYS central to Worcester Region management.

These shifts from originally serving girls to primarily serving boys in Boston and Worcester illustrate how the program model has adapted to changes in staffing, funding, and the census of DYS-committed girls. These shifts also reflect a desire on the part of Sherman, DYS, and community health center partners to expand the program to serve more youth. The motivation for this expansion on Sherman’s part appears due, primarily, to cost-effective service delivery, and ultimately to program sustainability. As Sherman explained,

…it’s that difference, that shift of how do we reach more kids and make this sort of… more broadly available and still be able to do it with the amount of money and time that we have, so that it is not so costly that it is not doable or fundable (Personal Interview, October 2008).

It is, thus, understandable that in order to keep the program afloat, Sherman expanded it to serve boys, but it is important to examine what is gained and what is lost with this shift. In Boston, what was gained by expanding to serve boys, is that the health advocate has succeeded in bringing clients to Sidney Borum Jr Health Center (SBHC), the partnering health center, which in some cases, appears to have resulted in strong connections between the participating boys and the clinic. This move to serve system-involved boys also strengthens the potential for the health center to be invested in the program for the long term. On the other hand, the fact that the MHPP advocate in Boston has not had any contact with girls since August 2008 is notable given that the program originated for girls in Boston, was the longest running site for the program, and according to staff of the girls’ CRC in Boston, the need for such services for these girls still exists (Personal Interview, October 2008).
The gender-specificity\textsuperscript{41} of the program remains, as the services are delivered to girls and boys in separate, gender-specific sites. The extent to which the program can be considered gender-responsive is detailed in the gender substudy section of this report and speaks to the risk of shifting the program from serving only girls to serving mostly boys and some girls. Key informants credited the original GHPP with raising awareness about the health and health care access needs and service gaps specific to system-involved girls. The program shifting to service provision primarily for boys raises the question of whether girls, with their special health needs, will receive the attention and services they need.

\textit{Collaboration with Health, Juvenile Justice, Philanthropy, and Evaluation Professionals}

From the program’s conception, Sherman recognized the importance of developing relationships with a variety of professionals to help inform the program model. These collaborations have benefited the program in multiple ways. Collaboration with health professionals has been particularly important for Sherman, since she does not have a medical or public health background. These collaborators have helped Sherman gain a better understanding of adolescent health and health care systems and informed her decisions to hire a nurse to staff the program and to partner with local community health centers. Collaboration with juvenile justice professionals has been essential to gaining entry into DYS facilities and CRCs, in building the necessary relationships with DYS and CRC staff to facilitate health services for youth re-entering their communities, and in working toward the program’s overarching goal of creating systems change. Collaboration with professionals from philanthropic foundations has led to multiple sources of funding for the program’s implementation and evaluation over the last four years.

These collaborators made it possible for Sherman to expand GHPP during the pilot phase of the project to serve more girls in Boston, to convene an advisory board during the program’s expansion planning phase, to expand the program to Worcester, and to expand the program to serve boys in addition to girls in both sites. Finally, collaboration with evaluation professionals has been perceived by key informants (e.g., program staff, funders, partnering health center representatives) as continually informing the program’s development and helping to make the program one that is thoroughly assessed. Sherman has described meetings with potential funders in which they decided to support the program after seeing that the program was being evaluated and reading evaluation reports that detailed the program’s implementation processes and lessons learned.

The limitations of these collaborations with various professionals have less to do with the collaborations themselves as with the collaborative process. Sherman’s collaborative efforts were most evident in the early stages of the project with the forming of the MHPP advisory

\textsuperscript{41} As noted in the gender substudy, the terms “gender-specific” and “gender-responsive” are often used interchangeably; here, we use the term “gender-specific” to refer to service delivered separately to girls and boys and “gender-responsive” to refer to service delivery that recognizes the unique needs of girls and boys and responds to those needs accordingly.
board, and have not remained as organized or consistent since that time. Key informants from DYS and at least one partnering health center have lamented the infrequency of communications or interactions with program staff over the past couple of years (Personal Interviews, 2008).

On the other hand, the onus for sustaining collaborations rests largely, and perhaps unreasonably, given the potential benefit to her collaborators, on Sherman as the MHPP program director. As a clinical professor and director of the Juvenile Rights Advocacy Project (JRAP) at Boston College Law School, she has had limited time and resources to manage the program single-handedly. However, as Sherman moves into a strategic planning phase and considers options for program sustainability, this is an opportune time to reconvene her key collaborators and utilize their expertise to review lessons learned, reassess program goals, and strategize about future directions. The planned group review of this evaluation report may offer one such opportunity to do so.

Locating Service Delivery in Community Re-entry Centers

One of the reasons DYS was originally receptive to MHPP was because it complemented the agency’s growing emphasis on the CRC model of supervision and support. That model was intended to provide more comprehensive services to system-involved youth re-entering their communities. Over the first three years of MHPP’s operation, DYS increased the number of CRCs across the state, and contracted with community-based organizations such as Roxbury Youth Works, Inc. (RYI) to manage the centers and offer system-involved youth advocacy, educational programming, case management, and outreach services. Locating a nurse at the CRCs to provide health services was seen as an added benefit, and in our view, it appeared to be.

The aforementioned shift from a nurse to an HIV-prevention counselor in Boston has, in some ways, shifted the location of service delivery. Rather than the “school nurse” type model, in which the MHPP nurse would meet with youth at the CRC to assess health needs and provide medical consultation and referrals for care, the current model focuses less on providing on-site services and more on connecting youth to services in the community. Sherman described this shift in the location of services as follows:

Now the new model is the hub from which you launch the kids out into the community where they get everything that they need. You don’t create these things in the community re-entry center. You simply create a pathway into all these other services that are in the community so that the kids don’t become reliant on the community re-entry center there; they are reliant on the community. And that is really the way you want to go; the community institutions become their institutions and that is definitely what this is now (Personal Interview, October 2008).

As Sherman notes, what is gained here is that independent health care management and increased connections to health services in the community are enhanced. However, the
community re-entry center has provided a space for youth to meet face-to-face and develop trusting relationships with the MHPP health advocates, which in turn has facilitated their connections to health-related services and supports. The fact that there is no MHPP health advocate on site at the girls’ CRC in Boston, for example, raises the question of how girls at that site will receive such services and supports. Thus, the shift away from the CRC model as the site of service delivery poses the challenge of how MHPP staff will effectively connect youth to the program and in turn to health services in their communities.

Connecting Youth to MHPP prior to Community Re-entry

One answer to the question raised by key informants during the initial needs assessment conducted by the evaluation, namely, how to effectively connect youth to the program, was that MHPP advocates meet with youth prior to their community re-entry. There was general consensus among MHPP informants that “backing the program into the system” would enable MHPP advocates to develop relationships with youth and health care staff in the DYS facilities and facilitate the program goal of continuous, uninterrupted care for youth, as well as the improved flow of health care information. This notion also led to DYS staff inviting MHPP advocates to participate in exit-planning meetings with DYS caseworkers, families, and youth prior to youth re-entering their communities. In recent interviews, senior DYS officials as well as CRC managers have noted the importance of this program component.

The first two MHPP advocates for girls in Boston made this component of the program a priority, meeting weekly with health care staff and girls in the Boston Metro facility, and planning for care upon community re-entry. They spoke of following up with girls they met in the facilities and agreed that this early establishment of the relationship helped to facilitate their ability to connect with these girls and link them to appropriate services. In particular, the original MHPP advocate in Boston related a story of meeting a girl who was pregnant in a DYS facility. The advocate helped this girl plan for the prenatal care she would need when she re-entered the community, and knowing the girl was unsure if she would continue the pregnancy, the advocate also spoke with DYS staff (those who knew of the pregnancy) about the importance of not letting other girls at the CRC know about the pregnancy, to minimize any pressure the girl might experience in making that difficult decision. The girl ultimately chose to have an abortion when she returned to the community, and the advocate was able to provide support to her through that process (Personal Interview, April 2007).

The current MHPP advocate in Boston began her tenure with MHPP while she was still working as an HIV-prevention counselor for DYS, and thus met many of the youth in DYS facilities prior to working with them in the community. The MHPP advocate in Worcester has occasionally visited the facilities for re-entry planning, and for a prerelease meeting for one girl. It was ultimately determined that MHPP advocates’ attendance at prerelease meetings was not an optimal use of time and resources, given the travel time required, length of the meeting, and the limited opportunity for the advocate to speak about the program during the meeting.
Sherman described the process by which she came to no longer rank as a top priority the process of connecting youth to the program prior to community re-entry. She came to believe that MHPP advocates’ time was best spent doing outreach to larger numbers of youth. Sherman acknowledged that having MHPP advocates meet with youth or staff prior to release might be best for those youth with complicated medical cases, where such youth may need medical services immediately upon re-entry. However, for most youth, Sherman expressed her opinion that meeting for the first time in the community would be satisfactory (Personal Interview, October 2008).

Thus, what is gained by this shift from more to less connection to youth prior to community re-entry is that advocates can spend more of their time reaching larger numbers of youth in the community. Yet if there is little connection between MHPP advocates, youth, and DYS health care staff prior to community re-entry, the program will need to determine other mechanisms to facilitate continuous, uninterrupted flow of medical information and care for participating youth.

Partnering with Community Health Centers

Sherman recognized the need for partnering with community health centers soon after launching GHPP. In her early, successful proposal to the Jessie B. Cox fund to support an expansion of GHPP, Sherman wrote,

Through the pilot it became clear that to institutionalize the GHPP model in Massachusetts (and nationally) Medicaid funds must be accessed to support the Nurse Advocate, and partnerships must be formed with community health centers so that DYS youth can bypass impediments to community health access (2004, p. 5).

Sherman enumerated additional benefits of partnering with community health centers, including increased credibility, support, and materials for the MHPP nurse advocate.

Over the past five years of MHPP’s operation, there have been three partnering community health centers: in Boston, Codman Square Health Center (D/CSHC) (from 2005 – 2007), and then SBHC (from 2007 to the present), and in Worcester, Great Brook Valley Health Center (GBVHC) (from 2006 to the present). This key program component of partnering with community health centers has remained steadfast through the duration of the program, and the strengths and limitations of these partnerships offer important insights that can inform future iterations of the program model.

The strengths of the community health center partnerships have included all that Sherman originally articulated: facilitating billing for the nurses’ services; providing credibility, support, and materials; and perhaps most importantly, providing a health care home for system-involved youth in facilities with specific missions to serve them. Pam Kane, the former liaison to MHPP from GBVHC, said MHPP “is specific to [GBVHC’s] mission,” which, she noted, was
“taking care of disadvantaged populations around health care” (Personal Interview, September 2008). Similarly, Bob Garcia, Director of Behavioral Health Services at SBHC described the fit between MHPP and the health center in this way:

The models that MHPP has…and its broader social goals and aspirations about empowering young people to access health care fit completely with the whole raison d’être of the clinic to begin with. (Personal Interview, September 2008)

Our data indicate that SBHC has served as one of the stronger health center partners for MHPP. The MHPP advocate in Boston has successfully connected boys to SBHC, and two boys that we interviewed spoke positively of the experience. One of these boys said he appreciated how “fast and easy” SBHC is, explaining,

Other clinics would just be so long and then they’d be overcrowded and overbooked…It’s not like a long process. You’re in and out real quick. Test results, physicals, and all of that…It’s a lot easier than a hospital, clinic. (Personal Interview, January 2009)

In addition to efficiency, SBHC primarily serves young people in the age range of DYS-committed youth who “fall outside of more traditional health care settings” (http://www.jri.org/Programs-Additional-Adolescent-Programs-Sidney-Borun-Health-Center.php). While D/CSHC and GBVHC are fully committed to serving youth in their communities, they serve individuals across the age spectrum, and in this sense, would probably be considered more traditional health care settings. Perhaps most importantly, SBHC appears invested in the program and its survival, and has partnered with Sherman to seek funding for MHPP’s next iteration.

The limitations of the community health center partnerships largely relate to the goal of connecting youth to care in their communities, and to program sustainability. Not all youth participating in MHPP have wanted to seek health care at the partnering health centers for a variety of reasons, including concerns for safety at the particular site, and a desire to seek care at a different health care home that is more easily accessible to them and/or where they have already established relationships with health care providers.

Given that a major MHPP goal is to connect youth to care in the community and thus improve their access to health care, if youth already have strong ties to a provider outside of the partnering center, it seems most in keeping with the program goals to sustain those connections. Yet, if few youth go to the partnering health centers, then issues of program sustainability arise. What incentive does a health center have to partner with MHPP (and thus commit time and resources) if it is not increasing its client base and/or fulfilling its mission to perform outreach to certain populations, such as system-involved youth? While partnering with community health centers has been a valuable component of the program model to date, continually assessing which health centers to choose as partners seems important in light of achieving program goals and long-term sustainability.
Program Implementation Analysis

Differences in CRC Structures

MHPP is an independently administered and funded program housed within several DYS CRCs. MHPP’s placement within the CRCs is unique, since all other programming occurring in the CRCs is part of the center’s official structure, and youth are generally mandated to participate in it to fulfill obligations related to their DYS involvement. In contrast, while MHPP is offered to all DYS-involved youth reporting to these centers, participation is voluntary.

DYS contracts with local nonprofit organizations to operate its CRCs, and these organizations have established distinct administrative procedures and programming for youth; many factors account for this diversity, including the amount of physical space available for CRC activities. The CRCs that house MHPP are testament to this variation, and as a result, the degree to which MHPP is integrated into the programming of the CRCs, and into the centers’ daily activities, varies as well. This section compares the structures of host CRCs along three dimensions—space, youth census and presence, and activities and requirements—concluding that MHPP’s ability to effectively serve youth, and to reach a significant proportion of the target population, is largely dependent on how well it, or its health advocate, is integrated into the CRC structure.

Space. The three primary MHPP sites, the Worcester girls’ CRC, the Boston girls’ CRC, and the Boston boys’ CRC, each have similar structural elements, but also evidence important differences. Each site has a common area intended for recreational purposes. The Boston girls’ CRC at which the Boston girls’ advocate worked, had the smallest and most restrictive recreational space—a small area with tables, and no other recreational activities. The Worcester girls’ CRC has a large open area with couches, a television, movies, a Wii video game console, and other activities, such as board games. Similarly, the Roxbury boys’ CRC has a large open space with couches, a pool table, a television, audio recording equipment, cards, and other leisure activities.

Each of the advocates has been provided with an office space in her respective CRC. The girls’ advocates were both given their own offices, and the boys’ advocate shared an office with a caseworker. Privacy was not reported to be an issue for any of the advocates. If the boys’ advocate needed to speak to a youth privately, she was always able to find an available room. Oftentimes, though, interactions between the boys’ advocate and youth, including initial assessments leading to a determination of health and health care needs, take place in the common area, which is large enough that the advocate and youth can go to one side of the room if necessary. It is also common for health-related discussions about well check-ups, health concerns, or insurance to take place over a game of pool. The boys’ advocate preferred to engage youth in this casual atmosphere. At the Dorchester CRC, she would otherwise have had to meet youth in a separate room, and saw this as a disadvantage of that CRC’s spatial features.
Youth census and presence. The number of youth attending each site varies according to the number of DYS-involved youth, released from custody and mandated to report, who live in the area that the CRC is zoned to cover. DYS has standard reporting regulations that apply to all youth, regardless of CRCs; however, there are several levels of regulations depending on the youth’s offense and behavior. If youth are attending school or are enrolled in a Graduate Equivalency Degree (GED) program, or are working, they may only be required to report to the CRC for a few minutes or to call their caseworker. During the summer, many youth have jobs, and the census at each CRC is at its lowest. The reporting variations combined with the census of each CRC can lead to significant differences in the number of youth who regularly report to each center. This is further complicated by the fact that the advocates are only present in the center for between ten and twenty hours per week. The amount of time that both advocates and youth are in the center at the same time is limited at the girls’ centers, resulting in limited access to youth for MHPP recruitment and engagement. Due to the larger census, access to a large number of youth has been less of a problem at the boys’ center; however, having only one advocate assigned to a large number of youth has limited that advocate’s ability to serve all youth who are eligible for MHPP participation.

At the Worcester girls’ CRC, the limited presence of the girls made it impractical for the advocate to hold health education groups for them, which had initially been one of her goals. There would generally not be more than three to five girls present in the center at a time, and sometimes there was only one girl, due to the girls’ varying schedules and reporting requirements. The girls’ reporting requirements would sometimes change (e.g., girls would not have to report for more than a few minutes if they were at the local community center), making it difficult to predict when youth would be in, and thus to plan activities. Additionally, sometimes girls would not report even when they were supposed to.

At the Boston girls’ CRC, the girls had very limited free time. Their time was occupied by mandatory classes and community service activities, which dominated the majority of the hours during which they were required to report to the CRC. One of the instructors of a mandatory class was unavailable for a period of several weeks, and the health advocate was able to take over the weekly time slot allotted to that class for that period to teach a health education class. Once the instructor returned there was no time available for her to meet with the girls in a formal group setting, and thus was unable to continue the formal, group-based health education component of MHPP.

At the Roxbury boys’ CRC, the advocate could generally expect the boys to be present for an hour at the same time each day. This time period was established as unstructured time, when the boys could engage in recreational activities available in the center. The presence of a substantial number of boys in the center during this hour was essential to the advocate’s ability to recruit youth into the program and get them connected with health care services. In contrast, at the Dorchester boys’ CRC, the boys would rarely be present in the center for a significant period of time, and if they were, they were likely to be participating in a required group activity. This factor was influential in the advocate’s choice to make the Roxbury CRC her
primary base for MHPP activities. She tended to see boys at Dorchester only if they were referred by a DYS caseworker, because the limited presence of the youth and the activity schedule were not conducive to efficient program recruitment and engagement.

\textit{Activities and requirements}. Each of these CRCs has a discrete set of requirements designed to structure the time youth spend at the center. The required activities combine with the nature of the physical environment to create very different atmospheres and degrees of temporal flexibility, some more conducive to integrating MHPP programming than others.

Girls at the Boston girls’ CRC who were required to report had one-half hour of free time upon arrival, during which snacks were available. They then had a number of required groups to attend that occupied the remainder of their time in the center. On days when they were not in required classes in the CRC, they were attending community service activities outside the center. This schedule left a very limited amount of time for the health advocate to develop relationships with the girls, and meet with girls one-to-one.

The environment at the Worcester CRC is characterized primarily by recreation. The only requirement for girls who have to report is that they see the mental health counselor, located on site, weekly. The remainder of their time in the CRC is spent engaging in recreational activities there. Often, the girls would be watching television or a movie or playing a video game, making it difficult for the health advocate to engage them in conversations about their health, entice them to come to her office to talk one-to-one about their health needs, or provide group education.

It appeared that the casual tenor of the environment does not support participation in a volunteer program such as MHPP. When the health advocate would try to create structured activities such as health education classes, or work with the girls one-to-one to help them develop skills to manage their own health care, she was competing with media entertainment and so, was naturally met with resistance from the girls. For example, when she suggested holding a group, the girls would show a lack of interest in participating: “They feel like I’m infringing on their time and I’m creating an unrealistic expectation” (Personal Interview). According to the advocate, the CRC staff prefers that the youth not be on-site for longer than necessary to fulfill their reporting requirements. If the health advocate was holding a group, the CRC staff would invite the girls to stay for it, but would not require them to do so. It is likely that the girls also do not want to be in the center for longer than they are required to be. The environment in this CRC, then, led the health advocate to rely on casual methods of interacting with the girls which were more in line with the center’s approach.

At the Roxbury boys’ CRC, boys who were expected to report in the afternoon were able to spend one hour in unstructured recreational time during which snacks were provided, and many would be required to attend groups following that. Weekly field trips outside of the center were also organized. The boys’ health advocate felt that the environment at the Roxbury CRC was community-oriented, and found the one hour of unstructured time to be an ideal
setting for engaging youth in the program. The CRC staff also worked with her to arrange for groups of youth to attend formal introductions to MHPP following their required group meetings. In addition, when she needed to make a health care appointment for a client, she was usually able to arrange with the boy’s caseworker for him to be excused from the required activities for that purpose. She described the caseworkers as very supportive of her efforts to provide youth with health care services.

**Strengths and successes:**
- A combination of factors at the Roxbury boys’ CRC, including the physical arrangement and availability of space, the number of youth regularly reporting, and the formalization of a set amount of unstructured time, enabled the boys’ advocate to regularly connect with youth, further develop relationships with them, and remind them of her availability to assist them with health-related services.
- All three CRCs provided appropriate space for the health advocates to meet with individual youth to discuss health matters privately.

**Challenges and areas for improvement:**
- The casual, unstructured atmosphere of the Worcester CRC made it difficult for the health advocate to establish her place in the center’s structure and form new relationships with youth. Within this setting, the advocate’s efforts to create organized activities around health and health care was received by some youth as an imposition on their free time.

**Relationships between MHPP Health Advocates and DYS and CRC Staff**

Creating strong relationships with staff members of both DYS and the CRCs in which MHPP health advocates were based was a vital aspect of the advocates’ role. These relationships facilitated smooth and effective functioning of the program, and benefited program participants.

**Relationships with DYS staff:**

Contact with youth in custody. One of the health advocate’s responsibilities is to connect with youth while they are still in DYS custody in order to promote continuity of care between treatment facilities and the CRCs where youth will be reporting. DYS staff members—health care personnel (particularly nurses) in the treatment facilities, and caseworkers for youth while in custody and after release—were critical to facilitating this connection.

The Boston girls’ advocate developed a relationship with nurses in a treatment facility from which girls would make the transition to the Boston girls’ CRC. At least one of these nurses had familiarity with MHPP because the program had existed at the Boston girls’ site prior to the current advocate’s tenure. The Boston girls’ advocate regularly
attended meetings with these staff members to review health-related information on those girls. The DYS nurses were able to provide the advocate with a link to the girls so that she could introduce herself and MHPP, and tell the girls that she looked forward to working with them when they began reporting to the CRC. Additionally, in some cases, she helped to facilitate the receipt of community-based health care planned for immediately following a youth’s discharge from custody. For example, she acted as a liaison, communicating with DYS nurses and with caseworkers, to ensure that a particular girl was able to get to an appointment that was very difficult to schedule.

The Worcester girls’ advocate attempted to make connections with nurses in the treatment facilities, but several difficulties arose during this process. Because neither the advocate nor the nurses work full-time, scheduling a time to talk on the phone or meet was a challenge. In addition, this advocate was the first MHPP advocate in the Worcester region, and the DYS nurses were not familiar with the program. Thus, the advocate had to develop a relationship with them, and build trust from the ground up; at least one DYS nurse questioned the necessity of another individual (the advocate) meeting with youth about their health care prior to their release.

Due to her preexisting relationships with clients reporting to the Roxbury boys’ CRC, the Boston boys’ advocate did not feel it was necessary to meet with youth prior to their release in order to begin to develop trusting relationships with the youth. She was confident that she would be able to reconnect with youth when they transitioned back in to the community and engage them in the program. In a few cases, she did meet youth in a treatment facility when a caseworker requested it on the basis of a client’s health care needs.

Communication about youth. It is fairly common for DYS-involved youth who are reporting to CRCs to return to custody for varying periods of time as a result of violating DYS rules. In some of these cases there was communication between advocates who had worked with youth in MHPP and DYS health care staff. This communication was advantageous to both the DYS nurses and the advocates, and was a step toward achieving continuity of care for MHPP participants.

In several cases, DYS nurses contacted health advocates requesting medical records or health history information about a youth who had returned to custody. Once relationships were established with DYS nurses, it was also possible for advocates to contact them and request a client’s medical records, such as dental records for a client who needed a root canal, or a pap smear report. In yet other instances, a DYS nurse would contact an advocate who was working with a girl that had served for a violation and again returned to the community, to share health information that would allow the advocate to facilitate appropriate treatment.
The Boston boys’ advocate would sometimes contact a caseworker when she was having trouble reaching one of the program participants. The caseworkers were very helpful in those cases; they would either set up an appointment for the youth to meet with the advocate or take the advocate to meet with the youth.

**Referrals.** DYS caseworkers would contact advocates if they discovered during their interactions with a youth that he or she had health care needs. DYS mental health clinicians, who were based in the CRCs, would also make introductions between youth and advocates. In some cases, particularly at the Boston girls’ CRC, the caseworkers would request that the advocate meet with a girl who said she was feeling ill, in order to verify that the youth was not trying to falsely use ill health as a way to circumvent reporting requirements.

If a youth revealed to a caseworker that he or she was concerned about a health problem, the caseworker would sometimes suggest to the youth that he/she visit with the health advocate when on site. Caseworkers also would frequently share information with the advocates, especially in the Worcester girls’ CRC and the Boston boys’ CRC, about a health-related problem a youth in their caseload was having. This information alerted the advocates to health problems as they surfaced, and helped ensure that youth’s health needs were being addressed. The advocates made clear to the caseworkers that while they greatly appreciated the information, any health-related information youth shared with the advocates was confidential and would not be shared with the caseworkers.

**Health advocates as a resource to DYS staff.** Several caseworkers utilized the advocates as resources in dealing with health issues, asked for information in order to better understand what was happening with individual youth, and requested recommendations from the advocates on how to approach a particular problem or concern. Reflecting on the health advocates who are nurses in particular, they also reported that they themselves benefited from having someone on site at the CRCs who understands specific health conditions and illnesses, who is knowledgeable about where to refer youth for care, especially those youth with serious medical concerns, who can provide health education, and who can communicate with health care providers in the facilities and in the community. As one caseworker said of the MHPP nurse who was located at the CRC where her clients report, “She has alleviated a lot of our pressure. It’s been great...she can answer our questions, she can tell us how the health care systems run, why we may not be able to get information; it just opens up a whole other line of communication” (Personal Interview).

42 Interview date has been removed, as informant requested anonymity.
Relationships with CRC staff:

Communication about youth. The Boston girls’ advocate regularly attended client review meetings with CRC staff. During these meetings, she would learn about all activities related to clients reporting to the CRC, including actions or behaviors of the client that were relevant to DYS and reporting regulations, updates on whether any youth had returned to custody, and information on girls that would soon be released from custody and begin reporting to the CRC. She felt that this information helped her understand contextual factors affecting that might affect the youths’ health needs, and might inform her approach to working with the girls in an individualized way.

The Worcester girls’ advocate echoed these sentiments regarding information shared with her by CRC staff: “I mean practically [all the CRC staff] are really helpful in terms of giving me the background of any of the girls and…you know just helping me understand what factors might come into play, [such as] family, or what their schooling situation is…”(Personal Interview). Although the Worcester CRC staff did not have regular client review meetings, they would notify the advocate when youth were going to be discharged to the Worcester girls’ CRC so that she could plan to meet with them immediately, begin to develop a relationship, and maximize time in order to meet their health care needs.

Health advocates as resource to CRC staff. CRC staff seemed to view the presence of the MHPP advocate as a valuable addition to the services offered to youth reporting to their sites. They expressed gratitude that the youth had someone who was an expert on health to consult about personal issues. In addition, CRC staff members sometimes asked advocates about advice in addressing a health-related issue with a client, or asked them to follow up with that client directly.

Strengths and successes:

- Having relationships with DYS nurses enabled MHPP health advocates to begin creating relationships with youth prior to their release to the CRCs. In addition, communication between DYS health care staff and MHPP health advocates improved the ability of both parties to manage a youth’s health care by allowing for the sharing of important health care information when youth moved between DYS facilities and the community.

- CRC staff and DYS caseworkers would make introductions between advocates and youth, and referrals in the interest of connecting advocates and youth. These introductions and referrals assisted the advocates with recruitment, and likely increased the number of youth who were served by MHPP. Due to the Boston boys’ advocate’s prior relationships with DYS caseworkers, there was a higher likelihood that they would make connections between this advocate and youth in need of health services.

- Information sharing between CRC staff and DYS caseworkers and MHPP health advocates
aids the advocates in learning about youth’s health-related needs and offering the youth services to address those needs.

- When health advocates are on site in the CRCs, CRC staff and DYS caseworkers can use them as a resource in order to better understand youth’s health care needs and thus better meet those needs.

**Challenges and areas for improvement:**

- Relationships between MHPP health advocates and DYS health care staff are necessary in order to achieve continuity of health care between treatment and the community for DYS youth. Health care staff at the Worcester area treatment facilities were evidently not provided with information about MHPP and the purpose of the connection between the Worcester girls’ advocate and youth in custody. Due to this, as well as scheduling challenges, the Worcester girls’ advocate was unable to regularly connect with youth prior to their re-entry to her CRC. Having had this access would have aided her in recruitment of youth into the program.

**Supervision of MHPP Health Advocates**

MHPP health advocates receive two types of supervision. Medical supervision is provided by professionals at MHPP’s partnering health centers, and program supervision is provided by the MHPP program director. While the medical supervisory component of MHPP is intended to provide support to the advocates related to the provision of health care services to program participants, the program supervisory component is intended to provide advocates with information and guidance related to program goals and operations.

*Supervision by a health professional.* Each health advocate was paired with a health professional from the partnering health center associated with their program site. Dr. Ralph Vettters, the medical director at SBHC, provided medical supervision to both the girls’ and boys’ health advocates for the Boston program. The supervisory relationship between Vettters and the Boston advocates was a mechanism for providing the advocates with oversight of MHPP participants’ cases, as well as health and educational resources. The advocates met with Vettters once every two weeks, and he was available for additional consultation on an as needed basis.

The Boston girls’ advocate found the clinical supervision with Vettters extremely valuable. Although she was a nurse, she did not have the scope of training or practice that Vettters has, so she looked forward to discussing clients’ cases and receiving feedback about how to approach them. He often raised issues that she did not consider, such as questions that should be asked of the youth, and health records of theirs that would be useful. She would then use these suggestions to further investigate the youth’s case in order to determine the appropriate health care course. The advocate would review each new client’s intake assessment with him, as well as clients about whom she was concerned. In one instance, she suspected that a client may have
obsessive-compulsive tendencies, and sought Vetters’s guidance. He suggested an approach for working with the girl to modify her behaviors. The regular supervision with Vetters was an important source of support for this advocate.

The relationship also provided the advocate with ongoing professional development. The advocate and Vetters would alternate bringing educational material to their meetings, such as data and research reviews, and case studies. In addition, Vetters provided the advocate with several presentation templates on health issues, which she was able to adapt for use with girls. He also gave her feedback on other presentations that she was planning to use in health education classes with girls.

The boys’ health advocate summarized what she saw as the function and value of the clinical supervision she received from Vetters:

… if I have medical questions; if a kid comes to me and says something and I have a concern about it; referrals—so if a kid talks about a specific issue as far as dentists or eye doctor or dermatology or things like that how we can go about addressing that (Personal Interview).

Also, since many of her clients became patients of Vetters through MHPP, it benefited both Vetters and the advocate to collaborate in order to make sure that youth’s health was being monitored. In some cases, the advocate had more frequent contact with a client than did Vetters. If she became aware that, for example, a client was not taking his prescription medication, she would consult with Vetters to determine how critical it was that the youth was not taking the medicine, and whether there was an alternative approach that would be effective. In other cases, Vetters would request the advocate’s assistance in contacting or delivering medical information to a client who had not followed up with him.

The medical director at GBVHC was made available to the Worcester girls’ advocate for medical supervision purposes. There was very little communication between the two (they met in person on one occasion), in part because the medical director left the health center during the advocate’s tenure, and in part because the advocate did not feel that she had many medical questions for her. It appears that the purpose of this relationship was not completely clear to the advocate.

In addition to the medical director, the Worcester girls’ advocate also received program supervision from an administrator from GBVHC. The two met monthly, and discussed program activity, such as what health issues youth were presenting, and what seemed to be successful or unsuccessful in terms of engaging youth in the program. The advocate viewed this supervisor as a person who could answer questions about the breadth of her position in MHPP, such as what she was able to offer to youth in the way of health supplies or first aid.

While the advocate did feel that she could seek assistance from the partnering health center, or refer to the institution for medical resources such as referrals or educational information, she
did not have the clinical supervision that was afforded the Boston advocates. Because the
Worcester advocate had a collegial relationship with the Boston girls’ advocate (they were both
nursing students at the same university), she sometimes received the health education
presentations given by Vetters to the Boston advocate. In addition, the two advocates
sometimes shared the experiences they were having at their respective sites, including
challenges and successes. While the Worcester advocate did not feel that she was receiving the
same level of support from her medical supervisor as the Boston girls’ advocate, this exchange
decreased the Worcester advocate’s feeling of isolation.

Program (MHPP) supervision. Program supervision was relatively minimal at all three
program sites. The advocates did not have regular meetings with the program director, and the
majority of communications between the director and each of the advocates were focused on
requests for information about program activities from the director. Occasionally, as the
program became more established at each site, the director would communicate expectations to
the advocates that were specific to program elements, such as regarding the number of
encounters with youth or their relationships with partnering agencies. In several instances, the
advocates reached out to the program director for information, guidance, or assistance. For
example, an advocate contacted the director to help her in making a connection with health care
staff in a DYS facility, as the director had relationships with all of the key players related to
MHPP.

Each of the advocates expressed some lack of clarity about what should be the focus of their
program activities, and what was expected of them in terms of program approaches and
outcomes. One advocate described setting up and proceeding with program activities in a “trial
and error” fashion (Personal Interview), and taking the initiative to check in with the program
director to verify that she wanted things to be done in the way she was doing them. Thus,
program supervision, as reported by the advocates, was generally prompted by them based on
their needs for guidance or information.

Program supervision was the most frequent at the Boston boys’ site. The program director
would check in with the Boston boys’ advocate on a more regular basis than with the other
advocates, making sure that she was receiving everything she needed and that the program was
running smoothly.

Strengths and successes:

- The medical director at SBHC was very involved in providing medical supervision to the
  Boston MHPP advocates. He served as a clinical supervisor and an educational resource for
  both advocates. The relationship between the supervisor and the Boston boys’ advocate was
  mutually beneficial because the advocate was able to assist Vetters in keeping in contact
  with MHPP participants who had become his patients. The reviewing of individual clients’
cases at clinical supervision meetings between Vetters and both of the Boston advocates
likely enhanced both advocates’ abilities to meet the health care needs of the youth
participants at their program sites.
Challenges and areas for improvement:

- The supervisory support provided by the partnering health center to the advocate at the Worcester girls’ site was not equivalent to that received by the Boston-based advocates. She was not able to discuss individual youth’s cases with a clinical supervisor, and thus did not receive case management guidance that may have benefited youth’s program outcomes.

- The health advocates were provided with minimal program supervision, including in the form of program orientation, leading to a lack of clarity about program goals and the program director’s expectations for the scope of their role, program activities, and outcomes.

Making the Transition into the MHPP Health Advocate Position

In the absence of a formal program orientation, the health advocates each experienced a period of self-directed transition when they started their positions at their respective sites. During this period, they developed relationships with key individuals who would play a critical role in program operations, oriented themselves to program procedures, and determined the expectations of them in their role and how to meet those expectations. This period of transition varied in length across the three program sites based on program history at that site, the program director’s involvement in the transition, and other factors.

The Boston girls’ site was the inaugural MHPP site, when the program existed as GHPP. A nurse had been in the position of the health advocate at that site for three years prior to the Boston girls’ advocate who provided the information for this present implementation study. Thus at the Boston girls’ CRC, and within the feeder DYS treatment facilities, there was familiarity with the program. Certain CRC and DYS staff members were familiar with the previous health advocate and her MHPP services. The former health advocate also met with the current health advocate to provide some orienting information and suggestions for moving forward, such as which girls might be good to target for program involvement. Because some of the girls reporting to the CRC had a relationship with the prior health advocate, they were more likely to utilize MHPP services offered by the current health advocate. Despite these benefits, there was still much work to do in establishing her own relationships with individuals who would be integral to the program running successfully. She described how she spent her time in the first month or so of her tenure:

…a lot of what I’ve been doing here is setting the ground work. So there hasn’t been as much health care focus right now; the things I have been doing is getting to know who’s who in DYS, getting to know who’s who at the CRC, getting to know who does what and where getting to know the clinician and that sort of thing. I also have been spending a lot of time just exposing my self to the girls because trust is a huge issue with these girls and you know health care is a private issue so you have to establish trust. (Personal Interview)

The Boston boys’ advocate also had some significant advantages, as a result of her former employment in DYS treatment facilities working as a sexual health educator with boys, which
facilitated her transition into the MHPP health advocate role. Namely, the advocate had preexisting relationships with DYS staff, CRC staff, and youth reporting to the boys’ CRC. These relationships allowed her to focus her efforts almost immediately after beginning the MHPP position on the substance of the programming, that is, on providing youth with health care services. Because she dealt solely with sexual health when she was in her DYS role, one challenge she had was to broaden the understanding of DYS and CRC staff, and youth she had previously worked with, about the scope of her role. She would no longer be helping youth only with sexual health care and education. On the other hand, sexual health concerns that boys at her program site were experiencing became an entrée into conversations about other health concerns.

Overall, the preexisting relationships this advocate had with youth proved to be a major benefit in her ability to involve youth in MHPP and meet their health care needs. Both the youth she had already worked with, and those who did not know her but observed the relationship their peers had with her, trusted her as a health care professional and felt comfortable sharing their health concerns with her from the start of her term as MHPP advocate. Similarly, her preexisting relationships with DYS and CRC staff were based on trust and collegiality. These relationships were beneficial because the advocate was able to notify everyone of the function of her new role and seek their assistance in making connections with youth, such as through referrals or connections with youth who were still in custody.

In contrast, and through no fault of her own, the Worcester advocate had no preexisting relationships with youth or staff, and was the first MHPP advocate at the Worcester site. These factors, combined with a lack of a formal orientation to the program or a program curriculum, made navigating the relevant systems and getting the program up and running particularly challenging. She had to forge new relationships with all the key players, build a referral base, and create a program curriculum for a program with no existing reputation, and with no ongoing supervision to guide her or provide feedback.

Strengths and successes:
- Both the Boston boys’ and girls’ advocate benefited from preexisting relationships with key individuals; this eased their transition into their MHPP role, and helped them to become familiar with certain MHPP related procedures and gain the trust of others relatively quickly.

Challenges and areas for improvement:
- When the advocates started out in their role, they were expected to navigate the learning curve associated with any new job on their own, without any formal orientation or program curriculum, and with no ongoing supervision. The advocates expressed a lack of clarity about program goals as well as the program director’s expectations of them.
- Because the Worcester program was nascent, no framework existed at the Worcester CRC or within the DYS health care division in Worcester to facilitate the advocate’s integration into
these institutions. In the absence of assistance in forging relationships with key individuals within DYS and the CRC at which she was based, the Worcester advocate had to dedicate significant effort to educating key individuals about the goals and potential benefits of the program, and establishing processes for working collaboratively with these individuals in the interest of youth. More scaffolding from the program director and DYS staff would have allowed the advocate to focus primarily on service delivery.

**Direct Program Services**

The components of direct program services discussed in this section include the following:

**Program model analysis:**
- Medical professional service delivery;
- Parent and family involvement;
- Health education;

**Program implementation analysis:**
- Recruitment and engagement of youth in MHPP;
- Linking youth with health services and supports; and
- Providing youth with tools to manage their health care.

**Program Model Analysis**

Several key program components relate to direct services. These include medical professional service delivery, parent and family involvement, and health education/health care education. Each of these components is discussed below, examining how they have changed over time and the implications of those changes.

**Medical Professional Service Delivery**

From the initiation of GHPP, Sherman determined that she needed to hire a medical professional who had the credentials and expertise to effectively assess system-involved youth’s health needs, access medical records, communicate with other medical professionals, and navigate the local health care system. Numerous informants, from DYS administrators to DYS caseworkers and providers as well as CRC managers, noted the importance of having a medical professional, in particular, a nurse, deliver MHPP services, saying that HIPAA laws (e.g., health information privacy protections) allow only medical personnel, not caseworkers, to access health records.

Sherman hired nurses from the start of the program until the spring of 2008, when she hired the first nonmedical advocate, an HIV-prevention counselor. Sherman had discussed with DYS administrators the possibility of DYS residential health care staff assuming a greater role in the community (e.g., going to the CRCs to deliver services in a way similar to that of the MHPP nurses). DYS administrators and health care staff expressed interest in this arrangement, but it
was ultimately determined that residential health care staff were overextended and could not fulfill this role. These conversations led to the hiring of the current MHPP advocate in Boston who worked as an HIV-prevention counselor within DYS facilities.

What has been gained by this shift from a medical professional to an HIV-prevention counselor delivering the service is that, in this particular case, the advocate brings with her established, trusting relationships with DYS youth and staff, which have in turn enabled her to easily connect to boys in the community and link them to care at SBHC. She also has extensive background and training in the area of sexual health, a primary health need for participating youth. However unlike the nurses, the HIV prevention counselor is unable to assess health problems, and she is limited in helping caseworkers understand health conditions to the same extent as a nurse could. Sherman expressed her concern about this latter point:

I think that going into this new model, one of the pieces that we have to see how it could fit in is this raising awareness and education on the part of the caseworkers of health issues, because that was part of the problem that we found at the very beginning when we went into this was that the staff were not including health in their service plans for the community because they didn’t know anything about it and they were scared of it…and having a nurse on site fixed that problem (Personal Interview, November 2008).

This concern is a valid one in shifting the service delivery model from a medical to a nonmedical professional. It may be somewhat alleviated by the Department’s plans to more actively train caseworkers in managing health care for youth re-entering the community. In the meantime, the current health advocate has a strong relationship with SBHC, which enables the boys she has referred there to get their health issues addressed quickly, and provides the advocate with resources, as well as support and supervision from medical staff at the clinic.

Thus, for programs like MHPP, the benefits of shifting from a medical to a nonmedical professional service delivery model is that it is potentially more cost-effective and allows for access to a wider range of personnel, especially during nursing shortages. The major limitations of a nonmedical professional are the inability to conduct health assessments and serve as a health care educator to DYS staff. However, some of these limitations may be mitigated if the person brings some level of health education training and established relationships with system-involved staff and youth, and has support and supervision from medical staff at a partnering health center.

Parent and Family Involvement

While parents and families are included in the MHPP logic model within intended project activities, outputs, and impacts (e.g., “Include youth’s parents in health care planning and delivery, and outreach to family through family screening, health education and program referral”), these intended outputs did not always occur and program staff communicated with parents to varying degrees, some not at all.
During the needs assessment interviews and focus groups in Boston and Worcester, DYS managers, caseworkers, community monitors, and program directors emphasized the critical role parents and guardians play in youth’s access to, and utilization of, health care, especially given that many system-involved youth live with their parents/guardians and that parents/guardians have to consent to their children receiving most medical services (Planning and Evaluation Report, May 2006, p. 40). The recommendations to MHPP that emerged from those focus groups as well as interviews with the original MHPP advocate included locating service delivery in a place that offers other health and social services to families in order to bring parents in, having the MHPP provider explain health insurance to girls and their parents, and over all to “broker the relationship” between families and health care (Planning and Evaluation Report, May 2006, pp 53-54).

Further, as noted in the pilot health survey and family substudy sections of this report, the girls and boys we interviewed described parental, in particular, mothers’ involvement, in their health care (e.g., scheduling appointments, reminding them about appointments, taking them to appointments). These youth also noted other family members who are sources of support for them with their health, including siblings and aunts. And family members’ own health behaviors—for example, whether or not close relatives visit the doctor when ill—also affect these young people’s approaches to health care.

The original MHPP health advocate in Boston felt parents should be “seen as part of the team” (Personal Interview, April 2007). She reported meeting privately with a girl and her mother in the CRC following the girl’s abortion, meeting with mothers in case review meetings at the CRC, and talking with mothers and grandmothers over the phone about topics related to medication, education, and struggles they were having with their daughters’ behavior (Personal Interviews, April – June 2007). This health advocate felt outreach to family members helped to provide additional support to girls as they made decisions regarding their health, education, and system involvement. She noted that parents were receptive to her conversations with them, saying “they appreciate people recognizing that they have a heavy burden in caring for these kids rather than being blamed” (Personal Interview, April 2007). She also discussed the challenges of reaching parents and obtaining consents from them, explaining that many had a general distrust of anything related to DYS, and noted, “these parents are just stretched thin in terms of resources to deal with these kids” (ibid.). The subsequent and current MHPP health advocates in Boston reported no contact with parents, and the MHPP health advocate in Worcester has had contact with some parents.

In discussing parental involvement in MHPP programming, Sherman has expressed her ambivalence about this program component:

…one of our goals is to shore up social supports and to improve social supports and improve health access. To the extent that parental involvement does that, it’s a plus, but if it doesn’t, then it is not a plus and it’s not really a goal. It never was an independent goal because it was never clear that it was in all cases, something you’d want. (Personal Interview, October 2008)
Given that it may not be clear in all cases if parental involvement is desirable or would help improve health care access and social support for participating youth, MHPP health advocates might speak with youth about the level of parental involvement they would find most helpful. Should MHPP staff discover a parent is very involved in a youth’s health care or a youth desires for their parent to be involved, he/she can increase efforts to reach these parents. Should MHPP health advocates discover a parent who is not involved, or is, but the youth desires her/him not to be, they can ask youth if other family members serve as a health care support for them, and then reach out to those individuals. It seems at the very least that parents or guardians should be informed about the program and have the opportunity to ask questions about the services provided.

The issue of parental and family involvement is a complex one, given the limited time and resources of the MHPP health advocates, the limited time and resources of parents of system-involved youth, the confidential nature of certain health information (e.g., sexual health), and the uncertainty of whether or not parental and family involvement will result in improving health care access and social supports for participating youth. Yet, this complexity should not deter program staff from increased efforts in this area (and thus increased support to MHPP advocates for this purpose). Our interviews with adult and youth key informants speak to the need for MHPP to involve parents or family members as part of the support and services offered to participating youth. The benefits for system-involved youth and their families in doing so, as illustrated in the efforts of the original MHPP health advocate in Boston described here and the efforts of the current advocate in Worcester described in the implementation analysis section below, point to the potential of this program component to facilitate the achievement of larger program goals.

Health Education

The final program component examined here is that of health education, which encompasses health care education. Though MHPP has never developed a formal health education curriculum, this component of the program has always been an implicit part of service delivery. All the MHPP health advocates over the years have integrated health education into their interactions with participating youth. For example, in Worcester, database records reveal that, for one participant, the MHPP advocate provided extensive health education to her on a number of topics, including consistency of condom use for pregnancy and STD prevention, dietary modifications for weight loss, and appropriate protection and treatment methods in response to a reaction to mosquito bites.

The first two MHPP advocates in Boston facilitated health education workshops with participating girls which, for the second advocate, occurred on a regular basis due to an unexpected opening in the CRC schedule for required group activities. The current advocate in Boston has not facilitated health education workshops in the community to date, although her job prior to MHPP was running sexual health classes in DYS facilities, so many of the boys participating in MHPP have attended her classes. The MHPP advocate in Worcester has led one
health education group, but factors related to girls’ attendance and interest, as well as the CRC schedule, have not been conducive to her facilitating subsequent groups.

The youth we interviewed report knowing a good deal about their health and the health risk behaviors of young people their age, and they report having received health education from a variety of sources in their life (e.g., DYS, parents, peers). One girl we interviewed expressed frustration with the MHPP health advocate for talking to her about a topic she already knew about and felt she had more personal experience with than the advocate. These youth perspectives speak to the need for MHPP health advocates to assess the health knowledge of participating youth on a case-by-case basis and offer health education that is in response to youth’s requests for information and/or is responsive to gaps in youth’s knowledge.

In addition to education specific to health conditions and behaviors, Sherman and key informants have emphasized throughout the program’s tenure the importance of health care education—teaching system-involved youth how to utilize health care preventatively (e.g., through a primary care provider rather than the ER) and how to manage their health care independently. All the MHPP advocates have integrated health care education into their interactions with youth. Examples from each advocate include discussing with youth the importance of building a relationship with a primary care provider, walking youth through the process of calling a provider and making an appointment, reminding youth about upcoming appointments, and following up with youth about missed appointments.

It appears that the current advocate in Boston working with boys has made health care education the central piece of her services, providing hands-on education by accompanying youth to appointments and pharmacies in order to teach youth how to access these health services on their own. One youth we interviewed said of this health advocate, “She was just like trying to help me get my foot through the door and then let me carry on with it” (Personal Interview, December 2008).

This more experiential learning approach utilized by the Boston boys’ advocate represents a significant shift in the service delivery model for the program. As youth learn to manage their health care more independently, such an approach may have the most potential for fulfilling the program’s long-term goals of improved access to health care and of improved health status.

Program Implementation

Recruitment and Engagement of Youth in MHPP

Because MHPP operates as an independent, voluntary program within the host CRCs, recruitment, engagement, and the maintenance of participation were central aspects of the health advocates’ role. The three health advocates brought their own unique experiences and perspectives to bear—not only on the approaches they used to engage youth in MHPP, but also in developing and implementing their own “style” of building relationships with the youth and
providing services to them. Below we review the strategies and techniques that they employed for these purposes.

**Strategies and Techniques for Recruiting and Engaging Youth in MHPP**

It was primarily up to the health advocate to introduce youth to the program, its goals, how it works, and the potential benefits of their participation, and they did so using a variety of approaches.

*Meeting youth upon community re-entry.* Both girls’ health advocates attempted to meet the youth as soon as possible after their release from treatment into the community. These advocates liked to conduct an initial health assessment at that point, involving a series of questions to determine the youth’s health-related history and current needs. During this initial meeting they would attempt to demonstrate to the youth the potential advantages of participating in the program, focusing on her individual health needs. Another rationale for this early contact was to avoid negative peer influence. If one or more girls attending the CRC chose not to participate in MHPP, this choice could potentially act as a deterrent to the participation of other youth, and to the ability of the advocate to develop positive relationships with new girls. As one health advocate observed,

…there is so much influence from peers and I think, I find the girls usually have someone else that they kind of stick together with so, and there’s two girls in particular that I’m thinking of, they really look for each other’s company when they are there and it seems as though there is almost like the ring leader, [if] she says “no she doesn’t want to talk to the nurse,” the others don’t talk to the nurse. (Personal Interview)

In contrast, when she was able to make contact with the youth during their first week reporting to the CRC, she felt it was more effective. The youth did not have the chance to be influenced by factors such as other girls’ attitudes about program participation, or the environment of the CRC, and she was able to do an intake with them. She explained,

…that helped because it was new to them, the whole CRC operation and what they are doing there, so I was trying to sort of start the expectation that they’ll meet with me and check in with me before they get the impression from the other girls that that’s not necessary. (Personal Interview)

*Meeting youth prior to community re-entry.* One way to increase the chances of a youth becoming involved in the program very soon after entering the community is to meet youth while they are still in custody. This is also consistent with the MHPP goal of continuous, seamless health care for DYS-involved youth. In several cases, the Boston girls’ program advocate was able to achieve this end by asking the DYS facility nurses to take her to meet girls who would soon be discharged to the Boston girls’ CRC. In these instances, she gave the girls an overview of the program, explained what she could offer them, told them which days she
would be in the CRC, and encouraged them to stop in to see her when they began reporting. In at least one case, this proved to be an effective recruitment method, and a girl did see the advocate when she arrived at the CRC. Even if a girl did not initiate contact with the nurse on her own, the previous meeting served as a point of connection, and an entrée into a conversation: The advocate could refer back to their meeting and remind the youth again of her availability to meet and offer services. This health advocate felt that this advanced meeting allowed the youth to begin to establish trust in her and therefore be more likely to utilize the program.

Use of formal group settings. Another avenue used by two of the health advocates for recruiting youth was to talk about the program in formal group settings. One of the girls’ health advocates led workshops on health topics with groups of girls, and she used these as a forum, not only to encourage girls to take advantage of her services, but to develop relationships with them that she could then build on when she encountered them in the CRC.

The advocate for the boys’ CRCs arranged with CRC staff to make a brief presentation to groups of boys at the end of another group activity they were required to attend. During these group gatherings, she would explain that her role in the CRC would not only deal with sexual health, and would ask a series of questions designed to get them thinking about their needs, and to show what she could do for them in her role. She emphasized preventive care, primary care, and health insurance. Examples of the questions she asked include, “Who knows how to get a physical in the community?” and “Do you know what you’re going to do [about health care] when you age out?” These questions seemed to provoke the youth to think concretely about their health-related needs, and possibly led them to consider issues that they would not have otherwise. The advocate would then explain that she could help them address any health-related issues or questions they had. She had youth who were interested in talking further with her sign their names on a sheet of paper, and indicate what their reporting schedule is. She used this information to arrange individual appointments.

Utilizing unstructured time. All of the advocates took advantage of unstructured time in the CRCs to approach youth and attempt to engage them in a health-related conversation. As will be discussed in-depth in the section on relationship building through informal interactions, casual interactions proved to be an important mechanism for engaging youth in the program. One advocate would approach youth in the common area of the CRC, introduce herself, and ask them when would be a good time to come to her office to meet with her. Another approach she used was to ask a girl, “Would you mind filling out some paperwork with me? It’s really quick; we’re just going to go over your health information.” This was usually an effective technique, leading many girls to complete an initial assessment with the nurse. She would also mention to the girls that she had free sexual health supplies, such as condoms, lubricant, and dental dams, in her office, attempting to entice them to come to her office where she could then begin a conversation with them about their health care.

Another health advocate would join youth in recreational activities in the CRC, and would then
ask them general questions related to whether they are in need of health services or if all of their health-related needs are being met. Often times, a health-related concern would come up, and the advocate would make arrangements to connect them to the appropriate services.

Referrals from DYS or CRC staff. Referrals from CRC staff and DYS caseworkers, and to a lesser degree DYS nurses, played an important role in MHPP recruitment. This was especially true for the girls’ advocates, because they had not been DYS or CRC employees, and thus did not have preexisting relationships with youth. However, referrals made an important contribution for all three advocates, in part because they were in the CRCs for only a limited amount of time each week and had fewer interactions with youth. Community Re-entry Center staff and DYS caseworkers and nurses had regular contact with youth and often knew of health-related issues they were having. Caseworkers also have some health history and health care utilization information about their clients in their files. Community Re-entry Center and DYS staff would make referrals to the health advocates when they interacted with youth and health came up. They would sometimes recommend a visit with the MHPP advocate, would introduce the advocate and the youth to one another in the CRC, and would communicate directly to the advocate that one of their clients had a health-related issue. If a health advocate was given information by a CRC or DYS staff member about a youth with a health problem, she could then approach the youth and indicate interest in talking with him or her. Each health advocate noted that while they welcomed this sharing of information, they made it clear to the staff members that all information they discussed with a particular youth would be confidential.

Another important aspect of the advocates’ role, then, was to educate CRC and DYS staff about the program and to form relationships with these individuals so that they could aid the advocates in connecting youth to the program. The advocates did this in several ways. The boys’ advocate informed her network of DYS and CRC staff (formed when she was employed by DYS) that she was taking on this new role. She also held meetings with CRC staff to formally introduce them to MHPP; they, in turn, would identify youth who had not had physicals in a long time, or who had other health needs. This health advocate was especially focused on recruiting those youth who had been in the community for a longer period of time, who were not reporting to the CRCs frequently, or who would soon be “aging out,” since those youth were more likely to have experienced a lapse in health care. She reasoned that the youth who had recently been in custody would have received health care while they were in a DYS facility, and were less of an immediate priority.

Both girls’ advocates participated in client review meetings with the CRC director, during which updates were given on girls who were reporting to the CRC, those who would no longer be reporting, and those who would soon be reporting. In some cases health-related concerns would surface, but these sessions also functioned as an opportunity for relationship building with CRC staff, as well as a source of insight into contextual factors affecting the youth that might influence the advocates’ approach to working with a particular youth. The relationship between advocates and DYS and CRC staff has the potential to lead to confusion on the part of youth about advocates’ relationship with DYS, and whether
information shared by youth with the advocate would remain confidential. The girls’ advocates were cognizant of this, and made sure to emphasize to participants and potential participants that they do not work for DYS, and that information revealed to them would not be shared with DYS or CRC staff. As one advocate explained,

...a big thing is making it very clear that I do not work for DYS. I think I say that every time I meet with the girls for the first time and I say it at the beginning of every group. Yes I do talk to [the CRC director] and yes I do talk to your caseworkers but I’m doing those things because if you want an appointment on Thursday but you need to report, they are going to trust me when I say you have an appointment, you aren’t going to come in. (Personal Interview)

Despite repeatedly underscoring this point, one health advocate felt that the girls remained somewhat distrustful about sharing personal health information with her.

The boys’ advocate formed relationships with her MHPP clientele while she was a DYS employee, and earned the trust of those youth in her previous role. It is possible that the youth who received services from her in her MHPP role were not clear that she was no longer a DYS employee, but this did not seem to deter them from participating in the program.

Advocates’ approaches to recruitment and participant engagement. One advocate felt strongly that because MHPP is a voluntary program, the impetus to participate should come from the youth. The advocate would spend as much time as possible being present in the common space of the CRC as a way to remind the girls that she was available and would enjoy the opportunity to work with them on health-related issues. However, she believed that the program director’s expectation was that she would be a lot more aggressive in pursuing youth to provide them with services. She described her perception of what the director expected her to do:

...like call their health centers and make sure they made appointments, do it that way, don’t check in with the girls, call their health centers to make sure they made appointments...for me that’s a little too big brother, and I don’t want them to feel like that. Once again I want them to take responsibility for their own health care and feel like adults, and feel like I’m treating them with respect and like they’re not adults but treating them with the respect that they are due and not...checking up on them every five minutes, like if you tell me something I’m going to believe you and you know, this is your health care and it’s your responsibility and I’m just here to help you. So, I mean that’s one thing that I think if, if that was a program goal that I probably didn’t meet. And it’s because of my own personal beliefs on how it should be done. (Personal Interview)

This advocate maintained that her approach both represented her own beliefs and furthered the program’s goal of preparing youth to manage their own health care. She felt that it was each youth’s choice how much or how little he/she wanted to participate in the program and in managing his/her own health care. She believed that by communicating these messages to the youth and by treating them like adults, they would feel respected and be more likely to trust
her, and thus to utilize her services. In addition, the advocate believed that it would be
counterproductive to force girls to have a health care relationship with her if they expressed
disinterest in doing so. To that end, she asked her clients directly what level of involvement
they wanted from her. For example, in her initial assessment with one girl some health issues
were identified that needed medical attention. The advocate asked the girl how she would like
to go about addressing those issues:

I asked, “well do you want to make the appointment with me, do you want to make that on your
own?” and she said, “oh I’ll make that on my own,” and I said, “okay, well do you want me to
bother you about it? Do you want me to check in and see if you’ve done it?” and she said,
“no…you might say something at the wrong time and the wrong place,” and I thought you know
what fine. That’s [her] choice…and I said “I’m here for you, you know where my door is.”
(Personal Interview)

She continued, “I want them to be here, and I want them to participate in this program, but I
also want them to do it voluntarily” (Personal Interview). This belief sometimes meant resisting
the desire to intervene in a youth’s medical care even if the advocate was concerned that a
health issue was being neglected. As a way to address this, the advocate created a system for
reminding girls when they had appointments of which the advocate was aware. This system
included keeping an appointment calendar in her office, leaving reminder notes on the CRC
director’s door for clients, and calling those clients who welcomed this level of involvement
from her.

Another advocate adopted a similar approach. Although initially this advocate was more
assertive in recommending and attempting to encourage treatment seeking with clients, she felt
that the effort was unidirectional, and that it might hamper youth’s interest in having a
relationship with her. Instead, she tried to rely on the youth approaching her if they were in
need of services, hoping that this encouraged an increased sense of responsibility on the part of
the youth for their health:

…the idea is more that the girls take some responsibility for their health and I was feeling like if
I’m there and checking in with them and I’m making all the effort then they back away and when
I instead say, “I am here for these hours, if you need me come see me,” I might miss some things
but I think they do start to realize that if they need something they need to take some
responsibility and seek some help, help themselves. And I’m not sure that more would be missed
that way because, I mean I have situations for girls who are missing appointments even though
we sat down, we established that there was desire for the appointment and I followed up and you
know I made sure the girl was aware of the time, and I reminded them and still you know, I
would have girls who missed appointments and it wasn’t a lack of service it was just their lack of
desire to follow through. (Personal Interview)

The advocate realized that girls’ participation in MHPP not only concerned their need for
services, but more importantly reflected their attitudes and values about health. She attempted
to apply this realization to her work with clients by finding ways to present health care as being relevant to her clients’ current lives.

There were also variations in advocates’ approach to the initial assessments with program participants. Two of the advocates, perhaps because of their nursing backgrounds, preferred to have a formal meeting with youth, during which time they asked a set of baseline questions about health history. The other health advocate preferred to engage youth in a casual conversation about their health in an informal setting. She provided an example of what this might look like: “…sometimes it could be something simple, like if a kid’s sneezing, [I’d ask him], “Oh you have allergies? Have you seen someone for that before? Do you have someone to go to?” (Personal Interview). She would also ask very general questions related to how a youth is adjusting since they’ve been back in the community, and would then transition into health-specific questions such as whether their health insurance was in order and how long it had been since they had seen a doctor. The information that emerged in these informal interactions became the basis for further program involvement.

Advocate-participant relationship. Advocates also had different perspectives on the nature and scope of their work with MHPP clients, and these perspectives, in turn, affected their approaches to building relationships with youth. They did, however, share basic strategies. For example, when advocates were meeting with youth and assessing their health care needs, they responded to verbal and nonverbal cues from the youth. Some youth were not comfortable disclosing much information about their health, which they considered personal information. Some became more comfortable once establishing trust in their relationship with the advocate. The advocates understood that the success they would have in building these relationships depended in part on their reactions to what youth presented to them.

One advocate described an interaction with a client who had a chronic illness:

…there is a girl that’s diabetic and…she wasn’t feeling very giving and I wasn’t gonna push, so I would have liked to know a lot more about, like what your daily blood sugar is, and how many times you check your blood sugar, but I wasn’t going to ask her because she wasn’t ready for me to do that. (Personal Interview)

Sensing that the youth was not ready to disclose too much information, the advocate did not press her on these issues. Similarly, another advocate tried not to pepper the youth with too many questions, but rather focused on rapport building by spending as much informal time with the youth as possible in order to let her know that the advocate was available and approachable. When working with a client, she sought a balance between expressing concern and delivering directives. Viewing herself as a health educator, she tried to share knowledge and offer advice from the perspective of a health professional, but believed that it was not her role to demand or dictate that youth make health-related changes or take certain actions. In situations that seemed more acute, this advocate would respond to a client who was reluctant to seek services by creating a verbal contract with the client, hoping this would encourage them to
take the appropriate action. She would then encourage the youth to follow up with her about progress made.

One of the advocates felt that youth’s reluctance to share or take full advantage of the advocate’s services might be based on the clients’ perceptions that she came from a very different background than they did, and that the two probably did not have many common experiences. She felt that this was an obstacle to overcome in working to create trusting relationships, and explained one strategy that she used to deal with this challenge:

> Just being there and proving, you have to prove yourself, so…I mean, and not, I’m not shocked by anything, so anything they tell me is not going to be like “oh you’ve had 30 sexual partners, okay,” seen that, done that, moving on. (Personal Interview)

It was important to this advocate to demonstrate to her clients that she was nonjudgmental about their health-related experiences, and that she had exposure to clients with similar experiences. This may have worked as a strategy to encourage their trust and comfort with her.

One of the advocates explained that her goal was not to act as a health care provider to the youth, but to facilitate the development of a compatible relationship between her clients and a health care provider. Thus, though she could assist in the growth and maintenance of the relationship between her client and a provider, she did not feel it was necessary to know the details of each client’s health care concerns. In order to facilitate that relationship, she would regularly engage clients in conversations about their experiences with a health care provider and a medical appointment, focusing on the quality of this experience and any concerns or questions they had about the process of seeking and receiving care, rather than health-related issues or outcomes. She would ask questions such as,

> How was it? How was the doctor…? Was there something that they asked you that you were concerned about? Did you have questions? Did you get a chance to ask him, “What’s going on?” Did you like it there? Is this a place you’ll go back to? …do you feel like you won’t go there on your own unless I were to take you? Should we try somewhere else? (Personal Interview)

She further explained how this approach was consistent with her understanding of the purpose of her position:

> …I don’t think I need to know every medical issue that the kid has. And part of me is like, this is not my business; in a way I feel like this is more of a caseworker type position, where I’m helping them get the services they need, and I’m helping them set up appointments…but as far as exactly what it was, and what was going on, unless the kid has questions about it, you know, I helped him get his medication and that’s that. (Personal Interview)

Although a health advocate’s eventual style has a strong personal dimension, it is also shaped by many structural factors, including the limitations and opportunities posed by the CRC
environment, the advocates’ professional training and experiences, prior relationships with
MHPP partners and youth, MHPP history at each of its sites, and the quality and nature of the
supervision the advocates received. In addition, youths’ individual characteristics (gender,
personalities, health needs, etc.) interact to determine their responses to the advocates and to
program services, and these reactions shape the advocates’ behaviors, we assume, in an
iterative fashion.

Relationship building through informal interactions with youth. The MHPP health advocates
at all three program sites have identified their informal interactions with youth as playing an
important role in program recruitment, relationship development, participant involvement, and
service delivery.

At the girls’ sites, the informal interactions occurred during unstructured time in the CRCs; the
Boston girls’ advocate also participated in off-site community service groups with participants
on two occasions. The advocates noted that during these times, they usually talked with girls
about general matters such as family or romantic relationships, reporting that these
conversations contributed to a more effective advocate-client relationship because they build a
sense of familiarity and trust, opening the door for increased comfort in disclosing health-
related information and concerns. While personal health information was not discussed by the
girls’ advocates during informal interactions, health-related conversations sometimes occurred
in these group settings, including discussions of topics such as nutrition, STDs, and future
family planning.

Speaking about the role of unstructured interactions with participants, a girls’ program
advocate had this to say: “I think it really helps. I think these girls have a lot of reasons not to
trust people right off the bat, so it helps to not just be there but show interest in whatever it is
that’s important to them” (Personal Interview). The boys’ advocate echoed this sentiment when
describing an example of working with a boy who mentioned he would like to become a tattoo
artist and hoped to learn Old English lettering. The advocate found examples of the lettering on
the internet and gave the youth a paper with the letters as a way of developing the
interpersonal aspect of their relationship, which she believes facilitates a more effective health
provider-client relationship:

I think it’s just little things like that, that, like one tiny small little extra step that to most people
would be nothing, I think it just shows a little bit more of how you respect that person…. I don’t
think, even though we are talking about heavier topics with what I teach and counsel around, it’s
not always that stuff that builds the trust…. A lot of times it’s those little things that made them
want to open up about the bigger stuff” (Personal Interview)

In addition to increasing mutual comfort and respect, one MHPP advocate felt that the informal
interactions, which she referred to as “face time,” served as a forum for introducing herself and
letting the girls know that she was available and what her role was at the CRC. Having a time
allowance in her schedule for “hanging out” with the girls was something she considered a
critical part of increasing the likelihood that the girls would take advantage of the services she could offer them in the CRC: “It is hugely beneficial into getting them here, having a rapport with them, and…them just knowing that I’m here” (Personal Interview).

This advocate attributed a decrease in program usage later in her tenure to restrictions in her hours of employment which did not allow her to spend informal time with participants. Earlier, she was attending classes outside of the CRC with clients, participating with them as a way to build another dimension of their relationship. When her hours were reduced, she was no longer able to attend those classes, she felt that the participants did not have the opportunity to become comfortable with her, and also that it was easier for them to forget that she was available to them. This advocate identified trust between herself and her clients as one of the most important goals to achieve, and also as the one that took “the longest to work on.”

The Boston boys’ advocate was in a unique position to build trust that bolstered her ability to meet the health needs of her clients. During her tenure working with youth in custody in the Boston area as an HIV-prevention counselor for DYS, a position which she held during the first six months of her MHPP tenure, the youth responded very well to her, and she developed a reputation as a trusted health care provider as well as a “cool” person. The advocate felt that the preexisting relationships with youth in custody gave her significant leverage in her new community-based role to effectively provide the extended health care services that the MHPP model offered. She explained,

I’m very lucky with the relationship that I have with the DYS clients that they do feel comfortable talking with me about that so I think that those relationships already exist, especially with some of these youths that have major trust issues, and you know, have poor communication skills with people they don’t know, that a lot of them already have that relationship with me, so their likelihood of continuing that relationship and coming to me with issues when they are in the community [is greater]. (Personal Interview)

Having preexisting relationships with youth seemed to support this advocate’s ability to engage youth in MHPP in several ways. She was able to introduce youth in custody to the program while she was still working in the DYS facilities so that they would know that she was available as an MHPP advocate once they returned to the community. When arriving at the CRC, the youth with whom she had preexisting relationships recognized her, and seemed to treat their relationship as a continuation of the services she had provided them while in custody. On many occasions, youth would approach her about a sexual health concern due to her formal role as HIV-prevention counselor, and she would leverage the opportunity to engage them in a conversation about other health issues. Youth who reported to the CRC with whom she did not have a preexisting relationship observed the comfort level that other youth had with her, and this may have aided in the development of trust between the advocate and these new clients.

Strengths and successes:
- Relationships between health advocates and CRC and DYS staff enabled more connections
to be made between health advocates and youth who could benefit from MHPP services.

- The relationships that the boys’ advocate had established with youth, and with DYS and CRC staff during her time as a DYS employee, facilitated recruitment of youth into the program.

- In Worcester, the caseworkers would bring MHPP program consent forms to their home visits with youth and their families, thereby assisting the Worcester girls’ advocate in recruitment of youth.

- Opportunities to interact with youth, such as through formal groups and during unstructured time, allow advocates to establish trusting relationships, and to show youth what MHPP can offer them.

- While efforts to recruit and engage youth in MHPP were initially approached on a somewhat trial-and-error basis by the advocates, each health advocate appears to have developed a professional practice of engagement and relationship building with youth, having responded to their observations of which techniques worked and which did not. They demonstrated evidence of being responsive to youth’s reactions to their approaches, and observant of youth’s unique attitudes about health care. The advocates also seem to have drawn on their respective professional experiences as well as personal philosophies to guide their approaches.

  **Challenges and areas for improvement:**

  - Relationships with CRC and DYS staff, and with youth, are critical for youth engagement in the program. However, while developing these relationships seems to be the responsibility of the advocates, they have limited time to dedicate to this work.

  - Several possible deterrents to youth involvement in MHPP exist, including the negative influence of other youth about program participation, and confusion about advocates’ relationships with CRC and DYS staff. In addition, in the Worcester program in particular, the girls expressed frustration that although the health advocate is a nurse, she cannot provide direct medical treatment. The Worcester advocate felt that this was a significant deterrent to girls’ involvement in the program at her site.

  - Currently, strategies and techniques for engaging youth in MHPP are left up to the health advocates to determine. In addition, there is a dearth of clear guidelines for the intended nature of the relationship between advocates and MHPP participants (e.g., advocate as health care provider, advocate only as facilitator of PCP relationship, a combination of both). Thus, this is an area in which significant variation exists across program sites.
Linking Youth with Health Care Services and Supports

One of MHPP’s primary goals is to improve system-involved youth’s access to health care. This goal was clearly communicated to the three health advocates, as it was one of two major foci in each of the three programs. The advocates felt that they were linking youth to health care services that the youth would be unlikely to have access, or to utilize, without such an intervention. The advocates also strongly supported MHPP’s position that continuity of care between DYS treatment facilities and the community was a particular challenge for the youth they were targeting, many of whom may not have had a health care home or a history of being attentive to their health care prior to their DYS involvement. Thus, the advocates attempted to make sure that youth had a connection to a medical provider in the community, preferably one which they utilized as a health care home.

Case management. Case management, or all activities related to managing a client’s health care, constituted the core of health advocates’ work, and included assessment, referrals, care and consultation, accompaniment to medical services, parent involvement, information gathering related to health or health care, and one-to-one health education.

Assessment. Once recruiting youth into the program, and each time new health issues arose for already enrolled youth, advocates would meet with youth to assess their health and health care status, discuss their health care options, and determine an appropriate health plan with them. Following assessment, the advocates would engage in other aspects of health management related to the determined health plan, such as assisting youth in scheduling medical appointments.

Direct medical care and consultation. Both of the girls’ health advocates are nurses, and occasionally they would provide direct medical consultation or care to youth presenting acute health problems. For example, one girl called the Boston girls’ advocate because she had a bump on her leg. The advocate advised her to come in to see her, and upon examining it was able to identify what it was. She then recommended over-the-counter treatment and advised the youth to go to a community health clinic the next morning. Another youth had low blood sugar when she was at the CRC, so the advocate gave her food, tested her sugar level, and stayed with her until her condition was stable. The Worcester girls’ nurse treated first aid issues such as blisters. She also examined youth who had minor skin conditions or infections and recommended the appropriate treatment.

The boys’ health advocate was not a nurse, but was a sexual health educator. When youth had sexual health concerns, in addition to referring them to a physician or a clinic for testing, she would sometimes provide counseling, such as answering their direct questions or reminding them about appropriate behaviors to stay safe. She was careful not to give medical advice, but rather to make sure that they were receiving the necessary medical attention. One boy’s girlfriend tested positive for an STD, and he then
went to get tested himself. The advocate followed up with him, telling him, “Remember, you can’t be sexually active with her right now, it takes this many days after [beginning the medication]. I know the doctor told you that, but you really want to make sure” (Personal Interview). The advocate kept track of the dates herself and followed up with the boy to make sure he remembered.

**Accompanying youth to appointments.** While the girls’ health advocates would occasionally accompany youth to appointments, such as to get a pregnancy test or to have a gynecological procedure if they did not want to go alone, the boys’ health advocate made it a practice to bring youth to health appointments if it was their first time going to a clinic. She explained her rationale for doing this:

> I always go to the first appointment with them. I usually won’t just send them on their own because a lot of times if they’ve never been to a place before, they don’t know what it looks like, they don’t know where it is, and they don’t know the people there, most likely they are not going to go. (Personal Interview)

This task required considerable coordination of schedules on her part. She had to schedule the appointment at a time when both she and the youth were available, and also notify the caseworkers if the appointment would occur when the youth was supposed to be reporting to the CRC. In several cases the boys’ health advocate also accompanied youth to the pharmacy if it was their first time going to fill a prescription.

**Coordination of care.** One aspect of the health advocates’ role involves acting as a liaison among multiple parties in order to be sure that a youth’s health needs are being met. Examples of such case management activities include resolving health insurance issues, helping a physician communicate medical test results to a youth, and requesting medical records from DYS nurses. The advocates also sometimes aided in the continuation of health care for youth who had been in the community and then returned to detention or treatment. In one situation, the Worcester girls’ advocate had worked with a girl who she suspected may have been pregnant but did not follow through with an appointment to get tested. Once the girl returned to DYS custody, the advocate contacted the facility nurse and communicated her concern. With the girl’s permission, the facility nurse received permission from the girl and gave her a pregnancy test.

In another case, a client was hospitalized for a serious injury; the youth’s DYS caseworker was notified. The boy was involved in MHPP, and the boys’ health advocate had previously notified the caseworker that he was receiving care at SBHC. The caseworker knew to contact Dr. Vetters there for the youth’s medical records. In this case, the advocate was an important link between parties, which benefited the youth and the health providers at the hospital.

Another characteristic example of an advocate acting as a liaison involved a girl being
denied prescription drug benefits. In this case, the advocate was notified that a girl was having this problem by a CRC staff member, and she was able to call the pharmacy and clear up the confusion.

Strengths and successes:

- The girls’ health advocates were both nurses, and were able to provide treatments and consultations to youth in the CRCs for minor health problems. Beyond direct treatment, they were able to apply their medical knowledge to recommendations for treatment. The boys’ health advocate, who was trained as a sexual health educator, sometimes supplemented her referrals with basic counseling about precautions and guidelines for safe behaviors.

- By accompanying youth to their appointments, the Boston boys’ advocate overcame a common hurdle among youth; she ensured that they kept their appointments. Once there, the youth generally had a good experience, and were likely to return for follow-up appointments if necessary.

- Due to their training and experiences in the health care field, the health advocates were able to act as advocates for youth when they were having difficulties getting medical appointments or when they were being denied insurance benefits.

- Youth, health advocates, and providers appeared to benefit when there was a network of relationships established between the advocates, CRC staff, and DYS staff. Advocates were sometimes notified of a health-related issue that a youth was experiencing by a CRC or DYS staff person, and advocates acted as a liaison among health care providers and DYS staff in many of these cases.

Challenges and areas for improvement:

- Health advocates sometimes experienced difficulty convincing youth to follow through with making or attending appointments or ongoing consultations with health care providers. Youth sometimes refused to allow the advocate to assist them in making appointments.

- The health advocates had limited hours in which to accomplish a wide and complex range of duties. One resulting consequence was their minimal presence in the CRCs to connect with youth face-to-face.

- Accompanying youth to an appointment is costly and time consuming. It involves coordination of schedules, transporting youth to the provider’s office, and sometimes waiting until the youth is done with the appointment and transporting them back to the CRC or home. If one health advocate is expected to cover three boys’ CRCs in the Boston area, the practice of accompanying youth to appointments may not be practical.
Referrals

Pursuant to the MHPP’s goal of connecting youth to health care in their communities, one of the primary activities of the health advocates was to make referrals for youth to receive health care. Referrals were frequently made during the initial assessment meeting with youth, when it was determined whether they needed routine care, such as gynecological exams or dental cleanings, or acute care in response to presenting symptoms. Referrals were also made throughout an advocates’ relationship with a client, as needed.

Participants’ need for referrals. The demand for referrals at each of the program sites varied. At the Boston girls’ site, the vast majority of clients had established providers with whom, as determined through assessment by the advocate, they were comfortable and wanted to continue to receive care. In general, the youth were able to tell her the name of the clinic they had previously gone to, and sometimes the name of the physician they preferred to see.

Many of the participants in the Worcester girls’ program also had preexisting provider relationships; however, often there was a significant lapse in that relationship because of the time the youth had spent in DYS custody. The advocate at this site would often assist youth in reconnecting with a previous provider in the interest of continuity of care, except in cases where the youth was displeased or uncomfortable with that provider.

Unlike the girls at both sites, the majority of boys in the Boston program did not have a primary care physician that they could identify or to whom they wanted to return. Some youth identified a clinic that they had been to in the past when they needed health attention, but in general the advocate found that they did not think of that clinic as a health care home or have an ongoing relationship with one physician there. For the minority of participants that did express a preference for a particular provider or clinic, the advocate facilitated a reconnection. The advocate suspected that the youth who were already connected to a provider were therefore not as likely to be in need of MHPP services.

If a participant did not have an established health care home, the advocates could either try to connect him/her with their program site’s partnering health center, or identify a community-based clinic that would meet the youth’s needs. Depending on the program, advocates tended to rely more heavily on one option or the other.

Partnering health centers. The partnering health centers officially employing the health advocates we interviewed for this implementation analysis were SBHC in Boston, and GBVHC in Worcester.

The SBHC was a successful partner for the Boston boys’ site for several reasons: The youth were comfortable traveling there via public transportation; it is a good match for the needs of the population; and the advocate had a professional relationship with Dr. Vetters, which benefited the youth who received their care at the clinic.
The Boston boys’ advocate was able to maximize use of SBHC. As has been discussed previously, it is her practice to accompany youth to their first appointment with a physician. She would usually drive youth to SBHC when they were being seen there for the first time; they quickly familiarized themselves with the area of the city, and then felt comfortable using public transportation to return on their own for follow-up visits.

The advocate was able to schedule appointments for her MHPP clients at SBHC with ease; she had relationships with the staff there which made scheduling appointments convenient, and the staff were accommodating to scheduling changes precipitated by the youth’s sometimes unpredictable lives. While normally this type of relationship with a health center’s staff would take time to develop, in this case it was automatic because of the partnership between MHPP and this clinic.

Since the majority of her clients did not have established health care homes, the Boston boys’ advocate referred them to SBHC in the vast majority of cases, and they established a primary care relationship with Dr. Vetters. According to the boys’ advocate, the youth she brought to SBHC for care spoke very highly of their experiences there, felt that they were getting individualized attention, and liked the atmosphere of the clinic. When providing referrals to specialists, Vetters would provide clients step-by-step instructions for contacting the doctor and then following up with him after being seen, thus providing more guidance than would likely be provided by another clinic that did not have a special emphasis on special populations of youth.

Vetters is also the medical supervisor to the Boston boys’ advocate. Because of the partnership between MHPP and SBHC, and between the boys’ advocate and the center’s medical director, a network was in place that allowed youth’s cases to be followed and managed even if they returned to DYS custody. When registering at the clinic, youth were given the option of signing a waiver that allowed the boys’ advocate to have access to their health records; in several cases, the advocate was able to communicate important health information, such as test results, to youth who had returned to custody. The advocate was also listed as the referral source on the youth’s paperwork so that if a youth did not follow up with Vetters or he was unable to contact them, he could seek assistance from the advocate in making contact, and increase the chances that the youth would receive needed follow-up care.

While SBHC was also the partnering health center for the Boston girls’ MHPP site, the advocate at this site felt that because the clinic was not in close proximity to the Boston girls’ CRC, it was not convenient for the girls to receive their care there. While she certainly benefited from the medical supervision provided by SBHC, she relied on clinics that were more local when referring girls who needed to establish a health care home.

The partnering health center for the Worcester girls’ program, GBVHC’s mission also had a philosophy that was consistent with the goals of MHPP and suitable for meeting the needs of MHPP’s population. However, an obstacle to realizing its potential as a referral source was the
girls’ expressed reluctance to going to the area of town in which the center was located. A number of the girls in the Worcester program told the advocate that they are “not supposed to go over there” (Personal Interview), but were rather supposed to stay in the area around the CRC. Evidently, both the girls and their parents were concerned about safety in the area of the center. Additionally, they preferred providers who were located in a certain geographic area, and did not want to take the bus to GBVHC.

**Identifying referral sites.** If youth did not have an established health care home, and if the advocates were not referring youth to the program’s partnering health centers, they identified other appropriate clinics and providers. As noted, this has rarely been an issue for the Boston boys’ advocate. The girls’ advocates spent a significant amount of time, particularly during the earlier part of their tenures, building a referral base. In doing so, they tried to draw on resources that were available to them, such as the MHPP partnering health centers. They also utilized the internet and personal connections. For example, one of the girls’ advocates worked part time at a community health clinic near the CRC, and made a number of referrals there. She summarized the benefits of creating personal relationships with the staff of a health clinic: She knew how the appointment scheduling system at the clinic worked, and as a result of her relationships with the staff, special arrangements could be made for youth who needed urgent care. She also was confident in the quality of care delivered at that clinic, whereas she would not be able to guarantee this at clinics with which she had no prior experience.

In other cases, advocates would refer youth to resources other than health care providers, such as teen parenting programs. In one case, a health advocate suspected that a client might be experiencing interpersonal violence in her relationship. In response, she spoke to the girl about characteristics of such violence, gave her the phone number to a hotline, and invited the girl to use her office space and phone to make the phone call.

**Strengths and successes:**
- The SBHC was an excellent partnering health center for the Boston boys’ MHPP site, with its focus on populations similar to MHPP participants, and collaboration with the Boston boys’ advocate to provide high quality, individualized health care to program participants. The boys who visited the clinic felt comfortable there, appreciated the special attention they received, and felt comfortable using public transportation to return for follow-up care.

**Challenges and areas for improvement:**
- The SBHC was perceived by the Boston girls’ advocate to be too far from the girls’ CRC, and therefore a less ideal partner for the Boston girls’ site in terms of its potential as a health care home for clients.
- While GBVHC, the partnering health center for the Worcester girls’ program, may have been a good fit in terms of its mission and available services, its location proved to be a deterrent for girls who participated in MHPP. The girls’ and their parents had safety concerns.
concerns about the area, and also preferred to use health centers that were closer to where they lived.

- Building a referral base requires connections and knowledge of the medical resources in a particular geographic area. Health advocates who did not have an established referral base may have been at a disadvantage in finding the best possible health care home for a program participant.

- When connecting program participants with health centers other than the partnering health centers, the advocates would represent themselves as advocates at a community center, but would not disclose the youth’s status as juvenile offenders, feeling that this information was irrelevant, or that it was unfair to the youth. While this practice certainly makes sense, it poses a challenge to MHPP establishing itself as a health services program for system-involved youth in the community. Thus, ongoing relationships with health centers cannot be formed. A professional relationship between advocates and health clinics, however, benefits youth receiving care at that clinic. The Massachusetts Health Passport Project is faced with the challenge of developing relationships with clinics that are supportive of the program’s goals and open to serving system-involved youth.

Parent Involvement in MHPP

Parent involvement in MHPP varied across program sites. The consent forms that youth were asked to sign in order to participate in the program included a section asking youth whether they had any objection to the MHPP advocate contacting their parents so that their parents could consent to the youth’s involvement. However, this section of the consent form was rarely explicitly discussed with youth during the consent process at the Boston boys’ and girls’ program sites.

The Boston girls’ advocate did not have any contact at all with parents throughout her tenure as the Boston girls’ advocate. Although only one of the participating program participants signed the line on the consent form objecting to parental involvement, the advocate did not contact any of the participants’ parents. She felt that the health information imparted to her from clients was understood, implicitly, to be confidential, so she was not comfortable sharing any information with youth’s parents whether they did or did not request that she not contact them. Therefore, the reason for presenting an option of contacting parents on the consent form (which she did not compose) was not clear to her. Further, she understood parent involvement to be in conflict with one of the program’s primary goals:

*I would call a parent in if [the youth] wanted me to. One of the overarching things in this [program] is to empower [the youth] about their own health care and so I feel like, if they want you to contact their parents, certainly, but I’m not going to go calling people without their permission.* (Personal Interview)
Similarly, the boys’ advocate was unclear about what a possible role for parents in MHPP could be. She echoed the above sentiments regarding confidentiality, and the feeling that parent involvement would be counterproductive of her efforts to enable program participants to be independent in their health care management.

In contrast, the Worcester girls’ advocate did discuss the parent consent option with participants, and found that the majority of them had no concerns about her seeking parental involvement in their health care, as long as she was only discussing basic health issues and nothing that the client and advocate agreed to keep confidential. There were several clients who had been placed in foster care, did not have a good relationship with their foster care parents, and therefore did not want the advocate to contact their guardians. Also, some girls did not have a good relationship with their parent or guardian and felt that the individual who cares for them would not be helpful in their health care management. In these cases, the advocate and the client agreed that if contact with a guardian became necessary from the advocate’s perspective, she would consult with the youth prior to any attempts to contact the guardian. The advocate estimated that she had contact with between 10 and 20 percent of participants’ parents or guardians, mostly over the telephone, and a minority in person, since she began working for the program. She was unable to contact some parents by telephone. Also, she did not contact parents in cases that youth with whom she had contact did not require any health care.

The advocate contacted parents or guardians when she was attempting to set up a medical appointment with a participant but the youth did not remember the name of the physician to whom she wanted to return for care. In cases that participants were familiar with their primary care physician, she found it a good way to connect with parents. She would introduce herself, explain the goals of MHPP, suggest what she saw as the appropriate care, and encourage the parent’s or guardian’s involvement in the child’s health care by sharing with him/her the reason that the child came to her to seek care, and sometimes asking the parent/guardian to schedule an appointment for the child. In cases where she felt that treatment was necessary, she would try to underscore the importance of treatment, warning of possible risks of neglecting a condition, such as progression into an infection. The advocate reported that parents would generally respond by following her recommendations and making an appointment for their child. From this advocate’s perspective, the interactions she had with parents were beneficial to them:

… there’ve been situations where parents weren’t sure how to proceed in certain circumstances and I help with the decision-making processes, helped with educating some parents about certain health conditions, and mostly I’ve helped with identifying providers and facilitating making appointments where it can be difficult for parents to do that in their busy day (Personal Interview).

Although she did not have consistent, ongoing contact with participants’ parents, she often encouraged her clients to discuss the health issues they presented to their parents, and would try to follow up with that parent herself.
Strengths and successes:

- The Worcester advocate made ongoing efforts to encourage parent or guardian involvement in program participants’ health care. The majority of MHPP participants at this program site welcomed this involvement, and the parents and guardians to whom the advocate spoke were responsive to her suggestions and requests to become engaged in managing their child’s health care.

Challenges and areas for improvement:

- There was significant variation between the Boston and Worcester programs in efforts to involve parents, likely in part due to lack of clarity about whether or not health advocates should prioritize parental or guardian involvement in MHPP participants’ health care plan, and if so in what ways. Two of the health advocates were unclear as to the purpose of involving youth’s parents in their MHPP health care plan, and thus did not discuss with youth whether they wanted their parents to be involved. By not discussing this with youth, an opportunity may have been missed to involve youth’s caretakers in their health care, and it is possible that these individuals may have played an important role in the management of their children’s health care in the long term, once youth were no longer involved in the program.

Providing Youth with Tools to Manage their Health Care

Related to the challenge associated with helping youth achieve continuity of care between DYS and the community, youth in this population, especially those who had been in DYS custody for several years, had become accustomed to DYS managing their health care, and for good reason: The youth were adolescents when they became DYS-involved. In general, adolescents do not have the skills to manage their own health care, and this is not a set of skills youth learn while in custody.

The long-term goal associated with the advocates’ efforts to impart health care management skills was for youth to eventually be knowledgeable and independent health care consumers. The advocates frequently referred to this goal in explaining their approach to their work. They each described having the hope that once being involved in the program for a period of time, the youth would no longer feel the need to rely on them, or on returning to DYS custody in order to attend to their health. To that end, the advocates tried to facilitate youth learning the necessary skills to assess their health care needs, obtain health care, develop good relationships with health care providers, understand how health insurance works, and maintain good health:

"And I hope they, you know when they age out, they do have the tools to know how to make appointments, know when to go, know when not to go to the emergency room, when to go to a community health center, when to go to their regular doctor. And that they learn about their health and what’s going, you know, and how to prevent diseases and how to cope with other [health conditions], that sort of thing. (Personal Interview)"
The advocates wanted youth to feel that they were in control of their health care, so the MHPP staff tried to achieve a balance between making sure that youth were getting the health care services they needed, even if that meant that the advocates did the work to connect them with that health care, and teaching youth to do it on their own:

*I don’t want to be, especially for girls aging out, relied upon so heavily that they don’t know what to do when they’re out there. I mean I see my role as kind of an intermediary to help them be independent. I want them thinking for themselves about their health.* (Personal Interview)

**Health Education**

Health education was employed as a strategy for providing youth with health management skills, and was at the center of health advocates’ program activities. Health advocates attempted to impart health-related knowledge and skills to program participants in either group settings or in one-to-one interactions with youth. As will be illustrated in the discussion below, formal group education is much less common both because it is not as practical to incorporate it into the structure of the CRCs, because health advocates have interactions with individual youth more frequently than they do with groups, and because the educational skills being imparted to youth seemed to be more suited to teaching in a one-to-one setting.

*Health education in a group setting.* The Boston girls’ health advocate had the opportunity to teach several health education classes with groups of girls in the CRC; topics included safe sex practices and STDs, reproductive health, female hygiene, and dermatological conditions. The advocate found this to be valuable for several reasons: It was a chance to build rapport, trust, and credibility with the girls, which might lead them to increase their use of her services; it was a way to address a health issue that she observed in a single girl but was likely relevant to other girls as well; and it was a forum for girls to raise questions that they might not ask in one-to-one settings.

The Worcester girls’ CRC did not lend itself to convening groups of girls for formal education because of low reporting numbers and incompatibility with the center’s expectations of reporting youth. However, the Worcester girls’ advocate took advantage of informal gatherings of girls to discuss health topics with an aim toward education. When the girls were “hanging out” in the common area of the CRC, she would sit and talk with them, trying to weave health topics into the conversation. These discussions would sometimes happen multiple times per day with the small groups of girls reporting at various times. Topics for discussion often emerged because of an issue affecting one girl; some of the girls would prefer to spend their time at the CRC in the common area, so if the advocate wanted to follow up with her on a health issue, she would ask if the client was comfortable discussing it in front of other girls. If the client was comfortable with this, an educational discussion relevant to all of the girls might ensue on issues such as safe sex, birth control, nutrition, and avoiding common contagious illnesses like the flu.
The Boston boys’ advocate noted that a youth she brought to a clinic for an appointment asked her to complete the paperwork for him because he did not know how to answer most of the questions. She found that the terminology that is standard on such forms, such as marital status and sexual orientation, was unfamiliar to many youth. In response, she held several small group sessions for boys addressing how to complete paperwork about health history and insurance information routinely necessary during a first visit to a health care provider.

*Skills related to health care system utilization.* As in the example above about health care paperwork, the advocates found that youth often lacked the basic skills needed to effectively use the health care system, and made them a significant focus of their work. By doing this, each of the advocates was working toward MHPP’s goal of preparing youth to manage their health and health care independently. Because the advocates were so frequently connecting youth with needed health services, they tried to use this opportunity as often as possible as a teaching tool. Many program participants were not accustomed to making health care appointments on their own. To teach this skill, the health advocates used several approaches, including making the appointment using the speakerphone while the youth was in their office so that the youth could hear both sides of the interaction; providing the youth direct instruction on how to make an appointment with a provider; and giving the phone to youth to make the call, but being in the room to provide guidance as necessary.

Youth’s responses to the advocates’ efforts to impart this skill varied, with some feeling comfortable right away, some being able to make a follow-up appointment on their own after learning how to do it from the advocate, and some trying it but giving up if they reached an automated answering system. The advocates sometimes had to make appointments for youth, especially if the health need was urgent, or if the advocate needed to accompany the youth and therefore needed to coordinate schedules. Sometimes it was tempting for the health advocates to take over when the youth were resistant to doing it on their own because they did not know what to expect or what to say. The advocates tried as much as possible to empower the youth with the tools to do it on their own, realizing that it was the lack of experience that was causing them to fear the situation. As one health advocate said, “I don’t want to be doing things for them as much as enable them” (Personal Interview).

Similarly, the advocates discussed with youth other procedures related to using the health care system, such as talking through the steps of how to find a provider on the internet. The boys’ health advocate, who accompanied youth to their first visit with a provider, felt that it was the ideal occasion for increasing their level of comfort with the health care system by supporting them while they experienced it. She instructed youth on how to check in with the receptionist, and how to behave appropriately in the waiting room.

The boys’ advocate also prioritized education about health insurance. A common approach she used was to ask youth questions about how their health insurance works, as demonstrated in the following quote:

I was talking to a [participant and I asked him] “Well what is MassHealth?” “I don’t know, but I have it, … like I can go to the doctor.” “Okay, well how do you go to the doctor? Can you go to any doctor? Can you just walk in somewhere and go?” And kind of just going [over] the basics of it, like, what is health insurance? And I printed off, I found some great stuff on the MassHealth website and printed a bunch of information about it that explains how to find a doctor, how to find a dentist, how to find an eye doctor…once you turn 18 and you are not with DYS how can you get MassHealth? How long can you stay under your parents’ [plan]? (Personal Interview)

If this advocate knew that a client would be aging out of the DYS system soon, she paid particular attention to this issue with the client, and made sure they were connected to the resources they would need to continue to maintain their health and health care on their own.

Knowledge related to seeking and obtaining appropriate care. Another major emphasis in MHPP’s “curriculum” was teaching the difference between urgent and nonurgent health needs, and correspondingly, the appropriate use of clinics versus hospital emergency departments. The advocates often used interactions with youth who had a presenting health problem to illustrate these distinctions, and attempt to change some youth’s patterns of utilizing emergency care services as their default health care choice. As the Worcester girls’ advocate described,

I’ve been trying to educate them about what an emergency room is really for, and when they should seek primary care services, and the benefit of having a relationship with a provider. You know, and getting to really know a doctor, and finding someone they feel comfortable with, and explaining that when they have that relationship they can be seen on short notice for urgent conditions, or acute illnesses. (Personal Interview)

Attempting to reinforce this message as much as possible, she tried to educate the youth about the consequences of missing appointments: Not only is the youth risking a lapse in prescription medication or missing a time-sensitive vaccination, but he/she is also risking losing the trust of the physician:

…if they miss the psych[iatric] appointments, then they lose their prescription because the psychiatrist won’t see them, they won’t continue their medication and then it’s a lot to wait to get a new psychiatric appointment. What do you do in the meantime? And how do you find somebody who is willing to write that next script. So that’s what we are trying to avoid is that skipped appointment in between. (Personal Interview)

She tried to communicate the importance of earning and keeping that primary care physician’s trust so that he/she will be more likely to accommodate youth on a last minute or emergency basis.

The Boston boys’ advocate educated clients about how the referral process works. In doing so, she was illuminating another aspect of the health care system relevant to effective utilization.
She was also highlighting the importance of developing and maintaining a health care relationship with a primary care provider, who acts as a steward of your health care:

   I sat down with him and talked about how the referral process works, so he understood, you know, this referral was made to the dermatologist, and that he would call the dermatologist to set up the appointment, and that he would be going somewhere else for the appointment, and then after that to contact [his primary care physician] and let him know what happened, and follow up with him about that. So he can understand the whole process, that everything is going to go back to the primary care, but you can go see these other specialists for other issues that you have. *(Personal Interview)*

   *Stressing the importance of maintaining personal health.* The advocates also focused on improving the youths’ personal health and health habits—which often proved to be a complex task. For example, it was difficult to convince MHPP participants that their current behaviors (in the instance below, eating and fitness habits) will have immediate and long-term consequences for their health:

   *And so I’m really just so much more focused on that motivational aspect and in trying to connect the concepts of health and what the girls can do for their own health to outcomes for the near future as opposed to long term down the road. I’m trying to connect it to how they are going to feel from day to day, you know how they feel when they look in the mirror and how they feel on their walk up four flights of stairs, you know, how they are sleeping, what kind of energy levels do they have and trying to focus on real tangible things. …but the long-term outlook doesn’t look, it’s just not something that’s on their radar; it’s a valuable message but it’s just not important. So that’s just a challenge, the motivational piece and trying to find ways to encourage these girls to take that step.* *(Personal Interview)*

The advocate attempted to address health issues with clients by making connections that would be relevant to adolescents.

   *Strengths and successes:*

   - The advocates had the opportunity to educate youth about fundamental aspects of the health care system that would improve their ability to navigate it on their own, and potentially decrease discomfort or fear associated with health care utilization.

   - One advocate expressed the hope that through the health education efforts of MHPP, youth who may have been marginalized by the health care system would learn that they can, and have the right to, gain access to quality health care, and do not need to depend on the juvenile justice system to provide it. She witnessed several examples of youth participants connecting with a primary care provider or using the health care system on their own for the first time and feeling empowered by the experience.
Challenges and areas for improvement:

- Though formal health education classes may have been an effective way to impart knowledge to youth, and may have had additional benefits such as rapport building between youth and the advocate, the structures of the girls’ CRCs did not support this type of programming.

- Engaging youth in educational discussions and activities related to health was sometimes a challenge due to their attitudes about health and lack of ability to understand the long-term consequences of current health behaviors.

Conclusions

This examination of the program model and implementation reveals a program that has been ambitious and conscientious in its efforts to address the health care needs of system-involved youth. Over the past five years, MHPP has changed in a variety of ways. Sometimes these changes have been planful and intentional, as in the case of switching partnering health centers in Boston, and other times, they have been reactive, for example, to unexpected changes in the census of committed youth, and to funding opportunities. Sometimes the changes appear to be undergirded by sound theory and practice knowledge, and at other times they appear more opportunistic—not necessarily incorrect, but not well-supported either. As illustrated by this analysis, most of these changes to the program model raise important questions about who should be served by MHPP, who should deliver the services, how the services should be delivered, and what activities and goals are achievable given limited time and resources.

The health advocates are the stewards of MHPP at their sites. To many, they are the face of MHPP. However, the implementation analysis illustrates the multitude of contextual factors that interact to limit or facilitate the capacity of the health advocates to work toward the achievement of MHPP goals. Our data speak to the strength of the current program model in Boston for boys. It involves partnering with a health center that shares the mission of MHPP, wants to serve and has had experience serving system-involved youth, and facilitates strong connections between providers and participating youth, and one that is staffed by a health advocate who a) brings previously established, positive relationships with participating youth and DYS staff, b) is skilled in casually developing trust and a good rapport with youth, and c) emphasizes educating youth to navigate every step of the health care system. The question remains whether such a model can effectively serve girls in Boston, whether it can be sustained over the long term, and how transferable it is to locations outside of Boston.

Interestingly, key informants have had differing perspectives on MHPP’s flexibility, with some seeing it as continually adapting to change and others seeing it as less able to do so. One informant, a program funder, with the former view, described the program’s ability to change as a key strength:
…one of the things about the program that I like has been what I would call it’s nimbleness, in that as it, because it’s constantly being evaluated, it gets information, they are able to make changes and shift. Even the shift from one health center to another. So there’s an insightfulness and a thoughtfulness. (Personal Interview)

Another informant, a senior DYS official, noted the need for MHPP to change in order to be more compatible with the Department’s desire to extend community health services to all system-involved youth:

…one of the struggles for us is that we need to generalize it for every kid everywhere and I think that the project is kind of wedded to a model and ... that model doesn’t work in lots of places for us, so I think if the project can adapt...and become more part of sort of a large discussion, then I think that could work. (Personal Interview, December 2008)

This informant explained that the “large discussion” to which he was referring was centered on the Department’s plans to train caseworkers to assume responsibility for health care oversight during community re-entry. Since DYS has maintained that hiring nurses or CRC-based health advocates statewide is not feasible, and that not all communities have CRCs, they have determined the caseworker model to be their most cost-effective option. How MHPP will join this discussion and coexist or somehow be integrated into the Department’s plans remains to be seen.

For her part, Sherman has fully acknowledged the imperative for MHPP to adapt to the systems in which it operates (e.g., DYS and community health). In reflecting on the changes in the program over the years, she said,

I would say in terms of the what is my lesson, is that there isn’t any clear right answer here, that programs like this have to fit within their hosting organization, their host systems, and in order to do that they have to be malleable, recognizing that there are certain principles, piece components, and they have to find a way to incorporate those components within the existing system. (Personal Interview, November 2008)

Sherman noted that her main concern all along has been the underlying problem that inspired her to create MHPP to begin with—that system-involved youth have significant, gender-specific health issues that often go unaddressed when they return to their communities. Thus, she said she is less concerned about the program living on exactly as she has done it and more concerned that this problem is effectively addressed (Personal Interview, January 2009).

Our data indicate that Sherman is both committed to finding new and more effective ways to address the reported gaps in care for DYS-committed youth re-entering their communities, and favors a program model like MHPP in Boston, which she believes most effectively fills these gaps. The challenge for MHPP evaluators is that with so much variability in MHPP’s implementation and in the juvenile justice and health care systems in which the program
operates, it is difficult if not impossible to test the program theory, assess outcomes, or
generalize findings. The program is, almost by necessity, in a constant state of flux within a
shifting landscape. Fortunately, what evaluators can do and have done in this analysis, is to
document program processes and shifts in the program theory, logic model, goals, and program
components over time; raise questions; and offer insights that will hopefully contribute to the
discussion about those new and more effective ways of addressing the health care needs of
DYS-committed youth re-entering their communities.

Recommendations

The following recommendations emerged from this analysis, and are organized by the program
model and implementation elements to which each pertains:

Program Theory, Logic Model, and Goals

- Continually reassess program theory, logic model, and goals in light of changes in funding,
  program implementation, and relevant systems. Prioritize documentation of progress
  toward program goals; this documentation can serve as a key data source for proposals for
  funding and for evaluation assessments of program outcomes.

Program Structure and Administration

Gender-specific, Gender-responsive Programming

- Ensure that girls and boys receive the attention and services they need and deserve. It seems
  worthwhile for girls in Boston to continue to be served.

Collaboration with Health, Juvenile Justice, Philanthropy, and Evaluation Professionals

- Reconvene key MHPP collaborators and utilize their expertise to review lessons learned,
  reassess program goals, and strategize about future directions.

Relationships between MHPP Health Advocates and DYS and CRC Staff

- In order to facilitate the development of the relationship between MHPP and DYS health care staff, formal introductions should be made by a DYS administrator and the MHPP director. During this introduction, the goals of MHPP can be reviewed, and arrangements can be made for regular communications between the two parties in the service of clients’ health. If the MHPP advocate was better integrated into the DYS and CRC systems, health advocates and DYS health care staff would have greater ability to meet youth’s health care needs, and more youth would potentially be served by the program. One factor that would contribute to this integration and speed the period of transition for future MHPP health advocates is the continuity of relationships between MHPP staff and DYS and CRC staff across MHPP staffing changes.

Locating Service Delivery in CRCs

- Locate service delivery in a place where youth have the opportunity to develop a trusting
relationship with the health advocate, while minimizing reliance on the health advocate and instead promoting independent health care management and increased connections to community services.

**Differences in CRC Structures**

- One possible way to improve the viability of MHPP in the Worcester CRC is to require that all girls participate in an MHPP activity (such as a health education class or a meeting with the health advocate) either once or on a regular or semi-regular basis, just as they are required to meet with the counselor. This approach could be pilot tested to gauge whether it improves or hampers girls’ engagement in MHPP services.

- The amount of formal programming required of girls reporting to the Boston girls’ CRC left little opportunity for the health advocate to spend time getting to know the youth and developing a trusting relationship. She was also unable to provide ongoing health education classes to the girls, which serve as a method for achieving one of MHPP’s goals, and as another way to forge relationships, because there was no room in the CRC schedule for her to do so. If MHPP services were incorporated into the girls’ CRC schedule in Boston, the health advocate would be able to increase her number of interactions with them, and this would provide more avenues for MHPP service delivery.

**Making the Transition into the MHPP Health Advocate Position**

- Formal introductions made by the MHPP program director and ideally a key DYS leader would help the advocates make important headway into establishing themselves in their role and building relationships with key individuals upon whom they must depend for central aspects of their work with and for youth recruitment.

**Supervision of MHPP Health Advocates**

- The function of the relationship between MHPP advocates and their supervisors at the program’s partnering health centers, whether it is intended to be related to health and health care issues, programmatic issues, or both, should be made clear to both parties. Advocates at all program sites should benefit from having the same type of supervision available.

- An increase in the regularity of meetings between the program supervisor and the health advocates would likely make the advocates feel more supported, improve the quality of program delivery, and increase consistency of program activities and outcomes across the three program sites to the extent that is appropriate.

**Connecting Youth to MHPP prior to Community Re-entry**

- Connecting youth to program services prior to community re-entry is especially important for those youth who are pregnant or have serious medical conditions that need immediate attention upon community re-entry. For those youth who do not have acute medical needs, other mechanisms must be put in place to facilitate a continuous, uninterrupted flow of medical information and care as youth transition to and from DYS facilities and their home.
Partnering with Community Health Centers

- Partnerships with community health centers should be periodically assessed in light of participating youth’s existing relationships with providers and issues of safety, convenience, and ease of appointment scheduling. Partnering health centers should share the mission of MHPP, want to serve and have had experience serving system-involved youth, and facilitate strong connections between providers and participating youth.

Direct Program Services

Medical Professional Service Delivery

- A professional with training in health care or health education, who brings previously established, positive relationships with participating youth and DYS staff, is skilled in casually developing trust and a good rapport with youth, and who emphasizes educating youth to navigate every step of the health care system, should be chosen. Nurses bring depth of health knowledge and can educate DYS staff and parents on health issues; they can also access medical records that are inaccessible to nonmedical professionals. However, they are more expensive to employ.

Recruitment and Engagement of Youth in MHPP

- Health advocates should be given formal opportunities to convene and discuss best practices for recruitment and engagement of youth, as well as to troubleshoot challenges they have faced in these areas. The lessons that can be learned by sharing could benefit the advocates in their work at their respective sites, and could contribute to MHPP curriculum development in this area.

- Consideration should be given to potential benefits of establishing a more specific set of guidelines regarding the intended nature of the advocate-participant relationship. While restrictive guidelines would limit advocates’ ability to be responsive to youth’s particular styles and needs, having a set of basic guidelines in this area would reduce advocates’ need to experiment with strategies which may or may not be effective, and may or may not contribute to achieving MHPP’s goals. Standardization of services across sites would also increase if such guidelines were developed.

Linking Youth with Health Services and Supports

- The expertise of MHPP partners and local health professionals should be drawn upon regarding techniques for facilitating long-term connections for youth with primary care providers, and instilling in youth an understanding of the value of this connection. Research and extant health care curricula should be referenced in order to impart to advocates an evidence-driven repertoire of strategies for adolescent health care management. Such research and curricula should be relevant to the particular characteristics of youth in the population being served by MHPP.
In order to support advocates’ capacity to connect with youth in informal ways, which they believe is critical to building trust and comfort and therefore to serving youth’s health care needs, advocates’ weekly time allowance should consider this to be a core activity of their work.

The practice of accompanying youth to appointments is costly and time consuming; however, this practice also seems to be effective and supportive of MHPP’s goals dealing with health access and health education. If this practice is to be maintained, additional health advocates are needed to serve youth in the same manner at all three of the Boston area boys’ CRCs.

Advocates should develop, or receive, a list of medical resources, as well as local health centers, ideally including information about each center’s philosophy, specialties, and a contact person.

Given the benefits perceived by advocates to having referring health centers at which staff are familiar with MHPP and its goals, the program should consider ways of developing relationships with certain community clinics (even beyond the partnering health centers) that are supportive of MHPP’s goals and can effectively serve its population.

When selecting partnering health centers, MHPP should be strategic in considering not only the mission of the health center and its congruence with the program’s mission, but also the likelihood that MHPP participants will make use of the health center’s services, and that MHPP advocates will feel comfortable referring youth to the center. Specific factors to consider in the selection process include proximity to CRCs, safety of the area in which the health center is located, and transportation options.

Program advisors felt that parents and families should be involved in the program. If the program is to endorse family involvement as a key MHPP program component, this position needs to be communicated clearly to the MHPP health advocates. It is the recommendation of the evaluators that the benefits of parent and family involvement to participating youth should be assessed on an individual basis. Outreach to parents and family members, when deemed beneficial, can include meeting or talking with them individually or in a group setting, offering health education to them, linking them to health resources in their communities or in the program’s partnering health centers, and collaborating with DYS to learn when and how they successfully involve parents/families, and connecting with parents/families at the same time or in a similar way.

Providing Youth with Tools to Manage their Health Care

Negotiating with CRC staff to implement program components within the CRC structure and schedule is perhaps better left to the program director than MHPP advocates. If formal health education groups are a desired component of MHPP programming, this is one area in which to gain cooperation of CRC staff in allowing for better integration of MHPP into
Advocates felt that an important area of health education to address with youth was the long-term affects of current health behaviors. This is an area that calls for supervisory support for the health advocates; both the medical supervisor and the program supervisor could work with the advocates to identify research on youth health care attitudes and practices that could inform techniques for addressing resistance some youth have to attending to their health care.

Health and health care knowledge should be assessed on a case-by-case basis with youth. Education efforts should be targeted to youth’s requests for information and/or respond to gaps in youth’s knowledge. Health care education that helps youth manage their health care independently for the long term should be prioritized.
EXPLORING THE MASSACHUSETTS HEALTH PASSPORT PROJECT AS A GENDER-RESPONSIVE PROGRAM

While none of the objectives of the Massachusetts Health Passport Project (MHPP) explicitly mentions gender, according to program director Sherman, MHPP attempts to approach its objectives (improving access to health care, changing relevant systems, improving youth’s social supports, and improving health status) in a “gender-responsive” way (Personal Interview). The program was originally established as the Girls Health Passport Project (GHPP), and served Massachusetts Department of Youth Services (DYS)-committed girls in one DYS-designated region of the state. Approximately one year ago, in its fourth year, MHPP formally expanded to include a boys’ component. Currently the program serves a segment of girls and boys committed to the DYS in two regions of the state. The MHPP refers to both the girls’ and the boys’ components.

Because GHPP and MHPP intend to deliver gender-responsive services, an increasingly popular approach in juvenile justice programs nationally, this substudy sought to shed light on the concept of gender-responsive services, and on how MHPP enacted this approach. That is, what would gender-responsive programming look like in practice? How do MHPP staff and agency partners understand this term and its relevance to MHPP services? And, to what extent, and in what ways, does MHPP deliver this goal of the program? MHPP can serve as a useful model of a program for juvenile justice system-involved youth which has gender-responsiveness as a goal. From the forthcoming examination of MHPP as a gender-specific or responsive program, lessons may emerge which can inform other programs for youth in this population.

Methodology

The design of this substudy was qualitative. A semi-structured interview was created, partially informed by an analysis of qualitative interviews previously conducted for the MHPP evaluation, and partially by the MHPP director’s interest in delivering the program in a gender-responsive way. The interview was conducted with six individuals, including the MHPP director, the MHPP health advocates, and two individuals (referred to as program partners) who are familiar with the MHPP because they work with MHPP youth participants in other capacities related to the program. Two interviews were conducted with each of the three MHPP health advocates, one at the beginning of the substudy, and one at the end of the project evaluation period, in order to capture any new observations or views that had formed over the course of their experiences working with youth in the program. One interview was conducted with each of the other substudy informants. A total of 10 interviews were held over a period of one year, from December 2007 through December 2008.

Interview data were analyzed using a qualitative data software package, Atlas.ti.

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software framework, segments of interview transcripts were selected and tagged with
categorical codes created for this substudy, which resulted in groups of texts from multiple
transcripts forming categories (Stewart & Shamdasani, 1990). The unit of analysis associated
with this procedure is a thematic unit (Ryan & Bernard, 2003). The analysis of data included in
this substudy is focused on themes in the literature that relate to gender-responsive
programming for (juvenile justice) system-involved youth.

Some informants in this study wished for their input to remain anonymous. Due to the small
number of informants, it was necessary to maintain anonymity of almost all study informants in
order to respect their wishes. However, the opinions of two informants, who did not request
anonymity, are associated with them by name.

Overview of the Report

This substudy report first summarizes the arguments of researchers related to the need for
gender-responsive programming in the juvenile justice system. It then reviews extant literature
on gender and the juvenile justice system, including what is known about the characteristics of
girls who are involved in the system. Literature on definitions, recommendations, and
guidelines for “gender-responsive” or “gender-specific” programming are then reviewed,
setting the stage for a more focused look at MHPP as a gender-responsive or gender-specific
program. Next, an assessment of MHPP according to gender-responsive program criteria is
provided, along with recommendations for how the program can better achieve gender-
responsive program outcomes.

Gender and the Juvenile Justice System

Several decades ago, to conjure up a picture in one’s mind of a juvenile offender was invariably
to imagine a boy. Today, while boys still outnumber girls in the juvenile justice population, girls
comprise a more sizeable proportion of the population than was true 25 years ago (Cauffman,
Lexcen, Goldweber, Shulman, & Grisso, 2007), and the gap in arrest rates between boys and
girls is narrowing (Cauffman, 2008). Girls represent the most rapidly growing segment of the
juvenile offender population, surpassing boys’ rates of delinquent involvement (Hubbard &
Pratt, 2002; Ravoir, 2005; Bloom & Covington, 2001). In 2006, arrests of girls accounted for 29%
of juvenile arrests nationally (Synder, 2008), and girls made up 14% of committed youth in 2006
(http://ojdnp.ojirs.org/ojstatbb/cjr/p/as/Offense_Committed.asp). In 2005, girls comprised 22%
of detained youth (Sickmund, Sladky, & Kang, 2008). In Massachusetts, girls comprised 15% of
total committed caseloads in DYS in 2008 (Massachusetts Department of Health and Human
Services, 2008).

While there has been an increase in rates of certain types of offenses, including violent offenses,
among girls over the last several decades (Cauffman et al., 2007), research indicates that girls
have not become more violent (Zahn, Hawkins, Chiancone, & Whitworth, 2008). Rather,
researchers largely agree that the increase in girls’ presence in the juvenile justice system is the
result of systemic changes rather than changes in girls themselves; in other words, girls are being arrested for behaviors that girls have always exhibited, but that were not previously treated as criminal. Girls’ arrests seem to be distinct from boys’ arrests, on the whole (Sherman, 2005), and that difference might well account for the increase. When compared with their male counterparts, female juvenile offenders are disproportionately arrested for status offenses, a class of offenses that does not exist in adult criminal law (Goodkind et al., 2006; Chesney-Lind & Okamoto, 2001; OJJDP, 1998a). These violations are considered to be less dangerous to society (OJJDP, 1998b; Cooney, Small, & O’Connor, 2008), and include running away from home, curfew violations, underage drinking, truancy, and prostitution (Sherman, 2005; Goodkind et al., 2006; Acoca, 1999; Cauffman, 2008). More delinquent girls than boys also experience repeated detainment for minor offenses and technical violations (Sherman, 2005). On the other hand, boys are more likely than girls to be arrested, charged, found guilty, and be placed in residential treatment in the juvenile justice system (Cauffman, 2008).

Researchers offer various interpretations to explain the increase in girls’ involvement with the juvenile justice system which began in the 1980s, including that policies defining criminal activity have been expanded, or enforcement has become more stringent for certain categories of delinquent behavior (Cauffman, 2008; Chesney-Lind & Okamoto, 2001; Sherman, 2005; Goodkind, 2005); that there has been a change in attitudes toward and policies for dealing with girls’ behaviors (Zahn et al., 2008; Hubbard & Matthews, 2008; Goodkind, 2005); that there are inequitable criteria for arrest and incarceration rooted in gender bias (Hoyt & Scherer, 1998; Chesney-Lind & Okamoto, 2001; Goodkind et al., 2006; Sherman, 2005); and that detention is viewed and used as a mechanism to protect girls or to provide them with needed services that they are not receiving in their communities (Zahn et al., 2008; Sherman, 2005; Goodkind, 2005).

Rationale for Gender-responsive Programming in the Juvenile Justice System

Regardless of the causes for the increase in girls’ presence in the juvenile justice system, the current reality warrants that consideration be given to addressing circumstances of system-involved girls which may be unique from those of system-involved boys. As a result of the historical predominance of male juvenile offenders, however, juvenile justice policies, treatment approaches, and facilities were designed with boys in mind (Cauffman, 2008; Cooney et al., 2008; Goodkind, Ng, & Sarri, 2006; Ravoira, 2005; Bloom & Covington, 2001; Sherman, 2005; Bloom et al., 2002b; Levick & Sherman, 2003; Zahn et al., 2008; Morgan & Patton, 2002), and remain more appropriate for boys than for girls. This means that in large part, girls have been detained and treated in facilities that were intended to serve boys, which, as Levick and Sherman (2003) argue, may amount to the discriminatory denial of girls’ rights to individualized treatment in the juvenile justice system. In addition, the majority of research on the factors leading to youth offending has, until relatively recently, been based on boys (Hoyt & Scherer, 1998; Hubbard & Pratt, 2002). Research based on male juvenile offenders may lead to misguided policies and programs for female juvenile offenders (Hubbard & Pratt, 2002; Sherman, 2005; Ravoira, 2005), or the population as a whole.
As Hoyt and Scherer (1998) point out, and others (Hubbard & Matthews, 2008) echo, “female delinquents are both similar to male delinquents and different than male delinquents” (p. 102). Thus, while some policies, practices, and programs developed for, and used with, male delinquents may also be effective with female delinquents, others will not be, and vice versa (Hoyt & Scherer, 1998; Bloom & Covington, 2001). Attending to the needs of system-involved girls, as well as boys, is consistent with certain justice system ideology, which has parity as a central tenet. As Bloom, Owen, and Covington (2003) argue, “…this does not necessarily mean that the exact same treatment is appropriate for both women and men” (p. 76). In fact, policies and programs designed for boys may not only be inappropriate for girls, but they may violate federal and state legal requirements for individualized treatment in juvenile justice services that acknowledge needs and contextual factors related to one’s gender (Levick & Sherman, 2003; Sherman, 2005). Instead, services that can be considered gender equitable are those which are meaningful to youth in ways that relate to their gender (Morgan & Patton, 2002; Bloom & Covington, 1998).

Federal policy regarding female offenders charges the states with the responsibility to address shortcomings and bias in juvenile justice policies, services, and treatment relating to girls. This charge was made through federal legislation in the 1992 reauthorization of the Juvenile Justice and Delinquency Prevention (JJDP) Act of 1974 (Bloom, Owen, Deschenes, & Rosenbarum, 2002b; Sherman, 2005). Specifically, the Act called for states to conduct

an analysis of gender-specific services for the prevention and treatment of juvenile delinquency, including the types of such services available and the need for such services for females, and a plan for providing needed gender-specific services for the prevention and treatment of juvenile delinquency. (Juvenile Justice and Delinquency Prevention Act, as cited in OJJDP, 1998a, p. 26)

Federal grant dollars were allocated under “Challenge E” to allow states to pursue these ends by engaging in a number of activities, among them “to ensure that female youth have access to the full range of health and mental health services, treatment for physical or sexual assault and abuse, self-defense instruction, education in parenting, education in general, and other training and vocational services” (Juvenile Justice and Delinquency Prevention Act, as cited in OJJDP, 1998a, p. 22).

Despite increasing attention to the growing number of females in the juvenile justice population and recent efforts made in understanding and meeting their particular needs, there are many obstacles to achieving a juvenile justice system that is responsive to girls. Namely, there are still few girl-targeted programs within juvenile justice programs nationwide (Zahn et al., 2008), and correspondingly, scant research exists on qualities of effective female-specific interventions (Bloom & Covington, 2001). Acoca (1999), who has extensively studied the health and educational needs of girls and women in the California justice system, argues that guidelines for a “comprehensive continuum of gender-responsive prevention, intervention, and graduated
sanctions services” for working with delinquent girls and those at risk of becoming system involved are acutely needed (p. 4).

**System-involved Girls: Characteristics and Predictors of System Involvement**

In order for programs and services targeting delinquent girls to be effective, they must consider empirically evident developmental needs, circumstances that bring girls into contact or at risk of being in contact with the juvenile justice system, and how these needs and circumstances influence girls once they are in the system (OJJDP, 1998b; Acoca, 1999; Cauffman, 2008; Sherman, 2005; Bloom & Covington, 2001). Research reveals that there are significant differences in variables that are associated with female and male youth offending. In a meta-analysis of research on the predictors of female delinquency, Hubbard and Pratt (2002) identified commonalities in the social and personal histories of girls who are incarcerated or identified as “delinquent” that distinguish them from their non-delinquent female peers. Some characteristics also distinguish these girls from delinquent boys: In addition to risk factors commonly found in studies of male delinquency, including a prior history of antisocial behavior, affiliation with antisocial peers, and antisocial personality, other factors were found to be prevalent predictors of female delinquency. Some of these are a history of physical or sexual abuse, poor school relationships, and difficult family relationships (Hubbard & Pratt, 2002). Research also suggests that the same risk factors may manifest different degrees of risk for girls or boys, or may affect girls and boys in qualitatively different ways. Understanding the unique needs of system-involved girls is important for creating effective interventions (Cauffman, 2008) and appropriate solutions to existing gaps in or biases in services.

In *Gender Matters*, Mead (2001) outlines principles to guide program design and development based on social realities related to gender. Two of these principles, *disproportionate impact of specific public problems, and differential impact*, highlight a potential disparity in the degree or extent to which girls and women are affected by particular social circumstances or problems, or in the way they are impacted by a problem (Mead, 2001). The following review of literature on delinquent female youth demonstrates these principles and supports a defense of gender-specific responses in the form of programs and services. In particular, delinquent girls will be seen to be disproportionately affected by *family discord, victimization, and mental health and substance abuse problems*. In some cases, mental health problems, substance abuse, and *risky sexual behaviors*, are also evidence of the differential impact of family discord and victimization on girls.

**Family Discord**

Literature suggests that while there is a tendency for family distress to be present in the lives of both female and male delinquent youth, female delinquent youth are more likely to come from family environments characterized by strife (Lederman et al., 2004; Timmons-Mitchell et al., 1997). Tension in parent-child relationships that sometimes becomes violent often results in girls being arrested for status offenses (Chesney-Lind & Okamoto, 2001; Acoca, 1999). Family-based
risk factors may also include lack of communication (Bloom et al., 2002b), experiencing the death of a parent or sibling, and lack of stability leading to foster care or other arrangements (Acoca, 1999). One study also identified family strengths, such as good communication and structure, as a major protective factor (Bloom et al., 2002b).

**Victimization**

While there has been a good deal of variance in empirical findings of the proportion of delinquent and system-involved girls who have suffered sexual abuse and resulting trauma, the evidence is unequivocal that a history of abuse and post-traumatic stress disorder (PTSD) affects a significant number of girls in this population (Lederman et al., 2004; Chesney-Lind & Okamoto, 2001), and is often a catalyst for their interactions with the criminal justice system (Acoca, 1999; Chesney-Lind & Okamoto, 2001). One possibly important distinction in past traumatic events among young offenders is that males are more likely to have witnessed violence, and females are more likely to have been the targets of violence (Cauffman, 2008). Zahn and colleagues (2008) contend that while girls are more likely to have experienced sexual assault, rape or sexual harassment, suffering neglect, physical or sexual abuse is a risk factor for delinquency for both boys and girls (Zahn et al., 2008). Some argue, though, that a history of abuse during childhood or adolescence is a more powerful predictor of delinquent behavior for females (Cauffman, 2008). Abuse histories in girls may be linked to mental health disorders such as depression and anxiety disorders (Bloom et al., 2003; Sherman, 2005; Goodkind et al., 2006), or may manifest in girls as externalizing disorders such as aggressive behavior (Sherman, 2005). Abusive experiences in the past may also affect girls’ emotional adjustment and their ability to trust others, and may be a factor in substance abuse (Bloom et al., 2002b).

Victimization and trauma is also a major catalyst leading girls to run away from home, which, as discussed previously, is a frequent cause of arrest for female delinquents (Chesney-Lind & Okamoto, 2001; Bloom & Covington, 2001), leading some to claim that the system is punishing girls for being victims of abuse (Goodkind et al., 2006).

**Mental Health and Substance Abuse Problems**

Multiple studies conclude that mental health and substance abuse problems are central issues in the lives of a large segment of the female delinquent population, and that a significantly larger proportion of delinquent females than males is affected by mental health disorders. Mirroring the general population, females involved in the juvenile justice system are more likely than their male counterparts to be affected by psychological illness (Zahn et al., 2008; Timmons-Mitchell et al., 1997; Cauffman et al., 2007; Sherman, 2005; Alemagno et al., 2006), and this disproportion is significantly more exacerbated in the juvenile offending population (Cauffman et al., 2007). Girls are especially affected by internalizing disorders such as depression and particular anxiety disorders (Zahn et al., 2008; Lederman et al., 2004; Corneau & Lanctot, 2004). Unlike trends in the nondelinquent population, female offenders also outnumber male offenders in rates of externalizing disorders (Cauffman, 2008). A high incidence of comorbidity of mental health disorders has been found in several studies. Depression, anxiety disorders, attention deficit
hyperactivity disorder, oppositional defiant disorder, and conduct disorder among them were found in Lederman and colleagues’ (2004) study of girls in short-term detention. Timmons-Mitchell and colleagues (1997) found that while girls in their study demonstrated higher scores than boys on a number of mental health measures, such as suicidal tendency, substance abuse proneness, impulsive propensity, body disapproval, and eating dysfunctions, among others, boys scored higher on measures for anxious feelings, conforming, introversion, and submission. Kataoka and colleagues (2001) found that depression and anxiety coexisted with one another, and with substance use problems, in a large proportion of the incarcerated girls in their study sample. Among girls at risk for system-involvement surveyed by Guthrie and colleagues (2002), 68% reported having used marijuana, 15% having used crack, and 11% having used heroin during their lives.

**Risky Sexual Behavior**

Girls in this population often engage in risky sexual behavior that may be explained in part by high rates of sexual abuse histories (Goodkind et al., 2006; Bloom et al., 2002b; Kelly, Owen, Peralez-Dieckmann, & Martinez, 2007). Girls’ first and subsequent sexual interactions are often with a male partner older than themselves (Lederman et al., 2004; Guthrie, Hoey, Ravoir, & Kintner, 2002; Acoca & Dedel, 1998). Sexual debut may also occur at young ages among system-involved girls; in one study involving girls ages 12-18 who were at risk for recidivism, the mean age for first sexual intercourse was 13.9 years (Guthrie et al., 2002). Evidence on safe sex practices and rates of sexually transmitted diseases (STDs) is inconclusive, yet these issues are undoubtedly a major concern among youth in this population (Lederman et al., 2004). Fifty-one percent of respondents in Guthrie and colleagues’ (2002) study reported using some form of birth control during their first intercourse, and 38% of respondents reported having had one or more type of STD. In Acoca and Dedel’s (1998) study of system-involved girls in California, reports of multiple sexual partners and inconsistent condom use were high, and half of girls reported having been under the influence of alcohol or drugs during intercourse. Due to these behaviors, Acoca and Dedel (1998) concluded that risk for pregnancies and STDs is elevated. Further research is needed to clarify trends in this area; however, because of the reliance on self-report, accurate results may be difficult to obtain.

**Linkages between variables related to delinquency**

As can be inferred from the literature on predictors and correlates of delinquency in girls, risk factors and difficult life circumstances are often interrelated (Ravoira, 2005). Research also suggests that these variables can continue to influence one another throughout the lifespan. There are developmental risks associated with delinquent and antisocial behavior in adolescence: Girls who engage in chronically problematic behavior may be more likely to abuse alcohol and drugs, and to experience mental illness in adulthood. Research also points to a tendency for abuse in interpersonal relationships; as adults, former delinquent girls sometimes either continue to be victimized or become perpetrators themselves (Cauffman, 2008). Given research suggesting long-term consequences of delinquent behavior, programs should be
developed with an eye toward addressing both predictors and current circumstances of
delinquency for girls, as well as the prevention of future consequences of adolescent
delinquency. Programs should aim to address both probable causes and consequences of female
adolescent delinquency.

Race and class

Another key factor that must not be overlooked in understanding the needs of delinquent girls
is the role of race and class in their system involvement. Incarcerated girls, and their adult
counterparts, are disproportionately people of color, namely African American and Hispanic
(Bloom & Covington, 2001; Acoca, 1999; Chesney-Lind & Okamoto, 2001). They also frequently
come from high-poverty backgrounds and communities (Bloom & Covington, 2001). These
trends, too, must be considered in terms of how they affect girls’ pathways into the juvenile
justice system, how they differentiate individual delinquent girls from one another, and how
these personal characteristics are interconnected with other variables that we know to affect a
great proportion of this population.

Findings of Particular Relevance to the Present Substudy Report

As illuminated in this review of risk factors common among delinquent girls or those at risk for
delinquency, a number of trends associated with delinquency are health-related, including
mental health problems, substance abuse, and sexual risk behaviors, thus underscoring the need
for system-involved girls to receive appropriate health services. In the present substudy, sexual
health—which encompasses risky sexual behaviors; safe-sex education; access to and
appropriate choice of contraceptives; sexually transmitted infection (STI) awareness,
prevention, and treatment; and pregnancy prevention and counseling—was considered by all
informants to be a primary health concern for both the girls and boys with whom they work,
and correspondingly was a major area of focus in MHPP program delivery. In contrast, most
likely because MHPP focused on youth’s physical health needs, mental health problems,
including those related to sexual abuse and trauma histories, and substance abuse were not
given significant attention by substudy informants when talking about the health needs of this
population, or of program participants in particular.

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While the research reviewed thus far certainly points to the promise of gender-responsive or
gender-specific programs and services for adequately meeting delinquent girls’ particular needs
and characteristics, there are few models of such programs (Sherman, 2005; Zahn et al., 2008;
Cauffman, 2008), and correspondingly, there is a dearth of empirical research to guide effective
interventions for girls in this population (Cooney et al., 2008; Bloom & Covington, 2001; Zahn et
al., 2008; Bloom, Owen, Deschenes, & Rosenbarum, 2002a). The following sections will present a
review of definitions and guidelines for programs and services for girls that take gender into
account, which can be used to facilitate program development and empirical investigations to
address the current deficiency. This discussion will incorporate recommendations and findings from research specific to the juvenile justice population, as well as literature focusing on nondelinquent female populations.

**Gender-specific and Gender-responsive: Defining the Concepts**

During the interviews for this substudy, informants were asked how they define the concepts *gender responsive* or *gender specific* as they pertain to programming and services; the informants were also asked whether they see the terms as distinct or interchangeable. Half of the informants were not familiar with the literature on these concepts, and were offering interpretations of the terms based on their own assumptions, beliefs, and experiences. Definitions offered by researchers, service providers, and program practitioners often feature shared definitional components and program principles. This section reviews the common themes that emerged from both the literature and the data collected for this substudy, as they pertain to programs serving system-involved girls.

The terms *gender responsive* and *gender specific* are often used interchangeably in the literature. Several informants in this substudy, however, felt that there was a distinction between the terms, though how they understood the distinction varied quite a bit. One informant said, “I don’t know, I think of *gender specific* as [being]…focused on…a set of beliefs about differences about gender, and *gender responsive* being more that you are reacting to something that has become evident of a gender issue” (Personal Interview). To this informant, then, gender-specific approaches would be fixed in predetermined ideas about gender-related needs, while gender-responsive approaches would allow for the discovery of a gender-related need or issue based on observations and experiences with the population.

Similarly, another informant seemed to view *gender specific* as being more limited in its potential to effectively serve youth, and favored *gender responsive*, which she thought to be associated with a philosophical view about how to work with youth: “I would say *gender specific* is all boys or all girls. And *gender responsive* is paying attention to gender as a whole and how it effects every aspect of your being and…providing services that match that” (Personal Interview). Dr. Ralph Vetters, a physician who provides services to a small segment of MHPP participants, felt that within the medical setting, gender-specific services would mean dealing with the clinical issues specific to each individual based on their biological sex, such as performing routine pap smears on female patients, but only performing rectal pap smears on male patients if they are HIV positive. In contrast, within the same setting, he felt that *gender responsive* pertained to creating a medical home and an environment that responds to the “presenting gender” of each patient (Personal Interview). While they were not necessarily in agreement about the exact nature of the distinction, each informant seemed to feel that gender-specific approaches were more automatic, while gender-responsive approaches involved being attentive to the particular needs of individuals in one’s current care that relate to their gender, and acting in response to those needs.
Drawing on the literature, the most basic expectation of gender-responsive or gender-specific programs and services is that they should strive to satisfy girls’ unique developmental needs, personal characteristics, and life circumstances. In the case of delinquent girls, this includes understanding girls’ pathways into the system, the multiple risk factors that research indicates are associated with girls’ system involvement, and how these factors interact with one another. Further, there must be an understanding of how these variables should shape program and service delivery, and an attempt to address some of those factors with the goals of appropriate and effective service provision, and recidivism prevention or reduction (Ravoira, 2005; Bloom et al., 2003; Bloom & Covington, 2001; OJJDP, 1998b; Sherman, 2005; Morgan & Patton, 2002; Hubbard & Matthews, 2008). Programs defined as gender responsive are not only characterized by serving a population that is all female, or by having female staff (San Francisco Commission on the Status of Women, 1999; Acoca & Dedel, 1998; Ravoira, 2005); they also recognize unique experiences associated with being a female in the juvenile justice system, and deliberately use this knowledge to inform all components of the program. Following gender-specific training, staff of such programs are knowledgeable about the unique needs of their population, and their knowledge assists them in developing an appropriate environment in which to deliver research-driven, targeted curriculum for programming and services (San Francisco Commission on the Status of Women, 1999; Bloom et al., 2003; OJJDP, 1998b; Morgan & Patton, 2002). These services are delivered with empathy for the past and current challenges faced by participants, and with an emphasis on the importance of relationships for girls (Bloom et al., 2003).

Terminology in this Substudy Report

Although the terms gender responsive and gender specific are generally used interchangeably in the literature, understanding the terms as distinct allows two equally important considerations to be taken into account when assessing programs for girls or for boys: the population targeted by the program, and how the program aims to serve the targeted population.

For the remainder of this substudy report, the term gender specific will be used in reference to programs and services that are intended to serve either girls or boys—not both—and to variables that relate specifically to girls as a group or boys as a group. Such a program can be considered gender specific because it organizes youth according to their gender, and because it is targeting a gender-specific characteristic or need. Programming that is targeted at a particular gender group generally assumes that there is a reason to do so, according to evidence that there is gender-linked variability in a particular area that the program aims to address. Gender-specific programs, however, do not necessarily exemplify gender-responsive principles.

Whether a program is gender responsive, however, is evident in elements of its design, including its objectives, leadership structure, methods for engaging participants, characteristics of the program environment, and techniques for achieving and measuring desired outcomes. A discussion of guiding principles and recommendations for gender-responsive programming culled from the literature will be discussed below.
A program can be considered gender specific, then, but fail to employ gender-responsive principles and approaches in its program design, operations and evaluation. A program can also be gender responsive without being gender specific; that is, mixed gender programs can thoughtfully incorporate gender-responsive principles in order to optimize outcomes for its female and male participants (Mead, 2001). Thus, a program that has no intention of targeting a gender-specific issue can still operate in a gender-responsive manner to most effectively serve both female and male participants. Finally, a program can be both gender specific and gender responsive; a program that serves only girls or only boys, and that incorporates principles and recommendations for gender-responsive programming would be described in this way.

**Respondents' Understanding of Gender-specific and Gender-responsive Programming**

The responses of informants in this substudy about these concepts reflect varying levels of congruence with components of definitions from the literature. Three overarching, interrelated themes characterized informants’ perceptions of gender-specific or gender-responsive programming and services: individualized assessment and treatment of all youth based on their needs, understanding contextual factors affecting youth's lives, and awareness of unique group-level needs associated with a youth’s gender. These themes are also reflected in informants’ perceptions of the needs of the youth targeted by MHPP, and the approaches and techniques used by those shaping and providing services to MHPP-involved youth, as well as program partners.

Sherman defined gender-responsive programming as that which is “…intentionally tailored to the needs, strengths and situation of the boys or girls who are in the program” (Personal Interview). This definition encompasses all three themes that have emerged in the data from this substudy. The “needs” of the participants refer to those group-level variables that are related to gender. Sherman believes that a gender-responsive program reflects an understanding of the ways a person’s gender may shape her experiences, in this case, particularly those leading up to and influencing her involvement in the juvenile justice system. Gender-responsive programming would provide services that take into account and attempt to address the effects of these experiences on individuals. Sherman’s inclusion of “strengths” in this definition alludes to the juvenile justice system’s national legislative commitment to individualized treatment of youth (Levick & Sherman, 2003); that is, to consider the unique aspects of each youth’s case would allow for recognition of individual strengths, and those strengths could guide treatment decisions.

While Sherman feels that it is important to acknowledge trends among same-gender youth in the system, such as pathways into the system, background experiences, and system impacts, she cautions, “That only works to a point… Not all girls are the same, not all boys are the same” (Personal Interview). And, of course, strengths are also an individual-level variable. So according to this principle, a gender-responsive program must identify and respond to the individual needs and strengths of its youth. However, in focusing on the individual, these programs should not overlook or fail to understand the systemic factors that have contributed
to her involvement (Goodkind, 2005; Hubbard & Matthews, 2008). Finally, gender-responsive program designs, Sherman notes, should also consider the circumstances, or contextual factors, that surround program participants and affect their lives. One example of context that is at the core of MHPP’s goals is that of continuity of health care. Sherman notes, “...the impact of the juvenile justice system on girls in particular is to disrupt continuity of services, so I consider it a gender-responsive element to repair the lack of continuity in the system by making a continuous thread in health care.” According to Sherman, in order for a program such as MHPP to be gender responsive, “...it needs to be related to other parts of the system and the way that system functions with girls or boys” (Personal Interview). In other words, an individual’s health is not isolated from other aspects of her life; it is intricately connected to and affected by them.

Support for each of these arguments, that gender-responsive programming should account for individual characteristics, contextual factors, and group-level gender-related needs, can be found in the literature, as well as in the responses of substudy informants, detailed below.

**Individual characteristics.** There is a significant body of literature outlining risk factors and needs unique to, or more prevalent among, delinquent girls, many stemming from contextually-based risks. Perhaps due to the historical emphasis on boys in juvenile justice research and treatment, more current research has tended to emphasize these group-level variables in order to make a case for girl-targeted policies and services. However, in addition to Levick and Sherman’s (2003) legally grounded argument for individualized treatment, other researchers and practitioners have urged that individual-level variables should not be overlooked in the provision of gender-responsive services. Cauffman (2008) makes an argument for the importance of individualized services as follows: “It is...becoming clear that female offenders are not a homogenous group and that treatment approaches ultimately should be tailored to suit individual needs defined more specifically than by gender alone” (p. 134). Cauffman is not disputing the promise of gender-targeted services; rather, she is making the case that the two are not mutually exclusive, but that recognizing and serving the needs of the individual should be a guiding principle, and a key component, of gender-responsive approaches. Knowledge of common patterns among female offenders should not interfere with service providers’ ability to meet the individual’s unique needs. Zahn and colleagues (2008) agree, stating that, “the focus should be on the individual youth and her specific needs and strengths” (p. 7).

When health is the focus of the program, an emphasis on individualized care seems particularly fitting. Vetter explained one way that this is relevant in the health care setting:

*Part of it is to be incredibly flexible and open to the whole concept of gender...we see a large transgender population of youth and young adults. So we have to be willing to be extremely fluid in our understanding of what gender means. And so a large part of my sexual history exam now includes asking people if they're interested in sex with female-bodied persons or male-bodied persons instead of saying boys or girls or men or women...I think it's that fluidity of approach that is a large part of having gender-appropriate health care...and being ready to change and
redefine and accept new definitions from the patient at any one particular time. (Personal Interview)

Vetters’s statement is an important cautionary note about making assumptions regarding the health needs of an individual, which, as he illustrates, can have the effect of inappropriately assessing a client’s health-related needs, and consequently failing to offer appropriate treatment. It underscores the importance of assessing individual needs, rather than allowing assumptions about gender-specific needs to be the sole guide of assessment and treatment practices.

Offering another perspective on the way that gender is relevant in the domain of health care, one of the MHPP health advocates interviewed for this substudy explained,

…in each relationship with a patient there [are] influences and constraints and things that kind of define the relationship and so gender is one of those things. So, I mean it’s part of the equation, I think it is important to understand how their gender effects their approach to their own health care system and helping to facilitate improvement in their willingness to adopt good health behaviors. (Personal Interview)

This opinion reinforces the idea of gender as an individual-level variable, as proposed above by Vetters. In this case, considering the component of gender in the “equation” of a program participant affects the provider-client relationship, and the methods that might be used by the provider in helping to facilitate better health in, and health care utilization by, her client.

A nurse who served as an MHPP health advocate approached program participants through the lens of nursing, which, as she explained it, includes “the overarching paradigms of…person, environment, health, and nursing, and how all those interact.” She went on to explain that within this philosophy, the primary value of knowing the contextual variables particular to a client is in understanding how these variables affect the individual’s health needs, beliefs about and experiences with health care access, and perceptions of health problems (Personal Interview). Related to this is the idea of expressing interest in, and care for, the “whole” girl or boy. She articulated this point as follows:

…the nursing philosophy is really to look at the person as a whole, and to assess their needs. And so that doesn’t, that’s not based on gender, that’s based on any individual, you look at them and you assess their needs. A lot of the men will have different issues than different men, and you are going to respond to them because those are their needs. So it’s not necessarily a gender-based thing; it’s an individualized care plan for everyone. (Personal Interview)

Another MHPP health advocate expressed the concept of the “whole person” in a different way:

I mean in my interactions I think it’s providing a sense that I’ve invested in that individual, that girl, not just as a health care patient, but as an individual with all kinds of needs and concerns
that go beyond whether she feels sick or not that day. But, you know, how she is doing with her friends. Even just respecting differences, you know, how she is different, and taking notice of little things too… the fact that they’ve changed their hair or whatever it is, I mean it’s just they seem to want a relationship that, I wouldn’t say is casual, but is more, it’s more that there is interest in the whole person. (Personal Interview)

This informant introduces another dimension of individualized treatment, which is not only to look at the unique health- and health care-related needs of an individual, but to learn about other, more personal aspects of that individual’s life which may not immediately seem related to health care. She believes that these individual-level variables affect client behaviors and the provider-client relationship, and other substudy informants expressed this belief as well, particularly in regard to girls.

Contextual factors. Many of the above quotes regarding the importance of individual-level variables suggest the role of contextual variables in shaping the individual. Morgan and Patton (2002) integrate the two into what they consider to be a holistic, or whole girl approach, which they feel is an important criterion for gender-responsive programs. They define it as such:

One of the ways to describe the whole girl within her social context is to picture the individual girl in the center of concentric circles. These circles represent relationships, systems, and society. A holistic approach to a girl’s life experiences takes into account each context or circle in which a girl lives… (p. 61)

Contextual factors discussed by substudy informants that are believed to be relevant to an individualized approach to a client include gender identity and sexual orientation; family, peer, and community relationships; and health care history.

The examples above reveal the difficulty of teasing apart “individualized treatment” and “context” in an analysis of the principles of gender-responsive services. The distinction is often in the emphasis individuals place on one or the other in their ideas and practice. The two concepts are very much interconnected; a critical avenue to understanding the needs of the individual as a whole person is to learn about and understand the influence of contextual factors on their individual behaviors and needs. All informants in this substudy mentioned the importance of contextual factors in the lives of the system-involved youth with whom they work. Contextual factors are believed by participants to influence a youth’s approach to health care, skills and resources available to the youth for managing her health care, the specific health problems faced by the youth with whom they work, and their ability as providers to effectively meet the health care needs of their clients.

As has already been seen, contextual factors that affect MHPP participants are not limited to those directly related to their gender. With regard to MHPP, some of the prevailing contextual variables believed to be linked with risk factors being targeted by the program have to do with
the youth’s involvement in the juvenile justice system. One MHPP health advocate noted,

…I think when we break it down and you take away gender, it’s youth who had no or very limited access to health care and had very limited knowledge about receiving health care…or getting a primary care doctor or making appointments…they just have very little experience or practice around it. (Personal Interview)

This informant tended to focus her attention on these factors in her work with the youth, believing them to be more central to her role in providing her clients with the skills needed to manage their own health care than gender-related variables. Another health advocate’s sentiments similarly highlight the limited health care utilization experience of both girls and boys in this population. She noted that her female clients in the program are unfamiliar with terminology such as “primary care physician,” or even OB/GYN or gynecologist, which she believed was an important element of both health care access and utilization (Personal Interview). Related to this point, one of these health advocates also felt that current challenges in the contextual realm of these girls’ lives, such as family, peer, and community variables, were often the most salient to them, thereby sidelining health as a priority (Personal Interview).

Group-level gender-related needs. As Sherman (Personal Interview, 2005) has pointed out, however, system involvement differentially affects girls and boys, and as has been discussed, contextual factors leading to system involvement also tend to differ by gender. Referring to contextual factors that are more likely to be present in the youth being targeted by MHPP, Vettet felt that particularly within the male juvenile justice population, youth may have fewer social supports and a “thinner” network of individuals and organizations compared with nondelinquent boys, leading to less health care utilization in the past:

 Whereas outside of juvenile justice, just looking at the demographics and things, they tend to have a little more substantial social support network, they tend to be more likely to be active in school and better in school and therefore have requirements for vaccinations checked, and school physicals checked, and those sorts of things. So those network tends to kick the boys back into health care more frequently then the people in juvenile justice…(Personal Interview)

Several of the informants expressed the belief that because girls have a menstrual cycle, they are more likely to be tuned into their bodies, and to have had experiences with health care providers, such as for gynecological exams. Some also felt that girls were more likely than boys

to be encouraged by family members and others to pay attention to their health and to visit
health care providers for check-ups. Boys, they felt, are less likely to have regular health-related
needs, and to be encouraged by others to attend to their health, thus having fewer experiences,
and less familiarity, with the health care system overall (Personal Interviews). Vetters’s quote
suggests that this is a particular challenge among delinquent boys.

Other issues raised by informants as context-related were specific to gender. In the context of
health care provision, community characteristics and social variables related to gender, race,
and class contribute to health-related risk factors, problems, and resources. Vetters’s example,
below, persuasively illustrates this:

…the girls certainly want a provider who knows what they’re up against, who knows about the
sexual risks and the pressure that’s out there. They want someone who knows what it’s like for
them as girls in those neighborhoods and the pressure to have sex…I think the boys would really
appreciate it if we understood clearly what threats they are up against from day to day. They’re at
risk of getting shot, they’re at risk of getting beat up, they’re at risk of getting pulled back into
gang activity and drug selling, that it’s hard to find a job. I think they do want us to know that…
That does guide our history taking and that does help us figure out what are the resources that
might be available to steer to them. (Personal Interview)

Thus, while there are some similarities in the contextual factors that affect the health of both
girls and boys in the juvenile justice population, there are others that appear to have
disproportionate impact on one group or the other, or affect girls or boys in different ways. One
example of this is violence, which is a risk factor affecting many boys and girls who are system-
involved. However, different types of violence are more likely to affect youth depending on
their gender. Vetters explained, “With the boys we have an increasing concern for gang violence
and exposure to street violence. For the girls it’s more an interest and a concern for violence in
relationships, violence in family” (Personal Interview).

The prevalence of STIs in this population was cited by all substudy informants as being among
the most pressing health concerns for both girls and boys in the system, and was believed to be
particularly concerning in light of other health care trends, such as lack of preventive care, and
lack of education about safe sex and the consequences of unsafe sex. However, here too, there
are special considerations related to gender. One of the MHPP health advocates noted that
while gonorrhea and chlamydia were present in higher rates of system-involved girls than
system-involved boys, this may relate to gender differences in the health care utilization
patterns noted above. If girls are getting annual gynecological exams, it may not be that the risk
and prevalence of these STIs is higher among system-involved girls, but that boys are getting
tested, and therefore diagnosed, less frequently.

Complicating matters, two of the health advocates pointed out that many STIs are
asymptomatic, therefore exacerbating concerns about boys’ lower utilization patterns among
several interview informants (Personal Interviews). In addition, Vetters pointed out that there
are misconceptions held by boys about STI testing techniques, such as that screening procedures are necessarily invasive. These misunderstandings, he believes, increase the boys’ resistance to getting needed health care and put them at increased risk. He suggested that education is essential to dissolving those myths, and that MHPP health advocates can be conduits of that information in order to alleviate unnecessary fears (Personal Interview). For girls, in addition to STI prevention, testing, and treatment, birth control choices and usage, and pregnancy, including prevention, options, and prenatal care, are dominant concerns. These are topics that MHPP health advocates report frequently addressing with their female clients through education, counseling, and referrals to female program participants or the girlfriends of male program participants (Personal Interviews).

In terms of the provision of health care, informants noted both shared and unique needs among boys and girls. Vettors observed that in the clinical setting, girls and boys seem to be seeking the same fundamental qualities in a health care environment and provider:

> They’re both looking for respect, for someone who listens and talks with them rather than tells them stuff, for someone who is able to maintain confidentiality that they feel is not going to go tell their nurse, or the MHPP person is not going to tell DYS or probation or their parents…They want a place that looks clean, looks professional, that looks like they’re getting the same quality of health care as anybody else. So those are the things that both boys and girls want. (Personal Interview)

Informants also noted some differences that they have observed related to health care utilization, comfort in discussing personal health, and relationships with health care providers. Echoing the above sentiment about boys having fewer past experiences utilizing the health care system, several informants felt that a primary focus of MHPP health advocates working with boys is increasing comfort in discussing health concerns, encouraging doctor visits, and decreasing fears related to physical examinations performed by physicians, particularly male physicians (Personal Interviews). Several of the informants felt that girls were more likely to report medical concerns, and to demonstrate willingness to seek treatment.

However, one MHPP health advocate shared a different observation based on her experiences:

> …on the first approach it seems like [boys] were more willing to tell me right up front what their health status was, who they use for health care…There was just not this initial resistance to a new person coming in and asking them these questions. They were…much more forthcoming and willing to accept someone new. (Personal Interview)

In comparison, this health advocate felt that gaining access to that type of information from the girls required much more time and relationship-building. She felt she had to earn their trust, and a reputation among their female peers as someone who could offer them something valuable.
One possible interpretation here is that boys are more forthcoming, depending on the type of information being requested; for example, telling her who their health care provider is may not be a piece of information they feel needs to be protected. In addition, considering the perceptions shared by other informants, it is possible that boys are not being entirely forthcoming about their health status, or are not aware of having health problems if they have limited experience receiving care. Girls, on the other hand, seem to be more forthcoming with some probing from a provider who has services to offer. Consider the following observation from another health advocate who specializes in sexual health and education:

> When I get referrals,...a lot of times...from the nurses that work with the boys, it could be a simple “hey this kid wants to meet with you, this kid’s got questions about this, this kid has a concern about this.” Whereas with the girls it can be like “well when I met with her she said this and this and this, and she had this incident, and this smells...,” and it’s like everything comes out... So I think that they are more open to everything going on in their body, and a lot of times when I’m talking to my girls groups, you know we talk about knowing your body and that kind of stuff, but I do a lot of that with boys now, because they don’t know their body at all. ...A lot of them really think that they do, but talking about doing, you know, testicular exams and doing things on your own is a huge thing, because a lot of them don’t know their body and don’t know what happens in their body and why it happens and signs to look for... A lot of them are less likely to go to the doctor but also less likely to pay attention to something. They see something and then it goes away and then they forget about it. It’s kind of like “oh it’s gone so I don’t have to worry about it; if I don’t see it, I don’t have anything to worry about.” (Personal Interview)

This analysis provides insight into some of the gender differences observed by substudy informants. If girls have more experiences with health care due to their menstrual cycle, openness of others to talking to girls about their health, and higher health care utilization rates than boys, then they may be more attuned to, and have more to say about, health issues they are experiencing.

There is another possible explanation for this observed pattern. One health advocate who worked with the girls expressed frustration about the limits of her role, which included not being able to provide any direct health services to her clients. As a result, she felt that the girls did not see her as providing a valuable service, and did not wish to invest the time in telling her their health problems if they would then have to repeat the information to a health care provider to whom she referred them. This health advocate indicated: “…some girls, have been very vocal; “Well you can’t prescribe meds, what can you do?” (Personal Interview). Another health advocate also observed this pattern among girls:

> I think [with] girls you have to work at it a bit more. Like they are not going to just tell you everything, lay everything on the table, like they are not going to, like I’ve had girls, so [there was a] girl who had unprotected sex the day that she came out [of detention], didn’t tell me this until I asked her whether or not she wanted a pregnancy test, so it took...knowing that she could get...
something here to kind of open that up. Otherwise she wouldn’t have told me. (Personal Interview)

One interpretation of these observations is that girls are more candid and descriptive about health information with selected individuals—those who they know will provide them with services. The hypotheses regarding girls’ and boys’ health care utilization, comfort level in discussing personal health, and their relationships with health providers, merit further investigation.

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It seems that there are sometimes conflicting perceptions, and some confusion, on the part of the health advocates about the needs of boys and girls that appear to be related to their gender. Interviewees’ observations were informed by their own experiences, as well as general ideas about the respective needs of girls and boys; less frequently did these informants make reference to literature to support their positions. In the context of a program that aims to be gender responsive, that aims to acknowledge individual and contextual factors as well as group-level needs, this poses a challenge, particularly in the area of group-level needs. Providers of services to program participants may not have all of the knowledge and tools necessary to offer effective services to youth, and in some cases assumptions may facilitate the services they provide. There is a substantial body of literature containing recommended guidelines and techniques to employ in developing and executing gender-responsive programs. Combined with the literature on correlates of delinquency in girls reviewed above, this literature contains theoretically and empirically based information that can offer guidance to program developers, and practitioners such as those interviewed for this substudy.

Gender-responsive Services: Guiding Principles and Recommendations

Boys and Gender-responsive Services

Very little, if any, literature exists on gender-responsive programs and services for boys. As Goodkind and colleagues (2005) point out, “Of course, boys have gender, too; however, this fact is often neglected in this literature and in others that deal with gender” (p. 56). As has been discussed, the juvenile justice system was shaped around the perceived needs and treatment demands of a male population; however, that does not mean that it is gender-responsive for boys. It may be shaped on stereotypes of masculinity. Thus, boys’ needs should be further evaluated, and programs should also be assessed based on whether they are meeting boys’ needs. Assessment tools should also be responsive to boys’ needs. While it should not be assumed that the inverse of girls’ needs characterize boys’ needs, it is possible that some of the needs and programming approaches discussed throughout this substudy report as pertaining to girls could be effective or useful in working with boys. More research is needed to evaluate how gender-responsive ideals and strategies can be applied to boys’ programming. The MHPP can begin this work on a micro level, and would benefit from doing so in order to ensure that it is
effectively serving boys’ health care-related needs.

Applicability of Recommendations to the Juvenile Justice Population

There are a number of overlapping recommendations for creating programs that effectively meet girls’ needs in the literature on female targeted programming in the general and the juvenile justice population. Some of these recommendations are derived from empirical studies or observations that emerged from applied work, including those made by Mead (2001); Ravoira (2005); San Francisco Commission on the Status of Women (1999); Bloom et al. (2002a); Acoca (1999); Wheeler, Oliveri, Towery, and Mead (2005); Ms. Foundation (2000); and Ms. Foundation (2001). Other recommendations highlighted here are rooted in theoretical perspectives related to female development; these include those made by Bloom and Covington (1998), Bloom and Covington (2001), Maniglia (1996), and Goodkind (2005). Still others are drawn from secondary analyses of empirical data collected by other researchers.

When comparing research on gender-responsive programming for a nondelinquent population of girls with research specifically targeted for juvenile justice involved girls, some similarities and differences can be noted. While many of the elements noted above by Sherman (2005) are encouraged in both bodies of literature, recommendations on programs and services for young female offenders are more likely to be targeted to the risk factors affecting this population. Core considerations in establishing girl-targeted programming, cited by numerous researchers in both bodies of literature, are the relative safety of the space, the ability to lead the program in a collaborative and empowering style, the inclusion of a mentoring component, and acknowledgment of diversity among girls. The virtue of gender-related data collection is raised repeatedly as well.

Core Considerations in Girl-targeted Programs

Safe Spaces

Creating safe and supportive spaces is a key dictate for girl-focused programs, but how safe space is defined varies in some respects. One dimension of safety is physical, or holding programs in places where girls do not feel that they are at risk for verbal or physical assault (Mead, 2001; Bloom & Covington, 2001; Bloom et al., 2003; Bloom & Covington, 1998; Morgan & Patton, 2002). Women and girls are subjected to various forms of male violence in private and public spaces (Mead, 2001), including unwanted sexual contact (Aleman et al., 2006). Girls who participate in coed youth programs frequently report being victims of sexual harassment within those programs (Mead, 2001). Considering the prominence of abuse victimization and trauma among system-involved girls, it is especially important that features of juvenile justice treatment programs and services do not mimic or perpetuate qualities of abusive relationships or conditions that many young female delinquents have experienced in their lives (Bloom et al., 2003; Acoca 1999; Sherman, 2005; Goodkind, 2005). Same-sex staff and supervision are one important element to consider in creating a safe environment for female offenders (Sherman, 2005), as are male staff who can model healthy female-male relationships with girls (Morgan &
Emotional and intellectual safety should also be considered; that is, within the program environment, participants should feel comfortable expressing their emotions, beliefs, goals, and fears, contributing their ideas, and exploring new points of view and areas of interest. Single-sex programs for girls are often intended to expose them to activities, experiences and roles that they do not normally have the opportunities to participate in due to normative gender-role expectations (Denner & Griffin, 2003). The San Francisco Commission on the Status of Women (1999), in its assessment of state services available to juvenile delinquents, pointed out that some program elements that are offered to boys, such as woodshop and computer skills, might be interesting and beneficial to girls as well. Gender-responsive programming should not perpetuate social conditions which limit opportunities for girls. In the words of Bloom and Covington (2001), “we must be sure that gender-based services do not become sexist services” (p. 10). Safe and nurturing program environments can allow opportunities for skill building that research indicates are consistent with girls’ interests, but that are not limited to those traditionally associated with being a girl. Female-focused programs can then encourage individual growth and development instead of being driven by stereotypes (Levick & Sherman, 2003). Environments characterized by safety on multiple levels can allow for the possibility of risk taking on the part of youth because mistakes are acceptable within the program environment. Safe spaces can also be a place for exploration of sensitive or personal issues such as those related to sexuality (Wheeler et al., 2005).

Collaboration and Shared Power

The second characteristic, collaboration and shared power, includes allowing girls to participate in the direction, design, and leadership of the program, and having their input guide its course (Wheeler, Oliveri, Towery, & Mead, 2005; Ms. Foundation, 2001; Denner & Griffin, 2003; Mead, 2001; Morgan & Patton, 2002). Bloom and Covington (2001) contend that gender-responsive programs should aim to empower their participants. Along these lines, Mead (2001) strongly recommends that programs for girls should be led by females, underscoring the benefits of girls seeing women in positions of leadership and being able to imagine themselves in such positions in the future. Correspondingly, Sherman (2005) and Goodkind (2005) argue that such programming should be strengths-, not deficits-focused. This can include the active involvement of girls in decision making about their treatment course (Sherman, 2005), so that girls act in collaboration with staff to determine appropriate services. As Ravoira (2005) contends, “When girl-responsive services are available, research and experience shows us that girls have significant strengths that can be drawn upon to overcome the multiple stressors and past trauma that create daily challenges for them” (p. 1).

The prevalence of sexual abuse history among delinquent girls has been demonstrated to lead to many potential risk factors and negative circumstances, including mental health problems and risky sexual practices, making them vulnerable to STDs and unwanted pregnancies (Goodkind et al., 2006). In addition, trauma resulting from victimization often leads girls to
have fewer or weaker coping mechanisms and protective factors at their disposal (Cauffman, 2008). Therefore, Goodkind and colleagues (2006) recommend programs to help girls not only cope with the negative effects of trauma, but to develop a sense of agency and control over their lives. Echoing one of the recommendations for single-sex programs for girls, they suggest that, “actively involving girls in program design and evaluation and in social change, and thus focusing on their positive attributes and contributions, is one constructive way to do this” (Goodkind et al., 2006, p. 472).

Mentoring and Relationships

A third key element of effective programs for girls is the presence of mentoring relationships (Ms. Foundation, 2000; Wheeler et al., 2005; Bloom & Covington, 1998). Girls have reported that older women play a central role in defining a space as safe, and they do so by building trusting and caring relationships with girls. They also act as realistic role models, or successful examples of what roles girls can aspire to, of what is possible (Wheeler et al., 2005; Morgan & Patton, 2002). In one study (Bloom et al., 2003), adult female offenders reported the belief that positive female role models could be one potential aid to prevent future engagement in criminal activity. These researchers also recommend that mentors should share racial, ethnic, and cultural characteristics of the clients they are serving (Bloom et al., 2003).

Related to the recommendation of a mentoring component, developmental research on girls has emphasized the role of relationships and care in girls’ perspectives on what is important in life and the choices they make at critical moments. Due in part to their socialization into caretaking roles, research suggests that women tend to protect their bonds with others and to choose connection over independence (see, for example, Chodorow, 1974; Gilligan, 1982; Brown & Gilligan, 1992). In their recommendations for gender-responsive programming, many refer to this research, urging that programs for girls in the juvenile justice system take into account the centrality of relationships in girls’ lives by providing opportunities for connection with adult individuals and services in the program context itself, and in girls’ communities (Bloom & Covington, 2001; San Francisco Commission on the Status of Women, 1999; Sherman, 2005; Bloom et al., 2003; Hubbard & Matthews, 2008; Morgan & Patton, 2002; Maniglia, 1996; Bloom et al., 2002a), which girls may be lacking if their family lives are chaotic or troubled (San Francisco Commission on the Status of Women, 1999; Alemagno et al., 2006).

Sherman explained that creating linkages for girls with their communities not only works against the negative impact of system involvement disrupting girls’ community relationships, but it creates good in the community that she believes discourages the system from further disrupting community connections by bringing youth back into custody (Personal Interview). Bloom and colleagues (2003) also encourage partnerships with community organizations in order to provide multi-level support to female offenders aimed at their life circumstances and challenges. Summing up the collective belief in the importance of both interpersonal and community relationships for girls, Bloom and colleagues (2002a) make the following argument:
A comprehensive approach should provide linkages and referrals to other community-based programs. These programs should be small and incorporate a staffing pattern that ensures the development of one-on-one relationships. They should be located in the communities where these girls and young women live. (p. 549)

The Role of Relationships in MHPP

According to all informants, relationship-building is an essential component in the ability of a provider to meet the health-related needs of a client. Drawing conclusions from both a general knowledge of relevant literature, as well as from their personal interactions with youth, some informants felt that this was a more important element in successful provider-client relationships with girls than it was with boys. As one substudy informant said,

There have been findings that relationships are really important, particularly with the girls and so that’s just something that when you think about gender-responsive services, that is really important to consider in the equation…these girls seems to need to really establish a relationship with a provider before they are willing to initiate care and trust that provider. (Personal Interview)

That trust, according to another health advocate, takes a very long time to develop. All informants agreed that effective relationships with youth in the domain of health would not be based solely on health care, and would move beyond the professional dimension. Echoing the above sentiment, another substudy informant observed that it was common for program participants to share things that are not directly related to health with the MHPP health advocate, and that this was an avenue for gaining access to the sharing of health-related needs: “I think how you get to their health is through all of these other issues” (Personal Interview). She elaborated on this observation by saying,

I think that part of building relationships with girls is not boxing yourself in and being available so you can make that next leap to wherever you want to get to. You...can’t just say, “Oh I’m only here to deal with your gonorrhea, I can’t talk about...” (Personal Interview)

Thus, personal-relationship building was viewed by this informant as a precursor to a health care relationship with girls. Several other informants agreed. Further illustrating the critical nature of showing an interest in the whole girl, and developing a personal relationship before establishing an active professional, provider-client relationship, one of the health advocates noted,

...often they’re not willing to talk to me about health, but then when I talk to them about how they’re doing in general, eventually they’ll come around to the health issue. And sometimes it is talking to them for a half hour about how they’re doing at home, how they’re doing with their friends, how they’re doing in school, and then maybe they’ll tell me that you know, after it’s been
a number of times where it’s only after that kind of conversation, I’ll find out something is going on health-wise. (Personal Interview)

If the development of an interpersonal relationship with girls is integral to an effective health care relationship, then continuity and longevity in health care providers is important for this population, as it will increase the chances of the girl forming a meaningful relationship with her treatment provider and thus achieving a greater degree of success in the program (OJJDP, 1998b).

What is the role of interpersonal relationship development in the health provider-male client dynamic? One health advocate, when asked what tips she would give to future health advocates to assist in their work with girls and boys, stated, “I would say to take some time with the girls and I would spend some time trying to get to know them beyond their immediate health concerns, and with the boys I just haven’t found that as necessary or essential” (Personal Interview). Similarly, another informant stated,

I think relationships are important for boys…I’m not denying that, I just, I don’t think that they rule their lives. I’m not sure that they run their lives based on their relationships with other people. I don’t think that’s how they define themselves. And I think that girls definitely define themselves that way. (Personal Interview)

As reflected in the above quote, it is commonly believed that relationships are not as central to boys’ lives as they are to girls’ lives. Some substudy informants, however, felt that relationship building played an important role in maximizing their effectiveness as a provider to the boys, as well.

Rather than sitting down in a formal way as a health provider and client and gathering information related to health, one health advocate who worked primarily with male youth preferred to develop an informal relationship through social interaction, as a way to build trust in her as a health provider. As she explained,

This is my technique…the social interaction instead of the “sit down, tell me about yourself” [approach]. I’m all about if there’s a new kid and he’s upstairs playing pool and I’ve never met him before, going up and hanging out, and playing pool with him, and interacting, or playing cards or doing something like that because they’re getting to know you more as, okay she’s cool, she’s someone I can talk to… I think that’s a big way to start to gain the trust…just being able to talk to them… I can be someone that you actually can talk to or play a game of pool with, and then we can actually do some of the work. (Personal Interview)

This health advocate felt strongly that gaining the trust of her male clients is vital, and another substudy informant concurred. Both felt that this was difficult to achieve with male clients because of a likely history of distrust of adults and authority figures. Vetters agreed that his ability to improve delinquent boys’ health care access and utilization, and therefore overall
health, is dependent on a trusting relationship:

There’s no way that the guys are going to really access and utilize health care unless they have a relationship with me…and they see me as a place where they can get help and they begin to see that there’s a place where it’s safe… I think better health care comes from having better relationships. When you get beyond the consumption approach and more into health education and the partnership approach, a medical home rather than a medical pit stop, it’s essential to getting the boys engaged at all. (Personal Interview)

Thus, those substudy informants who have worked primarily with male MHPP participants seem to feel that working on building trust in relationships with male youth is also a precursor to effectively meeting their health-related needs. Without that trust, the boys will not consider or act on any recommendations made about their health. Having established a trusting health provider-client relationship, the nature of the relationship sometimes extends beyond health-related matters. As described by one of the health advocates, “I think they value a relationship and when they build trust they think they can trust you for anything and really appreciate your opinion on anything” (Personal Interview). As an example, some of her male clients subsequently have asked her for advice on finding a job.

Judging from the observations of the substudy informants, while both girls and boys need to gain trust in their health providers in order to accept health care from them, relationship building with female youth seems to take on a more personal element and involve dimensions of their lives such as family, peers, and school, whereas relationship building with the male youth seems to be more about becoming comfortable with the one-on-one relationship dynamic. Further research in this area would be useful.

Challenges to relationship-building in MHPP. Notably, all three health advocates interviewed for this substudy reported feeling stifled by the limited number of hours they had in which to establish relationships with the youth at the level they felt necessary to achieve openness in the provider-client relationship. The health advocates who worked with the girls, in particular, felt that being present in the community re-entry center (CRC) for a greater number of hours per week would allow them more opportunities to interact informally with the girls, allowing the girls to become more comfortable with them and thus increase the likelihood that they would approach them for health-related services. The health advocate who worked with the boys also felt that more time would be invaluable to reaching a greater number of youth. It can be inferred from her comments about the importance of getting to know each youth informally before “doing some work” that the time required to build trust in her relationships with the boys is part of the reason that she cannot broaden her reach.

Diversity among Girls

Gender-responsive programs should not reinforce gender stereotypes or treat gender as an immutable characteristic. Rather, such programs would acknowledge that gender, unlike sex, is
socially constructed. While the recommendations for female-focused programming discussed thus far draw on research identifying trends in developmental patterns and social experiences of girls, we are reminded by Cauffman (2008) that while treatment approaches based on gender-responsive principles can be successful, there is still diversity among girls that should not be overlooked, and the variations in personal and contextual circumstances of each individual youth should be taken into account in order to effectively serve them:

The default approach to treating young women who engage in serious forms of aggression and antisocial behavior has been either to treat them the same as male offenders or to treat them differently, but as an otherwise homogenous group. This approach presupposes that one theory, model, or program can be used to understand and respond to the needs of all young women in the juvenile justice system…. (p. 132)

Cauffman goes on to argue that “treatment approaches ultimately should be tailored to suit individual needs defined more specifically than by gender alone” (p. 134).

The Value of Gender-related Data Collection

These observations reinforce the importance of ongoing data collection on gender-related variables. Even when empirical research exists to inform our beliefs about effective elements of gender-responsive services, individual programs should engage in their own data collection (Ravoira, 2005) to verify the accuracy of assumptions about what works, and to assess whether techniques are actually working with a specific population. Program evaluation is an important tool to be used in this assessment process, and can also make an important contribution to the larger field by measuring the efficacy of gender-responsive programming practices (Bloom et al., 2003).

Gender-specific and gender-sensitive indicators should be used in instrument development and data collection in order to avoid a faulty or incomplete portrayal of the juvenile justice population being targeted for services (San Francisco Commission on the Status of Women, 1999; Zahn et al., 2008; Cauffman, 2008; Acoca & Dedel, 1998; Bloom & Covington, 2001; Morgan & Patton, 2002; Hubbard & Matthews, 2008). Data collection measures and techniques that are not sensitive to unique aspects of development or trends related to gender may fall short in yielding indicators of potential strengths and pathways to health and well-being (Morgan & Patton, 2002). Data collected using tools that yield accurate information, and analyses that aggregate by gender, can be used to shape gender-responsive programming that works against any inequitable practices that exist in the system and serve girls’ actual (rather than assumed) needs.

Many juvenile justice programs likely lack relevant data to inform development of gender-responsive programs, services and policies. Girl-serving community-based organizations should be utilized to supplement juvenile justice programming for girls. Girls can participate in community programs, and staff and program materials from these organizations can be
resources to assist in tailoring programs appropriate to the target population (Sherman, 2005). Even if these community resources exist, however, states should allocate funding to gender-responsive programs and services (Bloom et al., 2003; Bloom et al., 2002a; Bloom et al., 2002b) and data collection efforts (San Francisco Commission on the Status of Women, 1999).

**Examining MHPP as a Gender-responsive Program**

To review, the central themes in the conceptual and practical recommendations for gender-responsive programming emerging from the literature include intentionally targeting the needs, characteristics, and life circumstances of youth—which in the context of juvenile justice programming includes those directly related to system-involvement—in all program approaches and components, including staff training; and creating a program characterized by safe spaces, a collaborative and empowering style, and an emphasis on relationships. Informants conceptualized gender-responsive services to be those that recognize the importance of individually driven treatment and services, awareness of contextual factors impacting participants, and knowledge of gender-related group-level needs.

What aspects of MHPP can be considered gender responsive according to these definitions and guidelines? This question is intended to assess the extent to which MHPP is achieving its goal of improving health care access and utilization using a gender-responsive approach. Criteria for gender-responsive programming discussed in the literature and criteria offered by substudy informants are used to evaluate MHPP’s progress toward this goal. In addition, perspectives on the above question of those involved in the program as staff or partners are analyzed. The results of this analysis are divided into three sections: program setting; health issues; and program structure, staff, and training. Recommendations will be made for addressing current gaps in program design and delivery in order to improve the gender responsiveness, and thus overall impact, of MHPP. Table 3.2 outlines the ways in which MHPP exemplifies gender-responsive program principles along these three major program dimensions, as identified in this substudy. The program elements outlined in the table, which can be characterized as gender responsive, can serve as a foundation on which to strengthen the program’s ability to deliver gender-responsive services.
Table 3.2: Gender-Specific and Gender-Responsive Elements of MHPP

<table>
<thead>
<tr>
<th>Program Dimension</th>
<th>Gender-specific elements</th>
<th>Corresponding MHPP Elements</th>
<th>Gender-responsive elements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program setting</strong></td>
<td>DYS community re-entry centers are single-sex. These centers are the home base for MHPP.</td>
<td>Single-sex environment may enable greater opportunity and comfort to discuss gender-specific health issues.</td>
<td></td>
</tr>
<tr>
<td><strong>Health issues</strong></td>
<td>Originally GHPP, the program was intended to ensure that girls’ specific health needs were being met. The program now aims to address girls’ and boys’ health needs, in single-sex program settings.</td>
<td>Gender-specific health assessment is available to health advocates for girls’ programs.</td>
<td>Health education workshops are given on gender-specific health issues.</td>
</tr>
<tr>
<td><strong>Program structure, staff, and training</strong></td>
<td>Female health advocates staff the girls’ programs.</td>
<td>Health advocates are selected based on having training and/or professional experience with youth of the same gender as their MHPP clients.</td>
<td>Health advocates believe it is part of their duty to take gender into account in the delivery of health care services to MHPP participants.</td>
</tr>
</tbody>
</table>

Note: Some of the gender-responsive elements of MHPP outlined here were reported to exist in all three program sites, while some were reported to exist only in one or two program sites; MHPP = The Massachusetts Health Passport Project; DYS = The Massachusetts Department of Youth Services; GHPP = The Girls’ Health Passport Project.
Program Setting

Researchers and practitioners who advocate for gender-responsive programming agree that the characteristics of the space in which a program is held are of principal importance, as is outlined in the above discussion about “safe” spaces for girls. It is important to note that in the initial design of GHPP, and in its implementation early on, the program director chose to locate the program in single-sex CRCs, in order to provide a gender-responsive foundation for its programming. In addition, she viewed at least one of these CRCs (the Boston Girls’ CRC) as having gender-responsive components in operation beyond the single-sex environment and thus to have supported the gender-responsive implementation of GHPP. It is likely that some elements of a gender-responsive program environment remain, while others have become attenuated (Personal Correspondence).

Only one health advocate commented on the matter of space in relation to the gender-responsive nature of MHPP. The central feature of importance to her was that the program space was single-gendered, which she believed positively affected the dynamics between the girls, eliminated potentially distracting effects of having boys present, and provided greater opportunity to focus on gender-specific health issues. To her, the gender-specific nature of the program environment laid the groundwork for gender-responsive participant outcomes. She offered several examples to support her position:

…[the girls are] reaching for condoms pretty liberally and talking to me, and I’m not so sure they’d be as quick to come to me if there were guys around. I think it might make them that much more conscious about seeking care…Just seeing how girls can be in the presence of a guy…I think their mindset really changes when there [are] boys present. (Personal Interview)

…it’s not really focused on what they might be if men were here. Looking their best and kind of jockeying for a position or whatever that would be. I think it gives more time and more space to be inward and focused on improving yourself. (Personal Interview)

Morgan and Patton (2002) agree with this health advocate about the importance and potential of an all-girls program environment, contending, “Many girls are taught to accommodate and please males, putting their own needs aside. Consequently, girls need to have time by themselves, to be themselves, and focus on their own issues and growth” (p. 62). In addition to believing that an all-girl environment was in itself a facilitator of program effectiveness, the health advocate quoted above talked about several instances when girls would casually talk about a gender-specific issue in the common area of the CRC, and she, as a health care provider, was able to join in the conversation and lend a health perspective where there may not have otherwise been one. In one instance, when some girls were sharing their ideas about family planning, she was able to offer not only a professional point of view, but also a personal one—as a woman. She commented, “I know that they hear what’s said, and I think that the more that they hear different views it may impact them some. So I think it’s really good to have those open conversations” (Personal Interview). The fact that the girls were talking openly about their
own ideas about family planning, and that the health advocate was able to join in the conversation, may be evidence of an emotionally safe environment.

While it may indeed be a result of some of the health education efforts of the advocates, there is potential for MHPP to purposefully incorporate the goal of empowerment into one-on-one or group health education by MHPP health advocates. The OJJDP (1998a) includes, among their recommendations for addressing gender-specific health issues, “Creat[e] programs to teach girls about the details of how their bodies function, particularly in relation to critical female specific issues such as menstruation and pregnancy. This type of information creates ownership for girls over their physical bodies” (no page number). Such topics fit into the framework of MHPP. Clearly, targeted programming around such topics would be optimally effective in a program environment that is considered by girls to be physically, emotionally, and intellectually safe. In fact, safety may very well be a precursor to participation in such discussions.

One health advocate reported having several formal educational workshops with girls participating in the program around topics such as sexual health and STIs, in which the girls seemed to feel comfortable asking questions about, and commenting on, the material being presented. There may have been elements of a safe environment in place that made possible the girls’ participation in these classes. For example, it is possible that the single-sex aspect of the re-entry centers supports the MHPP staff’s ability to provide gender-responsive health services to youth. Further investigation would be useful to determine what features of the space facilitate feelings of safety. It is also important to identify which existing elements of the space that facilitate safety are attributable to efforts of MHPP staff, and which to efforts of CRC staff, so that individuals contributing to a feeling of safety can continue to do so. That information can then be used as a baseline for understanding how to improve safety.

As in any program, it is likely that safety could be improved to enhance the experiences of MHPP participating youth. There may be factors that interfere with youth developing a sense of safety in MHPP activities. MHPP operates out of community re-entry centers—separate for girls and boys—to which youth must report after their discharge from DYS detention centers. Health advocates are allocated an office in one of these centers. Because youth’s involvement with DYS is involuntary, they may have negative connotations of the centers and of the time they are required to spend at the centers, particularly if they view their DYS-involvement as punitive. This does not, however, preclude their having positive connotations of this space as well. It is thus unclear whether the CRCs in which MHPP activities occur are judged by youth to be physically, emotionally, and intellectually safe. If they are not, the program environment may not be facilitative of optimal provider-client relationships, and may potentially interfere with efforts on the part of the MHPP director and staff to promote gender-responsive program practices.

Further inquiry into youth’s connotations with the CRCs, and into how MHPP participants understand the relationship between the program and DYS, would help illuminate whether MHPP staff must make a targeted effort to offset the location of MHPP activities in efforts to
create a safe program environment. Some challenges reported by MHPP health advocates related to reluctance on the part of female participants to take advantage of services offered by the program, or to share health-related information with the advocates, may be partially attributable to insufficient feelings of safety on the part of participants within the CRC environment.

With regard to program setting, MHPP has two components in place for the girls’ sites that reflect gender-responsive principles, including a single-sex program environment and same-sex program staff for the girls. These components enable informal conversations and formal classes about health topics that are gender specific, and have resulted in some evidence of a gender-responsive program experience for participants.

Table 3.3 offers recommendations for investigating the current level of safety within the program setting, and for prioritizing the gender-responsive program criterion of a “safe space” in MHPP activities.

**Table 3.3: Recommendations for Creating a Program Environment for MHPP that is Gender-responsive**

- Ask current female and male program participants about their perceptions of the CRC and what features of the space could be improved to increase their physical, emotional, and intellectual comfort level, and thereby foster their involvement in MHPP.

- Work with the girls’ CRC leadership and staff to assess safety of that space for girls. Conduct an inquiry into whether the characteristics of the CRC facilitate or inhibit safety in MHPP activities.

- Find out from male program participants what dimensions of safety are relevant to them, and perform the same assessment of the boys’ CRCs in which the program operates.

- Program staff should be mindful of the concept of safety in the development and execution of all aspects of the MHPP program, including informal interactions taking place in the CRCs, one-on-one health advocate-program participant relationships, health education classes, and provider referrals to community health centers.

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45*Although youth were asked these questions during the needs assessment phase of the evaluation, we are recommending collecting these data again from youth who are currently enrolled in the program.*
Health Issues

A major impetus behind the development of MHPP was Sherman’s concern about contextual challenges related to health and health care in the juvenile justice population, including lack of appropriate gender-specific health care in detention facilities, and disruption of community connections, among them health care services, due to system involvement (Sherman, 2005; Gallagher, Dobrin, & Douds, 2007; Sherman, 2007). As a health services program for system-involved youth, much of the gender-specific focus of the program director and the staff is naturally around health issues.

When the program began as a girl-targeted health program, Sherman considered a health assessment measure developed by Leslie Acoca (Acoca, 2005) specifically for use with MHPP female participants to be a fundamental gender-responsive program element, in that it was designed to assess female-specific health issues known to be common among members of the juvenile justice population. The measure has been used by the two MHPP health advocates who have a nursing background. However, one of the nurses did not find it practical to complete the health assessment with each female participant due to the girls’ seeming lack of patience or interest in spending a lot of time with the nurse talking about their health. This health advocate came to favor the gathering of health history information from her clients gradually over time, rather than using the assessment as an interview tool to be completed in one meeting with a client. In addition, when the program was expanded to boys, no equivalent measure was created to assess male-specific health issues that tend to disproportionately affect this population.

The health advocates who consistently used the Acoca health measure described her work with female program participants as “automatically” gender responsive because of the content of the health history she gathers from them, and the health information she attempts to impart to them. Due to her background in female health, she found it important to complete a thorough health assessment with her clients that focused on female health issues, such as,

…sexual debut, and how many sexual partners, and how many pregnancies, and how did this pregnancy go and how many abortions, and those are all, you’re a woman I’m going to ask you those questions…Also questions like ovarian cancer, breast cancer, those are questions I’m going to ask girls. (Personal Interview)

In this way, her approach to gender-specific health with the girls was not necessarily context-specific, but took into account group-level health factors unique to girls and women, and was intended to result in an individualized profile of each of her female clients. In addition, on one occasion, she led a feminine hygiene class for the girls in the program after determining that one of the girls in the group would benefit from some guidance in this area. Rather than singling out this girl and possibly making her uncomfortable, the health advocate saw an opportunity to address a single client’s needs while also addressing an issue pertinent to all of her female program participants. In this way, she included the gender-responsive tenets of individualized
treatment and group-level characteristics in her approach. In her assessment of her decision to provide this workshop to program participants, she characterized it as taking into account contextual factors of this specific population of girls: “it is gender responsive, because I’m looking at the needs of the population and responding to what they need. … I am responding to gender but it’s really responding to the needs of my population” (Personal Interview). Thus, unlike her preference for administering a comprehensive health-related needs assessment for all of her female clients, in this case, she was directing her services to those gender-related health needs that surfaced as relevant to this particular population.

One health advocate was particularly aware of tailoring health services to the boys and girls with whom she worked. The examples she gave exemplify gender-responsive health services by highlighting the necessity of identifying the unique needs of an individual that are rooted in their gender, even when dealing with health issues that affect both girls and boys. For instance, she explained,

…when we talk about birth control for girls it is very different than the way we talk about it with boys. …[With girls] you get into the whole body function issue with your periods and how you feel and what medication and what approach is best for you and you know, there just seems to be more factors. With boys it is usually very simple with using a condom and I mean I haven’t had the whole discussion with boys about pregnancy prevention which is an interesting concept to talk to the boys about…. (Personal Interview)

Just as there is gender-related, physiologically based variation in the above example, there are also ways that social factors affect gender-related health care, as described below:

Even if you take the concept of body image and weight, obesity and diabetes prevention, there’s just a different kind of conversation with girls about it. You know, like what you are supposed to look like, and you know with the boys it is very medical, this is what you should do and this is where you should be and this is what you should eat. And with the girls there is just so much about the meaning of food and why we eat… (Personal Interview)

Thus, effectively addressing issues related to physical health with girls and boys requires taking into account contextual factors and group-level distinctions related to gender that may manifest in health concerns and health behaviors, and influence care options.

When considering health education around STI prevention, she felt that it was important to acknowledge a tendency that she has observed among boys to be “eager” to take condoms that are made available to them, but reportedly, to use them inconsistently. Since STIs may not produce noticeable symptoms, she also felt that boys do not take STIs very seriously because “the consequences don’t seem to be real” (Personal Interview). On the other hand, while boys are forthright in their admission of having unprotected sex, she felt that the opposite was often true among the girls:
From the girls I usually get the “right answer”…what they know they’re supposed to say. And so what I do is give them the message that I would give in case: they are not being forthcoming, because I just feel like that is what’s happening most of the time. (Personal Interview)

Thus, in her work with both girls and boys in the area of STI prevention, this health advocate is being responsive to group-level trends she has observed by providing the information her clients need regardless of whether they directly express that need.

The above examples illustrate the complex nature of health issues, which are sometimes related to social issues or pressures affecting either girls or boys disproportionately. One such group of health issues are those connected to the female body, including body image and eating concerns, and the impact of sexual abuse on self-image (OJJDP, 1998). The OJJDP (1998) recommends that programs for girls likely to be affected by these issues should include structured opportunities to address these issues in a therapeutic way, suggesting avenues such as groups or individual therapy. The MHPP can incorporate such themes into existing program structures, such as health education classes, or create other activities for its female participants to target this gender-specific area of health.

It is clear that there are some examples of efforts on the part of MHPP health advocates to tailor their services to the multi-level gender-related nuances related to the health needs of their clients. However, among the three health advocates, each operating at a different program site and with a different population of youth, this is not being done systematically. Each health advocate is individually responsible for considering gender-specific variations in their work with MHPP clients. This means that whether group-level characteristics, contextual factors, and individual variables are taken into account when providing services and organizing activities for youth related to health and health care is left up to each health advocate. The health advocates, however, have varying levels of awareness of gender-specific health and health care issues, resulting in inconsistent service delivery. With little direct supervision of health advocates regarding issues of gender, and no specific program curriculum to guide them, no regulatory system is in place to ensure that the program is consistently gender responsive in matters of health and health care.

There is also no ongoing effort to assess program participants’ perceptions of the effectiveness of MHPP health advocates in meeting their gender-related health and health care needs. While the transient nature of some participants’ lives makes this task somewhat challenging, some participants are in the program for longer periods of time. Surveying current program participants about the health issues of concern to them, as well as their preferences for health

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46 While the health advocates were supervised by both the MHPP program director and by health professionals from the MHPP’s partnering health centers, it was not apparent that either type of supervision addressed gender-responsive service delivery explicitly. While it may have been the intention that these supervisory relationships serve as a forum for health advocates to raise gender-related questions and concerns, the data from this substudy do not indicate that they were utilized in this way. In addition, we are suggesting that the supervisors, as opposed to the health advocates, take the lead in initiating an ongoing conversation about gender-related issues with the advocates.
care utilization and provider relationships, would allow for the identification of variations in these concerns and preferences across program sites, and would ensure the continued ability of the program to offer targeted service delivery to this population. Participants should also be asked about their experiences in the program, including what works well for them and what could be improved. These data would provide feedback and information to health advocates that could help them refine their approaches in a methodical way. This assessment tool could have the added benefit of being used as a way to involve program participants in shaping the program, a practice that is advocated as a gender-responsive technique to be employed in girls’ programs (Wheeler et al., 2005; Ms. Foundation, 2001; Sherman, 2005). Without these efforts, MHPP is not guaranteeing that the gender-specific health and health care needs of its participants are being met, or that service delivery to program participants is consistently provided in a gender-responsive manner. The program is thus likely to be falling short of its goal of gender-responsive service delivery.

The MHPP has demonstrated its commitment to addressing gender-specific health issues by providing groups of girls and boys who are DYS-involved with the opportunity to work with a health professional who can help them with their individual health and health care concerns. The gender-specific health assessment tool provided to the girls’ health advocates has the potential to serve as one guide to these advocates in the provision of gender-responsive health care, in addition to being an educational tool for advocates who are not experts in girls’ health issues. The evidence reviewed in this section also highlights awareness on the part of health advocates of the gender-related nuances of health and health care issues, which is exemplified in their health education techniques. In addition, the health advocates quoted here seem to approach each client as an individual, but also to consider contextual and group-level variables that may affect their health and health care practices.
Table 3.4: Recommendations for Achieving Gender-responsive Health Care Services

- MHPP’s focus on gender-specific health issues is of critical importance, and is an appropriate program nucleus. However, this emphasis should not be to the exclusion of gender issues related to risk factors, development, and utilization trends. Literature should be consulted in order to increase staff familiarity with these issues, as well as with gender-responsive program techniques and approaches.

- MHPP’s goal of imparting skills to participants related to managing and being savvy about their own health care can be leveraged as a way to empower female participants, if it is purposefully approached in that way by health advocates. This may indeed be the result of advocates’ work to date aimed at improving girls’ health care access and knowledge. Learning about their bodies, how to care for themselves, and how to seek and obtain health care services that work for them can be empowering to girls (OJJDP, 1998; Morgan & Patton, 2002), including those who have victimization histories. It can simultaneously support the program’s goals of connecting girls to community agencies, and providing them with opportunities to develop relationships with caring adults. Curriculum should be developed to guide MHPP health advocates in addressing these issues.

- Query program participants to find out what elements of the program they like, and what recommendations they have for improving it. Also ask them what aspects of health and health care they would like to learn more about, and what methods they would recommend program staff employ to assist their learning. Analyze this information, and involve participants in efforts to modify the program to better meet their needs. This is one way to respond to the recommendation that gender-responsive programs allow girls to play a leadership role, and that their input should influence the program content and format.

Program Structure, Staff, and Training

Two interviewees, one who was a health advocate and another who is a program partner, felt that having a health advocate who specializes in gender-specific health care was the main reason that MHPP could be characterized as gender responsive. A third informant, also a health advocate, felt that the aspect of MHPP that could be considered gender responsive was the gender-specific health services offered by the health provider to whom a client was referred by the health advocate, rather than the interactions occurring between herself and the client within the program context.

Sherman has prioritized a background in female adolescent health in her hiring of health advocates who work at the female program sites. During the expansion and evolution of the program, one staff member initially hired to work with girls also began serving boys in the same region. The health advocate hired to work with boys in the other program region had
previously been successfully working in DYS detention facilities primarily with boys, but also with girls, with an emphasis on sexual health. Thus, while her formal training was not focused on boys specifically, she had a track record of forming effective health care relationships with boys and girls, many of whom she would go on to serve in the CRCs in her role as an MHPP health advocate.

When the MHPP health advocates at the girls' program sites were hired, they were provided with some written material about the contextual factors that affect girls' involvement in the juvenile justice system, and the interruption in health care services pursuant to these contextual circumstances (Personal Interviews). Due to the belief that the health advocates' female-specific health training and background have been the primary criteria on which hiring decisions were made, little information was shared during the staff interviewing process regarding the gender-responsive goals of the program, how these goals shape the structure of the program, or findings from the literature on gender-related health needs and utilization patterns. When asked about how the gender-responsive focus of MHPP was communicated upon hiring, one health advocate responded,

*I don’t remember if that term was used. They talked about the fact that it was all girls, but I think the emphasis on health was really the key for what we discussed in the interview, not so much a gender-based approach. It was discussed that the girls were separate from the boys, but that was discussed as more of DYS having separated them, and not really an objective of this program.* (Personal Interview)

She further explained that the aspect of the program that she considers to be gender responsive is not based on concrete program guidelines or directives given to her on how to provide gender-responsive services. Rather, if program services are gender responsive, it can be attributed to the individual efforts of the health advocates to incorporate contextual factors, individual factors, knowledge of group level trends, or a combination of those. These factors and trends are primarily related to health and health care problems and needs, and as will be demonstrated, interpersonal styles and the role of relationships. Another health advocate concurred:

*I don’t think [gender-responsiveness is] intrinsic in the program. …you get in there and you learn how to work with your population, so…it’s how that caregiver kind of responds… I don’t think there is a bigger structure or at least I’m not aware of a bigger structure that has directed me in working with the girls versus how I would be directed in working with the boys.* (Personal Interview)

Thus, the health advocates feel that a clearly defined gender-responsive program structure, and a set of directives or guidelines for them regarding the delivery of gender-responsive services, are lacking. Each of them expressed uncertainty about what gender responsive means, though they also view it as part of their role to deliver health services that are relevant to youth based on their gender as well as individual and contextual factors. However, there is not necessarily
concordance about what those services and factors are, or how to address them. Clearly articulated goals, program structures, and intended outcomes related to the gender-responsive nature of the MHPP are needed to guide staff in their work. Knowledge of the criteria for gender-responsive programming in the literature would also be beneficial in order to support staff in fulfilling the program’s mission.

In addition to information about gender-specific health needs and behaviors, MHPP health advocates seem to have developed ideas about what girls are like and what boys are like through their interactions with their clients, and these ideas likely affect their interactions with the youth, though they might not be aware of the ways it does so. All individuals have ideas about gender-related needs and patterns of behavior that they have developed throughout their lives, and so these ideas also have some bearing on providers’ interactions with youth, again, likely unbeknownst to the providers.

When asked about how their own ideas about gender-related needs and behaviors influence their interactions with program youth, two out of three of the health advocates indicated that while they believe that these ideas likely do have some bearing on their approach to youth, they are not necessarily conscious of it during those interactions. One health advocate reflected on the style of those interactions, believing it to be directed by the youth’s gender and her own beliefs about gender needs:

…I just have an awareness that there are certain things that [are] going to be more important when I talk to the girls versus when I talk to the boys and even how, like for instance with the girls, they seem to be much more willing to talk if I’m much more, not even casual or like a friend, but it’s like a low-key, less authoritative kind of way. You know, more of like a partnership where as with the boys they seem to be more responding to, “I’m the nurse and this is what I want to do, and what are your needs?” And it is just much more contractual. (Personal Interview)

This health advocate’s comments reflect her perceptions of how gender influences not only the content of the health services she offers to youth, but also her choices about how to relate to youth as a health care provider. Thus, it reflects her beliefs about girls’ and boys’ preferences for the relational approach of their health care provider, and thus is an important factor to consider when assessing program outcomes.

Another health advocate also shared her thoughts on a pattern she has observed in the program population related to how youth represent health problems to themselves and to others:

I think that a lot of the boys, especially…they are a little more likely to say, “I don’t have anything.” They are a little more likely to not want to go get checked out for it just because they don’t want to take the time out of their day and they don’t think that it’s a big deal and are more, not wanting to talk to everyone about it…. They don’t want to open up to everyone about it. Whereas, a lot of the, well not every girl, but a lot of the young girls…they don’t want everyone to know, but when they’re in a group of other girls and I mention something like chlamydia or
gonorrhea or anything like that, they just want to tell their story and they want to say what they went through with it. Whereas a lot of the guys, they don’t want anyone to really know about it.

(Personal Interview)

This advocate, too, has come to a general (though not absolute) conclusion about the preferences of girls and boys related to sharing health-related information with others. This, too, is a dimension of the health care provider-client relationship which is likely to affect a provider’s way of relating to youth, and creating spaces in which health-related information is shared and received. Exhibited in both of the health advocates’ observations is the widely accepted belief about girls tending to be more, and boys tending to be less, relationship oriented. While it very well may be true that the girls and boys who participate in MHPP are more or less comfortable with a relational style based on their gender, it may also be the case that the health advocates expect them to be so, and that this expectation guides their style and approach to working with and meeting the needs of the youth. Ongoing supervision of health advocates to address beliefs about girls and boys would help raise awareness of how such ideas affect advocates’ work and relationship with the youth they serve, and whether targeted efforts to modify styles of interaction with youth are necessary.

One health advocate was unsure about gender-related needs and behavioral norms, and how much to let these guide her own methods of working with youth:

… we’ve all been raised in a certain way…. I like to think that I don’t believe that girls can do this and boys can do that and girls need this and boys need that, but there are certain parts of that that are true; there has been research that shows that girls have different needs and boys have different needs. What would be nice would be to have some guidelines on which of those are true and which of those are false…figure out myths and facts and those sorts of things. I like to think that I keep it open enough so that I'm not influenced by you know, upbringing or environment…but it’s hard to see yourself in a completely objective light. (Personal Interview)

The words of this health advocate echo a call made by researchers for training of individuals working with girls and girls in the juvenile justice system, who are often unaware of criteria for female-targeted services (Bloom & Covington, 1998). Suggested areas of training encompass factors related to health, personal social development, and contextual variables related to system involvement. Those topics concerning health include how depression, suicidal tendency, and other mental health disorders may present themselves (Timmons-Mitchell et al., 1997), knowledge of substance abuse, its accompanying problems, and treatment strategies (Acoca & Dedel, 1998; Bloom et al., 2002b), and sexual exploitation and abuse histories (Bloom et al., 2002b).

It is unrealistic for MHPP health advocates to receive the level of training required to address this range of health issues, nor is it their role within the current MHPP model to provide treatment. However, more targeted training and supervision is possible. Training provided to health advocates should emphasize the types of issues that may affect members of this population, and how they may manifest in youth behaviors. Suggested topics of emphasis for
staff training in the area of personal and social development include gender-specific communication skills, relationship needs, and female adolescent development (Bloom et al., 2002b; Morgan & Patton, 2002). In the area of contextual factors potentially shaping past experiences of members of this population, it is recommended that staff working with delinquent girls be knowledgeable about gender-related delinquency patterns and impacts, as these will help to guide program strategies, and staff techniques for working with female program participants (Bloom et al., 2002b). Morgan and Patton (2002) call attention to the need for staff to not only be well-versed in issues pertaining to this population, but to be given the opportunity to examine their own biases, past experiences, and perceptions regarding gender and culture in order to understand how these may affect their relationships with youth.

While it is clear that being gender responsive when dealing with health issues is of particular importance, especially for a program such as MHPP, it is also the case, as demonstrated in the several examples noted above, that there are gender-related nuances related to the impact of health issues, health-related behaviors, and the provider-client relationship of which it is also critical to be aware. Professional training and experiences in health care for female or male adolescents may or may not prepare an individual for the potential multitude of ways that gender comes into play in both health and the health care setting, or the ways that group level variables, contextual factors, or individual variations demand responsiveness of program staff. A program that aims to be gender responsive can benefit its staff and clients by ensuring that staff members have adequate training in gender-specific elements of the health care issues related to the targeted population, as well as other gender-related trends that may come into play in a health-focused program.

The MHPP has a loose program structure, wherein the various program sites operate as individual entities, and the health advocates are essentially responsible for shaping the program at their site. In some ways, the health advocates can be viewed as “signifying” the program, because there is no concrete curriculum given to them to follow, and the program’s objectives are left up to their interpretation. As is true of the health advocates’ varying levels of knowledge about gender-specific health issues, by allowing the health advocates to shape the program objectives, activities, and approaches at their respective sites, MHPP is allowing the health advocates to determine the degree to which the program is being delivered in a gender-responsive manner.

The MHPP is lacking an established roster of clearly defined program elements that can be characterized as gender responsive. Importantly, there is no training of health advocates that provides them with the opportunity to explore the concept of gender-responsive service provision, what it means to them, and how it can be implemented at their program site. Additionally, staff are not provided with supervision designed to assess whether program practices are gender responsive. If MHPP should continue to operate using this health advocate-driven model, it will be difficult to ensure that the program is being delivered in a gender-responsive way. If it is the intention of the MHPP director that the staff-driven approach
be used as a gender-responsive modality itself, then more scaffolding for the staff is needed to support the desired gender-responsive program delivery outcomes.

Along the dimensions of program structure, staff, and training, a valuable gender-responsive asset of MHPP is its staff, who have professional training and/or experiences working with either girls or boys, and who apply the gender-related knowledge from their background to their work with MHPP participants. In addition, all health advocates believe in the importance of taking gender into account in their delivery of health care services to youth.

Table 3.5 outlines ways that MHPP can maximize its ability to be intentionally responsive to gender needs, and to deliver health and health care services in a gender-responsive way.
Table 3.5: Recommendations for Making MHPP More Intentionally Gender-responsive and Maximizing Gender-responsive Program Outcomes

- Articulate a program theory for MHPP that is related to gender responsiveness and health care. Create tangible documents that explicitly communicate the gender-responsive goals of the program, and how those goals are meant to be achieved through programming and operational practices (Morgan & Patton, 2002). These should reflect the actual needs of the population being served (Bloom et al., 2003). Share these documents with program staff so that they are unambiguous and can be incorporated into all program activities.

- Provide supervision and training for staff on gender-responsive programming research, as well as research on the needs of girls and boys in the juvenile justice population. This will ensure that staff understands the factors related to gender that affect the targeted population, and how those factors can be addressed through programming.

- In addition to training motivated by findings from the literature, qualitative data should be collected from the program population in order to clarify their preferences regarding the qualities of their providers and the ideal nature of the provider-client relationship. Possible trends in these preferences can then be identified.

- Have follow-up discussions with MHPP health advocates and program partners about whether they perceive the program to be incorporating gender-responsive strategies, and what program elements achieve or fall short of gender-responsive ideals. Alignment between the program director and staff, in particular in their perceptions of MHPP as gender responsive, is important and can guide program modification. Those who are delivering program services, and who have experience working with this population, have important insights and observations to share, and are instrumental in whether the program is received by youth in a gender-responsive way.

Conclusions: MHPP as a Gender-responsive Program

Guthrie and colleagues (2002), propose that programming for system-involved youth should be approached as an opportunity. These programs can intervene in challenging contextual and personal circumstances experienced by system-involved youth, or provide services that youth would be unlikely to have access to otherwise. They view health in particular as a highly promising conduit to positive outcomes for system-involved girls:

With appropriate health care and health promotion services, girls’ contact with the justice system can be viewed as an opportunity in which meaningful connections and interventions can be provided that are focused on facilitating the health of all girls. An encounter with the juvenile justice system can become not only a chance to educate,
rehabilitate, and enhance girls’ ability to become active and positive contributors to society, but also to provide quality gender- and age-responsive health care and health promotion services. (p. 421)

The MHPP’s goals are consistent with Guthrie and colleagues’ (2002) vision. While it is clear that elements of MHPP’s operational approaches may contribute to the achievement of this vision, a major finding of this substudy is that MHPP, its staff, and program participants, would greatly benefit from more deliberate efforts on the part of the program to explicitly incorporate gender-responsive principles. As recommended above, training for staff is an essential step toward doing this, because the health advocates are the nucleus of the program, and are almost solely responsible for carrying out its mission. A precursor to staff training, however, is a more clearly articulated set of guidelines defining the ways in which the program aims to be gender responsive. With the expansion of the program’s reach to include system-involved boys, now is the perfect time to consider the relevance and meaning of gender-responsive services for both female and male program participants.

Program evaluation is a useful tool for documenting effective gender-responsive program techniques, and such documentation is of great value to those that advocate for gender-responsive programming for youth in this population (Acoca & Dedel, 1998). As illustrated in this substudy, MHPP operates in important ways as a gender-responsive health services program for system-involved youth. A major benefit of MHPP’s investment in evaluation has been the ability to highlight existing elements of MHPP that can be considered gender specific and gender responsive, as well as the need for the program to develop more specific objectives for achieving gender-responsive services to allow for more robust and thorough measurement of the program’s achievements in this area.
References


THE INFLUENCE OF PARENTS AND FAMILIES ON YOUTHS’ HEALTH PRACTICES AND BELIEFS

It has been well-documented that youth involved in the juvenile justice system suffer disparate rates of physical and mental health problems when compared to youth in the general population. There are numerous explanations for this situation, for example, that, as a rule, these young people have limited exposure to quality health care. Research on the general population also suggests that the multigenerational transmission of health behaviors, attitudes, and knowledge—between family elders and children—influences young people’s approaches to maintaining their health. Aside from inferential knowledge, however, very little is known about how this process plays out for system-involved youth, and the extent to which it is implicated in the poorer health outcomes for these youth.

The substudy detailed in this report is embedded in an evaluation of the Massachusetts Health Passport Project (MHPP), a program designed for youth involved in the juvenile justice system. The goals of this program are as follows:

- Improve youths’ access to health care;
- Improve youths’ social supports;
- Improve youths’ health status; and
- Change the relevant systems to support these improvements. (This goal refers to the current gap in systematic health care access and delivery present within the juvenile justice system.)

Parent involvement might affect attainment by MHPP of all these goals, with the exception of the last one. Therefore, within the framework of this evaluation, one that seeks to understand the factors that might moderate program participation and effects, an understanding of the influence of parents on youths’ health practices is warranted.

We are specifically interested here in learning about youths’ health experiences and concerns, and the different perspectives of youth and their parents regarding their own health practices and beliefs. Thus, this substudy report explores the following topics:

- Health-seeking behaviors practiced by youth and their immediate family members;
- Parental involvement in youths’ health care;
- Perception of the quality of care received from medical provider(s);
- Youths’ health concerns about themselves and family members;
- Youths’ and family members positive and negative health practices;
- Perceptions of behaviors and practices that can improve youths’ and family’s health;
- Differences in health beliefs between youth and family, and youth and community; and

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The Massachusetts Health Passport Project Evaluation, Tufts University. Francine Jacobs, Principal Investigator; Rachel Oliveri, Project Manager.
Topics of health conversations with family.

**Review of the Literature**

A large body of research indicates that juvenile offenders have extensive psychosocial and physical health needs. An estimated 50-60% of this population suffers from psychological and emotional problems requiring mental health care, compared to approximately 15-20% of young people in the general US population (Shelton, 2002; Soler, 2002). Studies also indicate disproportionately high rates of physical health problems among juvenile offenders (Acoca, 2000), many of which are closely linked with disruptive or risky behaviors and detrimental environmental factors (Acoca, 2000; Atkins et al., 1999; Kroneman, Loeber, & Hipwell, 2004). Moreover, these youth typically do not receive the necessary care during and after their involvement with the juvenile justice system, despite their complex mental and physical health needs (Shelton, 2002; Soler, 2002). However, little is known about the impact of parents’ health beliefs and behaviors on youths’ own health beliefs and practices.

**An Ecological Perspective**

Ecological systems theory posits that all aspects of development—psychological, social, emotional, and biological—cannot be understood outside a person’s social contexts; for that reason, ecological systems theorists view child development in terms of the interaction between children and the settings, or systems, in which they live (Bronfenbrenner, 1989, 2002). Three kinds of systems are relevant to this discussion: 1) “natural” or intimate systems (family, friends, etc.); 2) proximal, often informal, systems (neighborhood and community groups, church affiliations); and 3) more distal, and/or formal, societal systems (schools, hospitals, public service policies). Each of these systems potentially offers the child a range of supports for his/her development; however these systems do not work equally well for all children. Indeed, for some, such systems may be absent altogether (i.e., no friends or family), or the potential benefits of engaging with system components may not be known (i.e., eligibility for food stamps). Sometimes the norms and values of one system conflict with those of another, as might be the case here, with family members following one approach to health care and the juvenile justice system (in concert with MHPP and partner health centers) advocating another.

An ecological view is, necessarily, a cross-generational view. For instance, children may, inadvertently or consciously, replicate their parents’ health beliefs and practices, “passing them down” from older to younger family members. Bowen (1978) has identified this phenomenon as the “multigenerational transmission process.” The transmission occurs on several interconnected levels, ranging from the conscious teaching and learning of information to the automatic and unconscious programming of emotional reactions and behaviors. Yet Bowen (1978) also suggests that the practice or belief being transmitted often contains some modest

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49 For a full review of the literature detailing the health status of juvenile offenders please refer to Section One of this report.
variation, and that these small differences between parents and their offspring lead, over many generations, to marked differences among the members of a multigenerational family.

Given the poor health outcomes for youth in the juvenile justice system, it is curious that across the literature there is virtually no mention of the role of parents and families—either in contributing to the problem or in solving it. Understanding the ecological features of this situation, including the multigenerational transmission process that may explain some of the challenges to improving health care access and health status, would help in crafting more responsive programs for this population.

Methodology

Substudy Rationale

Parental involvement was not a specific topic of inquiry in the evaluation of MHPP, but it emerged repeatedly during many project-related data collection activities. The specific structure for this study was derived from the lessons we learned while analyzing eleven key informant interview transcripts and three focus group transcripts with DYS staff and CRC staff in Boston, Worcester, and Brockton. From these transcripts we learned that parents appeared to play an integral role regarding youths’ health behaviors and outcomes, through direct involvement in the health care system, specific parental health behaviors, or beliefs regarding health that were transmitted to their children.

Key informants identified the following barriers for parents in accessing the health system:

- Parental fear of disclosing medical information;
- Cultural or family beliefs that conflict with standard medical practice [i.e., cultural stigma around psychological therapy];
- Lack of knowledge or organizational skills needed to access a primary care provider;
- Exigent parental issues (i.e., mental illness, substance abuse) that impede involvement or result in neglect of youth’s health issues;
- Absence of father figure because boys might feel more comfortable sharing health concerns with a male figure or male absence resulting in lack of disclosure in the part of girls because of increased tension between them and their female caregivers;
- No positive health modeling behaviors [“kids don’t always have familial models of accessing health care.” (Key Informant Interview, Boston)];
- Skepticism regarding gender-oriented services [“why (are you) providing services to girls and not boys?” (Key Informant Interview, Boston); and

50 See Section Three of this report for additional information on parent involvement in MHPP.
51 Key informant interviews and focus groups took place in the following locations on the following dates: Boston (January, February, April, August, and November, 2006; April, 2007), Brockton (March, 2006), and Worcester (January and September , 2006)
Reliance on a crisis management approach in dealing with health concerns, including the use of emergency rooms as primary source of care.

Although these numerous barriers were identified, DYS staff do believe, based on their experiences, that parents want to be more involved in the care their children receive.

DYS staff were also able to identify within-system changes that could help to facilitate parental access to health care for youth and in turn improve youth health status. For example, staff felt that a system could be put into place that would allow them to monitor whether or not parents were managing a youth’s health care. If it is found that parents are not monitoring their child’s health, staff could then take on a more active role in the youth’s health care. Staff also felt that DYS, in conjunction with the MHPP, could begin to ensure seamless care by working with the family to identify and connect with a health care provider prior to the youth’s re-entry into the community therefore enabling a smooth transition between the health care received while in lock-up and the care received in the community. DYS staff also felt that educating parents and youth about health access was important, particularly around how and when to access care.

In addition, DYS staff felt that families could benefit from family counseling; therefore they felt that DYS should provide these services, or at least connect families to family counselors in the community. Overall, staff felt that DYS needed to make every effort possible to involve parents in the care of their youth. Staff also felt it was important to maintain a theory of engagement that includes supporting families and their choices, as well as working within the parameters set forth by the family.

These findings suggested it was necessary to initiate this substudy to further our understanding about parental involvement around health among youth in the juvenile justice system.

**Recruiting the Sample of Informants**

Based on the parenting topics that surfaced during our individual interviews and focus groups with DYS and CRC staff, we decided to pursue a new line of inquiry. We were specifically interested in learning about the influence of parents on youths’ health practices. For this reason, open-ended interview protocols were created: one for youth and one for parents.

At the time we initiated this study two of the three MHPP programs were in transition, for this reason we chose to interview participants and parents in the Worcester program, as the MHPP Worcester nurse had a stable schedule and had already forged relationships with some of the CRC participants. The Worcester CRC where the MHPP nurse is housed serves only female juvenile offenders; therefore all of our participants were female. The MHPP nurse was asked to recruit parents and youth interested in participating in the substudy. The nurse was made fully aware of the objectives of the study and was provided with copies of introductory letters for both parents and youth. Parent and youth dyads interested in participating in the study were asked to provide updated contact information. The nurse then called them to schedule
individual interview times with the investigator. Although every effort was made by the nurse to recruit parents, no parents indicated interest in participating. For this reason, the study was limited to youth and their perceptions of their own and their parents’ health beliefs and practices. The nurse successfully recruited six girls to participate in the study. Interviews took place in a private office at the CRC, and each interview lasted approximately half an hour.

All of the participants were attending the CRC on a weekly basis. Participants were approximately 16 years of age (range 15-18). Four of the six participants lived with at least one biological parent and these same participants reported having a primary care physician. Two participants lived with either a friend or a significant other and reported not having a primary care physician. Furthermore, two participants disclosed a history of mental health issues. Finally, one participant reported being a parent herself.

Substudy Analysis

The interview transcripts were coded using a qualitative data analysis software package, ATLAS.ti. Codes were generated directly from the data and organized thematically. Twenty-three codes were generated for the following six general topic areas: 1) perceptions of health and received health care; 2) health beliefs, behaviors, and concerns; 3) discrepancies in health practices and beliefs; 4) health lessons taught and learned; 5) parental involvement in the juvenile justice system; 6) youth perceptions thoughts and feelings on parental involvement (see Table 3.6).
Table 3.6: Detailed List of General and Specific Topics Generated from Open-ended Interview Protocol (N = 6)

<table>
<thead>
<tr>
<th>General topic</th>
<th>Specific topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perceptions of health and received health care</td>
<td>a. Actions taken when family members feel ill</td>
</tr>
<tr>
<td></td>
<td>b. Actions taken when participant feels ill</td>
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<tr>
<td></td>
<td>c. Estimated use of medical services</td>
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<td></td>
<td>d. Perceptions of parental health behavior</td>
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<tr>
<td></td>
<td>e. Feelings about PCP (positive and negative)</td>
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<td></td>
<td>f. PCP involvement of parents</td>
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<tr>
<td></td>
<td>g. Perceived quality of care</td>
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<tr>
<td></td>
<td>h. Perceptions of MHPP nurse services</td>
</tr>
<tr>
<td>2. Health beliefs, behaviors, and concerns</td>
<td>a. Healthy parental behaviors</td>
</tr>
<tr>
<td></td>
<td>b. Healthy youth behaviors</td>
</tr>
<tr>
<td></td>
<td>c. Unhealthy parental behaviors</td>
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<tr>
<td></td>
<td>d. Unhealthy youth behaviors</td>
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<tr>
<td></td>
<td>e. Concerns about family members</td>
</tr>
<tr>
<td></td>
<td>f. Concerns about themselves</td>
</tr>
<tr>
<td>3. Discrepancies in health practices and beliefs</td>
<td>a. Differences in health beliefs among family and community</td>
</tr>
<tr>
<td></td>
<td>b. Differences in health beliefs among family and participant</td>
</tr>
<tr>
<td>4. Health lessons taught and learned</td>
<td>a. Topics of recent health conversations with family members</td>
</tr>
<tr>
<td></td>
<td>b. Lessons learned from caregivers</td>
</tr>
<tr>
<td></td>
<td>c. Lessons taught to family members</td>
</tr>
<tr>
<td>5. Parental involvement in the juvenile justice system</td>
<td>a. Parental involvement in CRC</td>
</tr>
<tr>
<td></td>
<td>b. Parental involvement in DYS while youth is in lock-up</td>
</tr>
<tr>
<td>6. Youth thoughts and feelings on parental involvement</td>
<td>a. Thoughts and feelings on parental involvement in health-related activities</td>
</tr>
<tr>
<td></td>
<td>b. Thoughts and feelings on parental involvement in medical settings or DYS/CRC</td>
</tr>
</tbody>
</table>

Note: PCP = Primary care provider; MHPP = The Massachusetts Health Passport Project; CRC = Community re-entry center; DYS = The Massachusetts Department of Youth Services.

Talking about Health: Substudy Findings

How to Take Care of Your Health

In order to get to the issue of how parental behaviors and family and community customs inform the health beliefs and practices of these girls, we first elicited their observations of their own health behaviors and those of their parents.
Actions Taken when Ill

Half the participants reported making their own medical appointments with their primary care providers when they became ill, with one reporting that her mother managed the scheduling of appointments for her. The remaining two participants stated that they would visit the emergency room whenever they felt ill, one because she hated having to wait to get an appointment to see the doctor (although she also hated having to wait in the emergency room and would often leave before seeing a doctor). The other participant stated that she goes to the emergency room because that is what her mother did with her when she was a child and, in addition, she does not like to wait for days before being able to see a doctor.

Although most participants (N = 4) stated that they would visit their doctors if they felt ill, a couple also described a triage system they had in place to determine whether they would make a doctor’s appointment. One girl noted that she would call the doctor if something “serious” was happening—vomiting or a headache, for example. Another stated that she would get some rest and take some over-the-counter medications and if she still did not feel well then she would proceed with the appointment. The two participants who reported visiting the emergency room whenever they felt ill also reported trying over-the-counter medications first.

Actions Taken by Family Members when They Are Ill

Participants described a variety of behaviors family members exhibited when they felt ill or needed medical care. For example, many participants shared that when family members felt ill they tended to contact their primary care physicians (N = 4). However, some of these same participants also noted that family members would take over-the-counter medications, rest, or ignore their symptoms altogether (N = 3). Some participants suggested that their mothers tended to ignore their symptoms or “ride it out” and avoided any contact with a doctor (N = 2). One participant offered that her family tended to go to the emergency room if a medical issue arose.

Estimating their Use of Medical Services

Participants were asked to estimate their use of medical services over the most recent 12-month period. Of the six participants, only three were able to share detailed information about their own service usage, the other three were unable to remember the number of medical visits they participated in during the past year. One noted that she had two medical providers, a primary care provider and a gynecologist, and that she met with her gynecologist every six months. She routinely saw her primary care provider every three months for check-ups, but in the most recent year, had met with this provider at least seven times. Another participant could not remember the number of medical visits she had participated in but she did offer that she had seen her (mental health) therapist on a weekly basis and met with her psychiatrist on a monthly basis. Finally, the third participant stated that she saw her primary care provider three times a year and her mental health provider once a month.
Perceptions of Parental Health Behavior

Of the six participants, four shared observations and insights about their parents’ use of medical providers. Three participants reported that their mothers had primary care providers, and one participant, who lived with her father, stated that he, also, had his own primary care provider and saw him whenever he needed to. However, this same participant stated that her mother did not like to visit the doctor, and in fact believed that her mother did not have her own provider and did not care about going to see a medical provider.

An aversion to, or avoidance of, the doctor seemed to be a relevant theme among the mothers of these four participants. For example, one participant who knew her mother had a primary care provider stated that her mother rarely visited the doctor. Another participant offered that no one in her family liked to visit the doctor and that her mother rarely sought out medical care with her primary care provider. In fact, this participant noted that her aunt had just visited a doctor after about a decade of going without primary care.

Perceived Quality of Health and Medical Care Received

Interactions with the Primary Care Provider

Participants discussed their primary care visits, and described interactions with their individual medical providers as well as their more general experiences with staff in the medical facility and the mechanics of using the services of that facility (e.g., the appointment-making process). The girls had many positive things to say about their primary care providers. Of the six participants, four had been with the same provider since early childhood, and two of them felt “very comfortable” with their providers. One of these two offered that she and her provider were “pretty close;” the provider for the second participant had also attended to various members of her family, including siblings, cousins, nieces and nephews. This girl could “connect with him because he is straightforward.” When asked to give an example of her provider’s straightforwardness, the participant described an instance when she was pretending to feel sick and the doctor “called her out.” The participant then seemed to express an appreciation for being called out; she figured that other doctors would have dealt with it in a passive manner.

Finally, one of the participants who often used the emergency room for primary care reflected on a doctor she had had as a younger child, whom she saw on a regular basis and with whom she felt comfortable. However, on one occasion she went to that office for a scheduled appointment and was told that her provider was no longer working at that clinic, and that she had been assigned to another physician. She was scared to see anyone else, decided to leave, and has not had a regular primary care provider since.

Participants also suggested areas in which the provision of their primary health care could be improved. For example, although generally satisfied with the care she received, one
participant—who had a long-standing relationship with her provider—felt that the clinic’s wait time was too long. She was under the impression that her provider’s office intentionally overbooked patients, which resulted in hour-long waits. A participant who regularly uses the emergency room reinforced this sentiment; she avoids seeing a primary care provider because she always felt she had to wait too long to get an appointment, and once she was able to secure an appointment she had to wait too long at the provider’s office to actually see him/her. She attributed this long wait to Massachusetts’s insurance mandate for all of its residents.

The primary care provider’s approach to involving parents. The relationships between primary care providers and the parents of these girls ranged quite broadly. Half the participants noted that their current providers actively involve their parents in their care. For one participant, parental involvement consisted of the provider explaining and providing literature on health issues and concerns the participant may have to her mother. Another participant offered that, although in general she is old enough to handle her health care, there are times when she does want her mother involved and brings her along, for instance, when she has pregnancy scares. The mother of a third participant is regularly involved in her care, especially with regard to her sexual health practices.

Two participants stated that their parents were not involved in their care—one because she did not want them to be and the second because she had no contact with her parents. Finally, one participant who mentioned not having a current provider, did share that when she was young her mother was involved in her care but once she got old enough to attend the visits on her own her provider stopped involving her mother in her care.

Assessing the Health Care System

Participants were asked to assess the quality of care they received from their providers, including primary care providers, mental health providers, and health providers while in DYS lock-up. Three participants spoke specifically to the care they received from their primary care providers, and overall they were satisfied with it. Two girls focused on the interpersonal quality of the care, with one noting that her provider was “good to her,” and the second that her provider was “generous and nice to her.” She also stated that, perhaps because her provider had known her and her sister for a very long time, she would rather “stick with the same person instead of going to somebody different that doesn’t know me.”

Although one participant did not speak directly to the quality of care she received from her providers, she did describe an experience of discontinuity of care that was disconcerting (and likely represented to her poor quality of care) during which she saw different doctors while in the custody of her mother, in lock-up, and in foster care. Although she felt she received “top quality care” from her primary care provider, this participant also felt that having to see different providers during lock-up and while in foster care limited the quality of care she received as these other providers did not know her full medical history. Finally, a participant with no regular primary care provider described this unsettling experience, also likely
representing poor quality care to her. She visited a medical provider and received an asthma diagnosis, but she continued to feel ill and ended up at her local emergency room. There she learned that she was suffering from a respiratory infection. This misdiagnosis was enough for her to leave her former provider, though she also noted that she had felt rushed during her appointments with her provider.

Perceptions of MHPP Health Advocate Services

In addition to their thoughts on medical services received in the community, participants were asked to talk about their perceptions of the services provided by the MHPP nurse. One participant stated that she had not had any contact with the nurse. Two of the five girls who have met with the MHPP nurse said they would seek her out if they needed her help.

One participant acknowledged that she would meet with the nurse if she needed to make an appointment or if she was scared to do something on her own, such as take a pregnancy test, but this same participant also mentioned that on a regular basis she turns to her mother to make medical appointments for her. Another participant stated that she felt the nurse was “great,” but because she is so close to her own doctor she feels no need to seek out the MHPP nurse. However, this same participant felt that MHPP was “great for kids who don’t feel comfortable with their own doctors.” This participant also felt that, girls “have a lot of needs and health problems and she (the nurse) is good to talk to.”

One participant stated that she liked the nurse but felt that perhaps the nurse was too persistent in trying to engage her. However, this participant did state, “If I ever need her, she’d be there.” Another participant stated that she tried to avoid the nurse, as she felt she did not need to interact with her. This participant felt particularly annoyed with the fact that she felt the nurse may have jumped to conclusions about a specific issue that they had discussed. The participant also felt that the nurse tried too hard to be friends with the girls at the CRC. Perhaps the bottom line for this participant, however, was that since the nurse worked with law enforcement, she was wary of her: “You work with the law, we don’t like you.”

Finally, one participant offered that, given the constraint of the MHPP nurse’s role as presently defined, the MHPP could not provide the help she wants—for example, in writing drug prescriptions. She compared the MHPP nurse with the nurse at her son’s child care center, whom she perceives as being able to be more helpful—providing direct medical advice regarding her child, and even transporting them (her son and her) to the doctor when her son was sick.

Health Beliefs, Behaviors, and Concerns

Healthy Youth Behaviors

Participants were very eager to describe their own healthy behaviors, areas of improvement,
One youth stated that being healthy meant “being updated with shots, making sure everything is fine with your body, getting physicals done, and taking showers everyday.” When asked to describe what makes her healthy, the participant stated that she keeps herself clean and gets check-ups as needed.

Another participant defined being healthy as being skinny and active, and eating less. This participant stated that she stayed healthy by walking to school and drinking water. A third participant saw being healthy as “feeling skinnier.” She stayed healthy by taking vitamins and her asthma medication, eating healthy foods like fruit and yogurt, and avoiding drinking and smoking. This girl felt that she was “pretty healthy.” A fourth participant interpreted being healthy as “not having anything...like no STDs, no diabetes.” She then proceeded to amend her statement by saying, “You can have diabetes and still be healthy, I think...if you are taking care of yourself, doing your insulin.” This participant also felt that being healthy meant going to the dentist, eating healthy food, maintaining a healthy weight, not smoking, and not drinking. She then stated that she tries to remain healthy by eating her vegetables, brushing her teeth before going to bed, and working out at times.

Two participants in particular were particularly voluble on this topic. The first had the following to say about being healthy:

Feeling complete health, because some people think that being healthy is like “oh you have to be a certain weight and everything” and you know I feel like it’s how you feel, comfortable about yourself and just for girls getting your yearly check-ups and basically pap smears. Just making sure everything is good with your body. I feel like you should keep a good relationship with your doctor, so in case you have anything that you don’t know about, or if you see anything on your body that is suspicious [you can] just call, you know, just ask the question.

When asked to elaborate on what she meant by “having a good relationship with your doctor,” this participant said the following: “From my point of view it looks like, like how I am with my doctor. Like I have been telling you, calling whenever I need it, or if I need to go there, you know, they welcome [you] with open arms, that’s what I think.”

The participant then described healthy behaviors she engages in:

...exercise, like here we have a program for the Y (YMCA). We get to go to the Y everyday and I eat healthy. A lot of people will be like”oh you are on a diet” [and I say] “no I am not on a diet, I am just eating healthy, that’s it.” Don’t get me wrong; I love chocolate but I had to cut down because I wouldn’t eat all day and then I would eat once a day, you know at like 9 o’clock at night and then I would go to sleep and that is bad. So like I think that you should eat like three times a day or more.

Finally, the remaining participant had the following to say about being healthy: “I never really thought it had a meaning; I just knew it was healthy. I just figure there are no problems.”
asked to describe behaviors she engages in which she feels are healthy, she enumerated: taking a shower, brushing her teeth, going to the gym, not drinking soda, and not eating chocolate. This participant also mentioned that she is “not really into all that stuff, like watching what I eat.” During her interview this participant also discussed her history of substance abuse and her current sobriety. She credited the following factors for allowing her to maintain her sobriety:

I keep busy. I don’t do anything anymore. I only talk to two girls, nobody else, except for my friends’ brothers and stuff; they are normal. Everybody already thinks that I am just going to be a screw-up my whole life; I don’t want to prove everybody right...I have already been to jail. I have already done all this. They have already predicted all that; they never predicted I was going to do good. So I do that now, to prove everybody wrong.

Unhealthy Youth Behaviors

All participants entered this conversation. One mentioned that she felt her one unhealthy behavior was smoking cigarettes. A second participant also felt she was unhealthy because she smoked cigarettes and was overweight. This same participant also discussed how she sometimes mimics her mother’s unhealthy behavior by not going to the doctor when she needs to: “I know I may need something from the doctors or I know I need to talk to them about something, and I just won’t call them...or I won’t show up to my appointments and stuff. That’s like my mom.” Another participant stated that her unhealthy behaviors included smoking cigarettes and marijuana.

One participant could not identify current unhealthy behaviors but did mention that in the past, she used to eat her one meal of the day late at night and go right to bed. She also mentioned that she never exercised. Another participant discussed both her past and present unhealthy behaviors: “Look, I was into drugs and stuff, so it had me, like everywhere I wasn’t supposed to be. Like I’m supposed to be coming here (CRC), I didn’t come here.” As for her current unhealthy behavior, this participant mentioned that she smoked cigarettes. The final participant shared that she did not eat vegetables, did not go to the doctor, and ate a lot of carbohydrates.

Concerns about One’s Own Health

Five participants discussed concerns they held about their own health practices and conditions. One participant reported that she is concerned about diabetes, as it runs in her family, and that she is afraid she may get AIDS or be unable to have children; she did not offer any reasons for these latter concerns. She hopes to visit a doctor soon. Another participant was concerned about being overweight, and another about the effects of the (birth control) pill that “messes [my] body up;” for this reason she stays away from it. She has also had a worrying ear infection for over a year. A fourth participant stated that she is worried about sexually transmitted infections (STIs). She began to talk about her boyfriend but she immediately stopped herself, possibly indicating a first-hand experience with an STI. She also believed that she may have allergies.
The final participant has asthma and has to take asthma medications; she receives the necessary prescriptions to control this condition from her OB/GYN.

**Healthy Parental Behaviors**

Participants shared observations of parental behaviors that seemed to help their parents stay healthy, behaviors that could be improved, and behaviors that, in general, “healthy parents” exhibit. Four of the six participants shared their thoughts on this topic. One participant mentioned that her mother exercises because of her high blood pressure but that she has to make sure not to overdo it. She also noted that healthy parents could “make sure not to get depressed” and go to a counselor when they are feeling down. Another participant stated that healthy parents would take care of themselves, for example, take their insulin if they have diabetes, go to the dentist, eat healthy food, not smoke, not drink, and maintain a healthy weight. This participant also felt that healthy parents would feed their children healthy food, and make sure their children floss and brush their teeth. Another participant felt that a healthy parent would be active and maintain a healthy weight. This participant did mention that her own mother “walks everywhere.” The final participant stated that a healthy parent would “do healthy things so she can be a role model to her kids,” for example, eat all her vegetables and limit her sugar intake. The participant then proceeded to share what her mother actually does: “My mom tells me I have to cut down on the amount of sugar I put in my coffee.... My mom does not make greasy food all the time...at least she tries not to.”

**Unhealthy Parental Behaviors**

Three of the six participants were able to identify their parents’ unhealthy behaviors. One participant stated that her mother does not go to the doctor, tends to buy a lot of fatty foods, and usually fries food. She also mentioned she wished her mother visited the doctor on a regular basis. Another participant stated that although her mother walks a lot, she also tends to eat too much, drink alcohol, and smoke cigarettes. The final participant stated that alcoholism runs in her family and that many of her family members smoke cigarettes.

**Health and Mental Health Concerns about Family Members**

Five participants articulated concerns for particular family members’ health. One briefly discussed her grandmother’s mental illness. A second volunteered that she worries about her mother’s health, that she may end up getting diabetes. This participant also stated that her mother rarely visits medical providers: “I try to talk to her about [it] but she doesn’t listen. She just doesn’t like doctors. She is stubborn.” She stated that her mother suffers from really bad migraines caused by tooth pain; her father suffers from heart problems and diabetes. She stated that she was afraid that “he is going to get a heart attack and die.”

A third participant stated that she was concerned because her family is overweight. She also stated that her mother suffers from depression and chest pains, and that she was concerned
with the amount of drinking done by her mother’s partner. The fourth participant stated that her aunt suffers from diabetes and is going blind. In addition, the participant shared that her aunt rarely visits the doctor. The participant stated that she does not want what has happened to her aunt to happen to her mother. She also stated that she wants her mother to visit the doctor regularly. The final participant shared that her mother suffers from arthritis, and has also refused to get a necessary colonoscopy done for two years, although she constantly reminds her mother to get the procedure done. In addition, she reported that her baby’s father also refuses to see a medical provider; this posture remained unchanged even after he was involved in a car accident.

**Discrepancies in Health Practices and Beliefs within their Networks**

* Differences in Health Beliefs between Themselves/Their Families, and their Communities

Two participants identified clear differences between health-related behaviors they observe in their homes or practice themselves, and those practiced in their communities. The first mentioned that her mother tends to serve vegetables with every meal, and she believes that few members of her community do the same. The second, who had recently become a mother, also noted some dietary differences. She mentioned that she was “big on milk,” but that no one she knows likes to drink milk. She also noted that she encourages other young people at the CRC, and students at her school as well, to practice safe sex by having them take condoms. This participant also talked about the importance of drinking water but realized that many of her peers do not like to drink water; therefore, she encourages them to mix water with crystal light rather than drink sodas or juice.

Several of the youth offered examples of discrepancies between themselves and their family members on these matters. The first participant offered that she had had to get off birth control pills because her father felt that only “married women should be on birth control.” Although she found the pills helpful in regulating her period, she chose to stop in order to follow her father’s wishes. This participant also disagreed with her mother on another issue: Her mother “thinks that not going to the doctor isn’t a big deal,” but she feels that “it is a big deal because you’re not getting… medicines, you’re not checking yourself, you’re not getting the stuff you need.”

A second participant, who had no contact with her parents, noted that her parents had been medically neglectful. As a child she would always “get ear infections and then I had urinary tract infections a lot…the only reason why… I even had to go to the doctors [was] because my school reported it. Not my parents.” When asked if she felt that her medical needs were taken care of by her subsequent caregivers she answered: “No… I used to get strep throat and everything and I just had to deal with it.”

The final participant described the polar opposite views on seeking medical care taken within her family: On the one hand, there were family members who took their health for granted. On
the other, there were family members she considered to be “hypochondriacs.” “My sister… she goes to the doctor for everything… like my cousins and stuff are like that. Like I mean for everything, like if their kid has a bruise, they go to the doctors.”

**Health Lessons Taught and Learned**

*Topics of Recent Health Conversations with Family Members*

Three participants offered topics of discussion. The first recalled a health-related conversation she had had with her mother; it had occurred about two years ago and was the last one of this type she could remember. She had been concerned over the fact that her mother was too stressed and kept on saying she was going to die. And she had tried, unsuccessfully, to get her mother to go to the doctor. Another participant reported on a recent conversation with her mother during which her mother decided to put her on a diet because she felt she was gaining too much weight.

The third girl stated that upon their move to a new apartment about a year ago, she and her family had to deal with an infestation of bed bugs. This led to the participant and her mother having an extensive conversation about getting rid of mattresses and seeking out medical treatment for the bites. The participant is still worried about this, as her mother continues to wake up with bites all over her body.

*Health-related Lessons Learned from Parents and Caregivers*

Four participants had lessons of this sort to relate. Two learned the importance of keeping medical appointments from their mothers. As one girl noted, “She shows me how to … take care of myself. When I have to get an appointment, she tells me never [to] forget that appointment that you made… she tells me basically to be [on] top of it.” The second discussed this lesson from her mother as follows: “To always go to your appointments… because if you don’t go, you won’t know what’s wrong with you.”

Another participant had learned about birth control from her mother. When asked what she specifically learned about birth control, she stated, “Like [to] stay on it… that is all. She always tells me to stay on it, but I am not on it at all, because it just messed up my period, but besides that… that’s it.” The final informant had learned to “drink milk and eat healthy.” She also stated that her mother “was really big on doctors…. She doesn’t really care now.” In other words, this final participant lived in an environment where, as a child, her primary caregiver emphasized the importance of seeking medical care when necessary. However, over time, the participant’s caregiver apparently became more ambivalent about seeking out care for herself.

*Lessons Taught to Family Members*

Finally, participants were asked to discuss health lessons they felt they had taught their family
members. Three of the six participants shared their experiences. One participant relayed the lessons she learned from an AIDS Awareness Group to her mother. Another told her mother they needed to call the Board of Health in order to hold the landlord accountable for the bed bug infestation in their apartment. The last participant noted, “She (the participant’s mother) has high blood pressure, and I always buy her unsalted butter…. I looked it up and every time I go to her house I take all the coffee and stuff like that, so she can’t drink it, but she just buys more.”

**Youth’s Perspectives on Parental Involvement in Health-related Activities**

In this context, the term health-related activities refers to any activity (including involvement in MHPP) involving health but not directly involving a youth’s primary care provider or any other kind of medical provider. Of the six participants, four had thoughts to share regarding parental involvement in health-related activities.

The first participant stated that her mother got her her health insurance and also stays in phone contact with the MHPP nurse. When asked how she feels about this, the participant stated: “Whatever happens to me basically, she’s there. She has to be there. I am only seventeen. If I’m eighteen I can go on my own.” She also mentioned that she was okay with having her mother speak to the MHPP nurse.

The second participant stated that she felt her father has had an impact on her health choices. For one, she discussed stopping birth control because her father did not feel she should be on it. She also felt her father pushed her to finally visit her doctor. The third participant stated that her mother either encourages her to “ride it through” when she is feeling ill or she (the mother) calls the doctor for her. The fourth participant was able to reflect on her childhood experiences of neglect: “I rarely went to the doctors…. I never went to the doctors in (State X). The whole time I lived there I never went once.”

**Thoughts and Feelings about Parental Involvement in Medical Settings**

Five participants shared their thoughts and feelings about parental involvement with their doctors. The first participant shared the following about her mother’s involvement in her health care: “’cause honestly if I didn’t have no one…to relate to and let them know what’s going on, I mean I don’t know how I would be. I probably would be a whole different person.” This participant’s statement appears to imply that her caregiver is an important source of support, so much so that she feels she would be a different person without it.

In discussing her doctor’s inclination to involve her mother in her case, another informant stated, “Sometimes I don’t like it. Like sometimes I just want to be on my own. I want to be grown already so sometimes it bothers me, but then again it doesn’t because she is my mom so, it’s alright.” She continued, “Sometimes I would like for them (her parents) to know what’s going on with me. But as I said before, sometimes I just want to be grown and do everything by
myself.” As to which times to involve them and which not, she offered, “I think when it gets really serious like and [sexually transmitted disease] (STD), if I get one or if I overdose on drugs or if I’m like really sick in the hospital or have to be kept overnight. [But] when [I get] a pregnancy scare…I don’t like my parents in my business when that happens.”

The third participant stated that she wanted to have her mother involved in her care because she did not like to be alone with the doctor. The fourth stated that she felt her mother should have no role in her health care: “I am getting older now so….I just feel like everything, well yeah, most of the things I do, is me. I’m just confidential and independent.” In fact, this had been how she had felt and behaved for years. “Once I turned like 10, I think…I was just like, ‘I’m going by myself’, you know, ‘you don’t have to be here.’ Especially when I had, like my first pap smear, I was like, ‘No…I don’t want you around.” Finally, the last participant stated that her mother was not involved, and she mentioned the assumption of confidentiality between her health care provider and herself. Interestingly, this expectation of confidentiality between medical provider and patient was barely mentioned by the participants when discussing their parents’ involvement in their care.

Conclusions and Recommendations

The literature on the health status of youth in the juvenile justice system consistently mentions the disparate rates of negative health outcomes among this group when compared to the general population of youth (Acoca, 2000; Anderson, Vostanis, & Spencer, 2004; Feldmann, 2008; Soler, 2002). Furthermore, negative health outcomes among youth in the juvenile justice system appear to be closely linked with disruptive or risky behaviors and detrimental environmental factors (Atkins, Pumariega, Rogers, Montgomery, Nybro, Jeffers, & Sease, 1999; Krezmien, Mulcahy, & Leone, 2008; Kroneman, Loeber, & Hipwell, 2004; Robertson, Dill, Husain, & Undesser, 2004; Vermeiren, Jespers, & Moffitt, 2006). The literature also indicates that youth in the juvenile justice system typically do not receive the necessary care during and after their involvement with the juvenile justice system, despite their often complex mental and physical health needs (Shelton, 2002; Soler, 2002). For these reasons, we investigated the possible impact of parental health beliefs and behaviors, and parental involvement with their children’s health and health care, on these youths’ behaviors in this arena.

The girls who participated in this study had much interesting information to share about their use of health care, and the perceived effect their parents’ beliefs, practices, and involvement have had on their own health status and practices. Among the major findings are the following:

- Many of the girls in the study had a stable, long-standing relationship with a primary care provider, and they generally were satisfied with the care they received from this provider.

This finding suggests a more nuanced notion of the circumstances of girls in the juvenile justice system regarding access to community health care than is generally considered to be the case, or that MHPP assumes in its goals and objectives. That having been said, a wider and deeper
investigation is necessary, first to determine if, indeed, these girls do have the connection to a primary care provider that they report. Then, a companion study of boys’ access to, and utilization of, health care is in order; recent qualitative research conducted by Jacobs (2007) provides some support for this contention among system-involved boys.

Even granting that the situation is better than expected among study participants, this finding might reflect the relatively advantaged circumstances for residents of Massachusetts regarding access to health care; system-involved youth in other states may well be as underserved or unserved as is commonly believed. Finally, having a primary health care provider—even one who is well-liked and seen to be of high quality—is different than having a true health care “home;” the latter includes many critical activities (e.g., making and following up on referrals; coordinating care, including mental health services) that are generally not “billable,” and therefore not reliably part the usual medical practice. Therefore, these girls still might be “underserved,” and in need of the kinds of support MHPP provides, even though they do have a primary care provider.

- The majority of these girls’ parents were involved in their health-related activities.

It seemed to us that some of the participants viewed this parental engagement as welcomed, tangible evidence that their parents were concerned for their welfare, that they “cared.” There was also, however, some ambivalence expressed by a couple of the same girls, primarily because they wanted to be perceived as, and behave as though they were, “grown up.” And one participant had no interest whatsoever in having her parents involved in this way. Jacobs (2007) found a similar level of maternal involvement among the system-involved boys included in her study. Parenthetically, a number of the providers seem to routinely involve parents in their children’s medical visits—a move that was generally, (though not always) accepted by the girls.

This finding pertains to the services MHPP provides. It suggests that the program should include parents in a thoughtful, planful way, perhaps offering some types of involvement (e.g., health education workshops) to all parents, and other types (e.g., participation in individual health-related consultation) on a case-by-case basis, only with the youths’ consent.52

- The issue of confidentiality with regard to sharing health information with parents was not a central concern.

Only one participant who still had contact with her mother mentioned her expectation that her physician keep the substance of her medical appointments confidential; nor was this a major concern expressed among a sample of boys involved in the juvenile justice system (Jacobs, 2007). This finding contrasts with the opinion of several of the adult informants involved in the larger MHPP evaluation who maintained that confidentiality was a major concern for DYS-involved youth as they gained access to, and used, health care. Likely both positions are true to

52 Further discussion of parental/family involvement is presented in the Pilot Health Survey findings in Section One of this report as well as in the Program Model and Implementation Analysis in Section Three of this report.
some degree, since this desire for confidentiality probably varies by characteristics related to the participant, the overall relationship with his/her parents, and the subject matter at hand. If MHPP determines that communication with parents about youth’s health concerns might be beneficial, addition investigation into how to proceed to protect, but not overprotect, confidentiality would be in order.

- The majority of the respondents perceived of their parents’ “health circumstances” as more imperiled than their own.

The girls were quick to note that their parents did not appear to take such good care of themselves. For example, although a majority of the girls had a relationship with a medical provider whom they trusted and with whom they felt comfortable, their parents were not as well situated with regard to their own health care. Indeed, their parents generally ignored health problems, and hardly ever visited a medical provider. In response, some of these young participants assumed the “parental” role vis-à-vis the appropriate use of health care, consistently encouraging their parents to seek out medical care, and to change their “unhealthy” behaviors (e.g., poor nutrition; lack of exercise; use of drugs, alcohol, and cigarettes). So, these girls are not only grappling with their own health concerns (i.e., sexual health, diabetes, substance use, etc.), but they are also concerned about the health status of their loved ones.

- Many parents tried to “do the right thing” in relation to their daughters’ health care and health status.

Notwithstanding their own health behaviors, parents encouraged their daughters to visit the doctor when they were sick. These parents also were actively engaged in their children’s health care by making medical appointments and attending visits, appearing to follow the adage, “Do as I say, not as I do.” This dissonance between how parents want their children to behave so as to maintain their health, and how they themselves behave on their own behalf, might offer an opportunity to MHPP to positively affect health practices within the family as a whole, across family members.

**How Might these Findings Inform MHPP Operations?**

These findings underscore the importance of parents in the acquisition and utilization of health care among DYS-involved youth, as well as the more general health-related beliefs that all people hold, and the behaviors that they demonstrate. These data suggest that MHPP should attempt to include parents, in some organized fashion, at least to some degree. Perhaps the MHPP nurse could serve as a health educator, not only to youth but also to their family members, at a minimum developing health-specific materials and topical workshops. By teaching family members, the MHPP nurse has the potential for affecting multigenerational change. Furthermore, youth could feel more encouraged to be active participants in the
maintenance of their own good health if they received reinforcement, by way of actual behavior, from their parents.

Based on participants’ suggestions, MHPP might also reconsider the level of service provided by the nurse. It appears that at least a few of the participants want a more “traditional” medical provider in the CRC, someone who could prescribe medications and accompany them on their medical visits. Overall, it appears that these participants may benefit from someone who is available to them should they have any questions regarding their health, someone who will teach their family members about the importance of seeking out prompt medical treatment, and someone who will encourage them to continue to seek out their own medical treatment in a prompt fashion.

**Recommendations for Future Research**

Small qualitative studies do not “generalize” well, and this one is no exception. Its sample size was small, and consisted of female participants only. Parent interviews were not conducted, and information on youth’s health practices were collected based on youth’s self-report, rather than actual data from health visits or behavioral observations. The best of what emerges from such a study is a provocative set of findings that points the way to further investigation and program experimentation—a standard that we believe has been met here.

Among the suggestions for additional research in this area are the following:

- It would be important to expand this line of inquiry to a greater number of participants to determine whether the themes identified in this investigation are further substantiated and to uncover other significant themes in understanding the impact of parents on youth’s health beliefs and behaviors.

- The majority of juvenile offenders are male, and some research findings seem to indicate that the health outcomes of male juvenile offenders are worse when compared to female offenders or the general population. Being that only females participated in this study, it would be vital to interview male juvenile offenders in order to understand the perceived impact of parents on their health beliefs and practices. Since we learned from our participants that parents have affected their beliefs and practices and that these participants also concern themselves with their parents’ health, male participants could elucidate whether these findings are generalizable to both boys and girls.

- Parents were not interviewed, due to difficulties in recruiting them. Future studies on parental involvement would benefit from gathering first-hand information from both youth and parents. It could be that the girls who participated in this study have a limited understanding of the intricacies involved in their parents’ health beliefs and behaviors. For example, a parent might be following up with her medical provider on a regular basis but chooses not to share this information with her child. This could result in a discrepancy
between what the youth perceives and the way in which the parent actually behaves. Investigations that include both youth and parent reports will only allow us to gain a better understanding of the transmission of health beliefs and practices from parent to child.

- Finally, secondary data in the form of observed health behaviors could also allow us to further our understanding of the multigenerational transmission of health. Therefore, gathering data from medical visits, daily nutrition practices, exercise habits, and health-related conversations, for example, could allow an in-depth understanding of how parents affect youth’s health behaviors rather than solely depending on participants’ perceptions of their own health experiences.

- Finally, future studies on parental involvement in youth’s health care would benefit from examining exactly how parents are involved. This study indicated that while some girls’ parents were involved in getting them health insurance, contacting medical providers by phone, “pushing” them to go to the doctor, and accompanying them to appointments, other girls’ parents were involved in their health care to a lesser degree. Learning to what degree and in what ways parents are involved in their child’s health care would inform efforts to assist youth with their health care needs. For example, it could be that some parents are more involved in bringing their child to the emergency room than to a primary care physician for care, and thus those youth and parents might benefit from increased education about and connections to routine, preventive care.
References


SECTION FOUR: THE PERCEIVED EFFECTS OF MHPP

To this point we have addressed important evaluation questions pertaining to the operation of the Massachusetts Health Passport Project (MHPP). But most people, when they think of evaluation, consider it a set of activities meant to answer the “does it work?” question—is this program achieving the expected results (Tier Four: Achieving Outcomes in the Five-Tiered Approach [FTA])? In this section, we answer those equally important questions in two ways: In the first component, we describe how a range of knowledgeable individuals perceive the program to have effected the desired results. In the second component, we focus on the goal of systems change, presenting an analysis of the program’s efforts to achieve that end. These two components, along with our analysis of the MHPP logic model, as illustrated in Table 3.1 in this report, give a measure of the extent to which MHPP achieved its intended outcomes.
TIER FOUR: PERCEIVED EFFECTS OF THE MASSACHUSETTS HEALTH PASSPORT PROJECT

It was the initial intention of this evaluation to assess both MHPP program processes and its observed outcomes. However, because of factors outside our control, this assessment of program outcomes is, rather, at the level of perceived effects, or those program effects as perceived and reported to us by key informants. Although the assessment of perceived effects does not include the “objective” measure of program impact, it offers a valuable indication of progress toward the achievement of program goals, in most cases directly from those most closely involved with and affected by the program. Within the FTA (Jacobs, 1988; Jacobs & Kapuscik, 2000), the documentation of perceived effects is an activity that straddles Tiers Three and Four.

From August – December 2008, we conducted perceived effects interviews with MHPP program staff, Department of Youth Services (DYS) senior officials, regional managers, health care providers, caseworkers, liaisons to the program from the partnering community health centers, Community Re-entry Center (CRC) directors, a representative of one of the program’s funders, six girls participating in the MHPP Worcester program, and two boys participating in the MHPP Boston program (N = 25).

Our analysis centers on those perceived effects relevant to three of the four main MHPP program goals: improving health care access for enrolled youth, improving social supports for enrolled youth, and improving health status for enrolled youth. We do not include the fourth goal of creating changes in the relevant systems (i.e., juvenile justice and community health care systems), as perceptions of effects in this area are detailed at length in the Systems Change substudy included in this report. This analysis also includes discussion of perceived effects on several groups of potential beneficiaries: youth, parents, DYS, and partnering health centers. We conclude the analysis by interpreting these perceived effects in light of factors that have both limited and facilitated MHPP’s ability to attain its goals.

Perceived Effects on Youth

Improving Health Care Access for Enrolled Youth

Of the four overarching MHPP goals, improving health care access for enrolled youth was the one goal that the majority of informants agreed the program had achieved to some extent. DYS staff at all levels spoke of the “disjointed” health care youth received prior to MHPP when re-entering their communities, and credited the program with connecting (or reconnecting) youth to community health care providers and services. One DYS caseworker in Boston noted how MHPP helped link boys in her caseload to Sidney Borum, Jr Health Center (SBHC), which she

53 These included an unexpected drop in the census of girls at the participating CRCs, and a smaller research budget than anticipated.
described as facilitating their access to care:

…they give them a place to go where they are comfortable going, the kids are able to get there fairly easily, if they need an appointment they’re accommodating—their hours are not the typical 9-5 doctor’s hours, so the kids are able to access those services when they need them (Personal Interview).

This description of SBHC illustrates how factors related to the location of care—one’s health care site, easily accessible location, and accommodating hours for appointments—can influence health care access. This same caseworker also described another facilitator of health care access, a strong relationship between patient and provider, which she said developed between two of the boys in her caseload and Dr. Vetters, the physician to which MHPP refers youth at SBHC:

I know one of my kids, any time anything ever happens, he wants to call Dr. Vetters…they are comfortable with him and willing to let him know what’s going on, keeping in touch when they have a medical issue and all that (ibid).

She described how Dr. Vetters had been “fabulous,” checking in at the hospital with one boy who had been shot. The two boys we interviewed also spoke positively about Dr. Vetters. One said, “He was nice. Just talked about everything before he did it and explained things,” and he described SBHC as “fast and easy” (Personal Interview, January 2009). The other boy, who was 18 years old and reported not having a doctor since elementary school, said he had seen Dr. Vetters “six or seven times” in less than a year (Personal Interview, December 2008). The cause of these frequent visits in a short period of time was largely due to multiple, serious injuries this youth experienced and underscores the importance of his participation in MHPP, which connected him to an accessible health care site and provider.

It seems that more than one of the factors associated with the location of care—one’s health care site, easily accessible location, and accommodating hours for appointments—must in place to help improve youth’s health care access. For example, in Worcester, although one caseworker noted that the MHPP health advocate was able to get appointments quickly through its partnering health center, Great Brook Valley Health Center (GVBHC), most of the girls participating in MHPP did not feel comfortable going there because they said it was not located in a convenient and safe enough area.

It is beyond the scope of our evaluation to assess the suitability of all the locations of care MHPP health advocates have referred youth to over the past four years, or to assess all patient-provider relationships for participating youth. Nonetheless, the positive effects attributed to MHPP’s partnering health center in Boston suggest that it is important for programs like MHPP, with the goal of improving system-involved youth’s access to health care, to consider where youth are being connected to care and to whom they are being connected for that care. Another important factor to consider is who is connecting youth to community health care. One CRC manager noted how one of the MHPP nurses, due to her knowledge of how to navigate
the health care system, was able to facilitate youth’s access to health care in ways that caseworkers were unable to do:

*I mean on individual clients they’ve been able to get some appointments that caseworkers may not have been able to get. [The MHPP health advocate] has been able to make some phone calls and been able to get a couple of emergency appointments or things that a caseworker may not be able to do--they would depend on the parent and sometimes it wouldn’t happen in the past so I think that’s an impact. We had one client that needed to get into a substance abuse program and [the MHPP health advocate] was able to help us out, also around kind of going around certain things that she was aware of that the caseworkers weren’t* (Personal Interview).

As the Massachusetts Department of Youth Services (DYS) moves toward having caseworkers manage health care for youth re-entering their communities, this perceived strength of having an MHPP nurse facilitate youth’s access to care speaks to the need for having health care personnel (possibly those subcontracted to work in the DYS facilities) available to caseworkers for assistance with health care access issues. On the other hand, the MHPP health advocate in Boston is not a nurse, and she has successfully facilitated access to care for many of the boys participating in the program. Thus, the MHPP in Boston makes the case that regardless of professional status, whoever is connecting youth to community health care needs to know, at the very least, how to navigate the local health care system and how to locate health care sites and providers that are accessible and responsive to youth’s health care needs and preferences.

Our interviews with youth informants reveal a difference along gender lines, although we cannot claim that this difference is generalizable given the small sample size. The two boys we interviewed reported they had not seen a primary care provider for some time and were now receiving care on a regular basis at SBHC, as a result of their MHPP participation. All but one of the girls we interviewed were already connected to primary care providers and did not attribute their access to care to MHPP. However, one girl noted that even though her mother makes all her appointments, she herself would go to the MHPP health advocate for scheduling a pregnancy test, which she said she would be “scared” to do, and would not want her mother to know about. This example suggests that programs like MHPP might be especially helpful to improving youth’s access to care for certain types of services that youth might not otherwise obtain out of fear, embarrassment, or a desire for confidentiality.

All MHPP program staff claimed to have succeeded at helping youth attain this goal. As one MHPP health advocate noted,

*I’ve been able to connect girls with health care providers, and I think there’ve been some girls who have been able to seek treatment who otherwise would not have.* (Personal Interview)

Our interviews with MHPP health advocates, as well as our review of their monthly reports and their documentation of service delivery in the MHPP database, indicate that they worked toward improving youth’s access to care through a variety of methods, including a) assessing if
youth had a primary care provider in the community and if so, reconnecting them to that provider, and if not, referring them to the partnering health center; b) providing youth extensive assistance with appointment making; c) accompanying youth to medical appointments; d) following up with youth about services received; and d) providing health care education aimed at teaching youth how to access care independently (e.g., how to fill prescriptions, understand health insurance coverage).

While we cannot claim that MHPP improved health care access for all participating youth, our data reveal that program staff actively engaged in efforts to improve access to care for the youth they served, and key informants, mostly adults, but also two participating boys, attributed improvements in this area to MHPP.

**Improving Social Supports for Enrolled Youth**

According to the MHPP logic model, the goal of improving social supports for enrolled youth referred to support from families, health care providers, and community services and programs. Most informants were unsure whether or not MHPP improved social supports for enrolled youth. A few informants noted that a primary role of certain CRC staff (e.g., clinicians, caseworkers) is to connect youth to social supports, thus suggesting that others in the system are also paying attention to this area of need.

The MHPP health advocate in Worcester felt her communications with parents and with case managers around girls’ health needs helped to improve their health related supports (Personal Interview). In Boston, the MHPP health advocate reported that providers at SBHC were a source of social support for one boy whom she referred there, noting they assisted him with a variety of issues, including housing. She said she also referred boys with children to Healthy Families Massachusetts, a program that provides supports to teenage parents.

A representative of one of the partnering health centers said the MHPP health advocate was herself a source of social support for youth, and most of the girls and the boys we interviewed corroborated this, describing the MHPP advocate as someone they go to, or would go to, when they are in need of help. One girl said she knew if she ever needed the MHPP nurse, she would be there for her. Another girl described the support she and other girls receive from the MHPP advocate in this way:

> I think it’s good to have her here. For us girls, especially because girls, we have a lot of needs and health problems and all that and she’s good to talk to. I think it’s really good to have her here, because like I said, I have a good relationship with my doctor, but most girls and most people don’t, so it’s good to have her to talk to. (Personal Interview)

Similarly, when we asked one of the boys how effective MHPP had been in providing him support, he responded, “fully, 100%” (Personal Interview). He identified Dr. Vetters at SBHC
and the MHPP health advocate as the people he would go to with health concerns. He also said the MHPP health advocate had given him support around his job search.

The youth we interviewed identified a variety of social supports in their life, including parents and family members, friends, work colleagues, and doctors. Our data suggest that of these reported sources of support, MHPP advocates primarily helped connect youth to doctors. A couple of MHPP advocates made efforts to involve parents and family members as supports to individual youth around health and educational issues. While MHPP advocates, to varying degrees, used the program database and Acoca health assessment screening protocol to document youth’s social supports, we do not have sufficient data to conclude that the advocates then succeeded in improving the quality or quantity of those supports. It thus seems important for programs such as MHPP to engage in assessments of youth’s social supports and to document any and all efforts related to strengthening those supports.

**Improving the Health Status for Enrolled Youth**

From the original conceptualization of the MHPP logic model, improving the health status for enrolled youth was envisioned as the “ultimate goal,” based on the assumption that improving health access, changing the relevant systems, and improving social supports for youth would inevitably lead to their improved health status. The adult key informants we interviewed offered examples of individual youth whose health they felt had been improved through their participation in MHPP, and these examples centered on three or four youth with serious injuries or chronic illnesses.

Key informants, in particular two senior DYS officials, a caseworker, and a health care provider pointed to the “follow-up” care that MHPP health advocates provided as a critical factor in improving the health status of these youth who had complicated medical cases. Our interviews with the current Boston MHPP health advocate reveal the extent of this follow-up care, with hours spent accompanying the youth to appointments and visiting them in the hospital (e.g., for the girl in need of infusions and the boy who experienced multiple injuries).

We did not ask the girls about MHPP’s effect on their health status, but when we asked this of the boys, one gave specific examples, including connecting him to a nutritionist, which he reported has changed his diet, and helping with his recovery from a facial injury (Personal Interview, December 2008). The other boy we interviewed only spoke of SBHC (which he conflated with MHPP), and described the extent to which he thought the health center improved his health:

> I don’t think they helped me improve it because there was nothing wrong with it unless I had something and they gave me some medicine or some treatment, but they just helped me maintain it (Personal Interview, January 2009).

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54 Interviews with girls were conducted for the Parent Influence Substudy and the interview protocol included a limited number of questions about perceptions of MHPP services.
This boy’s comment suggests that for those youth who do not have serious medical issues, linking youth to services that will assist them in maintaining their good health may be the program’s most realistic, achievable goal.

A representative of one of the partnering health centers spoke to how particular MHPP services have strong potential for improving youth’s health status in the long term. For example, he noted how the fact that the MHPP advocate was bringing in youth for sexually transmitted infection (STI) testing and treatment is a form of preventative health care that would improve health for them and their partners (Personal Interview, September 2008). Similarly, one of the MHPP advocates described how some of the girls with whom she worked who were overweight experienced significant weight loss, which she attributed to an emphasis both on her part and others at the CRC on exercise and healthy eating. She said staff at the CRC connected the girls to an exercise program at the local YWCA and she accompanied one girl to the orientation for the program. In addition, she talked with girls about their diets and nutrition and she spoke with CRC staff about having healthier snacks at the CRC (e.g., “fruit cups and apple sauces” instead of “Yo-Hos and Ring Dings,” Personal Interview).

These examples from the community health center representative and the MHPP health advocate illustrate the important role that community health centers, DYS and re-entry center staff, and community service organizations, all must play in order for programs like MHPP to make progress towards goals like improving the health status of system-involved youth. Thus, while we cannot claim that MHPP has succeeded in improving the health status of all system-involved youth enrolled in the program, our data indicate some likely progress toward this goal, facilitated by consistent follow-through on the part of MHPP health advocates for those youth with serious medical issues, and by support from those individuals, programs, and services connected to it.

**Perceived Effects on DYS and CRC Staff**

In addition to the perceived effects of MHPP on participating youth, our data speak to effects of the program on DYS and CRC staff. In particular, several informants described how MHPP health advocates have relieved DYS and CRC staff of managing youth’s health care in the community, thus allowing them to focus on their other case management responsibilities (e.g., linking youth to educational, employment, and social services). Informants also reported how MHPP advocates have facilitated communication among staff around youth’s health care needs, and have served as a resource to staff.

One of the MHPP health advocates shared her perception of how the program has helped to relieve DYS and CRC staff of managing youth’s health care in this way:

> I know that the case managers have told me that they’re really happy to be able to not have to work through the medical issues themselves and that they’re pleased to have someone to hand that off to because they’re not always sure what to do (Personal Interview).
Indeed, DYS and CRC staff we interviewed noted how MHPP advocates help “free up” staff to focus on providing other services to youth. As one CRC program director said, “The Health Passport Project has actually assisted in doing our job” (Personal Interview, December 2008).

Several informants credited MHPP with facilitating communication among staff around youth’s health care needs. One DYS nurse described the impact of the program on medical providers like herself who provide health care services to youth in DYS facilities as “huge.” She said the MHPP advocate with whom she worked communicated with her regularly, and she could always count on her to follow up on medical issues with girls who were soon to be released to the community, something she had not always been able to do with caseworkers prior to MHPP (Personal Interview).

One caseworker said that she and the MHPP health advocate communicate frequently about the health needs of youth in her caseload and for that reason, “...now more so than before there is a more consistent line of communication” (Personal Interview). A senior DYS official described a case where DYS providers in the facilities and an MHPP health advocate communicated about a girl who was in need of health care upon release to the community. This communication resulted in the MHPP advocate visiting the girl in the treatment facility to discuss a plan for her care. The senior DYS official who described this case said, “That was really my first real involvement and my first demonstration that [MHPP] was working” (Personal Interview).

Caseworkers and CRC managers we interviewed also spoke of how MHPP health advocates served as a resource to staff, helping to answer their questions about specific health issues and educating staff about the importance of a preventive health care approach. To this latter point, one caseworker described how MHPP was a resource to her and other CRC staff:

The before picture was kind of like, we treated immediate concerns, visible concerns, now we’re trying to do the whole thing, you know, teach children to do even just the yearly exams, the check-ups—the things that every adult would do for themselves (Personal Interview).

One of the CRC managers noted how the program also helped educate staff about girls’ health needs and gender-specific programs. She said the MHPP health advocates helped her staff understand how girls’ health needs can affect them socially and educationally (Personal Interview). Finally, one caseworker described the multiple benefits of having the MHPP health advocate on site at the CRC:

She has alleviated a lot of our pressure. It’s been great. She can answer our questions, she can tell us how the health care systems run, why we may not be able to get information; it just opens up a whole other line of communication (Personal Interview).

While not all the informants we interviewed could speak to impacts of the program on DYS and CRC staff, those that did described a positive impact, particularly in terms of relieving

caseworkers of managing youth’s health care in the community, facilitating communication among staff around youth’s health care needs, and serving as a resource to staff. Our data reveal that DYS staff (e.g., caseworkers and health care providers) as well as individual youth, appear to have benefited from the support, education, and communication provided to staff by the MHPP health advocates. Given the Department’s plans for caseworkers to assume primary responsibility for youth’s health care management upon community re-entry, these findings suggest a need for DYS staff to have additional support from health professionals in doing this work.

Perceived Effects on Partnering Community Health Centers

The informants representing partnering community health centers all described how MHPP has had a positive impact on their organizations, particularly in terms of its enabling them to conduct outreach to a population of youth they wanted to serve. As noted in the Systems Change substudy, Michelle Rue, Director of Health, Education, and Outreach for Dotwell/Codman Square Health Center (D/CSHC), the program’s original partnering health center in Boston, credited MHPP with changing the center’s approach to working with system-involved youth. She spoke of how the partnership with MHPP helped her agency realize that with system-involved youth’s probation restrictions and daily reporting requirements, services needed to be brought to the youth, “meeting them on their ground” (Personal Interview, April 2007). Thus, by employing the original MHPP nurse in Boston, D/CSHC was able to bring health services to system-involved youth at the DYS CRCs.

Similarly, Bob Garcia, Director of Behavioral Health Services at SBHC, the current partnering health center in Boston, described the benefits of partnering with MHPP as such:

I think that one benefit would be that we are able to outreach to the youth that we identify as part of our mission, in a way that doesn’t cost us any resources. So it supplements our outreach efforts in that regard. It also, I think, educates us about a population with which we don’t have a lot of familiarity. I think we have a lot of familiarity with at-risk young adults, but we seem to have targeted over our history a population that isn’t necessarily DYS involved or court involved. So I think we are able to learn about a segment of the population we hope to target and in a more effective way (Personal Interview, September 2008).

A representative from GBVHC, the partnering health center in Worcester, also spoke of the ways in which the program has benefited it:

We are at the Worcester Jail, the Worcester County Jail, we are at MCI Framingham, we have lots of transitional programs for people coming out of jail into the community with HIV, so there are a lot of connections for us in the correctional system, and in many ways it’s great to be involved earlier on, and you know, to be able to intervene when people are at a different stage in this whole process. And so I think it’s been good for us to be involved in the DYS system (Personal Interview).
These perceived effects speak to the importance of programs such as MHPP partnering with health centers that are aligned with the program’s mission and are committed to meeting the particular health needs of system-involved youth. The extent to which these partnering health centers have actually met the health needs of participating youth has been variable and, as discussed earlier, has been influenced by youth’s perceptions of the safety of the center and youth’s desire to seek care at a different health care home that is more easily accessible to them and/or where they have already established relationships with providers.

Perceived Effects on Parents

By and large, informants were unsure of the effects of MHPP on parents of participating youth. Two MHPP health advocates spoke of their communications with individual parents and grandparents around health and educational issues, and they perceived these communications to be helpful to parents. One of these advocates described her support of parents in this way:

… there’s been situations where parents weren’t sure how to proceed in certain circumstances, and I helped with the decision making processes, helped with educating some parents about certain health conditions, and mostly I’ve helped with identifying providers and facilitating making appointments where it can be difficult for parents to do that in their busy day (Personal Interview).

A few informants, including a caseworker, DYS health care provider, and CRC manager said they did not know of an impact firsthand but conjectured that the program was helpful to parents given that it provided someone to assist their children with making medical appointments and helping them get to those appointments. These and other informants said they had received no negative feedback or complaints from parents, but again could not speak to specific impacts. Our data, or lack thereof, on MHPP’s perceived impacts on parents reflect in part the fact that the program does not identify parent involvement as one of its major process goals or program strategies; staff have not regularly communicated with, or involved, parents in the program. In turn, because most parents have not been involved in the program, it was not realistic for us to conduct perceived effects interviews with parents, which would have allowed for the most direct assessment of how, if at all, they perceived the program to have an impact on them.

Conclusions

Of the three MHPP goals discussed here, improving health care access for enrolled youth was the one goal that the majority of informants agreed the program had achieved to some extent. Our data reveal that program staff actively engaged in efforts to improve youth’s access to health care in their communities, referring them to care at the partnering health centers or

55 See the Systems Change substudy that follows, and Section Three of this report.
reconnecting youth to previously established providers. Informants were not as confident about the role MHPP played in the improvement of social supports for youth, though our data suggest that MHPP advocates were themselves a key source of social support around health care for these youth and they connected youth to community providers, who were in turn a source of support for many youth. In terms of the goal of improving youth’s health status, informants agreed this was a goal that is difficult to measure in the short term. Our data indicate progress toward this goal, as seen in the critical role MHPP advocates played in linking youth with serious injuries and chronic illnesses to the care they needed and the overall efforts of the MHPP advocates to help youth connect to a regular source of care and to educate youth about the importance of a preventative approach to their health care.

The key informants we interviewed reported positive impacts of MHPP on specific individuals involved in the program, and conveyed a sense that the program has strong potential for a positive impact over the long term. One of the boys we interviewed said, “It’s a good program. I appreciate it.” When asked how long he would like to stay involved in the program, he replied, “till it expires…hopefully never” (Personal Interview). The adult informants we interviewed credited the program with offering the “most consistency we’ve ever had,” and a “better continuum of health care services than prior” (Personal Interviews). One caseworker spoke to the impact of the program on bringing a preventative approach to health care to participating youth:

I just think it has had a great impact as far as education goes, as far as our clients are actually really getting involved in their regular routine health care. Dentists’ appointments, check-ups, physicals. Before, their only physicals would be in a locked facility that we had them in. So as far as that is concerned they’re more aware of their health care now (Personal Interview).

Similarly, Dr. Vetters of SBHC described how MHPP has influenced youth’s health care utilization:

It begins to get them integrated into the health care system and begins to teach them how to use it. I think the guy said, “I have a doctor now,” so they’re not going to go to the emergency department; they’ll come see me or call me instead. It’s a better utilization of health care. It’s more cost effective. It hopefully will contribute to better longitudinal care and follow-up (Personal Interview, November 2008).

One MHPP health advocate said the program helped her gain a new appreciation for the role of motivation in health, pushing her to think about what makes these youth want to be healthy and how she can affect that motivation. She felt the program has the potential to create a culture where health care maintenance is desirable, where youth will want to take care of themselves. As she explained:

I’m starting to see…it’s becoming okay to talk to the MHPP nurse. And I think that’s just the beginning and I think you know it would be a wonderful thing for these girls to have a place
where this is the message that they routinely get is that they need to take care of themselves, eat well, that they are important and worth taking care of (Personal Interview).

One of the limitations of this perceived-effects study is that many of the informants we interviewed did not feel they knew enough about the program to speak of its effects. As one senior DYS official remarked, “I can’t speak to how well it’s working because I don’t know how well it’s working because I don’t see enough of it” (Personal Interview). This informant felt the program needed to increase its visibility and suggested that program staff meet more regularly with regional directors and program directors to introduce themselves and the program. Other informants, including the boys, indicated that many youth, parents, and DYS staff are unaware of the program, or have heard of it, but are unsure of the services offered. These reports suggest that the program may want to increase its communication and outreach efforts, though we recognize this is difficult to achieve with limited funding and limited staff to oversee its operations.

As discussed in Section Three of this report, there are numerous factors on the individual, family, community, and system levels that could, and likely do, moderate the program’s positive influence on all those affected by the program, system-involved youth in particular. For example, MHPP can link youth to a health center in their community, but if that center is located in an area deemed unsafe by participating youth or is one that does not accommodate the needs of this population, then MHPP is limited in its efforts to improve health care access for participating youth.

Similarly, if CRC staff, as described previously, build a relationship with a local community center to offer youth an exercise program, and agree to healthier snacks on site, this helps to facilitate MHPP staff in their efforts to improve youth’s health status. Many factors, including greater collaborative efforts among those working with MHPP, more funding, a greater number of health advocates, and/or a larger enrollment of youth in the program, all would likely enable the program to make progress toward achieving its program goals and to have greater potential for creating a positive impact.
SYSTEMS CHANGE AND THE MASSACHUSETTS HEALTH PASSPORT PROJECT\textsuperscript{56}

The operational program theory of MHPP is that “better health care access coupled with systems change will yield better health for system-involved girls,”\textsuperscript{57} and boys as well. In attempting to understand the ways in which MHPP has been involved with systems-change efforts, this substudy report addresses the following questions: 1) Which systems are involved in MHPP? 2) What exactly is meant by systems change? 3) What do the program evaluation’s data reveal about systems changes, if any, that have occurred since the initiation of MHPP? and 4) What are the strengths and limitations of MHPP as a model of systems change? In addressing these questions, this substudy report reviews the relevant literature on systems change and situates the analysis in the specific timing and context in which the program was developed and has been operating over the last four years in Massachusetts.

Methodology

This systems change substudy relies primarily on qualitative data in the form of informants’ self-report, and while it draws mainly on informants’ perceptions of change, it also documents actual or observable change as evidenced by DYS documents and programs.

Data Sources and Analysis

The data reviewed and analyzed here include interview and focus group transcripts from conversations with senior DYS officials, DYS health care and direct service workers, MHPP staff, community health center partners, and funders (N≈80), as well as notes from meetings with DYS and program staff and with MHPP advisory board members, program documents (e.g., proposals, logic model), and DYS documents (e.g., annual reports). The interview and focus group transcripts were coded using a qualitative data analysis software package, ATLAS.ti. Codes were generated directly from the data and organized thematically. Cross-case analysis (Miles & Huberman, 1994) was used to examine perceptions of systems change shared across the interviews.

The Systems Involved and the Intended Systems Changes

In the early development of MHPP, program founder and director Francine Sherman, JD articulated a program theory model or logic model, the outline of program activities and outputs that are assumed, if implemented, to result in the achievement of program objectives (McLaughlin & Jordan, 1999). This logic model reveals that the systems in which MHPP intends to effect some change include DYS and state and local health care delivery systems (i.e.,

\textsuperscript{56} Substudy authors: Rachel Oliveri, MA, and Francine Jacobs, Ed.D.
\textsuperscript{57} See Massachusetts Health Passport Project Planning Grant proposal to the Jacob and Valeria Langeloth Foundation, 2005.
MassHealth and community health centers). The logic model also indicates that the changes the program would like to see in the systems involved include formal integration of comprehensive, continuous health services for system-involved youth prior to and upon community reentry and fiscal collaboration to sustain these services. Specific examples of anticipated program impacts on the system, as outlined in the logic model, include a continuous medical record for system-involved youth, parent involvement in health planning, and MassHealth reimbursement for nurse services at the CRCs. Some of the program’s articulated systems changes were conceived of as short-term outcomes, while others were expected to be intermediate and long-term outcomes. This study examines the program’s intended impacts on the relevant systems, discusses the facilitators and obstacles to affecting systems change, and notes where the program has succeeded in affecting change, where it has not, and where it is making progress toward that goal.58

The Context for Systems Change

Systems change does not typically occur spontaneously or in isolation; it is a long-term, dynamic process often informed by past and current events, interpersonal and organizational networks and relationships, and the political and economic climate at the time of the intervention. Systems change as it relates to MHPP is influenced by all of these contextual factors, in particular, those historical and political forces specific to the Massachusetts juvenile justice system.

An Overview of Change in the Massachusetts Juvenile Justice System

The key system in which the MHPP operates and intends to effect change is DYS. This public agency, which dates its origins to the opening of a reform school in Westborough for 400 boys in 1846, has undergone many changes over the years. Administrative oversight for the system has shifted from boards of trustees to the Department of Education to its current location within the Office of Health and Human Services. Public criticism of mismanagement and abuse within the “training schools” in the 1960s led to a period of deinstitutionalization in the 1970s, where many of the state operated facilities were closed, and status offenders59 were separated from serious offenders. The agency then sought private providers to contract for programs, serving as the basis for the current community partnership system. The 1970s and 1980s were characterized by an expansion of secure units, group homes, educational services, and other specialized treatment services (Office of Health and Human Services, 2009).

Nationwide, whereas “community-based programs, diversion, and deinstitutionalization became the banners of juvenile justice policy in the 1970s” (Office of Juvenile Justice and Delinquency Prevention, 1999, p. 4), highly publicized juvenile crimes in the 1980s and 1990s created the widespread perception that juvenile crime was growing more violent and rampant. Thus, “the pendulum began to swing toward law and order” (p. 4), and the 1990s were

58 See Table 3.1: MHPP Logic Model Analysis, p. 124 of this report.
59 Youthful offenders whose offenses pertain to their minor status (eg., truancy).
characterized as “a time of unprecedented change as State legislatures crack down on juvenile crime” (p.5). Indeed, in Massachusetts, the early to mid 1990s were marked by an increase in the census of youth committed to DYS custody, the highly publicized murders of four youth in DYS custody, and a resulting emphasis on public safety and crime prevention.

In the late 1990s, the Department underwent a strategic planning process, developed day reporting and then community re-entry centers located in towns with the highest concentrations of system-involved youth, and established operating standards, practices, and policies. In the last decade, during the time that MHPP began, DYS has expanded services for those youth considered “serious and violent offenders” and has created new separate facilities and programs for girls committed to DYS custody (Office of Health and Human Services, 2009). While many of the “get tough” policies of the 1990s are still in place nationally and statewide, more recent reform efforts signal a new emphasis on creating alternatives to detention, integrating positive youth development approaches, addressing racial and ethnic disparities in the system, and enhancing or expanding mental health, substance abuse, community re-entry, and gender-responsive services (Hsia & Beyer, 2000; Merlo, Benekos, & Cook, 1999; Nissen, Butts, Merrigan, & Kraft, 2006; Stanfield, 1999; Ziedenberg, 2006). As Ziedenberg (2006) explains,

Significant new research on adolescent development and the demonstrated success of evidence-based practices have buoyed efforts to reestablish more rational and effective policies. While some still beat the drum for harsher measures, a group of innovative state leaders from across the country are creating a new path toward fair, rational, effective, and developmentally appropriate models for juvenile justice reform (p. 3).

One theme that emerges from this recent literature on juvenile justice reform is the importance of involving all the stakeholders—from senior administrators to line staff to youth and their families. In writing about girls and detention reform, Sherman (2005) describes The Center for Young Women’s Development, a program in San Francisco operated entirely by girls who are either currently or formerly involved in the juvenile justice system. Reflecting on her work to promote leadership and activism in these girls, the executive director, Marlene Sanchez, who was herself a former system-involved youth, said, “Young people who are affected firsthand by the system will be the ones to change it” (p. 62). Indeed, in any systems-change effort of this nature, it seems especially important to keep sight of how youth are affected by and effect changes in the juvenile justice system. The MHPP grew out of Sherman’s direct advocacy work with system-involved youth. Through MHPP evaluation, a handful of youth were interviewed about their health care needs and ideas for improved services, and these youth voices helped to inform MHPP’s expansion planning and service delivery model.

System-involved Youth and Health Care

The intersection of system-involved youth and health care is another important piece of the context in which MHPP intends to effect systems change. The DYS provides health services to
all youth in out-of-home placements. This includes on-site health care staff at secure facilities, health assessment during admission of youth to detention, screening for sexually transmitted diseases (STDs) and other illnesses, HIV/STD education, and for adjudicated youth, a complete medical history and physical examination (repeated annually when youth are in out-of-home placements), dental examination and treatment, immunization updates as required, and voluntary HIV testing and counseling (Office of Health and Human Services, 2009).

According to Ed Dolan, Deputy Commissioner of DYS, the health care of system-involved youth upon community re-entry is monitored by caseworkers, but largely the responsibility of youth and their families. Dolan noted that DYS provides no formalized health management in the community, but that “DYS will make the effort to connect with community providers when there is an ongoing issue” and offer support to families in managing health care (Personal Interview, April 2007).

The DYS caseworkers spoke of the challenges of overseeing health care-related services, saying, for example, that they face long waits when trying to schedule appointments for youth to see mental health clinicians, are sometimes unable to understand medical transcription on a youth’s medical record, and find MassHealth to be a “purposeful puzzle” (Focus Groups, January and September 2006). A group of DYS health care providers and administrators said caseworkers do not always see health care management as their role and need more education and training in this area (Focus Group, 2006). Informants at all levels within DYS agreed that there was a need for a program such as MHPP that places a medically trained professional in the community who understands the systems involved (i.e., DYS, MassHealth, and local community health centers), who facilitates communication among the different systems, and who assists youth, their families, and their caseworkers in accessing and managing their health care during community re-entry.

Another part of the health care context for system-involved youth in Massachusetts is recent statewide legislation intended to improve services related to children’s health, in particular children’s mental health. In November 2006, the Massachusetts Society for the Prevention of Cruelty to Children, and Children’s Hospital/ Boston released a report entitled Children’s Mental Health in the Commonwealth: The Time is Now. Based on the report’s recommendations, Representative Ruth Balser and Senator Steven Tolman sponsored “An Act to Improve Children’s Access to Mental Health Services,” which was filed in January 2007. In addition, the Rosie D. lawsuit of January 2006 ruled that Massachusetts had violated Medicaid laws by failing to provide necessary services to children with emotional, behavioral, or psychiatric disabilities. As a result of Rosie D., the US District Court ordered the State of Massachusetts to make home-based services available to all Medicaid-eligible youth in need of care by June 30, 2009. Given that one of MHPP’s primary goals is to improve system-involved youth’s access to health services, including mental health services, these legislative initiatives offer a critical backdrop to MHPP’s efforts to work with DYS and community health care systems towards this goal.

When examining the context in which MHPP is operating, it becomes clear that the systems
involved are complex and have their own developmental rhythms. The following review of the literature provides several theoretical frameworks for understanding systems and how they change. Throughout the literature review, we integrate an analysis of MHPP data and explore how these theoretical frameworks can be applied to the program’s systems-change efforts.

Observing Systems Change through the MHPP Lens: Necessary Core Concepts

Rogers (1995) defines a social system as “a set of interrelated units that are engaged in joint problem-solving to accomplish a common goal” (p. 23). Social systems are often studied in terms of how they develop, how they affect and are affected by the individuals who comprise the system, how they interact with other systems, and how they change. For the purposes of this substudy report, the literature reviewed here draws upon theories of organizational development and examines the ways in which new ideas (such as MHPP) influence a social system. This review also explores the various factors that appear to facilitate systems change, both in general and more specifically within the juvenile justice system. Findings generated from an analysis of MHPP data are integrated throughout this section.

“Diffusion of Innovations”

Rogers (1995) examined the diffusion, or spread, of new ideas through a social system and developed a theory for how and why an innovation is adopted or rejected. He outlined five characteristics of an innovation that affect its rate of adoption:

- Relative advantage, or how much the innovation is perceived as better than what came before;
- Compatibility, or how much the innovation is perceived as consistent with existing values and past experiences;
- Complexity, or how much the innovation is perceived as difficult to understand and implement;
- Trialability, or how much the idea can be tested before its adoption; and
- Observability, or how visible the results of an innovation are to those considering its adoption (p. 15).

Rogers found that “innovations that are perceived by individuals as having greater relative advantage, compatibility, trialability, observability, and less complexity will be adopted more rapidly than other innovations” (p. 16).

This framework is useful for examining how an innovation such as MHPP came to be adopted by DYS and partnering health centers. In terms of relative advantage, the DYS informants we interviewed agreed that the program offered an opportunity to better meet the health care needs of youth re-entering their communities. Prior to MHPP, caseworkers were responsible for this piece and informants noted that while some caseworkers prioritized health issues and had the knowledge and skills to address them, others did not. Pam Kane, the former School-based Health Center Manager for GBVHC, who served as the liaison to MHPP in Worcester, described...
the program as “this resource that didn’t exist before” (Personal Interview, September 2008). In terms of compatibility, there was overwhelming consensus that the program fit with the Department’s positive youth development, gender-responsive, and community re-entry-focused approaches. In addition, informants from the partnering community health centers (e.g., D/CSHC in Dorchester, GBVHC in Worcester, and SBHC in Boston) spoke of the compatibility between the program and their mission to improve the health care of youth in their communities, particularly their efforts to do outreach with especially vulnerable youth populations such as those in the juvenile justice system. In terms of trialability, the pilot phase of the program not only facilitated early buy-in from the Department and partnering health centers, but also contributed to their support of the program’s expansion.

The final two elements that Rogers theorized as influencing the rate of an innovation’s adoption, its observability and complexity, are not as consistently present throughout the program’s history as the other components. Data from the early stages of the project indicate that informants had a clear understanding of the program—who the program staff were, how the program model was being implemented, its goals, etc. This early clarity about the program is likely due to the fact that the informants we interviewed had participated in advisory board meetings or focus groups that were part of the evaluation’s needs assessment research. Thus, they had received information about the program, had met face to face with program staff, and for some, were on site where the program was being delivered. In the later stages of the project, some informants had difficulty articulating the program model or its effects, and were unclear about who program staff were, where they were located, and which youth were being served. This lack of program observability and increasing complexity appear to have undermined, to some extent, the program’s diffusion and full integration into DYS; it also speaks to the need for program staff to maintain communication with stakeholders about changes in the program model.

Facilitators of Systems Change

In addition to the factors Rogers described as influencing the rate of adoption of innovations, other key elements that have been shown to facilitate change in organizations include small-scale strategic actions (Dym, 1998; Senge, 1990), leadership and collaboration (Barton & Butts, 2008; Feely, 1999; Hausman, 1994; Nissen, Merrigan, & Kraft, 2005; Sherman, 2005; Townsend & Carroll, 2002), and the “readiness” of organizations to change (Dym & Hutson, 1997). More specifically, within the juvenile justice system, system-wide changes appear to be largely influenced by shifting public attitudes and pressure, public policy decisions, economic factors, legislative efforts, and new research (Nissen, Butts, Merrigan, & Kraft, 2006; Stanfield, 1999; Ziedenberg, 2006).

Small-scale Strategic Actions

Peter Senge, a key figure in the field of organizational development and behavior, describes organizations as dynamic systems, continuously changing and adapting to internal and external
phenomena. A central tenet of his systems change theory is what he terms the principle of leverage:

> The bottom line of systems thinking is leverage—seeing where actions and changes in structures can lead to significant, enduring improvements. Often, leverage follows the principle of economy of means: where the best results come not from large-scale efforts but from small well-focused actions (1990, p. 114).

Small-scale actions that influence change have been referred to as leverage, tipping points (Gladwell, 2000), or forays (Dym, 1994), and appear key to the study of how organizations and social systems evolve. Dym (1994) defines forays as “movements away from one way of behaving or thinking toward another” (p. 1). He argues that forays offer a creative, efficient, and cost-effective approach to systems change, one that often meets with less resistance than found in comprehensive change projects (p. 2). According to Dym, sometimes forays are already in progress within an organization and other times they need to be created. Generating forays involves selecting a compelling and achievable project, framing it as urgent, experimental, and meaningful, and including “those who have the power to spread its influence” (p. 3).

The MHPP could easily be described as a “small well-focused action” or a “compelling and achievable project,” one that was framed as “urgent, experimental, and meaningful” and included “those who have the power to spread its influence.” Project director Sherman exercised leverage by seeing where a change in structure—positioning a health care professional in the community to address the health needs of system-involved youth—could lead to potentially long-lasting improvements.

**Leadership and Systems Change**

Rogers (1995) notes the important role of “change agents,” those individuals who lead the effort to spread new ideas through a system. In her cross-state analysis of family support programs, Hausman (1994) refers to change agents influencing innovative child and family policy. She expounds upon the qualities of these “policy entrepreneurs” (King & Roberts, 1987), noting in particular, the importance of flexibility:

> Policy entrepreneurs engaged in an iterative process of learning, molding, adapting, or “fine-tuning” their original program design to fit new understandings gained from practice in the field (p. 141).

In addition to a flexible management style, Hausman found effective policy entrepreneurs to be persistent, “engaged in imaginative searches for private and public funding” (p. 137), building alliances, launching new programs on a pilot basis, and exercising creative timing, that is, “knowing not only how, but when to maximize opportunities and make optimal use of their own equity and leverage” (p. 139).
Our data indicate that Sherman aptly fits Hausman’s description of a policy entrepreneur. She has demonstrated a great deal of flexibility, adapting the program continuously over the years, changing program goals, staff, sites, and health center partners in response to feedback from program collaborators, the fluctuating census of committed youth, sources of funding, and evaluation findings. Sherman has also secured funding (to date private), built alliances (e.g., most formally, the advisory committee in the early stages of the project), launched MHPP on a pilot basis, and exercised creative timing in introducing the project when she did. A representative from one of the program’s funders noted Sherman’s passion for her work as one of the key strengths of the program (Personal Interview).

Specific to the field of juvenile justice, Barton and Butts (2008) speak of the important role of leadership in spearheading programs with a positive youth development approach:

One of the most important factors that appears to facilitate successful implementation of these innovations is the commitment, credibility, and competence of leadership. As seen in several of the programs included in this study, the top administrator was responsible for establishing a vision for strength-based, positive youth development; allocating resources to support implementation; empowering, encouraging, and/or requiring adherence to the new model; and championing the approach with external stakeholders (p. 43).

Similarly, in describing gender-responsive reform efforts, Sherman herself (2005) notes how “reform for girls is advanced most effectively when it has champions, leaders either inside or outside of the system” (p. 74). She contends that “because girls’ issues are often among the last to be addressed and can be buried within other, broader system issues, a leader dedicated to interjecting a girls’ agenda into each discussion is critical” (p.75). Sherman is unquestionably such a leader when it comes to system reform for girls, as evidenced by her years of advocacy work in this area, numerous publications on the topic, including the one cited here, and her role as a consultant on issues affecting system-involved girls—locally for the Hyams Foundation’s Girls’ Initiative in Boston, as well as nationally through the Annie E. Casey Foundation’s Juvenile Detention Alternatives Initiative.

Collaboration in the Service of Systems Change

In examining reform efforts in the child welfare system in upstate New York, Townsend and Carroll (2002) describe how system change came about over a three-year period of interagency collaboration. Defining collaboration as “exchanging information, altering activities, sharing resources, and enhancing the capacity of another for mutual benefit and to achieve a common purpose” (p.20), they outline eight steps toward interagency collaboration in child welfare. The first of these involves “a collaborative leader,” who “inspires commitment and action, leads as a peer problem-solver, builds broad-based involvement, and sustains hope and participation” (p.

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60 Interview date has been removed, as informant requested anonymity.
The authors note that “in order for the collaborative to be a vehicle for systems change, the leader lends his or her influence and authority, perception of fairness, and credibility to the mission of the organization” (p. 21). They continue to posit that “collaborative leaders must be ‘systems thinkers’ who focus on underlying trends and forces of change rather than on the process of daily practice” (p. 21).

Sherman fits this description of a systems thinker; she appears less oriented toward day-to-day program management, and more interested in developing innovative projects and program models. Sherman’s collaborative leadership was especially evident in the early stages of the project, with the forming of MHPP advisory board. She convened the advisory board three times from the summer of 2005 through the spring of 2006. The board consisted of MHPP staff, DYS officials, program funders, and a range of professionals from the medical, public health, juvenile justice, and evaluation and research fields. The advisory board assisted the program in thinking through plans for expansion and addressed issues related to funding opportunities, data management, and the health needs of Massachusetts system-involved youth.

Sherman believes the advisory board meetings were a turning point for DYS, giving agency officials “a time to kind of pause and think in a big way about what they wanted to do” (Personal Interview, October 2008). The DYS Deputy Commissioner Dolan echoed this sentiment, describing the advisory board meetings as “enormously helpful” and “an eye-opener for us.” In reference to addressing gender in health care delivery, he said that the meetings “helped shaped our thinking that we may need to do this differently” (Personal Interview, December 2008).

Since those early advisory board meetings, Sherman has not convened a similar broad-based group of advisors. She has maintained relationships with DYS and the partnering health centers through occasional conversations and meetings, including a series of meetings beginning in the fall of 2007 with MHPP staff and DYS, community health centers, and evaluation representatives to discuss the health survey pilot study. Sherman also collaborated with SBHC to submit a foundation grant proposal in the fall of 2008. In addition, DYS invited MHPP and SBHC to jointly submit a federal grant proposal in the spring of 2008.

Effective collaborations are flexible and evolve with changing needs, and are characterized by strong leadership and communication among the stakeholders, equitable commitment of time and resources, and a shared vision (Feely, 1999; Nissen, Butts, Merrigan, & Kraft, 2006; Townsend & Carroll, 2002; Ziedenberg, 2006). While Sherman and the program’s stakeholders have articulated a shared vision of improving the health of system-involved youth, their communication, time, and resources have not been consistent throughout the program’s history. In terms of communication, some DYS, CRC, and partnering health center representatives have expressed a desire for more regular meetings with program staff and more communication from the program about changes in program staffing and implementation (Personal Interviews, August – December 2008).
In terms of time and resources, prior to the recent round of grant applications, DYS and the partnering community health centers did not participate in seeking public or private funding for the program; Sherman sought and secured all funding for the program’s operation and evaluation on her own. Given the implausibility of Sherman continuously supporting the program single-handedly, the long-term sustainability of the program and its ability to effect systems change are largely dependent on the involvement of the key partnering agencies. Thus, going forward, Sherman must exercise her collaborative leadership skills and actively engage program stakeholders in determining together how best to achieve their shared vision of improving the health of system-involved youth.

The “Readiness” of Organizations to Change

While small-scale actions, leadership, and collaboration have been shown to facilitate change, organizations often resist change when they are not ready for it. Dym and Hutson (1997) examine this idea of “organizational readiness” and note that despite the most careful planning and the existence of charismatic leaders, there are times when change efforts fail simply because organizations are not ready. Dym and Hutson make a case for identifying states of readiness within an organization, and then creating interventions that match these states of readiness (p. 33). They emphasize that “there must be a fit at the point of intervention… “fit is the key variable in determining success” (p.35).

Our data indicate that the introduction of MHPP coincided with a shift in DYS toward a “positive youth development” (PYD) model, increased efforts to provide gender-responsive services, and a growing emphasis on the CRC model intended to provide more comprehensive services to youth re-entering their communities. It appears that all three of these developments within DYS contributed to the Department’s early receptivity to MHPP.

In terms of the PYD model, DYS Deputy Commissioner Dolan said MHPP “fits in nicely” with its approach to serve youth holistically. He explained the PYD theory that if youth are receiving good health care, good education, and good supports, then they will do better in the long run: “Our goal is not only to prevent recidivism and reoffending but also to create healthy youth” (Personal Interview, January 2006).

During the time MHPP has been operating, the Department has also increased its efforts to provide gender-responsive services. Examples include the hiring in 2005 of a Director of Female Services, the shift in several sites (e.g., Boston and Worcester) from coed CRCs to single-sex centers, the opening of a new all-girls facility in Westborough, and the tracking of gender differences in health care utilization within DYS facilities. As to this latter point, one senior DYS informant explained that the agency learned girls were consuming more hours of health care

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61 “The Positive Youth Development approach understands that all young people need support, guidance, and opportunities during adolescence. It also looks toward creating supportive communities for all young people and at the same time, engaging youth to contribute to the well-being of the larger community” (http://www.acf.hhs.gov/programs/fysb/content/positiveyouth).
than boys and thus they doubled the number of medical hours available to girls as of July 1, 2005 (Personal Interview, January 2006). Several of the gender-responsive services implemented by DYS were outlined in its 2005 Annual Report:

During Fiscal Year ’05, DYS was funded to implement a Female Services Initiative. Currently, there are several ongoing initiatives within the Department that were specifically funded by the Massachusetts Legislature to enhance services to the female population. DYS increased compensation for clinicians in programs for females to attract qualified professionals. The Department obtained psychiatric stabilization services for young women in crisis; and DYS established an independent living program for females transitioning back to the community from residential settings. Additionally, DYS hired a Director of Female Services to oversee statewide programming, develop gender-specific policies and procedures, and drive an agenda for improved services for young women in DYS care. Finally, in November 2005, DYS and the Department of Capital Asset Management (DCAM) broke ground to construct a new 45-bed state of the art female specific assessment and secure treatment facility in Westborough. (p.20)

In addition to the state-wide services, the DYS 2005 and 2006 annual reports describe Boston-based initiatives serving girls in the system and include the Girls Health Passport Project (GHPP). Significantly, GHPP and MHPP are the only programs listed in these reports under health services “in the community” (Massachusetts Department of Youth Services 2006 annual report, p. 30).

The program’s focus on community re-entry also aligns itself well with the Department’s efforts in this area. As documented on July 20, 2005 in MHPP advisory panel meeting notes,

Commissioner Tewksbury expressed the Department of Youth Services’ commitment and support for the project which enables DYS to pilot and improve their efforts in the areas of health and community transition. The GHPP/MHPP model is consistent with their vision for the Community Re-entry Centers (CRCs) to make transitions back to the community easier and more successful. (p.1)

A senior DYS informant echoed this sentiment, noting that MHPP complements the CRC model in that it responds to the specific needs of youth in their communities and utilizes existing services in the community (Personal Interview, January 2006). Over the first three years of the program’s operation, DYS increased the number of CRCs across the state and contracted with community-based organizations such as Roxbury Youth Works, Inc. (RYI) to manage the centers and offer system-involved youth advocacy, educational programming, case management, and outreach services. Our data indicate that DYS and RYI staff viewed the program as another much-needed service for youth re-entering the community.

Not only was it fortuitous for MHPP that DYS was in a position in its development to welcome the intervention, but the “readiness” of local community health centers to partner with the
program also facilitated the program’s ability to effect change in the systems involved. The D/CSHC in Dorchester, GBVHC in Worcester, and SBHC in Boston all were receptive to the program when introduced to it by Sherman. They expressed interest in broadening their outreach to serve system-involved youth in their communities and felt the program was a good fit for their outreach efforts. Pam Kane from GBVHC said MHPP “is specific to [GBVHC’s] mission,” which, she noted, was “taking care of disadvantaged populations around health care” (Personal Interview, September 2008). Similarly, Bob Garcia, Director of Behavioral Health Services at SBHC, and liaison to MHPP in Boston, said, “The models that MHPP has…and its broader social goals and aspirations about empowering young people to access health care fit completely with the whole raison d’être of the clinic to begin with” (Personal Interview, September 2008).

Our data thus indicate that DYS and the program’s partnering health centers were ready to adopt this innovation called MHPP and to rethink how to address health care for system-involved youth re-entering their communities. There was indeed “a fit at the point of intervention” (Dym & Hutson, 1997, p. 35). Sherman acknowledges this fortuitous timing of the program that facilitated its adoption:

We hit this at the right time. So if this was ten years ago when we were doing this, I’m not sure it would have had the same result; we hit it at the right time, everything in Massachusetts is about health at this moment, the changeover in DYS, Jane [Tewksbury], the new staffing, the emphasis on community, you know all of that fit well with this initiative, so we hit it at the right time and we provided an answer to them for how to deal with something, and we provided an answer that was being evaluated and thought through (Personal Interview, October 2008).

This review of the literature on theories of systems change provides a context for understanding how MHPP developed and influenced the juvenile justice and health systems involved. We now turn from theoretical perspectives to the practicalities of systems change. In the following section, we use MHPP as a case study to examine approaches that have been used to effect change in juvenile justice systems nationwide.

### Approaches Used by States to Effect Change in Juvenile Justice Systems

In 1998, The Office of Juvenile Justice and Delinquency Prevention (OJJDP) invited states that had received funding from the State Challenge program (a product of the 1992 reauthorization of the Juvenile Justice and Delinquency Prevention Act of 1974) to submit examples of activities they had undertaken to improve their juvenile justice systems. The OJJDP then compiled the list below of eleven key themes that emerged from these national system change efforts (Hsia & Beyer, 2000, pp. 5-10). Although MHPP is a relatively small, young, and targeted initiative, our data reveal that it has, nonetheless, engaged in many of these major systems-change activities, as detailed below:
1. Use data to produce policy changes and legislative reforms.
This approach has been articulated as a long-term goal of MHPP, but has not been evident to date. At this stage in its development, it is not realistic to expect that data from MHPP could produce policy changes and legislative reforms.

2. Use research to guide reforms in service delivery.
From its inception, MHPP has used research to inform the development of the program model and its implementation. All of the program’s grant proposals cite research on gender-responsive programming, systems reform, and the health needs of system-involved youth as a basis for the program’s development. The program’s advisory board included those with research backgrounds in the fields of adolescent development, health care, juvenile justice reform, and program evaluation. Research reports from MHPP evaluation team informed the program’s early expansion and its service delivery to boys.

3. Increase public awareness and professional competence through training conferences, publications, and technical assistance.
Sherman and senior DYS officials have spoken publicly about the project in different forums related to juvenile justice, health care, and gender-responsive programming. Sherman’s Juvenile Rights Advocacy Project (JRAP) at Boston College Law School published a guide for practitioners entitled Consent to medical treatment for minors in Massachusetts (2006), and Sherman wrote a piece on MHPP entitled Access to Community Healthcare for Youth in the Juvenile Justice System: Initial Lessons from the Massachusetts Health Passport Project in the October/November 2007 issue of Women, Girls, and Criminal Justice. Sherman is also in the process of co-editing a book on health and well-being in the juvenile justice system.

4. Develop curricula on gender-specific issues for juvenile justice personnel and service providers.
While MHPP does not offer a formal curriculum on gender-specific issues for juvenile justice personnel and service providers, the advisory board meetings, MHPP evaluation reports, and communication between the nurse/health advocates and DYS and CRC staff have all drawn attention to the gender-specific health needs of youth in the system.

5. Develop curricula on gender-specific issues for female offenders.
MHPP addresses gender-specific health issues for female offenders in its design and delivery. Sherman also contracted with a public health professional to work with a group of system-involved girls in Boston to develop a curriculum around what girls need to know about health care. Plans are in progress for the girls to engage in participatory research, interviewing each other on health access and education issues such as how you find a doctor, get to a doctor, make appointments, etc.

6. Draft program regulations, policies, and/or procedures for statewide use by drawing on recent and specific program experience.
This approach has been identified as a long-term goal of the program and one that will require additional resources. In the program’s most recent grant application, Sherman and Garcia
(Director of Behavioral Health Services at SBHC) articulated their desire to publish tools to spread best practices and promote replication (Foundation grant concept letter, September 2008).

7. Develop screening instruments to guide service planning.
MHPP nurse advocates have utilized versions of Leslie Acoca’s “Girls’ Health Resources Screen Protocol” (2005) as part of the enrollment process for girls. In addition, in consultation with program staff and partners, MHPP evaluation team developed a series of surveys to assess past and current health- and health care utilization-related patterns in the Massachusetts juvenile justice population. These surveys are intended to assist MHPP and its partners in targeting health services accordingly to the population they serve.

8. Implement demonstration programs at additional sites.
On a small scale, MHPP has expanded from its original pilot program in one site serving girls in Boston. The program has primarily operated in two CRCs serving girls in Boston and Worcester, but has more recently expanded to additional sites to serve boys in both of those communities.

9. Fill a significant service gap in a substantial way.
In the needs-assessment research conducted by MHPP evaluation team (Jacobs et al., 2006), there was broad consensus that the health needs of system-involved youth were not being adequately addressed during community re-entry and health records or information were not being efficiently communicated or transferred between internal (e.g., facility) providers and outside (e.g., community health) providers. Thus, informants underscored the need for a program like MHPP to fill this service gap. It is not possible to date to claim that MHPP filled this gap in a substantial way, but it has demonstrated its efforts to provide a needed service at its program sites.

10. Form ongoing and sustained partnerships to provide coordinated services.
MHPP has formed ongoing and sustained partnerships with DYS and community health centers to provide coordinated health services to system-involved youth in Boston and Worcester.

11. Develop capacity in the private sector to increase the overall capacity of the service system.
MHPP has engaged in public-private partnerships by securing private funding for the project and serving as the bridge between system-involved youth and community-based health agencies. Thus, on a small scale, the project has increased the capacity of the private sector to serve system-involved youth and in turn has increased the capacity of the public system intended to serve these youth.

MHPP has engaged in most of these systems-change activities. For some, such as developing gender-responsive curricula for service providers and drafting program policies and procedures, increased efforts in these areas would strengthen the program and likely increase
its effectiveness in this arena. For others, such as using data to produce policy changes and legislative reforms, it is not expected that MHPP could undertake such a task at this point in its development. Given that MHPP is a small-scale and relatively young initiative that is not yet statewide, it is impressive that it has already taken steps similar to those made by much larger national systems-change efforts.

MHPP Perceived Impact on the Relevant Systems

Informants from DYS and the partnering health centers shared what they perceived to be the influences of MHPP on their agencies during the course of their involvement with the project. According to DYS Deputy Commissioner Dolan, “MHPP has been an engine for change and an engine for thinking about this domain of DYS kids’ life; it has raised questions about what DYS should be doing around kids’ health” (Personal Interview, April 2007). Another senior DYS informant described MHPP as “the bridge from the health services provided within DYS to health services provided in the community” (Personal Interview). Michelle Rue, Director of Health, Education and Outreach for D/CSHC, the program’s original partnering health center in Boston, credited MHPP with changing their approach to working with system-involved youth. She spoke of how the partnership with MHPP helped her agency realize that with system-involved youth’s probation restrictions and daily reporting requirements, services needed to be brought to the youth, “meeting them on their ground” (Personal Interview, April 2007). Thus, by employing the original MHPP nurse in Boston, D/CSHC was able to bring health services to system-involved youth at the DYS CRCs. One systems change that occurred through D/CSHC’s connection with MHPP is that it began to contract with DYS to provide substance abuse testing and treatment for system-involved boys in Boston.

MHPP made its transition to SBHC as the official community health center partner in Boston in the fall of 2007; the SBHC is eager to serve system-involved youth and has expressed interest in contracting with DYS to provide behavioral services. In addition, Bob Garcia, the director of SBHC, is assisting Sherman in seeking funding for MHPP and in thinking strategically about how to carry the work of the program forward (Meeting Notes, November 28, 2007).

There is consensus from MHPP program staff as well as DYS and community health center partners that the measure of true impact would be that the program becomes integrated, institutionalized, or as Dr. Ralph Vettes of SBHC, said, that it becomes “an embedded part of the system rather than this sort of overlay or sideline” (Personal Interview, November 2008). Which system should house the program, however, is not completely clear. There is evidence to suggest that significant program elements have already been integrated into the public juvenile justice system (DYS). One example of this is found in the Requests for Responses (RFRs) that DYS issues to its residential facilities and community re-entry centers to monitor health care service delivery. These RFRs now require documentation of communication between DYS

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62 Interview date has been removed, as informant requested anonymity in the dissemination of our research.
health providers and community providers, including, for Boston and Worcester, documentation of contact with MHPP nurses. As a senior DYS informant explained,

_These performance and outcomes measures in the RFRs will monitor how centers are providing services that connect youth to health care. So basically they are monitoring service providers to implement the core values of MHPP program-connectedness to health care providers. This is a tangible product of MHPP_ (Personal Interview, 2007).

Another example is the inclusion of the program in DYS annual reports, and yet another is the integration of MHPP nurse advocates in case review meetings at the community re-entry centers and in the 90-60-30-day planning meetings that DYS convenes at the residential facilities. In addition, we understand that the DYS Director of Health Services as well as DYS health care staff and caseworkers know that the MHPP nurse advocate is a point person they can go to (and have gone to) to address specific health concerns about a girl or boy re-entering the community.

In the fall of 2007, Sherman also initiated conversations with DYS about the possibility of DYS residential health care staff assuming a greater role in the community (e.g., going to the CRCs to deliver services similar to the way MHPP nurses were doing). DYS administrators and health care staff expressed interest in this arrangement, but it was ultimately determined that residential health care staff were overextended and could not fulfill this role. However, these conversations led to the hiring of the current MHPP boys’ advocate in Boston, who formerly worked as an HIV-prevention counselor within DYS facilities. Given that the Boston boys’ advocate was employed by DYS and has strong ties with DYS-committed youth and DYS staff, her work with MHPP has signified an important step toward bridging MHPP services and the DYS system.

Finally, the survey instruments that have been developed by the MHPP evaluation team—in consultation with MHPP staff, and representatives from DYS and the partnering community health centers—signify the potential for “institutionalizing evaluation to assess health practices and health access practices of DYS youth” (Foundation grant concept letter, September 2008), thus further integrating the program’s goals into that system.

While these are all promising examples of how aspects of MHPP have been integrated into DYS, the program is not _fully_ institutionalized or embedded there. Over a year ago, DYS Deputy Commissioner Dolan noted that, “In the future DYS will overtake the need for MHPP…. It is DYS’s responsibility to extend this work across the state, not MHPP’s responsibility” (Personal Interview, April 2007). In a recent interview, Dolan discussed steps that the Department has taken to do just that; for example, it now scans all its standard medical forms and plans are underway to create an electronic health file that can be transferred between DYS residential medical providers and community health providers.

In addition, the Department plans to train caseworkers to identify, and make connections with,
health providers in the community. Dolan noted how MHPP helped shape the agency’s thinking about the training of caseworkers, helping DYS officials realize they cannot assume that staff are conversant with the health care system. Dolan reiterated what he said in an earlier interview during the program’s expansion planning period: that DYS could not afford nurses at every CRC, that CRCs were not in all areas, especially rural areas, and yet, that DYS needed to find a way to provide this needed service to all system-involved youth across the state. He said that DYS is “extrapolating the lessons” from MHPP, keeping the “spirit of the project” and “applying it to all kids in all settings” (Personal Interview, December 2008). Dolan said he felt it was time for discussion about what the next steps should be in the evolution of the project and welcomed the program’s input about the directions the Department is now considering to address health care in the community.

It is possible to view the Department’s plans for connecting all committed youth to health care in the community as evidence of MHPP’s effect; we expect that is probably the case. However, the Department’s plans, for reasons of feasibility, do not include one of MHPP’s key elements, which is a health care professional delivering the service. Numerous informants, from DYS administrators to DYS caseworkers and providers as well as CRC managers, noted the importance of having a health professional, in particular, a nurse, manage youth’s health care in the community. These informants explained that HIPAA laws (e.g., health information privacy protections) give only medical personnel or those employed by a medical facility (thus, not caseworkers) access to personal health records. The CRC staff said they have benefited from having someone on site who understands specific health conditions and illnesses, who is knowledgeable about where to refer youth for care, especially those youth with serious medical concerns, who can provide health education, and who can communicate with medical providers in the facilities and in the community. As one caseworker said of the MHPP nurse at her site, “She has alleviated a lot of our pressure. It’s been great...she can answer our questions, she can tell us how the health care systems run, why we may not be able to get information, it just opens up a whole other line of communication” (Personal Interview).

However, across interviews, these same informants agreed that in order for the program to be truly effective, the MHPP nurse should be available on site for more hours and should be able to provide some basic care, rather than solely referring youth to care. Yet the program model has already begun to shift in these areas, particularly in Boston. The MHPP advocate in Boston works mostly remotely and is no longer on site with girls. She is an HIV prevention counselor and social worker-in-training who would be unable to provide basic care even if it were possible. Nevertheless, given that DYS administrators do not consider the CRC-based health professional model a feasible option, keeping this element of the program would require Sherman to continue to raise outside funds, or, as she has discussed recently, conduct a financial analysis and make a case for the community health centers to sustain the program (Personal Interview, October 2008).

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63 Interview date has been removed, as informant requested anonymity.
This brings us to the second option for program sustainability, which is locating the program in a community health center. While this option allows for medical professionals employed by the health center to deliver the service, it raises other concerns related to feasibility and the program’s goal of improved and more long-lasting health care access for committed youth: What are the incentives for the health center to participate? Would youth want to go to this health center, thus increasing the client base for the center and/or fulfilling its mission to do outreach to certain youth populations like system-involved youth? Is the health center one that youth could use long-term, and does it serve all ages, including infants and young children, should these youth become parents?

The current partnering health centers in Boston and Worcester offer insight into the challenges raised by these questions. The GBVHC in Worcester is a full-service clinic offering health services across the age spectrum, including family planning and pediatrics. However, girls participating in MHPP in Worcester claim not to use GBVHC because it is too distant from where they live, and it is located in an area they consider unsafe (Personal Interview). For SBHC, while some boys participating in the program have become clients of the center, it may not be viable as a long term health care home for them given that the center is not in close proximity to where most of these boys live and it primarily serves young people ages 13-29 who “fall outside of more traditional health care settings.” While this description of who SBHC serves reflects who these system-involved youth are now, it may not be as fitting in later stages of their lives. Thus, in considering locating the program at a community health center, Sherman must weigh the program’s goal of improving long-term health care access with issues of feasibility, location, safety, and target population.

There is also a third option, that of locating the program outside the partnering systems, in a different setting altogether, such as Street Safe Boston, which Sherman has recently noted as a possibility (Personal Interview, January 2009). Street Safe Boston was launched in 2008 by Mayor Thomas Menino, The Boston Foundation, the Boston Police Department, and other leaders in the private and civic sectors. The intent of the program is to reduce violent crime in five Boston neighborhoods by providing an array of services to youth at-risk for committing violent offenses. This option would certainly shift many components of the MHPP program model, including service delivery and target population, given that much of the outreach to these youth is done through street workers, and while some youth would be DYS-committed youth, others would not.

Regardless of the direction in which Sherman decides to focus her efforts, an important question for program sustainability and in turn, systems change, is what “the program” actually is, or at the very least, what are the most essential goals and elements of the program model that Sherman intended to be institutionalized? Is it a health professional delivering the service? Is it gender-responsive service delivery? Is it changing how youth think about and utilize health care? Is it improving their access to health care in the community for the long term? In order for

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64 Interview date has been removed, as informant requested anonymity in the dissemination of our research.
Sherman to determine how best to carry the program forward, she and her collaborators must determine what the key program elements and goals are, and what is gained and lost by shifting the program model to meet the demands of funders or the partnering systems.

**Strengths and Limitations of MHPP as a Model for Effecting Systems Change**

MHPP provides one model, albeit one that has shifted and changed over time, for how an innovative project can affect change in the juvenile justice and health care delivery systems.

Table 4.1 illustrates the strengths and limitations of MHPP as a model for effecting systems change, as perceived across informants interviewed for this Systems Change substudy.
<table>
<thead>
<tr>
<th><strong>Program strengths for affecting system change</strong></th>
<th>DYS central admin informants</th>
<th>DYS general staff informants</th>
<th>DYS health care providers</th>
<th>MHPP staff</th>
<th>Funders</th>
<th>Community health center informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program leadership and staff</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Facilitating collaboration among stakeholders.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Complementing the approaches of the relevant systems.</td>
<td>X</td>
<td></td>
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<td>X</td>
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<tr>
<td>Fulfilling existing needs and gaps in services.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Increasing communications and connections between DYS providers and community providers.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Providing a fully funded service for youth and evaluating its progress.</td>
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<tr>
<td><strong>Program limitations for affecting system change</strong></td>
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<td>Lack of fiscal collaboration among the relevant systems.</td>
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<td>X</td>
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<tr>
<td>Transcience of system-involved population.</td>
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<td>X</td>
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<tr>
<td>Fluctuating/limited numbers of youth served.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
</tr>
</tbody>
</table>
The strengths of the program that have been reported to influence systems change to date include the following:

- The ability of the program staff to build relationships with and facilitate collaboration among the key stakeholders (e.g., DYS and community health center staff, nurses, funders, evaluators, youth);
- The program’s timing in that it complements the developing approaches and programs of the relevant systems;
- The program’s ability to fulfill existing needs and gaps in services;
- The program’s emphasis on increasing communications and connections between DYS providers and community providers; and
- The program’s ability to offer a fully funded service and to evaluate its implementation processes and outcomes.

Given that the program is relatively young, has operated in two resource-rich sites in Massachusetts, and has served a small population of youth, its reported influence to date on the relevant systems is impressive.

In terms of the relationship-building strength of the program, Sherman developed relationships with DYS through her work representing system-involved youth for a decade before piloting MHPP. As she noted, “The culture of the relationship between advocates and DYS is goodwill. Generally advocates have been able to do well by working along with the people they know within DYS. It’s a community of people who all know each other” (Personal Interview, March 2007). These early connections enabled MHPP director to pilot the program in a DYS reporting center and appear integral to DYS’s receptiveness to the program’s expansion.

The MHPP advisory committee also served as an important vehicle for program partners to contribute their perspectives and have the opportunity to be actively involved in program planning. One senior DYS informant credited the advisory committee for pushing the agency’s
thinking about the health needs and gender differences of system-involved youth. Thus, MHPP was not acting as a sole outside agent of change, but included and engaged representatives of the systems they were intending to influence in the change process.

In addition, the original MHPP nurse in Boston made it a priority to build relationships with DYS and community health center staff. This early cultivation of relationships with program partners led to her eventual inclusion in weekly case review meetings with staff at the CRC, her regular meetings with DYS health care staff inside the facilities, her ability to connect youth to local health centers and community resources, as well as her eventual ability to advocate for girls in the system. To this latter point, in certain cases where DYS caseworkers expressed concern that girls were missing school allegedly due to health problems, they trusted the MHPP nurse to confirm the seriousness of the health problems. In one case, the MHPP nurse succeeded in advocating for less restrictive involvement in the system for one girl in order to minimize the interruption to the mental health care she was receiving in the community (Personal Interview, May 2007). These examples reflect how DYS staff came to recognize the MHPP nurse as a valued source of information about the health and health care needs of the youth they serve. Given that the original MHPP nurse served as the face of the program, her ability to gain credibility among the program partners was critical to their early receptiveness to the program and their eventual willingness to make changes in the way they thought about and delivered health services to system-involved youth.

Two additional strengths of the MHPP model relate to how it both complemented existing or developing approaches and programs within the relevant systems as well as fulfilled needs and gaps in the systems. As previously described, MHPP dovetailed with the positive youth development (PYD) approach of the Massachusetts DYS, as well as its expansion of the CRC model and its developing programs responding to the needs of girls in the system. By complementing existing system approaches and programs, MHPP facilitated program buy-in and positioned itself to influence further changes in the juvenile justice system.

During the MHPP evaluation’s needs assessment (Jacobs et al., 2006), DYS staff at all levels spoke of the need for many of the key components of the MHPP program, including the need for gender-responsive health services, health education, improved communication regarding health and health care needs between DYS providers and community providers, and improved access to health care for youth re-entering their communities. Informants across our interviews reported that health care among system-involved youth re-entering their communities was often inconsistent, infrequent, and disjointed. They spoke of the lack of preventive care, the overuse of the ER, and the youth’s difficulties navigating the health care system (e.g., setting up appointments, filling out forms, understanding health insurance) among system-involved youth (Focus Group, September 7, 2006). Informants credited MHPP with providing some consistency in care for the girls at the Boston site, and DYS Deputy Commissioner Dolan said that the original MHPP nurse “pushed the standard of care” where DYS had been “underperforming in this area” (Personal Interview, January 2006).
Another facilitator of systems change has been the program’s emphasis on strengthening communications and connections between DYS providers and community providers. To date, the MHPP nurse/health advocates in Boston have had regular contact with DYS health care staff, and this contact has helped to facilitate the transfer of health information about youth prior to their community re-entry. In addition, as noted earlier, DYS administrators were receptive to health care staff in Boston, increasing their contact with youth in the community. Lastly, the interest expressed by the director of SBHC to provide behavioral services to system-involved youth could further strengthen the connections between DYS and community providers.

One final strength of the program as a model for effecting system change has been the skill of the program director to secure funding to support program operations and evaluation over its planning and expansion phases. These sources of funding include private foundations and health care agencies. The ability to influence systems invariably takes time, and thus having support for piloting the program, planning its expansion, staffing sites with health professionals, and evaluating its progress has enabled the program to gain credibility, build relationships, and generate lessons learned for potential expansion or replication efforts in the long term. Sherman’s successes at fundraising have been impressive, particularly in a period of economic uncertainty. As discussed earlier, it remains to be seen if Sherman will want to, and if so be able to, sustain the program in its current form or need to change the model in a way that allows DYS or the partnering health centers to carry it forward.

In addition to its strengths as a model for effecting system change, MHPP also has some limitations in this area. The key factors that have been reported to limit the program’s ability to have a documented, significant impact on the relevant systems include the following:

- Continuing shifts in the program model;
- Difficulty serving large numbers of youth and connecting the youth served to the partnering community health centers; and
- Health professional service delivery model that is unaffordable for DYS to sustain.

Shifts in the program model have included moving from primarily serving girls to serving boys as well, from more to less connection with youth and staff in facilities prior to community re-entry, from on-site, in-person services to more drop-in and phone consultations with youth, and from nurses to a health educator delivering the services. Some of these shifts, such as hiring a health educator to serve as the MHPP advocate in Boston, were intentional decisions, while others such as the shift from serving primarily girls to boys were reactive to exogenous factors, for example, funding opportunities and changes in the census of committed youth. Regardless of how they came about, these shifts make it difficult to test the program theory and its impact on the relevant potential beneficiaries because the program, understandably but nonetheless, has not been implemented in a consistent way or as it was originally designed.

The inability of the program to reach greater numbers of youth is in part due to the inherent
transience and fluctuating census of committed youth. Participating youth often go AWOL, undergo frequent changes in guardianship and residential placements, are reincarcerated, or “age out” soon after program intake. In addition, the census of girls, the original target population for the program, has greatly diminished since the program began. The program is also voluntary, and thus there are youth who have chosen not to participate or not to continue participating after one or two interactions with an MHPP health advocate. All these factors have made it difficult for the program to consistently serve a sizeable population. Even for the youth who have participated in the program, not all have wanted to seek health care at the partnering health centers for a variety of reasons, including concerns for safety (as seen in the case of D/CSHC and GBVHC), and a desire to seek care at a different health care home that is more easily accessible to them and/or where they have already established relationships with a provider.

In terms of the affordability of the program model, throughout our interviews with DYS officials, they have asserted the lack of feasibility in staffing the program with health professionals. As Deputy Commissioner Dolan said in our first interview with him, “If we could put nineteen [MHPP advocates] out there, it would be ideal, but we can’t afford it” (Personal Interview, January 2006). When Sherman proposed having the health care providers at the DYS facilities extend their services to the community, DYS officials also deemed this option not cost effective, given that the extra work demands would require increased time and compensation.

The program’s geographical scope also, again understandably, limits its ability to serve as a national model: It has only been operating in two sites that are rich in health-related resources, serving a small population of youth, and located in a state with an emphasis on community re-entry services and with health insurance coverage for all youth committed to the system. It is not possible to know at this point how much influence the program could have in other contexts such as rural settings or states with little or no emphasis on gender-responsive services and community re-entry programming. It is of course possible that the program could succeed in other settings, but it has not been tested sufficiently to make this claim.

Conclusions

Dym and Hutson (1997) note that “the patterns that hold a system in place and make it resistant to change can be disrupted” (p.40). They argue that “the desire for stability seems to always overtake the desire to change and learn” (p. 34), and as theorized in many disciplines such as developmental psychology and biology, change often emerges from a state of disequilibrium. Thus, interrupting patterns of thinking and behaving enables opportunities for growth. The MHPP succeeded in interrupting patterns of thinking and behaving within the partnering juvenile justice and community health systems and thus created an opportunity for growth and change within those systems.

Our perceived-effects data indicate that MHPP has informed the Department’s thinking about and planning for the health care needs of youth in their custody during community re-entry,
and that it has also encouraged the partnering community health centers, namely D/CSHC, GBVHC, and SBHC, to increase their efforts to serve system-involved youth. These changes appear significant to us, and impressive given the size of MHPP and its funding challenges. If, however, the true indication of program impact, as some informants have asserted, is the full integration of the program into these systems, then this goal has not been achieved to date and is unlikely to be achieved without a radical change in the program model or the willingness of the partnering systems to fully absorb the program in its current form.

It is important to acknowledge that MHPP envisioned its intended systems changes as occurring in the short term, the intermediate term, and the long term (see Table 3.1). There is evidence to date that MHPP has achieved some of its intended short-term changes in the relevant systems (e.g., MHPP staff involvement in case meetings at the CRCs and request for participation in prerelease planning at the facilities) as well as some positive unintended changes (e.g., inclusion in RFRs for DYS facilities and CRCs). Intermediate systems changes appear to be in progress (e.g., DYS seeks staff who address health issues in the community), and the long-term changes are, for the most part, yet to be achieved (e.g., Health is integrated into DYS re-entry services formally). Ultimately, MHPP set arguably overambitious systems-change goals for a program of its size and one with limited funding and limited staffing to oversee the program’s operations. In this context, it is understandable that MHPP did not achieve all of its intended impacts on the relevant systems, and the changes it did effect are impressive.

MHPP is now positioned to undertake strategic planning about the future of the program. It is difficult to predict which systems changes will be in effect for the long term, which may only be temporary, and how changes in staff, program partners, and funding will reverse or advance the progress that has been made to date. Regardless of what the future holds, MHPP serves as an interesting and compelling case of how a promising innovation set about to effect change in the juvenile justice and health care delivery systems.
References


SECTION FIVE: FINDINGS AND RECOMMENDATIONS

The Massachusetts Health Passport Project (MHPP) evaluation produced a wide range of findings about the program’s operations and its perceived effects. In this section we present the study’s major findings; those more specific to particular elements of the program are contained in the relevant previous sections. In addition, we include a series of recommendations that reflect these general findings; again, more specific recommendations are included in the earlier sections.
FINDINGS AND RECOMMENDATIONS

Major Findings

The evaluation produced scores of findings with relevance to MHPP operations and the attainment of its goals. The findings noted here are considered the most consequential for policymakers and program designers.

- **MHPP is an example of a promising private/public partnership in health care.** Collaborations of this sort generally are difficult to establish and maintain; Sherman’s considerable skills in this area, combined with the Massachusetts Department of Youth Services’ (DYS), and the partnering health centers’, willingness to join the effort, represent a core strength of this program. This is an essential element of any attempt to innovate in health care services for youth in the juvenile justice system.

- **MHPP appears to have influenced DYS’ approach to providing for the health needs of youth under its supervision, as well as the partnering health centers’ level of attention to, and interest in addressing, those needs.** The MHPP’s focus on the health of system-involved youth, and the imperative to have good quality health care available when they return to their neighborhoods and communities, was reported by many to have affected the institutional behaviors of both systems. In this sense, MHPP appears to have made significant progress toward achieving its desired outcome of system change. On the other hand, MHPP, in its current form, has not been fully adopted by either system, and is unlikely to be in the near future.

- **The principles that undergird MHPP have found broad resonance among the evaluation’s informants, and across the relevant theoretical, empirical, and practice-oriented literatures.** These principles pertain both to the desired outcomes for health-related interventions for system-involved youth, and to the approaches to be used to achieve them. They include, for example, the goal of improved health access, and ultimately health status, of system-involved youth; the promotion of gender-responsive programming; the investment in developing and sustaining professional collaborations; and the belief that building supportive and nurturing relationships with youth is the cornerstone to achieving these goals.

- **While the full MHPP model may not be sustainable or replicable, there are specific elements of the model which seem eminently exportable.** The MHPP model in its current form, with its emphasis on independent health professionals managing youth’s health care at community reentry centers, appears not to be sustainable within this state’s juvenile justice system. In addition, other contextual factors such as the reliance on private funding, a relatively health resource-rich state that provides health insurance coverage to all youth committed to the DYS, and a relatively progressive juvenile justice system make the model less exportable to other states without such an infrastructure in place. However, certain programmatic
components—for example, connecting youth to a community health provider, providing youth with health education, and building relationships between community agencies in the interest of serving youth’s health needs—are likely generalizable to other contexts.

- The MHPP goals were overly ambitious for a program of its scale, supported by “soft” funding, and dependent on the active support and participation of the agencies and individuals involved. However energetic the program’s director and staff, there are limits on the ability of a modest program such as MHPP to have the effects—on health access, health practices, health status, social supports, etc.—it intended. At a minimum, this is an issue of “dosage” —too little intervention to comprehensively address the health care needs of system-involved youth. Further, factors on the individual, family, community, and system levels (e.g., the transience and fluctuating census of committed youth, lack of long-term investment in the program from the partnering systems) likely moderated the program’s ability to achieve its goals.

- It is difficult to estimate the reach or “penetration” of MHPP into the population of DYS-involved youth needing its attention. The program database includes ~116 youth, across the sites, over the five years of MHPP’s operations; a percentage of these youth were seen more than once, some on numerous occasions. In addition, MHPP health advocates interacted informally with other youth who are not represented in the database. The MHPP staff work limited hours, and spent a percentage of their time providing indirect or collateral services for their clients—consulting to DYS and Community Re-entry Center (CRC) personnel on specific health problems, working through health insurance matters, etc. Since the program did not set target figures for the number of clients to serve, and indeed, the census at CRCs fluctuates sufficiently to make that hard to do anyway, we cannot judge the effectiveness of MHPP’s outreach efforts. There was, however, a large drop-off in Boston girls served which warrants further investigation.

- While MHPP did not develop a formal health “passport” document, it did demonstrate—with individual youth—the possibility of providing continuous care and executing appropriate transfer of medical records. The process of developing and implementing a specific passport was more complicated than initially expected, due in large part to issues of confidentiality and practicality. However, examples from this study suggest that the program’s aim to provide continuous care to youth was attainable. Our evaluation documented cases of pre-release health planning for youth, communications, follow-up, and transfer of medical records among facility and community providers facilitated by MHPP health advocates. In at least one case, MHPP staff successfully advocated for a participating youth recently reconfined to a DYS facility, to receive uninterrupted care from a community health provider.

- The program’s visibility faded over the period of the evaluation. During the early phase of this evaluation, the program enjoyed relatively high visibility, related to some degree, to the several advisory committee meetings that occurred during that time and to the first health advocate’s regular communications with DYS staff in facilities and in the CRCs. As the program proceeded, this initial level of communication among program partners was not
sustained, which might account, in part, for the decrease in visibility. For example, during our final set of interviews, several informants indicated that numbers of youth, parents, and DYS staff were unaware of the program, or had heard of it, but were unsure of the services offered. This appears different than what was the case earlier on.

- Many system-involved youth who participated in MHPP reported having primary health care providers. Nonetheless, health advocates reported that many were also responsive to, and appeared to need, MHPP services. Adult informants during the needs assessment phase of this evaluation frequently reported that system-involved girls often did not have primary health care providers; these concerns were expressed about boys as well. While this is likely true for a proportion of this population, both girls and boys, our findings suggest that youth may well be more connected to care than some expect. What remains unclear, however, is the extent to which these system-involved youth have a true health care “home” (as opposed to a PCP)—an entity that, similar to the MHPP model, coordinates care (including mental health services), follows up on referrals, advocates for the clients in dealings with other institutions, etc. This might be a better indicator of health care coverage for this population, and we suspect that such a gap still exists for numbers of these youth.

- Many of the health concerns expressed by youth, and by others on their behalf, are shared by girls and boys. Issues that affected both girls and boys included those related to sexual health; hygiene, nutrition and exercise; and mental health; however, these issues appear to affect girls and boys in different ways. Thus, a gender-responsive orientation to discerning effective ways of addressing these topics with system-involved youth remains a useful approach to programming.

- It appears that youth’s parents are more involved in their health care than was initially assumed. The MHPP model does not include parents or other family members in a central way. The origins of this decision are not clear, but they likely reflect the desire to protect youths’ confidentiality in these matters, and also perhaps the assumption that the relationships between youth and their parents are often strained, that parents would not choose to be involved or would be unable to maintain involvement, and that the youth would just as soon negotiate these issues themselves. In our view, this choice should remain the youth’s to make, however, MHPP might profitably research this issue, with the possibility of including parents and families in some planful way.

- Both the nurse health advocates, and the HIV prevention counselor (non-nurse) health advocate, offered thoughtful, generally well-received, programming. This might suggest that the specific credentials of the health advocates are less important than their ability to build relationships with youth and staff and to implement services that are based on sound judgments about what their potential clients want and need, and that fit their own expertise. This evaluation, however, could not ascertain whether, by whatever approach, the goals of the program were met, so the necessity of using medical personnel remains an open question.
In general, MHPP’s constituencies appreciated its intentions and the efforts of its director and staff. Across the evaluation, key informants we interviewed reported positive impacts of MHPP on specific individuals involved in the program and conveyed a sense that the program has strong potential over the long-term. Some of the promising elements they noted were in the areas of increased connections to health care, continuity of health care, and increased awareness of preventive care.

Although the evaluation did not analyze data to establish “observed effects,” individual examples of the desired results were repeatedly brought to our attention—a promising if not conclusive, finding. The following adapted case, based on interview data from the current Boston-based health advocate, serves as one such example:

...Two nights ago there was a young man who is involved in the program who was shot in his neck...he’s still in the hospital and undergoing surgery...his caseworker contacted me because when he got to the hospital his heart rate was very low, so the nurses were asking if there were any medical records or if there were issues with his heart rate before, blood pressure or anything like that...so she contacted me and I called Dr. Veters immediately the next morning...and then contacted “Laura” the nurse over at DYS who had dealt with him for a couple years. Information was exchanged between “Laura” and Dr. Veters, which went over to the hospital. They were able to give the history because he had just had his physical with Dr. Veters and had special blood work done because of his high blood pressure...Dr. Veters is going to the hospital to see how he is doing and kind of check in with him because they had started to create a relationship...when he gets released from the hospital, Dr. Veters can continue with his after care and follow up with him on everything...

Recommendations

The purpose of this set of recommendations is two-fold, first to guide Massachusetts Health Passport Project (MHPP) staff and collaborators in their thinking about how to export core elements of the program to other settings, and second to highlight areas for further research pertinent to the development and potential adaptation of a program such as MHPP.

Program-specific Recommendations

There are several MHPP program elements that emerge from this study that appear critical for any program such as MHPP, serving the health needs of system-involved youth. These include establishing interagency collaboration, building relationships at all levels, facilitating continuous care through transfer of medical information and records, and connecting youth to community health providers committed to them. The following recommendations speak to these program elements:

- Concentrate efforts on developing and maintaining strong interagency relationships. System-involved youth appear to be best served when multiple agencies collaborate to meet their
needs. These interagency relationships often develop from relationships on the individual level, e.g., between program staff and youth, between their caseworkers and their health care providers, between youth and their health care providers, and so forth. In order to maintain the active engagement of partnering organizations, regular opportunities for developing these individual relationships as well as for collaborators to meet and exchange ideas is critical.

- **Hire program staff with experience, expertise, and/or a vested interest in building relationships with system-involved youth and staff; provide training and supervision for that dimension of the job.** Developing strong relationships with youth and those who work with them inside and outside the system is essential to serving them well. Given their often complex relationships to authority figures and other adults in their lives, system-involved youth require time and a variety of methods to build trusting relationships with those attempting to assist them. In addition, caseworkers and other juvenile justice and community health care staff need opportunities to develop strong working relationships with those outside the system.

- **Use these strong relationships to facilitate transfer of medical information and records.** Given that system-involved youth often confront serious medical conditions and that they experience many interruptions to their health care due to their system involvement, and at times, transient lives, the facilitation of medical information and records is critical.

- **Connect youth to community health providers, or preferably, to a health care “home,” invested in building long-term relationships with youth.** System-involved youth, like all youth, need continuous, consistent, integrated health care services. This type of care is found in the health care “home” model, in which individuals are connected to a variety of health care services, receive follow up on referrals, and have the opportunity to develop long-term relationships with providers. Ideally, the connection to this care is coordinated prior to youth re-entering their communities. In communities where there are health centers that are invested in, cater to, or have interest in and knowledge of serving system-involved youth, a health care professional on staff could perform outreach to youth and serve as the interface between youth and juvenile justice staff and other community health services. This health center professional could also consult to or train juvenile justice staff in helping youth to manage their health care upon community re-entry.

- **Establish a facilitative, working relationship between the “inside” providers of health care (when youth are detained) and the youth’s “outside” providers (primary care physicians, or health care homes, in the community).** These outside providers should include the MHPP health advocate, or the person in that role. Quality health care for these youth requires continuity between these two providers. The obligation to develop this relationship is equally the community provider’s, who should be available to consult while the youth is detained, and to participate in pre-release planning related to health care.
Integrate health education into pre- and post-release services for system-involved youth. Similar to most adolescents, system-involved youth are in need of assistance managing their health care. Integrating the type of health education that addresses how to get medical records, how to make a doctor’s appointment, how to know when to seek urgent care versus routine care, would greatly benefit youth. Ideally, such education would occur prior to and following youth’s community re-entry, during which youth are assisted in establishing a long-term health care plan.

Research-based Recommendations

A central premise of this evaluation is that good data are critical to good decisions about programs. For that reason we offer here recommendations for the direction that further research should take. These recommendations are organized into two broad categories: The first contains activities to help understand, validate, and/or challenge the theoretical assumptions undergirding a program such as MHPP—for example, the extent to which system-involved girls and boys differ in their preferred mode of health care. The second set relates to specific program components, and are meant to clarify aspects of MHPP’s actual operations—for example, the calculation of the “coverage” (percentage served) that MHPP achieves among eligible youth—and to determine program effects. Jacobs’s Five-Tiered Approach (FTA) to evaluation\textsuperscript{65} considers both types of research activities as essential components of a comprehensive evaluation strategy.

Establishing the Program’s Theoretical Base

In this country, most public programs are initiated to fill the gap between the current circumstances for a particular population, on the one hand, and what is considered an acceptable circumstance for those individuals, on the other.

\begin{itemize}
\item Program architects should be able to support their call for a new or modified program with evidence that such a gap or problem actually exists, and with data that detail the nature and magnitude of that problem. These are the core elements of a needs assessment. The problem needs to be defined precisely, but at least initially, without the preferred solution tucked into that definition. For example, with reference to a program such as MHPP, one might focus, first, on the disparity in health status between system-involved youth and other youth in comparable communities, rather than on data confirming the relatively low percentage of these youth who have a primary care physician. It may end up that increasing the percentage of youth with PCP’s is the best strategy toward improving their health status, but other possible programmatic options that may be more immediately achievable, or more reasonable given the particular community, are obscured if the needs assessment is organized around data with an implied solution.
\end{itemize}

\textsuperscript{65} Jacobs, 1988; Jacobs, 2003; Jacobs & Kapuscik, 2000
Analysis of the problem includes presenting the data in meaningful subgroups for comparison—by gender, place of residence, age, family configuration, etc., as well as by health concern or condition. (The data from MHPP confirm that understanding the differences and similarities of the health problems of girls and boys is particularly critical to designing promising health support programs.) It could be, for example, that youth in certain communities are more affected by particular conditions (e.g., urban neighborhoods and asthma) than others; these data are critical to establishing the dimensions of a problem. There are several public sources of these kinds of data; in addition, a survey of current system-involved youth would help define the range of health problems to be addressed.

Occasionally, at the end of this phase it is determined that the identified problem does not exist, or exists only in a limited fashion, not warranting a new intervention. This is one appropriate conclusion to a needs assessment.

- **A thorough review of extant data on the implementation and outcome results of programs designed to address similar problems should be undertaken.** There are many potential sources of data for this review, ranging from evaluation studies reported in academic and professional journals, and on reputable public agency websites, to detailed “best practices” reports available from professional membership and/or advocacy organizations. The weight given to the evidence should reflect the rigor of the research design employed; nonetheless, all these materials help array the options for programming in a broad manner, so that considered choices can be made.

- **Programs should be designed in a way that credits the views, and preferences for service modality, expressed by all stakeholders, but in particular, by their potential consumers; the process of collecting and analyzing these data is called a demand assessment.** Too often programs are initiated without input from the people to be served by them. In our view it is imperative to collect, analyze, and make use of data that describe how these individuals define their problems, and how they would like to receive help to ameliorate them. In the case of MHPP, for example, participants extolled the virtues of health professionals (including MHPP advocates), who worked to establish relationships with them, respected their opinions (even though they did not always agree), treated them as real people. Indeed, sometimes it seemed to us that the content of any given interaction was less consequential, from the youth’s perspective, than the feeling he/she had that someone interpersonally trustworthy was available to them. If this is the case, then the training of health advocates should entail at least as much attention to this aspect of the program than to the equally necessary other, more knowledge-based training subjects. Youths’ preferences for the degree of parent involvement in these services, and the type of service (e.g., group discussion of health education topics vs. accompanying youth to medical appointments and chatting on the way) to be offered, for example, should be reflected in the program’s design. Knowing this information as a program is being developed (by surveying youth in DYS custody, for example) is a wise way to proceed.
Programs should be designed to reflect their particular contexts—the opportunities and constraints—that existing policies and already established institutions present to implementing a successful program. At a community level, this activity is called an environmental scan. Not only should programs be responsive to the various stakeholders’ ideas of how services should be provided, and be knowledgeable about what the research literature recommends. Their design should also be based, empirically, on knowledge of what resources to solve the identified problem already exist in that locality; and the strengths and limitations of, and possibilities in, those institutions in playing the desired service role. An excellent health center that is located in a neighborhood that youth do not feel comfortable visiting is not the best choice for a health care partner; a service model that relies on health professionals who are in great demand, and therefore are expensive to employ and difficult to keep, might likewise be a less promising choice in a particular economy than it might be at another time. Infrastructural issues—transportation, building accessibility, manpower availability—must be considered as well.

**Recommendations for Research on Program Operations**

This evaluation assumes a continuous demand for program-based research—in essence, evaluation—to maintain a nimble, well-functioning program, best able to achieve the desired results. The following recommendations are offered in that spirit:

- **To begin, a juvenile justice system must have the technical capability to generate data about its youth, the conditions of their system involvement, their family and community relationships, and their health status and health care utilization.** This participant data system must be flexible, relatively easy to use, and accessible to juvenile justice personnel both inside detention facilities and in the community. Periodic aggregated reports that include the health status of youth in individual facilities, and those reporting to individual CRCs, should be generated to allow for contemporaneous comparisons across sites, and comparisons across time within individual sites. In this way, particular needs (for example, for primary health care coverage) within particular geographical locations, or evidenced by particular subpopulations, can be identified and possibly addressed. To the extent possible, in the context of confidentiality requirements, data on individual youth might be shared with community-based health care personnel, to facilitate the re-entry of youth to their communities.

- **Health centers, for their parts, should use their extant databases to better understand the health needs of youth in their caseloads.** Presumably community health centers maintain considerable patient databases. Again, within the parameters of confidentiality requirements, they could anonymize, and then analyze, aggregated data to help plan health services for all youth, including those in the juvenile justice system.
The environmental scan proposed for the design phase should be periodically updated to reflect changes in community resources, new opportunities or necessities for collaboration. Since any program dedicated to improving the health status and health care access and utilization of youth depends on resources outside the juvenile justice system, continuous attention to that larger context is warranted. Systematic tracking of these resources within communities, and across states for that matter, keep programs alert, and facilitate possible partnerships, for example, in securing grant funding for innovations.

A schedule of periodic data collection from stakeholders in any health-focused initiative should be developed and implemented. Program consumers have critical information to share—not at a single moment in time, but as they continue to use (or cease using) services, as programs change their offerings or their personnel, and as, in this case, they mature and their concerns or requirements change. The perspectives of other stakeholders—program staff, parents, agency personnel, community providers, for example—also likely change over time, and should be considered periodically as well. Among the topics to include in these data collection activities are the following:

- Satisfaction with/perceived effects of particular program components (location, personnel, specific activities); probe for gender, regional, age differences (youth);
- Satisfaction with/perceived effects of program, program components; by affiliation, professional discipline, geography, familiarity with program (other stakeholders);
- Topics to include in health education components (youth, other stakeholders); and
- Extent to which parents should be involved in programming (youth, parents, other stakeholders).

A series of indepth studies of particular service-related issues that might affect program design in the future should be initiated. Several of these topics surfaced during this evaluation that could not be addressed sufficiently, and exemplify the type of issue that might warrant further attention. These include the influences that parents, families, and cultural communities have on youth’s health practices and beliefs; the nature of the health advocate/youth relationship; perceptions of these youth by community health care professionals; parenting among youth in custody, to name a few.

At the appropriate time, an outcome study to measure program results—to answer the “does it work?” question, should be undertaken. Ultimately, programs should be held accountable to the standards for effects they set for themselves in their stated goals and objectives. Data collected for this purpose should be “observed” (objectively reported), in addition to “perceived” (reported as having occurred, without external confirmation), and the research design should include a comparison group so that differences in effects can be plausibly attributed to the program. This outcome study would answer the following questions:
- What dosage (how much service, of what kinds) is needed to achieve a positive result?
- Which issues of concern related to health status, access to health care, individual health practices, are the most amenable to intervention?
- In what ways do individual and community characteristics moderate the effects of programs?
- Which aspects of programs, or which program in their entirety, are more cost-effective and/or cost-beneficial?

**Program-based research should be a standard component of program operations.** Given the complexity of the issues being addressed here, and the “constancy of change” in our current social and economic environment, program-based research seems a virtual necessity for any intervention of this nature. While some portion of this work requires independent contractors, much of it can be done “in-house,” with relatively modest amounts of training and support, strategically scheduled.
References


