



Mental Health Advocacy Program for Kids
Report of Baseline and Follow Up Evaluation Data
March 2017-June 2022

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Prepared for

Health Law Advocates

by

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INTRODUCTION:

This report has been prepared for Health Law Advocates by the Boston University School of Public Health Evaluation Team to present preliminary findings of baseline and follow-up evaluation data for the Mental Health Advocacy Program for Kids (MHAP for Kids). The information presented includes data from March 1, 2017 when MHAP for Kids launched through June 30, 2022 which marked the end of the most recent complete school year. Data presented are from all families receiving staff attorney services during this time period, except where specified that the data are only from the subset of families who provided survey and questionnaire information prior to staff attorney assignment (baseline) and again at case closure (follow-up). The report's structure and the analytic methods used are described below.

REPORT ORGANIZATION

This report is broken down into seven main sections (1) Program Details, (2) Youth and Family Characteristics, (3) Engagement in Academic and Mental Health Services, (4) The Work of Staff Attorneys, (5) Evidence of Program Impacts, (6) The Role of COVID-19 in Family Experiences, and (7) Accountable Care Organization Referrals.

- 1. Program Details (pages 5-8).** This section focuses on program details related to the reach of MHAP for Kids, including the flow of youth referrals to each of the sites open between March 2017 and June 2022. Data used are from the MHAP for Kids administrative data. Key questions include:
 - What is the design of the MHAP for Kids Program?
 - When and where did MHAP for Kids sites open across Massachusetts?
 - What organizations or agencies are referring youth to the MHAP for Kids program?
 - How is the program able to address demand for services?

- 2. Youth and Family Baseline Characteristics (pages 8-11).** This section explores the reach of the program through describing the youth and families who participated in MHAP for Kids. This includes the demographics of the youth, family and youth risk profiles, and youth court involvement at baseline. Data for these analyses are from MHAP for Kids administrative data, and parent/guardian self-reported questionnaires. Key questions include:
 - What are the demographic characteristics of youth enrolled in MHAP for Kids and how do they compare to those in the pilot program, J-MHAP?
 - What are the mental health risks for youth at baseline?
 - Are MHAP for Kids youth involved in the court system? To what extent?
 - What are the family risks at baseline, specifically those related to adult depression, family conflict, and stress?

- 3. Baseline Engagement in Academic and Mental Health Services (pages 12-14).** This third section details youth use of educational and mental health services prior to involvement in MHAP for Kids, and their experience with barriers to accessing those services. Data for these analyses are from MHAP for Kids administrative data, and baseline interviews with parents/guardians. Key questions include:
 - Are youth excluded or sent home from school before they begin work with MHAP for Kids?

- To what extent are youth engaged in mental health services in their schools? To what extent do they engage in mental health services in an outpatient or community setting, use crises or emergency services for mental health, or experience hospitalization or inpatient psychiatric care?
 - What types of barriers have families faced trying to access services prior to their work with MHAP for Kids?
- 4. The Work of Staff Attorneys (pages 14-17).** This section describes the work of the staff attorneys. Though a brief description of how they use their time is presented, detailed case examples provide a better sense of the complexities of staff attorneys' work with families. Data for this section come primarily from MHAP for Kids administrative data. Key questions include:
- How long are MHAP for Kids cases open and what level of services do they receive during that time?
 - How many goals do families create with their staff attorneys and are those goals completed when the case closes?
 - What are some examples of work staff attorneys do to help families?
- 5. Evidence of Program Impacts (pages 18-22).** This section provides the results of the follow-up analyses and points to evidence of the program's likely impact on youth and family outcomes. Data for this section come primarily from baseline and follow-up questionnaires and interviews completed by families, and MHAP for Kids administrative data. Key questions include:
- Are there changes in youth and family mental health-related risk and functioning following work with MHAP for Kids?
 - Does youth court involvement change between baseline and follow-up?
 - Did staff attorneys identify prevention of further court-involvement related to their work?
 - Did engagement with mental health services within schools or in outpatient, inpatient or emergency medical settings change?
 - Were there differences in families' report of their experience of barriers to accessing mental health services after working with MHAP for Kids?
- 6. The Role of COVID-19 in Family Experiences (pages 22-27).** This sixth section describes the ways in which the COVID-19 pandemic and related remote schooling impacted families through youth school engagement and behavior at home. Information for this is from surveys and weekly logs administered to families with open cases during the pandemic. Key questions include:
- What were families' pandemic-related experiences like during the spring of 2020? What was the impact of remote learning on their youth's mental wellbeing and school engagement?
 - What did families experience during the second school year during the pandemic (2020-2021)? Where youth attending school in-person, remote, or in a hybrid modality? Were school support services for 504 plans and IEPs provided? What was the impact on youth mental health and school engagement?

- What did families experience during the third school year during the pandemic (2021-2022)? What were the mental health symptoms observed and concerns held by parents/guardians?

7. Accountable Care Organization Referrals (pages 27-29) The seventh and final section examines the impact of relationships established between MHAP for Kids and several Accountable Care Organizations that directed referrals for youth identified by the ACO. Data sources include MHAP for Kids administrative data, as well as, baseline and follow up interview and questionnaire data. Key questions include:

- Did youth referred to MHAP for Kids via an ACO differ based on age, gender, or other demographic characteristic?
- Were youth and family risk profiles different among ACO-referred youth?
- Were youth referred by an ACO have similar engagement with school, outpatient, inpatient, or emergency mental health services?

ANALYTIC METHODS

Overview: The trajectories of youth and family risk are dynamic and may change over time. By looking at trajectories of change surrounding the period of MHAP for Kids engagement, we assessed the association between staff attorney involvement and improved youth and family outcomes.

Methods: In order to understand whether there was any change in the overall risk profile of MHAP families during participation in the program, follow-up interviews were conducted with a subset of families (n=164). (1) Scores on the measures of risk for youth and parents at follow-up were compared to scores at baseline to determine if there were any changes in risk over time. (2) Additional areas compared include youth school status, barriers to accessing care, parent ratings of youth health, and youth service use. Statistical analyses were conducted to compare baseline and follow-up data.

Paired t-tests were used for continuous variables and tests of marginal symmetry were used to examine changes from one category to another in categorical variables. For simplicity, in most cases we show the baseline and follow-up percentages, not the changes from one category to another. P-values reported for these tests were used to assess level of significance of the results. A p-value measures the likelihood that a change observed is due to chance. We considered p-values less than or equal to 0.05 as statistically significant, meaning that the changes observed are not likely to be due to chance and rather reflect a true change over time.

SECTION 1: PROGRAM DETAILS

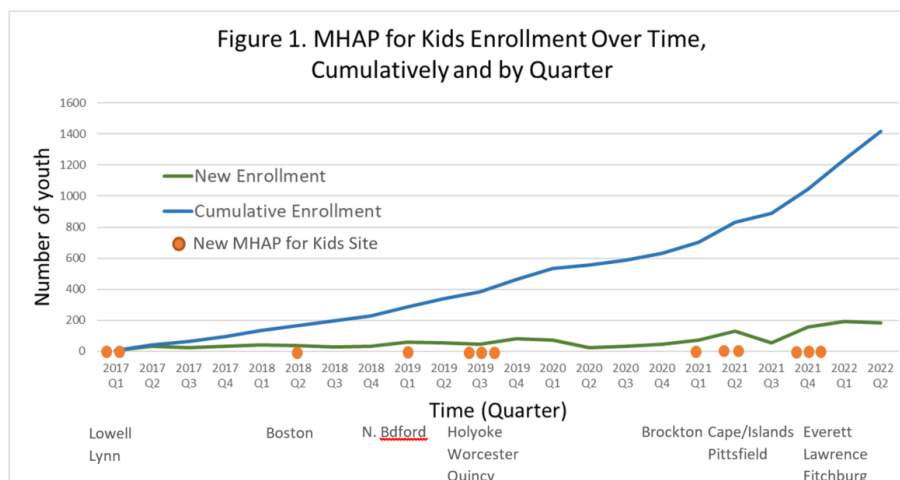
PROGRAM OVERVIEW

The Mental Health Program for Kids (MHAP for Kids) serves families whose youth are in need of access to appropriate mental health services and are court-involved or at-risk for court involvement. MHAP for Kids began providing services for youth in Massachusetts on March 1, 2017, when it opened its first two sites embedded within the state-funded Family Resources Centers. Informed by its pilot program, the court-based Juvenile Court Mental Health Advocacy Project (J-MHAP), MHAP for Kids has adapted its services to assist families who may not already be involved with the court. Staff attorneys represent families at no cost, providing the following types of services: begin or improve special education services; secure and/or coordinate community-based mental health services; collaborate with state agencies like the Department of Children and Families, Department of Mental Health, and the Department of Developmental Services; advocate for general education accommodations, and; assist with health insurance coverage.¹

Beginning first in the two counties that were home to the pilot program, Essex and Middlesex, MHAP for Kids has grown over time and opened sites that now serve all counties across the Commonwealth. Represented in Figure 1, the sites include: Lynn and Lawrence (Essex County), Lowell and Everett (Middlesex County), Boston (Suffolk County), New Bedford (Bristol County), Holyoke (Hampden County), Worcester and Fitchburg (Worcester County), Quincy (Norfolk County), Brockton (Plymouth County), Hyannis (Barnstable, Dukes, Nantucket Counties), and Pittsfield (Berkshire County, also serves Franklin and Hampshire counties). The timing of the opening of each site is captured in the enrollment timeline, Figure 1.

PROGRAM ENROLLMENT ACROSS SITES

As of June 30, 2022, 1419 youth have been engaged in MHAP for Kids. Enrollment began during the 1st quarter of 2017 and proceeded steadily until the 1st quarter of 2020 (Figure 1). From March 15, 2020, to October 1, 2020, 40 youth enrolled in MHAP for Kids compared to 116 youth during the same period in 2019. It is important to note that during 2019, MHAP for Kids opened four new sites and no new sites during 2020. Combined with the availability of spaces in existing MHAP for Kids sites, the impact of COVID-19 may have resulted in a slower rate of enrollment for the program overall during this time, as depicted by the slope of the line in all four quarters of 2020 in Figure 1. As described in a previous



report, there were fewer enrollments in MHAP for Kids from March 15, 2020, to October 1, 2020, compared to the same period in 2019 due to the COVID-19 pandemic. This decrease in the program's previous steady enrollment is multi-faceted. Program staff reported that many systems came to a halt

during spring 2020. For example, as schools closed and transitioned to remote learning, team meetings and administrative processes were put on hold; the juvenile courts temporarily closed; residential treatment facilities delayed new residential placements until COVID-19 processes could be developed and implemented, and; other systems experienced similar delays or disruptions. To illustrate this, administrative program data note that staff attorneys had secured at least three residential placements for youth who could not be successfully placed until sites established COVID-19 precautions for accepting new patients. As all the systems that support youth struggled to manage during the early months of the pandemic, MHAP for Kids sites became unable to close many cases that otherwise would have been resolved. This impacted capacity to enroll new cases. In 2021, 6 new sites opened and enrollment rates return to a steep slope through the first two quarters of 2022. (Note: The site in Barnstable County was temporarily closed in quarter 3 of 2021 and consolidated with the New Bedford site in Bristol County. The Barnstable County site reopened in quarter 4 of 2022.)

Figure 1 depicts the cumulative enrollment of the program over time, inclusive of when new sites opened. The bottom line (green if in color) represents each new case that opened within a given quarter, and the top line (blue if in color) represents the total number of cases ever opened to date.

Given that Lowell and Lynn were the original sites for MHAP for Kids and held the legacy of the J-MHAP pilot, it makes sense that these two sites would have provided services to the highest proportion of clients over time (Lowell: 21.5%, Lynn: 19.9%), though their proportion of cases overall is decreasing as new sites open (Table 1). Worcester, Hampden, and Suffolk, were the non-J-MHAP counties with the largest MHAP for Kids enrollments.

	Total	White	Latinx/Hispanic	Black	Biracial	Asian	Missing
Middlesex	21.5%	44.6%	23.9%	8.2%	12.8%	4.6%	5.9%
Essex	19.9%	40.4%	37.2%	5.3%	14.5%	<5	<5
Worcester	12.6%	46.9%	24.0%	7.3%	16.2%	4.5%	<5
Hampden	11.5%	19.0%	54.6%	9.8%	13.5%	<5	<5
Suffolk	11.3%	13.0%	31.7%	42.2%	9.3%	3.1%	<5
Bristol	8.8%	48.8%	23.2%	10.4%	13.6%	<5	4.0%
Norfolk	5.9%	44.1%	8.3%	13.1%	13.1%	<5	17.9%
Plymouth	3.3%	66.0%	12.8%	<5	9.3%	<5	<5
Berkshire	3.0%	53.5%	14.0%	11.6%	16.3%	<5	<5
Barnstable	1.0%	42.9%	<5	<5	<5	<5	<5
Unknown/Missing	1.3%	--	--	--	--	--	--

Most sites predominantly enrolled white youth with the exception of Suffolk and Hampden counties where white youth made up 13.0% and 19.0% of cases, respectively. The racial breakdown is provided in Table 1. For the purposes of privacy, any cell with fewer than five people is suppressed.

Participant age at intake and gender show similar patterns across sites, overall, with most youth being males, aged 12-17 at enrollment, and who speak English at home. Hampden county had the highest percentage of Spanish speakers across all sites (31.9% compared to a range of 2.3-15.5% in others). Full details on age, gender, ethnicity, language, and referral source by site is found in Appendix A, Table A.

REFERRING AGENCY

In our first baseline report of data collected on youth enrolled through Fall of 2020, most families were referred to MHAP for Kids via the court/legal system (31.9%). This was, in part, influenced by the established relationships with the Essex and Middlesex juvenile courts from the J-MHAP pilot program.

The rate of referral in Middlesex and Essex from the court/legal system remains around 30% (25.9% and 29.1%, respectively), followed closely by Berkshire (25.6%). Other counties range from 4.5% to 16.8%. Despite these continued rates, the court and legal system is now the third most common referral source at 18.2% overall. A full breakdown can be found in Appendix A, Table A.

Analyses of program data through June of 2022 (Table 2) show a noticeable shift with healthcare organizations providing significant, and now the most, referrals to MHAP for Kids.

Healthcare Organization	27.0%
Community Organization	19.1%
Court/Legal System	18.2%
Family Resource Center	13.6%
Previous MHAP Client	6.1%
State Agency	5.6%
HLA	3.7%
Unknown/Missing	3.2%
Client	2.1%
School District	1.3%

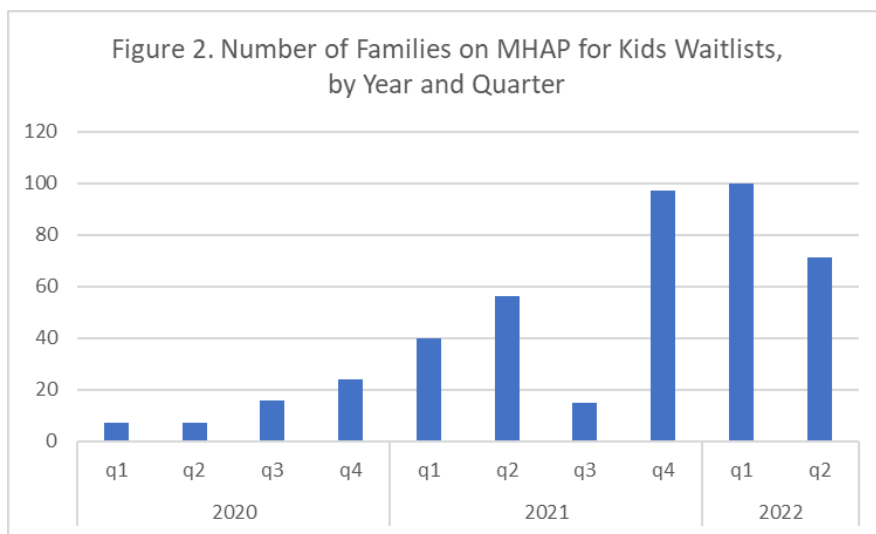
Across all sites, 27% of youth were referred from a healthcare organization, increased from 23.1% in December 2021. Plymouth had the highest healthcare referral rate with over 40% of youth (42.6%). Barnstable (35.7%), Suffolk (34.2%), Essex (31.6%), and Hampden (30.7%) counties each had around one-third of referrals coming from healthcare. In all other sites, healthcare referrals ranged from 13.6-28.2% (Middlesex = 28.2%, Norfolk =19.1%, Worcester = 18.4%, Berkshire = 16.3, Bristol = 13.6%). Referrals from community organizations has increased to be the second most common at 19.1%, similar to 18.1% in 2021. Worcester seems to have a strong connection to community-based referrals with 36.9% from community organizations. Barnstable and Berkshire counties also each have more than one-third (35.7% and 32.6%, respectively), compared to a range of 7.8%-26.4% in other counties. Family Resource Centers comprised 13.6% of referrals across all sites but 28.0% of Bristol county referrals. Full details of referral source by site are found in Appendix A, Table A. At the county-level it is expected that the newer sites will experience bigger fluctuations in their referral distribution just given their smaller client population. Overtime as the number of MHAP for Kids families expand, consistent referral patterns emerge. The changing pattern of referrals at a program level is an indication of the meaningful integration of MHAP for Kids into the Family Resource Centers and the community-level relationships, along with partnerships with both healthcare providers and insurers.

WAIT LIST

Due to the demand for MHAP for Kids services in Massachusetts, the program maintains a waitlist. Waitlist data (defined by using a threshold of time from intake to case opening exceeding 14 days) is available for 433 youth. The average time on the waitlist was 64 days (median = 42 days). These youths compare to those who did not spend more than two weeks waiting for their case to open. They had similar psychiatric diagnoses, prescriptions, and school engagement at baseline to those who did not wait (Appendix A, Table B). Worcester county, whose first site opened in the third quarter of 2019 and second at the end of 2021, operates the largest waitlist overtime with a total of 108 youth having ever been on it. Middlesex (first site opened in 2017 and second at the end of 2021) has the second highest with 82 youth ever having to wait more than two weeks, followed by Hampden county with 49 and

Essex (first site in March 2017, and second at the end of 2021) with 47. Bristol and Norfolk have waitlists of 38 and 37 respectively. Suffolk, Plymouth, Berkshire and Barnstable all have waitlist numbers under 30 (28, 24, 17, 3 respectively).

The waitlist, as defined here, first appeared in 2020 coinciding with the COVID-19 pandemic and sharp increase in the prevalence of pediatric mental health concerns throughout the United States. This waitlist, as depicted in Figure 2, shows the increases over the pandemic years. In order for any county to have a waitlist, families must need to be referred to the site. The MHAP for Kids program, though



statewide in its current reach, is outpaced by the demand, as many families continue to struggle to access appropriate and needed mental health services for youth. It is possible that as the program becomes more integrated into communities and strengthens relationship with referral sites (e.g., accountable care organizations) demand could also continue to grow

based on increased awareness of MHAP for Kids services.

SECTION 2: YOUTH AND FAMILY BASELINE CHARACTERISTICS

Staff attorneys work closely with each family to serve their individualized needs. In order to understand common characteristics across these families, some information was collected by the program on all participants and reflect the full clientele of MHAP for Kids (1419 youth). Additionally, because this report centers around the differences between youth and family characteristics after working with MHAP for Kids compared to before, analyses were largely limited to a smaller subset of MHAP for Kids youth whose families completed both baseline and follow-up data collection. Information was collected via enrollment and closure interviews with a paralegal or other program staff (n=159), and via self-administered questionnaires provided to parents/guardians at enrollment and closure (n=164). Due to resource constraints, interviews and questionnaires were administered only in English and therefore the results are not generalizable to the MHAP for Kids group as a whole.

The questionnaire and interview used standardized instruments to collect information regarding overall health, general stress, strengths and difficulties of the youth, family conflict, and caregiver depression symptoms. Each of the tools used was selected because of their wide use among youth and their families, as well as the existence of published norms for each measure, which were established using community or national samples. The selection of measures allows for the comparison of MHAP for Kids participants and the broader population. Youth details described in this report are all based on their parent or guardian's responses, with the exception of cases when youth were 18 years of age or older and wanted to report on their own behalf.

YOUTH DEMOGRAPHICS

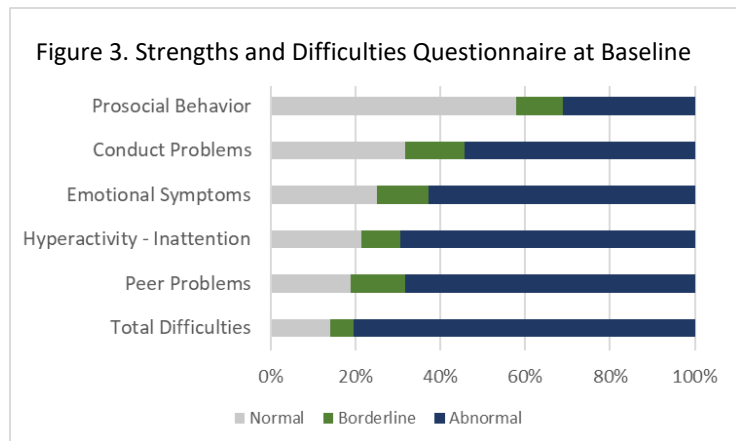
Youth in MHAP for Kids were mostly male (64%) from English-speaking households (82.9%) (Table 3). These are consistent with the characteristics of youth participants in the J-MHAP pilot program. MHAP for Kids, however, included a more diverse racial/ethnic population than J-MHAP, with a lower percentage of white youth and a higher percentage of Black, Latino/Hispanic, Asian, and Biracial youth. MHAP for Kids were on average substantially younger than youth in the J-MHAP pilot. These demographic shifts are likely the result of moving the program from the courts to community-based organizations (i.e. the FRCs), facilitating self-referrals or referrals from systems beyond courts, like healthcare organizations, that interface with eligible youth and families. The comparison of demographic data between the pilot and the existing program is summarized in Table 3.

Demographic	J-MHAP pilot (n=152)	MHAP for Kids (n=1419)
Age (mean (min, max))	15.7 (8, 22)	12.1 (3, 22)
Male (%)	60.9%	64.2%
Race/Ethnicity (%)		
White	66.5%	39.8%
Latino/Hispanic	20.4%	29.8%
Biracial	4.6%	13.8%
Black	5.9%	12.5%
Asian	.6%	2.3%
Other/Missing	1.9%	1.8%
Household Primary Language, English (%)	92.8%	82.9%

YOUTH RISK PROFILES

During baseline data collection, families were asked to rate youth physical and mental health on a scale from 0 to 10, where 0 is the “worst possible” health and 10 is the “best possible” health. The mean physical health score was 7.9 reflecting very good levels of physical health. The average mental health score was 5.2, representing fair or poor mental health.

On the self-administered questionnaire, parents/guardians provided information to help us assess youth functioning. The Strengths and Difficulties Questionnaire queries parents on youth emotional and behavioral difficulties and the impact of those difficulties on everyday functioning. The measure contains 5 subscales: prosocial behavior, conduct problems, emotional symptoms, hyperactivity-inattention, and peer problems. The latter 4 scales are summed to create a total difficulties score. The average total difficulties score among MHAP for Kids participants was 21.2 (sd = 6.7), which is nearly 3 times higher than the published norm (Table 4). Similar findings are present



for each of the subscales, including prosocial behavior, for which youth score approximately 2.5 points lower than the normed samples. This is higher than reported among pilot families indicating that at baseline, MHAP for Kids youths’ difficulties had yet to be stabilized through appropriate intervention. It is also worth noting that these scores have remain stable since our first evaluation report two years ago, indicating the consistency of severity of MHAP for Kids youth, overtime.

In Table 4, participant scores were averaged and compared to a published community sample, or

Table 4. MHAP for Kids Youth Functioning on the Strengths and Difficulties Questionnaire Compared to Norms^{3,4,5}	
	Number of standard deviations from norm
Youth Measures	
Emotional Symptoms	+2.0
Conduct Problems	+1.8
Hyperactivity – Inattention	+1.8
Peer Problems	+2.1
Prosocial Behavior	-1.9
Total Difficulties Score	+2.5
Impact of Difficulties	+1.5
Family Measures	
Parent Perceived Stress	+1.1
Parent Depression Symptoms	+1.5
Family Conflict	+3.5
+ indicates the mean score is higher or worse than the norm	

“norm.” Scores are reported based on the number of standard deviations (presented as an absolute number) MHAP for Kids participant scores deviate from this norm. This approach was used to allow readers to better contextualize youth risk. In a normally distributed population, 68 percent of values will fall within one standard deviation from the mean (average), and 95 percent of values will fall within two standard deviations from the mean. In interpreting these data, MHAP for Kids families’ scores indicates severe risk factors across all domains when compared to general community data. For a pictorial representation of these data, please

see Appendix B, Figures A and B.

More than 50% of youth scored into an “abnormal” category on the subscales: 69.9% for hyperactivity – inattention, 69.5% for peer problems, 62.8% for emotional symptoms, and 54.3% for conduct problems (Figure 3). Based on the total difficulties score, a full 80.5% of the MHAP for Kids participants are categorized as “abnormal” and an additional 5.5% are categorized as “borderline.”

YOUTH COURT INVOLVEMENT

During the intake process, families reported that 27.4% of youth had ever had any court-involvement, inclusive of care and protection, delinquency, permanency, and child requiring assistance or status offense cases. Staff attorneys additionally tracked the court involvement of youth and indicated that 111 (8%) of youth had active open cases when they began working with MHAP for kids, and among them 12% had multiple open cases. Most cases (67%) were for status offenses which were before the court as a Child Requiring Assistance (CRA) case. Approximately 9% of these youth had both a CRA and a delinquency matter at the same time, and 15% had just a delinquency case. The remaining 9% had other matters before the court like a civil restraining order, being the victim in a criminal case, or being involved in a custody matter.

PARENT/GUARDIAN AND FAMILY RISK PROFILES

The majority of parents/guardians who responded to the baseline data collection reported that their own health ranged from good to very good (64.4%), accounting for nearly two-thirds of all respondents,

with the remaining third reporting fair or poor physical health. Twenty-nine percent reported limitations in moderate activities and 39.7% reported difficulties climbing several flights of stairs. Physical health also caused 38% of respondents to accomplish less than they would have liked and 10.6% were limited in their work or activities most or all of the time during the past 4 weeks. Similar findings were found for emotional problems, which resulted in 51.7% of respondents reporting accomplishing less than they would have liked and 40.3% reporting they did not do work or activities as carefully, as usual, most or all of the time during the past 4 weeks. Thirty-seven percent of respondents reported that pain interfered with their normal activities more than a little bit during the past 4 weeks. Twenty-seven percent of adults reported that their physical health was much worse compared to 1 year ago; this proportion increased to 34.3% for emotional problems.

The Perceived Stress Scale was completed by parents/guardians to assess how situations are deemed stressful based on ideas of predictability, control, and stress load. Parents of MHAP for Kids participants reported a mean stress score of 20.3 (sd = 7.5) (Appendix A, Table C). This is 1.1 standard deviations above the published norm, representing greater than normal stress among MHAP for Kids parents (Table 4).

Parents also reported their depressive symptoms on the Center for Epidemiological Studies Depression Scale (CES-D). The mean score for MHAP for Kids parents was 22.1 (sd = 12.9), which is 1.5 standard deviations higher than the published norms. CES-D scores can also be assessed using a cut-off score of 16; persons with scores at or above 16 are categorized as having at least mild depression. Other studies have estimated that in the community approximately 19% of adults would score above the cut-off. Among MHAP for Kids families, over 3 times as many parents meet this clinical cut-off for depression symptoms (66.0%), indicating the mental health needs of caregivers in this program. Thirty-nine percent of families indicated symptoms of major depression (scores at or above 27). These results are very similar to what was measured among parent/guardians at baseline among J-MHAP families and what has been consistently found among MHAP for Kids parents since our earliest analyses.

Parents/guardians also filled out the Conflict Behavior Questionnaire which evaluates family functioning using assessments of youth behavior and interactions between parents and youth. The average score (mean = 9.3, sd = 6.1) among MHAP for Kids parents was 4 times higher than published norms indicating a much higher average level of conflict in these families' homes.

Court-Related Service	Ever Considered But Did Not Use	Ever Used
Out-of-home placement	14.9%	4.6%
Calling the police	7.0%	28.9%
Parent filing a CRA case	3.3%	5.2%
School filing a CRA case	0.7%	11.8%

Additionally, to understand the impact of youth challenges, data were collected on whether parents/guardians ever considered using outside court-related resources like an out-of-home placement or calling the police to address their child's needs. Table 5 summarizes the thoughts and actions of caregivers. One-fifth of families

considered out-placing their youth (19.5%). Thirty-five percent of parents considered calling the police for support with their youth's mental health problems. Twenty-three percent of families were advised to file a CRA, and some parents or guardians (8.5%) considered filing one for help with their child, while 12.5% had their child's school file one.

SECTION 3: ENGAGEMENT IN ACADEMIC AND MENTAL HEALTH SERVICES

YOUTH ACADEMIC ENGAGEMENT

During the baseline interview, parents and guardians were asked a series of questions to understand their youth's engagement with school. More than half (55.7%) of youth enrolled in MHAP for Kids were in adolescence (age 12-17 years). About one-third (33.4%) were in middle childhood or elementary school age (6-11 years). Pre-school aged (3-5 years) children accounted for 5.5% of MHAP cases and young adults (18-23 years)

were 3.9%. Within the subset of families who completed evaluation data collection at baseline, 90.3% were attending school full-time with over half (54.6%) in a special class for children with learning problems, 31.9% in a special class for children with behavioral problems, and 26.3% in a special class for children with emotional problems.

Twenty-two percent of youth were in a special school placement. Complete details on school engagement can be found in (Appendix A, Table D). Despite these specialized educational supports, youth experienced a high-level of disciplinary action with 19.3% having been suspended in the year prior, or 21% who had been sent home because of their behavior in school in the past year.

Table 6. Baseline MHAP for Kids Youth Service Use Compared to Pilot Youth		
	J-MHAP Pilot %	MHAP %
School Engagement		
School Suspensions in the 12 months before enrollment	46.2	19.3
Type of Service/Placement		
In-school therapy or counseling	70.83	59.3
Special classroom for learning, emotional or behavioral needs	50.98	62.5
Special school for youth with emotional or behavioral needs	31.11	21.5
Mental Health Services Received		
Outpatient Services:		
Mental Health Provider	92.16	78.4
Crisis or Emergency Services (emergency room, in-home crisis services)	69.57	39.9
Received a prescription for medication for emotional, behavioral, or substance use reasons	91.18	69.6
Took medication for emotional, behavioral, or substance use reasons during past year (at least 1 week)	88.89	95.1
Partial Hospital or Day Treatment	16.33	26.0
Overnight Services:		
Hospital	44.00	34.2
Residential Treatment Facility	35.42	18.8
Drug/Alcohol Treatment Unit	5.77	<5
Other Out-of-Home Placement:		
Group Home	13.46	5.2
Detention center/prison/jail	13.73	2.0
Emergency Shelter	10.00	2.6
Foster Home	<5	4.7

YOUTH SCHOOL SERVICES USE

Many youths who participated in MHAP for Kids received services to address behavioral or mental health problems through their school. Fifty-four percent of youth were reported to participate in a special class for children with learning problems, 33.3% participated in a special class for children with behavioral problems, and 28.6% participated in a special class for children with emotional problems.

Approximately 59% of MHAP for Kids youth received school-based counseling. Twenty-four percent of youth received medications for problems with concentration, behavior, or emotions that were taken at school. Nearly across the board, youth are experiencing fewer supports and placements than youth enrolled in the J-MHAP pilot. This may be a factor of MHAP for Kids intervening earlier in kids' trajectories, before existing systems have intervened. Complete details on school service use can be found in (Appendix A, Table D).

YOUTH OUTPATIENT BEHAVIORAL HEALTH SERVICES UTILIZATION

The vast majority of youth were already receiving mental health care for identified mental health conditions prior to their work with MHAP for Kids. Youth received mental health services from mental health professionals (78.4%), pediatricians or family doctors (34.2%), counselors or family preservation workers (50.3%), or mentors (31.3%) (Appendix A, Table E). In addition to receiving outpatient care, 86.4% of youth had at least one medical condition, with the average number of diagnoses as 2.5 with a range of 1 to 7.

Table 7 summarizes the diagnoses parents indicated during their intake call. Nearly two thirds (63%) of youth were on psychiatric medications at baseline. Among the youth whose parent/guardian filled out baseline data, 36.7% had ever received services from a social services agency, compared to 50% among the 182 families that provided data presented in the fall 2020 report. Complete data on outpatient behavioral health services can be found in Appendix A, Table E.

Approximately 40% of youth reported receiving emergency room (42.2%), in-home crisis services (39.9%). Both are costly and indicative of mental health issues that are not stabilized.

Thirty-five percent engaged with community mental health centers or outpatient services. Partial hospitalization or day treatment programs were used by 26.0% of youth, which is a much higher percentage than observed in the J-MHAP pilot (Table 6). Probation or juvenile corrections officers were involved with 14.7% of youth, compared to nearly a quarter of youth included in the fall 2020 baseline report. This shift is likely due to the expanding referral sources for MHAP for kids that are encountering youth in need of services outside of the court system. Ten percent or few of youth ever received services from an educational tutor (10.4%), telephone hotline (8.7%), respite care provider (8.6%), self-help group (5.5%), spiritual advisor (3.9%), or other healers (3.3%). Seventy percent of youth ever received a prescription for an emotional, behavioral, or substance use problem. Approximately 95% of youth took this medication regularly for at least one week while 78% of youth took medication regularly for at least 1-year.

Condition (n=1216)	% Youth
ADHD/ADD	49.6
Anxiety Disorder	39.8
Depression	31.5
Autism	26.9
Trauma	22.2
Other Mood Disorder	11.2
Other Conduct Disorder	9.5
Major Mental Illness	9.0
Intellectual Disability	4.9
Attachment Disorder	3.6
Obsessive Compulsive Disorder	3.2
Learning Disability	2.8
Suicidal Ideation	2.3
Other Communication Disorder	1.5
† Numbers do not sum to 100% as youth may report more than 1 condition	

YOUTH INPATIENT BEHAVIORAL HEALTH SERVICES UTILIZATION

Some youth experience overnight stays in a variety of systems to help manage their mental health needs, thus the use of inpatient services was also queried. Thirty-four percent of youth in the evaluation sample had an overnight hospital stay. Residential treatment centers were used by approximately 19% of youth. Fewer youth lived in a group (5.2%) or foster (4.7%). Hospital stays among MHAP for Kids youth are similar to those of youth from the J-MHAP pilot (Table 6); however fewer MHAP for Kids youth experienced other out-of-home placements possibly indicating intervention earlier in youth's trajectories. Follow-up over time will yield more information on the ability of the program to interrupt unnecessary outplacements for youth.

FAMILY EXPERIENCE WITH BARRIERS TO SERVICES

Families also shared information about any barriers they may have ever faced while trying to access mental health services for their youth before beginning work with their MHAP for Kids staff attorney. Parents/guardians were provided a list of common barriers to health services asked to identify, of those they faced, which were the most bothersome to them. This full list of barriers and their definitions is provided in Appendix A, Table F.

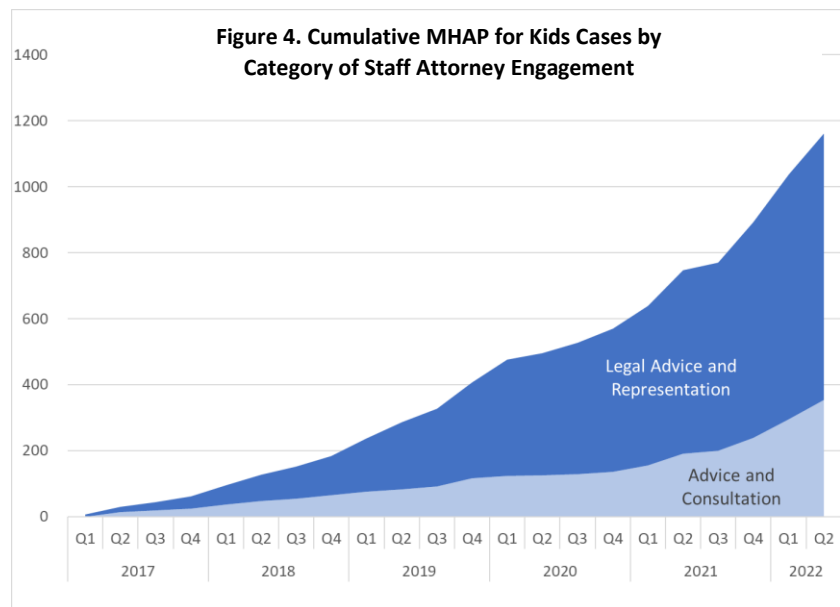
Experiencing barriers to accessing care was a near universal (96.9%) experience of MHAP for Kids families, who reported that the barriers impacted mental health services for their youth. Of the barriers reported, bureaucratic delays, like excessive pre-visit paperwork or authorizations, difficulty getting an appointment in a timely fashion or being put on a waiting list, or offices where the phone is not answered or calls are not returned, was the most frequently identified bothersome (79.9%) barrier. Approximately two-thirds rated time (65.4%), and incomplete information (65.4%), and nearly half reported the unavailability of services (49.1%) as the bothersome barriers. Cost and transportation were also commonly reported (36.5%, and 38.4% respectively).

MHAP for Kids families also experienced substantial barriers related social consequences to seeking care. Nearly half (49.7%) of all parents and guardians reported experiencing fear, dislike, or distrust of professionals as a bothersome barrier. Similarly, 47.2% reported having a previous negative experience. Others indicated that anticipation of a negative reaction from others (20.1%), self-consciousness (18.2%), anticipation of an out-of-home placement (17.0%), and anticipation of losing parental rights (15.1%) as significant barriers to accessing mental health care for their youth.

SECTION 4: THE WORK OF STAFF ATTORNEYS

MHAP for Kids has provided services for 1419 youth across the Commonwealth in just over 5 years. Families who wish to engage in services first complete an intake process with the program's paralegals followed by review and approval of the case by the program's senior director. MHAP for Kids staff attorneys then work with families to provide needed services at the level that is appropriate for the circumstances. For some families this means receiving legal advice and consultation, and for others it involves more in-depth legal support including representation. Overall, approximately 30% of all cases receive services at the advice and consultation level. Figure 4 shows the cumulative number of cases that fall into the two main staff attorney support categories overtime. The figure represents the total numbers of cases, with the slope showing fluctuation or change in the cases initiated for each category. This fluctuation was particularly evident early in the COVID-19 pandemic (quarters 1-3 of 2020) when approximately 90% of cases required legal help and representation, and 10% for advice and consultation

(indicated by the plateau in the advice and consultation line). By the fourth quarter of 2020, the balance between representation (85%) and consultation (15%) began to shift and by the second quarter of 2021 had returned to approximately 70% and 30% again, respectively. This change in the focus of staff attorneys may indicate a combination of both the complexity of cases during the early days of school and court closures requiring more in-depth services, as well as the possible delay in receiving new cases seeking lower-levels of program support.



The average length of a completed case between March 2017 and June 2022 was 202 days or 6.7 months, with a minimum of less than one month and a maximum of 2.3 years.

Staff attorneys work with families to develop the goals the attorneys will pursue. While HLA’s Mental Health Advocates in the J-MHAP pilot program also did this, the pilot program had a scope of work directed by the court where MHAP for Kids does not. This should mean that

the goals that drive staff attorney work are likely the result of parent/guardian wishes without influence from the court. Data on goals is available for 989 MHAP for Kids participants. The average number of goals per participant was 4.8 (median = 4.0) and ranged from 1 to 47 goals. Upon case closure, staff attorneys were able to complete 74% of all goals.

STAFF ATTORNEY EFFORT WITHIN VARIOUS SYSTEMS

Staff attorneys tracked their work by documenting all the contacts they made on behalf of families to health practitioners, state agencies including the Department of Mental Health, Department of Children and Families and Department of Elementary and Secondary Education, and court-related contacts including probation officers and other attorneys. For the 1408 youth receiving MHAP for Kids services, the most frequent modes of contact were emails and texts (20% of reported contacts) with an average of 8 hours per case (maximum = 134 hours), telephone calls (20% of contacts) with an average of 5 hours per case (maximum = 58 hours), and documentation (20% of reported contacts) with an average of 2 hours per case (maximum = 47 hours).

CASE KEY EVENTS

Staff attorneys track *key events* or pivotal moments in a case. As of June 30, 2022, there were 1019 key events recorded for 412 youth. The average number of key events in a case is 3 with a median of 2, and a range of 1-30 events. These data highlight the complexities of MHAP for Kids cases and document both challenges and successes faced by families during their work with staff attorneys. Some examples of challenging key events include youth suicide attempts, hospitalizations or emergency department visits, and illness or death in the family. Some case successes include a youth discharged from inpatient

program with a follow-up plan, a school district agreeing to cost-sharing a residential placement, and newly qualified services obtained within the existing school. Four youth ID numbers (as all identifying information has been removed from the data used for this report) were selected at random to highlight the types of case events denoted by staff attorneys.

Example 1. This case is a 14-year-old Latina female with a history of trauma and school bullying. Her staff attorney worked to assist the family with navigating providers to obtain a diagnosis and assessment of educational needs. The case had 16 specific goals related to the assessment of mental health and education issues, obtaining evaluations from the school district, and support for navigating a diagnosis process with providers. Additionally, goals addressed establishing ongoing educational supports (both a 504 and Individualized Education Plan or IEP). Finally, the remaining goals related to assessment and supports for mental health crises. Notable key events in the case included two crisis assessments for suicidal ideation, securing an independent evaluation, and ultimately the youth becoming eligible for an IEP. The case was still open after 7 months, and 13 of the 16 goals had already been achieved.

Example 2. This case is an 11-year-old white male child who was frequently missing one or more days of school each week when he started working with MHAP for Kids. The staff attorney worked with the family on a total of 7 goals, 5 of which were directly related to school assessment, evaluation, performance, and alignment of the IEP. The remaining two goals were related to home mental health supports and additional assessments for trauma. A series of five key events over a six-month time span show success with negotiating both evaluations and supports from the school with an indication that the parent was pleased with the results. The child expressed suicidal ideation and a new therapist with specialized training was secured and the school was responsive with IEP and safety supports. Ultimately the case closed with the child successfully remaining in the school.

Example 3. This case is a 13-year-old white male youth who began work with MHAP for Kids with an open CRA case in juvenile court filed by the parent after receiving pressure from both DCF and the child's school. At the beginning of his case he had six mental health diagnoses and expressed enjoying his school but had difficulty with emotional regulation, particularly at home. The staff attorney worked with the parent on 22 goals that ranged from securing in-home services and a trauma evaluation, advocating for school supports and crisis services, applying for Department of Mental Health services, and assisting with securing respite care for the parent. Key event in this case included admission of the youth to a Community Based Acute Treatment (CBAT) program and successfully collaborating with probation resulting in the judge dismissing the CRA case because the family was working with MHAP for Kids. Six of the nine total key events are related to the parent calling mobile crisis for supports at home, during one event it is noted that mobile crisis refused to respond. The youth was found eligible for Department of Mental Health Services. At the time the case closed, 18 of the 22 goals were successfully completed.

Example 4. This case is a 14-year-old Black male youth who began work with MHAP for Kids with two mental health diagnoses and an open CRA case filed by his parent. He was regularly attending school but had difficulty staying in his classroom and was ultimately suspended. His mom was concerned that the school was not the right fit and wanted an alternative school setting. The staff attorney worked with the family to identify 12 goals largely focused on advocacy to secure appropriate special education supports and placement. Additional goals related to applying for DMH services, and

securing outpatient mental health resources through the Children’s Behavioral Health Initiative (CBHI). At the beginning of his time with MHAP for Kids, he was transferred from court to an inpatient hospital stay for suicidal ideation and intensive community-based therapeutic services were secured. He moved into a DCF group home for more supports but refused therapy and was moved to a new group home where he completed online remote learning from an alternative school during the pandemic. Key events note that he left both his school and the DCF group home without permission. Ultimately he was placed in a higher-level DCF special education therapeutic residential placement and received compensatory services for missed school. When the case closed all but one goal was successfully completed.

SECTION 5: EVIDENCE OF PROGRAM IMPACTS

Youth and family risks are dynamic and able to change over time. Scores on standardized measures of risk indicated changes from the beginning of families' work with MHAP for Kids, to the time their case closed. These changes point to an association between the work of the staff attorneys and improved youth and family outcomes. Results related to youth and family functioning along with youth involvement with the court, engagement in services, and experience of barriers are presented here, with full data tables found in the appendix as indicated below.

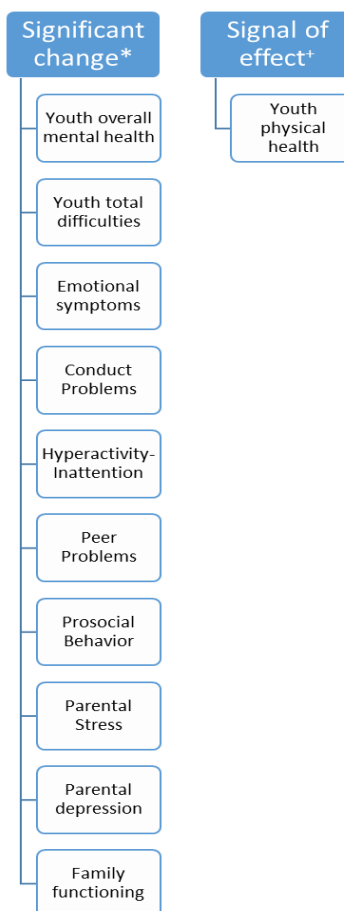
YOUTH AND FAMILY FUNCTIONING AT FOLLOW UP

We found statistically significant differences across all measures of youth and family mental health risk, including overall mental health, total difficulties along with every subscale of the Strengths and Difficulties Questionnaire, parental levels of perceived stress, parental mental health, and overall family functioning (Figure 5). While not statistically significant there was also a signal of effect for youth physical health having improved, as well.

For example, at baseline, 80.5% of youth were rated with an "abnormal" level of difficulties, compared to only 59.2% at follow-up ($p < 0.001$). This is driven by the 24.4% of youth who were originally rated as having "abnormal" difficulties at baseline who were rated as having "normal" or "borderline" difficulties at follow-up. This pattern of moving from abnormal to normal or borderline was seen across all subscales indicating stabilization of emotional symptoms, conduct problems, hyperactivity/inattention, and problems with socialization.

In terms of parental well-being, while 66% of parents met the threshold for depressive symptoms on the CES-D tool, only 53.7% did at follow up. This decrease was also seen in the higher scores indicating major depression which changed from 39% to 25% at baseline. Not only are these shifts significant from a statistical perspective, they combine with other reductions like parental stress and family conflict and likely have a meaningful impact on family functioning. More details are presented in Appendix A, Table G.

Figure 5. Changes in Youth and Family Mental Health and Functioning



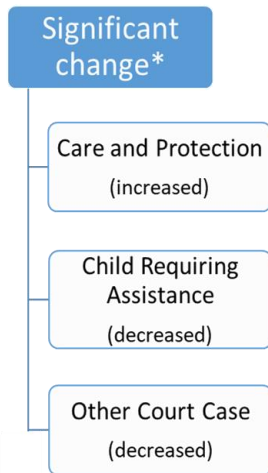
*Changes observed were statistically significant (not due to chance, $p \leq .05$)

†Changes observed showed a signal of effect (not likely due to chance, $p \leq .10$)

YOUTH COURT INVOLVEMENT AT FOLLOW UP

For the purposes of this analysis, court-involvement extends beyond an existing open court case, to any

Figure 6. Changes in Open Youth Court Cases from Baseline to Follow-Up



interaction with the legal or justice systems. Families were asked about their consideration and follow through with engaging with Department of Children and Families to outplace their child, with the police to help handle a mental health issue, and initiating a Child Requiring Assistance case for status offenses. At follow-up, more families thought about (from 14.9% to 16.2%), and followed through (from 4.6% to 10.4%) with outplacing their child. This increase may reflect placements aligned with goals the family worked toward with the support of their staff attorney. Families were less likely to call the police for help with their child's mental health than at baseline. Those who had considered calling the police, but did not follow through, dropped from 7% to 4.5% at follow-up. There was also a significant decrease in those who actually called the police from 28.9% to 12.8%. Though these are statistically significant changes, the analytic design does not allow for identification of causation. However,

decreases in familial and youth risk along with increase health care utilization seem to indicate that during the time with MHAP for Kids, mental health was stabilized and drastic and costly measures simply were not needed at the rate they were at baseline. More details can be found in Appendix A, Table H.

There were changes in open court cases at the time of follow-up, as well. The shift in care and protection and child requiring assistance cases were each statistically significant (Figure 6). Care and protection saw an increase from .6% to 1.1%. CRA cases decreased from 6.2% to 2.9% at the time of the case closing (Appendix A, Table I).

One of the main goals of the MHAP for Kids program is to decrease or prevent court-involvement, so staff attorneys documented their actions that served as prevention in this regard. Through June 30, 2022 staff attorney's recorded the prevention of further court-involvement on 71 cases (Table 8). This documentation helps contextualize the quantitative differences seen in CRA cases, for example. In 29 cases, staff attorneys were able to successfully advocate for the dismissal of a CRA case because it no longer was necessary. While the quantitative data show an increase in care and protection cases, the staff attorneys worked to successfully prevent a care and protection case from being filed because needed services had been acquired through MHAP for Kids efforts. Staff attorneys impacted 18 delinquency cases through avoiding adjudication because of competency (7 cases), avoiding arraignment (8 cases), avoided or shortened pre-trial detention (6 cases).

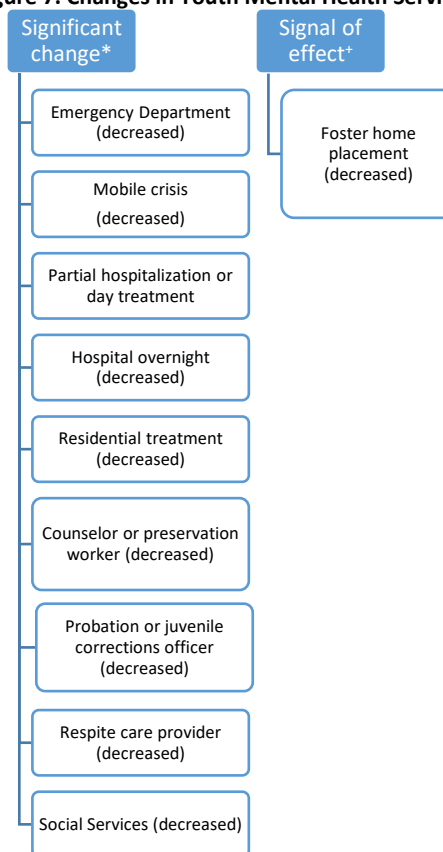
Table 8. MHAP for Kids Staff Attorney Documented Court Prevention	
Court Prevention (n=1421)	Youth (n)
CRA dismissed early because staff attorney secured needed services.	(29)
Potential care and protection case was not filed by DCF because the staff attorney secured needed services for the youth/family.	(24)
Adjudication of a delinquency matter was avoided because staff attorney assisted the youth's attorney by flagging competency and/or criminal responsibility concerns	(7)
Arrestment avoided on a delinquency charge because staff attorney assisted the youth at a clerk magistrate's hearing and the petition never issued.	(5)
Arrestment avoided on a delinquency charge because staff attorney advocated for the youth to participate in a diversion program.	(3)
Pre-trial detention avoided or shortened because staff attorney helped advocate for youth to return to the community.	(3)

YOUTH ENGAGEMENT IN ACADEMIC AND MENTAL HEALTH SERVICES AT FOLLOW-UP

MHAP for Kids youth had a baseline-level of engagement with school and mental health services that already showed connection with systems of care. Despite encounters with services youth mental health was not well-managed, necessitating further intervention. Following work with MHAP for Kids, there was a significant increase in specialized classroom and school placements (Figure 7). Other school services remained at their baseline levels and there were no changes in the proportion of youth experiencing suspensions or school exclusion during their time working with MHAP for Kids. Parents were more likely to report that their child's grades were above average at follow up (15.7% compared to 10.7%) however, these results were not statistically significant. More details found in Appendix A, Table D.

Similar to findings in the J-MHAP pilot evaluation, families experienced fewer emergency room visits (from 42% to 17.5%), in-home mobile crisis interventions (from 39.9% to 23.5%), and fewer hospital stays (34.2% to

Figure 7. Changes in Youth Mental Health Service Utilization⁵



⁵Results should be interpreted with caution due to differences in the look-back period at baseline and follow-up

*Changes observed were statistically significant (not due to chance, $p \leq .05$)

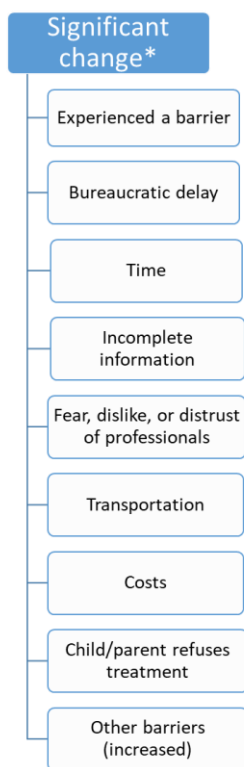
†Changes observed showed a signal of effect (not likely due to chance, $p \leq .10$)

13.6%) or placements in residential treatment (from 18.8% to 7.8%). There were also decreases in other supports like use of a counselor or family preservation worker, respite care, and social services. These changes should be interpreted with some caution, as at baseline parents/guardians reflected on the past 12-months, but given the average duration of a MHAP for Kids case they only reflected on the past 6-months for the follow-up assessment. This does introduce some bias to the findings, however other data about these families suggest that they engage with MHAP for Kids at a time of crisis or increase intensity of mental health need. The decrease in familial stress and documentation of the work accomplished through collaborative goals these changes in costly health services utilization may also be a result of MHAP for Kids intervention. Full details are in Appendix A, Table D.

FAMILY EXPERIENCES OF BARRIERS TO CARE AT FOLLOW-UP

As presented earlier in this report, nearly all families reported encountering bothersome barriers to accessing care for their child. Following work with MHAP for Kids there was a significant increase in the number of people reporting not experiencing a barrier to care (from 3.1% to 10.7%). Additionally, we saw a reduction in barriers like bureaucratic delays, time, and incomplete information which were the

Figure 8. Changes in Youth and Family Mental Health and Functioning



⁹Results should be interpreted with caution due to differences in the look-back period at baseline and follow-up

^{*}Changes observed were statistically significant (not due to chance, $p \leq .05$)

top three most commonly experienced barriers at baseline. Table 9 summarizes the change in barriers over time. While there were nine categories that showed significant change (figure 8), there were also 9 that did not. A few of these are of note. First, language is one of the barriers we assessed, however all the people who participated in data collection were proficient English-speakers who likely would not be the demographic that might struggle with a language as a barrier to care. Also there is one barrier that we would not expect to see change with MHAP for Kids involvement: service not available. Despite improving access to services, the program cannot overcome a service not being offered. For the remaining barriers, like previous negative experience, or socially-based fears of negative consequences like loss of parental rights or negative reactions from others may be difficult to overcome. However, we did measure a significant change in the barrier of fear, dislike, or distrust of professionals which speaks to the impact staff attorneys and paralegals have on establishing productive relationships with youth and their families. One barrier, child/parent refuses treatment did increase (from 8.8% to 17.6%). This finding is difficult to interpret as it may be the family feeling empowered to say when certain therapies are not right for them or it may be exposure to more options leads to more

opportunities for refusal. More should be investigated on this barrier.

		Baseline	Follow-	
Bothersome Barrier		%	up %	p-value
Significant improvement	Bureaucratic Delay	79.9	61.0	0.0002
	Time	65.4	44.0	<0.001
	Incomplete Information	65.4	41.5	<0.001
	Fear, Dislike, or Distrust of Professionals	49.7	34.6	0.0043
	Transportation	38.4	27.7	0.0213
	Cost	36.5	20.8	0.0013
	Child/Parent Refuses Treatment	8.8	17.6	0.0125
	Other Barriers	3.8	12.6	0.0066
	No Barriers	3.1	10.7	0.0075
No significant change	Any Services Affected by Barriers	88.9	80.6	0.3750
	Service Not Available	49.1	41.5	0.1753
	Previous Negative Experience	47.2	39.6	0.1686
	Anticipation of a Neg Reaction from Others	20.1	26.4	0.2116
	Refusal to Treat	18.2	18.2	1.0000
	Self-Consciousness	18.2	23.3	0.2682
	Anticipation of Out-of-Home Placement	17.0	17.0	1.0000
	Anticipated Loss of Parental Rights	15.1	13.2	0.7493
Language	1.9	3.1	0.6250	

SECTION 6: THE ROLE OF COVID-19 IN FAMILY EXPERIENCES

On March 17, 2020 schools in Massachusetts shifted from in-person education to remote learning due to the COVID-19 global pandemic. MHAP for Kids made efforts to ask families each week about their experiences with remote learning and with their youth’s behavioral and mental health symptoms. MHAP for Kids gathered data near the beginning of remote learning from 32 families and 48 families during the extended period of remote learning through June 2020.

FIRST PANDEMIC SCHOOL YEAR: SPRING 2020 At the start of remote learning, 60% of parents and guardians rated their youth’s mental health at or below a score of 5 on a scale of 0-10 where 0 is the worst and 10 is the best possible mental health. Only 7% of youth had mental health ratings above a score of 7. Among these 32 families, 59.4% reported that the youth had a personal laptop or tablet at home on which to do schoolwork while 40.6% reported that the youth had a shared device. Nearly 70% reported that their youth had reliable WiFi with which to connect to school and approximately half (53.1%) had a quiet study space.

When asked about the ease of communication with schools, 47% of families had heard from their schools within the first week following the transition to remote learning, while 44% heard from their schools after the first week. Less than half of families reported having regular communication from schools (44%), while 38% described communication as irregular. Only 79% of families expressed knowing how or who to contact at school if they had a question, with 22% not knowing.

Families were asked to participate in extended school closure logs each week during remote schooling. Among the 48 families who completed at least 1 extended school closure log, the average number of logs completed was 2.6 (median = 2); some families completed up to 11 school closure logs.

Many of the youth involved with MHAP for Kids have an Individualized Education Program (IEP). Of the families who filled out weekly logs, just over half of the youth (54%) had an IEP. All of these families reported receiving IEP services at some point during remote schooling in spring 2020, though some families expressed concerns that services were inadequate to fully meet their child’s needs. Quotes from parents to illustrate this include:

“I continue to have concerns that her individual remote learning plan is generic and not catered to her individual needs. I’m also concerned that although it has been identified in her IEP that she requires specialized and individualized teaching...none of this has happened.”

“The harder the works gets the more unstable she’s being. It’s not fair they aren’t working with us to accommodate her.”

When asked if youth completed their assigned work, 35% of families reported their child never completed their work for any of the weeks the log was filled out. The leading reasons families reported work was incomplete included: that the child was unwilling (33%) or did not understand (29%) and that there were technical difficulties (15%). Nearly half (48%) of families reported concerns that their youth may not receive credit for their work or would be held back. These concerns were held by parents (96%), youth (35%), or expressed by the school (25%).

The vast majority (96%) of parents reported observing social, emotional, and or behavioral challenges during this time, as summarized in Table 10. The average family reported 3 challenges per week. The distress caused by these challenges is difficult to compare to family life before remote learning as we only started collecting weekly information during the pandemic. However, qualitative comments provided by families suggest that youth social, emotional, and behavioral challenges were made worse during COVID-19. Examples of family comments suggesting that challenges were increasing are reflected in Table 11.

	%
Anxiety	66.7
Youth refused to do work	58.3
Verbal Aggression	50.0
Refused to get out of bed, sleep issues	45.8
Physical complaints	33.3
Physical aggression	29.2
Other	29.2
Property destruction	27.1
Left home without permission	14.6
None	6.3

Table 11. Illustrative Parental Responses to Youth Challenges Faced During COVID-19 Remote Learning

“He is getting worse.”

“Just deteriorating.”

“Emotionally this is getting the best of him.”

“Actually talking with therapists about having a chins filed she’s been horrible daily because of having to do school work.”

“Worried about these new/increased symptoms he’s been having for a few weeks. Spells, disassociating, short term memory loss, irritability, anger, argumentative, and destructive behavior.”

“[His] agitation that he might not pass because of the tablet not working now and on several other occasions which causes anxiety to peak which causes meltdowns with [him] because of his frustration level and inability to have control of his situation.”

“...Homeschooling has been extremely challenging...He becomes frustrated when he doesn’t understand the question or knows the answer in which then he begins to escalate and misbehave.”

SECOND PANDEMIC SCHOOL YEAR: DECEMBER 2020-JUNE 2021

As the 2020-2021 school year started, it became clear that remote learning would remain in place, at least at the beginning of the school year. From December 2020 through June 2021 data were collected in the form of a one-time survey (n=100), and weekly logs to document family experiences (n=494 logs).

Parents/guardians were asked to rate their child’s mental health at the beginning of the current school year on a scale of 0 = worst and 100 = best. The average score was 53.5 with a median of 50. Families reported that 69% of youth had their own laptop or tablet for their work from home, 71% had reliable WiFi to facilitate connection to the school, and 54% had a quiet study space. This is similar to what parents reported at the beginning of remote learning in the spring of 2020 with an increase only in families reporting access to a personal laptop. Eighty-four percent of families indicated that they knew who to contact if their child has questions regarding schoolwork, compared to 79% in the previous spring.

Upon the beginning of the 2020-2021 school year, approximately one-third of students (31%) had received extended school year services during the summer of 2020. Most families reflected on the previous year’s grades as below average (60%), with 37% indicating average grades. Only one family stated their child’s academic work was above average in June of 2020.

Families receiving MHAP for Kids services experienced hardships related to COVID-19. For example, half of all families reported COVID-related loss of income. Twenty-six percent of families lost reliable child care, 19% experienced the illness or death of a family member, 8% had family or friends move in or out of their households, and 7% changed their housing.

Parents/guardians were also asked about the concerns they had for the school year. They were able to select as many concerns as applied and the vast majority of families had at least one worry (Table 12).

Table 12. Concerns Parents Have for 2020-2021 School Year	
My child did not focus well last year and I worry that will happen again	69%
I worry remote learning will negatively impact my child’s mental health	59%
My family struggled to stay on top of my child’s online learning	50%
I worry my child may become sick attending in-person school	31%
I worry other members of my family may become sick because my child is attending in-person school	30%
I worry about being able to maintain my employment and support my child’s online learning this year	27%
I worry in-person learning will negatively impact my child’s mental health	24%
I worry that the safety/cleaning protocols at my child’s school are not adequate	24%
My child was held back in school and I worry that will happen again	10%
I don’t have any concerns	<5%
Other concerns with illustrative quotes: <u>Abuse</u>	30%

<p><i>"My child was not provided a safe environment to return to in person school due to a teacher threatening and discriminating her towards her disability and therefore was emotionally and mentally impacted..."</i></p> <p><i>"School was physically abusive in the past..."</i></p> <p><i>"I am worried about the abuse of power the School system is using to call DCF and Get the Juvenile court system involved."</i></p> <p><i>"The staff actually does more to try and trigger him into having behaviors..."</i></p> <p><i>"I worry my son will be abused again physically and emotionally due to his disability and the school personnel not treating him appropriately or fairly."</i></p> <p><u>Lack of appropriate services</u></p> <p><i>"My child's IEP has not been followed and he has been excessively disciplined."</i></p> <p><i>"Child getting denied appropriate services again"</i></p>	
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Approximately 30% of families had other concerns not listed on the survey. These included some worries related to not having access to full services when the child is remote, but the vast number of qualitative comments were related to in-school risks like lack of appropriate services, schools’ ability to abuse power and involve the courts and department of children and families, and physical abuse of the child during the school day (Table 12).

The weekly data showed that over time, about one-third of logs were completed for students who were in-person all week (34.4%), about one-quarter were online all week (24.3%), and 11.5% were hybrid.

The remaining third (28.7%) reported their child did not attend school that week, with the most common reason being ‘other’ (85%), and 12% due to avoidance or refusal. Among those who selected “other”, reasons included hospitalization, quarantining due to COVID-19 exposure, or school vacation. Those accessing materials remotely were primarily using some combination of live sessions (32%), independent online work (24.3%), videos (4.9%), or printed materials (3.9%).

One-quarter of families reported that their student had the ability to access extra help if needed, with 18% reporting that no extra support was offered, and 4.7% reporting extra help was offered but the family missed the available time.

Table 13. Youth Social/Emotional/Behavioral Challenges Observed During Remote Learning	
	%
Anxiety	75.7
Verbal Aggression	49.2
Depression	48.2
Negative self-talk	44.1
Physical complaints	42.1
Refused to get out of bed, sleep issues	40.1
Youth refused to do work	33.0
Physical aggression	24.1
Other	12.6
Property destruction	11.9
None	6.7
Left home without permission	3.4

Twelve percent of logs reported that a child completed their work for the week. Of the 61.4% who reported their child did not complete their work, 22% needed more support, 19% had a child who was unwilling, 18% had a child who did not understand the work, and 6% had technical difficulties. Another 35% listed other reasons nearly all of which were that there was no work to complete.

Just over half of the weekly logs had data for a child with an IEP (52.2%). Of those, only 45% received services that week. Less than half of parents filled out how helpful they thought the IEP services were for the week, and among those only 6.2% reported that they were not helpful at all (slightly helpful = 14.0%, moderately helpful = 10.9%, very helpful = 5%, extremely helpful 8.9%). Parents also rated how helpful communication from their school was during the past week. The results are divided into quarters 22.3% thought it was not helpful, 23.7% thought it was slightly helpful, 26.5% thought it was moderately helpful, and 22.5% thought it was very/extremely helpful.

When asked about the child’s behavior at home and at school about half felt that it was the same in that week as it had been in the week prior (52.2% and 54.3% respectively). Similarly, about 18% felt behaviors had gotten worse (home = 18.6%, school = 17.6%). Encouragingly, 24.7% of families thought their child’s behavior at home improved since the previous week, with only 17% reporting improvement for school-related behaviors. Parents also had the opportunity to select social, emotional, and behavioral challenges they observed during that week (Table 13). The vast majority of parents reported on the weekly log that their child exhibited at least one of these challenges (93.3%).

THIRD PANDEMIC SCHOOL YEAR: SEPTEMBER 2021- JUNE 2022

For many families the 2021-2022 school year marked a full return to in-person learning, though some MHAP for Kids families were able to still participate in remote or home-schooling. As in the second year of the pandemic, parents were asked to complete weekly logs about their ongoing experiences.

Nearly 700 families (n = 695) filled out at least one weekly log between September 1, 2021 and June 30, 2022. Given the shift away from remote or hybrid options for most families, much of the data collected about the week of schooling reflected that the majority of youth were in-person for full weeks (61.7%). If they were not in-person it was not because of online or hybrid learning (1.2% and 4.2% respectively) but because the youth was out of school (33%). The biggest reason for missing school for a full week was vacation, though 10% were a result of youth refusal to attend, or physical illness (8.3%).

Table 14 Social/Emotional/Behavioral Challenges Observed 2021-2022	%
Anxiety	71.4
Depression	51.0
Verbal Aggression	48.4
Refused to get out of bed, sleep issues	39.0
Physical complaints	37.0
Negative self-talk	33.6
Physical aggression	27.0
Youth refused to do work	21.1
Other	18.9
Property destruction	16.0
None	4.3
Left home without permission	3.6

The weekly logs also allow parents to note specific social, emotion, or behavioral challenges they observed. These data continue to indicate the severity of needs of youth and the experiences of families (Table 14). When compared to last school year, families still report high levels of anxiety and depression. There is some variation of other symptoms with refusal to get out of bed appearing more often than negative self-talk in this past school year. Nearly 19% of families indicated other observations which included: self-harm, suicidal ideation, COVID-19, eating issues, hallucinations, and panic attacks, among others.

Parents are given the opportunity to share in an open-ended way any new concerns they had that week. For the 2021-2022 school year 547 details the complexities of their lives. Some described grief from loved-ones who had died, others shared COVID-

related absences for youth who needed to isolate or quarantine. Other themes were related to requests for help, ongoing frustrations with lack of school support, or families celebrated schools who were supportive of their child's needs, and improvements from the youth, among many others.

Requests for help:

"PLEASE HELP MY CHILD"

"DESPAIR, DISGUST, DESPONDENCY, when asked about school during a therapeutic intake he was fighting tears and could not speak. When asked about school during a doctor appointment [my child] was so upset he refused to continue and had to leave to compose himself."

Lack of support from schools:

"School interaction has been difficult.... Attempted to suspend my son for long term over charges that they heard may have been filed ... Took him out of school for 2 days.to investigate."

"The school is taking no responsibility for not keeping my child safe just telling me [my child] did not follow protocol and left school without permission. He was missing and the school didn't notify us that he even missed his 12 pm meds they waited until the end of the day to contact us."

Support from schools:

"[my child] has been doing great in her new school. She's cooperative and has been doing well academically and socially. She seems much happier and talks more about her day at school."

"With [my child] being at a new school now. I do not get the daily phone calls from school about his behavior. There have been no suspension. Although [my child] has not learned when and how to use his own coping skills , he is being directed and following staffs correction and encouragement to take steps to calm down."

"I am hopeful since the District had finally stepped up and approved...educational services for [my child]."

Youth Successes:

"[my child] attended the whole week for the first time this year"

"I will give credit to my boy he is trying at home ,trying hard at school"

"[my child]did great last week he only missed one day but he is still struggling getting up on time for school and when he is in school he is struggling with his work"

SECTION 7: ACCOUNTABLE CARE ORGANIZATION REFERRALS

MHAP for Kids has successfully built relationships with health providers and accountable care organizations (ACO) as referral sources of families in need of advocacy. Regardless of referral source, all families participate in the intake and approval process to ensure their needs are matched with the scope and abilities of the staff attorneys. Even so, youth in MHAP for Kids youth have variability in their level of need and severity of their mental health status. To better understand and identify any systematic

differences among youth referred by an ACO, we conducted comparisons on demographics, youth and family risk and service utilization. Data on 87 youth referred by ACOs were compared to youth not referred through an ACO (n = 1386).

ACO YOUTH DEMOGRAPHICS

In terms of demographics, there was a statistically significant difference in age that is driven largely by the higher likelihood of referrals for preschool aged youth from ACOs compared to other sources, 12% and 5% respectively. In terms of gender, though we cannot conclude that the groups are different, the p-values is less than .1 (p=.089) suggesting that given the right conditions they might be. Table 15 summarizes the breakdown for age and sex. Variation in preschool-age, and female referrals may be indicating a pattern of referrals that could further expand the reach of MHAP for Kids into populations of importance. Female youth have been underrepresented in the program thus far, and stabilizing the mental health of youth early in their trajectories may offer meaningful shifts for family and youth outcomes. There were no statistically significant differences across race/ethnicity, or language for youth referred through an ACO compared to youth who were not (Appendix A, Table J).

Table 15 MHAP for Kids Youth Age and Gender by Non-ACO or ACO Referral			
	Non-ACO n=1386 %	ACO n=87 %	p-value
Age			0.053
Preschool (3-5)	5.1	12.1	
Middle Childhood (6-11)	33.8	27.7	
Teens (12-17)	55.7	55.4	
Young Adults (18-23)	3.8	4.8	
Unknown	1.6	0.0	
Gender			0.089
Female	31.3	43.4	
Male	65.0	51.8	
Other	2.1	3.6	
Unknown/Missing	1.6	1.2	

ACO YOUTH AND FAMILY RISK PROFILES

The comparison of youth referred to MHAP for Kids via ACOs and those who were referred through other means showed no statistically significant differences across any youth or family risk profile measures. Youth had similar scores related to their overall difficulties, emotional symptoms, conduct problems, hyperactivity and inattention, and prosocial behaviors. For one subscale of the SDQ, peer problems, the p-value of .089 may signify potential for a difference and more could be known with a larger sample. No differences were found across parental depression symptoms, perception of stress, or family conflict. Full details on these measures can be found in Appendix A, Table K.

We also looked at parental experience of engaging the court system to help with their youth’s mental health challenges. There were no significant differences across any of the baseline questions including

consideration of calling the police, receiving advice to file a CRA, filing a CRA, or the child’s school filing a CRA for the youth. Additionally, there were no differences for having considered or followed through with placing the youth outside of the home because of mental health challenges but the p-value was .06 which may signal the possibility. Among the families referred through an ACO, none of them had ever consider or followed through with outplacing their child. More details on court-engagement is in Appendix A, Table L.

ACO YOUTH SCHOOL ENGAGEMENT AND SERVICE USE

In terms of school engagement, youth referred through an ACO were just as likely to be suspended or sent home from school in the 12-months prior to working with MHAP for Kids as their non-ACO-referred counterparts. There were no statistically significant differences across any school service use measure, but perhaps a chance that those from the ACO could be more likely to already be in a class for children

with learning problems (p=.07). No differences were found across outpatient, crisis, or overnight service utilization with one exception. Families referred by the ACO were not likely to indicate that their child was receiving mental health care from a pediatrician or family medicine doctor (p=.002). These data should be interpreted carefully given the small ACO referral sample size. A summary of school engagement and service use is in Table 16 with full details available in Appendix A, Table M.

Identification of families through their ACO participation data seems to be a promising mechanism for connecting families to MHAP for Kids services that identifies and youth as in-need of MHAP for Kids services as those who enter through other referral mechanisms.

Table 16. Baseline MHAP for Kids Youth Service Use by Non-ACO and ACO Referral			
	Non-ACO %	ACO %	p-value
School Engagement			
School Suspensions in the 12 months before enrollment	23.2	7.1	.158
Type of Service/Placement			
In-school therapy or counseling	59.3	57.1	.892
Special classroom for children with learning problems	57.1	80.0	.128
Special school for youth with emotional or behavioral needs	29.4	46.7	.370
Mental Health Services Received			
Outpatient Services:			
Mental Health Provider	83.4	78.6	.633
Emergency Department Services	45.7	40.0	.662
In-Home Crisis Services	45.6	40.0	.670
Partial Hospital or Day Treatment	27.1	13.3	.236
Overnight Services:			
Hospital	39.2	40	.948
Residential Treatment Facility	18.8	<5	.063
Drug/Alcohol Treatment Unit	<5	<5	.720
Other Out-of-Home Placement:			
Group Home	6.0	<5	.329
Detention center/prison/jail	1.7	<5	.609
Emergency Shelter	3.9	<5	.437
Foster Home	<5	<5	.295

SUMMARY

The first five years of MHAP for Kids have shown steady expansion and fairly consistent enrollment that was slowed considerably during the COVID-19 pandemic, due to no new sites opening during 2020 and the impact of the pandemic on the educational, healthcare, and court systems staff attorneys navigate in their advocacy. The youth and families served by the program are younger and more racially and ethnically diverse than those in the pilot, J-MHAP. MHAP for Kids has persistent disparities in enrollment by sex but there is some indication that ACOs have the potential to help identify female youth in need of MHAP for Kids services. Data from referral sources show that MHAP for Kids has established strong relationships with healthcare organizations and community-based organizations while maintaining established connections with court-related referrers. One such example is the relationship with individual ACOs who partnered with MHAP for Kids to connect ACO-identified youth with the program. The youth identified through this stream were largely similar in risk profile and demographics to youth who come in through other mechanisms.

The COVID-19 pandemic has impacted youth mental health as indicated qualitatively by parents in weekly logs during the past three school years. Data from the 2021-2022 school year have highlighted important parental concerns about the ability of schools to provide sufficient services and youth experiences of abuse of power. These findings are repeated from the 2020-2021 school year and indicate a level of stress and dysfunction in many interactions with schools that may be exacerbated by pandemic stress.

MHAP for Kids families are living in a great deal of stress. Youth and families have consistently scored much higher than community norms on all risk-assessments for youth behavior, adult depressive symptoms, stress, and family conflict. While this risk profile pattern is similar to families in the pilot, MHAP for Kids youth accessed fewer school and health services prior to enrollment. This may indicate that these youths are receiving MHAP for Kids intervention earlier in their trajectories. Analyses of program data show statistically significant improvements in youth and family functioning across a broad range of measures after working with MHAP for Kids. Data also show a decrease in costly health services like emergency or crisis intervention and hospital and residential treatment stays. The nonrandomized design of this evaluation does not allow us to assume causality; however, it is plausible to infer that the staff attorneys successfully stabilized youth mental health, improved household functioning, and prevented costly and intense interactions with both the medical and legal systems for many youths in the MHAP for Kids program.

Future analyses will continue to investigate the reach and impact of this novel program and explore the perceptions of MHAP for Kids held by key stakeholders .

APPENDIX A: DATA TABLES

Table A. Demographics of MHAP for Kids Participants by County of Enrollment

	Barnstable		Berkshire		Bristol		Essex		Hampden		Middlesex		Norfolk		Plymouth		Suffolk		Worcester		Unknown/ Missing	
	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)
Age																						
Preschool (3-5)	<5		<5		4.8	(6)	3.9	(11)	6.8	(11)	5.6	(17)	<5		<5		8.1	(13)	7.3	(13)	<5	
Middle Childhood (6-11)	35.7	(5)	37.2	(16)	32.8	(41)	30.1	(85)	43.6	(71)	26.2	(80)	22.6	(19)	27.7	(13)	34.2	(55)	39.7	(71)	<5	
Teens (12-17)	57.1	(8)	55.8	(24)	56.0	(70)	59.6	(168)	46.0	(75)	53.8	(164)	52.4	(44)	70.2	(33)	50.9	(82)	48.6	(87)	27.8	(5)
Young Adults (18-23)	<5		<5		5.6	(7)	4.6	(13)	<5		3.0	(9)	<5		<5		4.4	(7)	3.9	(7)	<5	
Unknown	<5		<5		<5		1.8	(5)	<5		11.5	(35)	17.9	(15)	<5		<5		<5		61.1	(11)
Gender																						
Female	<5		25.6	(11)	26.4	(33)	29.4	(83)	31.9	(52)	32.8	(100)	33.3	(28)	38.3	(18)	36.0	(58)	33.0	(59)	27.8	(5)
Male	71.4	(10)	72.1	(31)	68.8	(86)	65.3	(184)	66.3	(108)	59.3	(181)	56.0	(47)	61.7	(29)	61.5	(99)	64.3	(115)	33.3	(6)
Other	<5		<5		4.0	(5)	2.8	(8)	<5		3.0	(9)	<5		<5		<5		<5		<5	
Unknown/Missing	<5		<5		<5		2.5	(7)	<5		4.9	(15)	10.7	(9)	<5		<5		<5		38.9	(7)
Ethnicity																						
White	42.9	(6)	53.5	(23)	48.8	(61)	40.4	(114)	19.0	(31)	44.6	(136)	44.1	(37)	66.0	(31)	13.0	(21)	46.9	(84)	<5	
Latinx/Hispanic	<5		14.0	(6)	23.2	(29)	37.2	(105)	54.6	(89)	23.9	(73)	8.3	(7)	12.8	(6)	31.7	(51)	24.0	(43)	<5	
Black	<5		11.6	(5)	10.4	(13)	5.3	(15)	9.8	(16)	8.2	(25)	13.1	(11)	<5		42.2	(68)	7.3	(13)	<5	
Asian	<5		<5		<5		<5		<5		4.6	(14)	<5		<5		3.1	(5)	4.5	(8)	<5	
Biracial	<5		16.3	(7)	13.6	(17)	14.5	(41)	13.5	(22)	12.8	(39)	13.1	(11)	12.8	(6)	9.3	(15)	16.2	(29)	<5	
Mising/DK/Ref	<5		<5		4.0	(5)	1.8	(5)	<5		5.9	(18)	17.9	(15)	<5		<5		<5		66.7	(12)
Participant Language																						
English Only	85.7	(12)	97.7	(42)	88.8	(111)	85.8	(242)	66.9	(109)	78.7	(240)	79.8	(67)	89.4	(42)	77.0	(124)	87.2	(156)	50.0	(9)
English + Other	<5		<5		<5		3.6	(10)	<5		3.0	(9)	<5		<5		<5		3.4	(6)	<5	
Spanish	<5		<5		<5		6.4	(18)	31.9	(52)	9.8	(30)	<5		<5		15.5	(25)	7.8	(14)	<5	
Other Only	<5		<5		<5		<5		<5		5.6	(17)	<5		<5		3.7	(6)	<5		<5	
Unknown/Missing	<5		<5		4.0	(5)	3.9	(11)	<5		3.0	(9)	15.5	(13)	<5		<5		<5		44.4	(8)
Referral Source																						
Court/Legal System	<5		25.6	(11)	16.8	(21)	29.1	(82)	10.4	(17)	25.9	(79)	8.3	(7)	<5		16.8	(27)	4.5	(8)	<5	
Healthcare Organization	35.7	(5)	16.3	(7)	13.6	(17)	31.6	(89)	30.7	(50)	28.2	(86)	19.1	(16)	42.6	(20)	34.2	(55)	18.4	(33)	33.3	(6)
Community Organization	35.7	(5)	32.6	(14)	20.0	(25)	7.8	(22)	26.4	(43)	13.1	(40)	26.2	(22)	25.5	(12)	14.3	(23)	36.9	(66)	<5	

State Agency	<5	<5	7.2	(9)	7.5	(21)	5.5	(9)	4.6	(14)	<5	<5	5.0	(8)	6.2	(11)	<5					
Family Resource Center	<5	<5	28.0	(35)	8.5	(24)	12.9	(21)	12.8	(39)	14.3	(12)	12.8	(6)	14.9	(24)	16.2	(29)	<5			
HLA	<5	<5	<5		2.8	(8)	4.3	(7)	3.0	(9)	<5	<5	3.1	(5)	6.7	(12)	<5					
Client	<5	<5	<5		3.6	(10)	<5		2.6	(8)	<5	<5	5.0	(8)	<5		<5					
Previous MHAP Client	<5	<5	7.2	(9)	6.0	(17)	8.6	(14)	5.9	(18)	<5	<5	3.7	(6)	8.4	(15)	<5					
School District	<5	<5	<5		1.8	(5)	<5		<5		<5	<5	<5		<5		<5					
Unknown/Missing	<5	<5	<5		<5		<5		3.0	(9)	17.9	(15)	<5	<5	<5		55.6	(10)				
Health Insurance (Medicaid/ACO)																						
Not ACO	71.4	(10)	95.4	(41)	96.8	(121)	94.3	(266)	96.9	(158)	88.2	(269)	75.0	(63)	78.7	(37)	85.7	(138)	96.7	(173)	38.9	(7)
ACO	<5	<5	<5		4.3	(12)	<5		6.7	(21)	8.3	(7)	21.3	(10)	11.8	(19)	2.8	(5)	<5		<5	
Unknown/Missing	<5	<5	<5		<5		<5		4.9	(15)	16.7	(14)	<5	<5	<5		<5		<5		61.1	(11)

Table B. Youth on Waitlist Compared to All Youth in MHAP for Kids

	Denominator	%	mean	sd	median	min	max
Total	663	65.3					
Length of time (days) on Waitlist (>14 days)	433		63.9	56.7	42	15	489
		All (n=1408) %	Waitlist (n=433) %				
At Least 1 Mental Health Condition		86.4	92.8				
Autism		26.9	35.1				
Suicidal Ideation		2.3	3.2				
Trauma		22.2	25.2				
Attachment Disorder		3.6	3.2				
Other Mood Disorder		11.2	12.5				
Other Conduct Disorder		9.5	10.6				
Intellectual Disability		4.9	6.2				
Learning Disability		2.8	3.0				
Other Communication Disability		1.5	1.9				
Depression		31.5	31.9				
Anxiety		39.8	46.9				
Obsessive Compulsive Disorder		3.2	5.1				
ADHD/ADD		49.6	56.4				
Major Mental Illness		9	8.3				
Mental Health Psych Medications		63.1	66.7				
School Attendance							
Attended almost every day		52.3	48.1				
Missed 1-2 days per month		8.2	9.0				
Missed 1 day per week		6.6	6.4				
Missed >1 day per week		17.2	20.1				
Missed almost every day/did not go		15.7	16.4				
Court Involved (>age 12 years only)	206	40.7	31.6				

Table C. MHAP for Kids Baseline Risk Characteristics and Published Community Norms

Domain	Baseline Mean (SD) Or %	Published norm Mean (SD) Or %	Standard deviations from norm	Interpretation
Family Functioning				
Parent perceived conflict ➤ Conflict Behavior Questionnaire (CBQ)	12.17 (5.84)	2.4 (2.8)	3.5	Higher scores indicate more negative perceptions.
Parent Mental Health				
Parent Stress ➤ Perceived Stress Scale	20.3 (7.5)	13.0 (6.4)	1.1	Higher scores indicate more stress.
Parental Depression ➤ Center for Epidemiological Studies Depression Scale (CES-D)	22.1 (12.9)	9.3 (8.6)	1.5	Higher scores indicate greater depression symptoms.
At least mild depression (CES-D ≥ 16)	66%	19%	n/a	≥ 16 indicates any depression.
Youth Functioning				
Total Difficulties ➤ Strengths and Difficulties Questionnaire	21.2 (6.7)	7.1 (5.7)	2.5	Higher scores indicate more difficulties.
Emotional Problems ➤ Strengths and Difficulties Questionnaire	5.2 (2.6)	1.6 (1.8)	2	Higher score scores indicate more difficulties.
Conduct Problems ➤ Strengths and Difficulties Questionnaire	4.1 (2.6)	1.3 (1.6)	1.8	Higher score scores indicate more difficulties.
Hyperactivity-inattention ➤ Strengths and Difficulties Questionnaire	7.3 (2.4)	2.8 (2.5)	1.8	Higher score scores indicate more difficulties.
Peer Problems ➤ Strengths and Difficulties Questionnaire	4.6 (2.2)	1.4 (1.5)	2.1	Higher score scores indicate more difficulties.
Prosocial Behavior ➤ Strengths and Difficulties Questionnaire	6.1 (2.6)	8.6 (1.3)	-1.9	Higher score scores indicate fewer difficulties.

Table D. Comparison of School Engagement and Services at Baseline and Follow-up									
		Total	Baseline			Follow-up			p-value
		(n)	%	\bar{x}	(sd)	%	\bar{x}	(sd)	
Attending School		(154)							0.555
	No		9.7			10.4			
	Yes, full time		87.0			87.7			
	Yes, part time		3.3			2.0			
Special Class for Children with Learning Problems		(141)	54.6			55.3			1.000
Special Class for Children with Behavioral Problems		(135)	31.9			33.3			0.878
Special Class for Children with Emotional Problems		(133)	26.3			39.1			0.024
Special School for Children whose Problems Cannot be Handled by Regular School		(149)	21.5			30.9			0.024
Individual Psychological Counseling or Therapy Delivered in School		(145)	59.3			62.1			0.684
Medications for Concentration, Behavior, or Emotional Problems Taken at School		(148)	23.7			21.6			0.736
Suspended in Previous 12/6 Months		(114)	19.3			18.4			1.000
Number of Suspensions in Previous 12/6 Months (only kids in school at both time periods)		(114)		0.6	(1.9)		0.5	(1.5)	0.517
Sent Home for Behavior in Previous 12/6 Months		(119)	21.0			24.4			0.608
Number of Times Children were Sent Home for Behavior in Previous 12/6 Months (only kids in school at both time periods)		(119)		1.1	(3.1)		1.2	(3.0)	0.664
Grades in School		(121)							.3969
	Above Average			10.7			15.7		
	Average			33.9			33.9		
	Below Average			55.4			50.4		

Table E. Comparison of Mental Health Service Utilization at Baseline and Follow-Up				
	Total	Baseline	Follow-up	p-value
	(n)	%	%	
Outpatient Services				
Telephone Hotline	(149)	8.7	10.7	0.6900
Self-help Group	(146)	5.5	11.0	0.1338
Community Mental Health Center or Outpatient Mental Health Clinic	(153)	35.3	34.6	1.0000
Mental Health Professional	(153)	78.4	77.8	1.0000
Emergency Room	(154)	42.2	17.5	<0.001
In-home Crisis Services	(153)	39.9	23.5	0.0019
Pediatrician or Family Doctor	(155)	34.2	25.2	0.1034
Partial Hospitalization or Day Treatment Program	(154)	26.0	9.1	<0.001
Drug or Alcohol Clinic	(155)	0.7	0.0	1.0000
Counselor or Family Preservation Worker	(153)	50.3	19.6	<0.001
Probation or Juvenile Corrections Officer	(156)	14.7	7.1	0.0169
Spiritual Advisor	(156)	3.9	6.4	0.3877
Respite Care Provider	(152)	8.6	2.6	0.0352
Any Other Kind of Healer	(154)	3.3	0.7	0.2188
An Educational Tutor at Home	(154)	10.4	5.8	0.1671
A Mentor	(147)	31.3	34.0	0.6718
Social Services	(150)	36.7	17.3	0.0002
Inpatient Services				
Hospital	(155)	34.2	13.6	<0.001
Drug or Alcohol Treatment Unit	(153)	0.0	0.0	n/a
Residential Treatment Center	(154)	18.8	7.8	0.0033
Group Home	(153)	5.2	2.6	0.3877
Foster Home	(150)	4.7	0.7	0.0703
Detention Center, Prison, or Jail	(153)	2.0	0.7	0.6250
Emergency Shelter	(153)	2.6	0.0	0.1250

Table F. Description of Barriers from Child and Adolescent Services Assessment⁶	
Barrier	Description
Bureaucratic delay	Bureaucratic hurdles such as excessive pre-visit paperwork or authorizations, difficulty getting an appointment in a timely fashion or being put on a waiting list, or offices where the phone is not answered or calls are not returned.
Transportation to treatment/services	Reluctance to use services caused by difficulty getting to treatment site.
Incomplete information	Difficulty in getting services caused by lack of information about where to get services or how to arrange them.
Time	Reluctance to use services caused by lack of time to get treatment or to make arrangements for treatment.
Service not available	Non-availability of a particular service desired by a subject (such as counseling or drug rehab) because it does not exist in the area where the subject lives.
Cost of treatment/services	Inability to use services or underutilization of services caused by perception that services could not be afforded or paid for; insurance would not cover cost
Refusal to treat	Being refused by the service for various reasons: lack of space/beds, problematic history of subject, fear of liability, etc.
Fear of consequences	1. Reluctance to use services caused by fear that subject's children might be at greater risk of out-of-home placement; or 2. Reluctance to use services caused by fear that subject might be seen as an unfit parent and lose parental rights.
Child or parent refuses treatment	1. Youth refused to go for treatment; or 2. Parent refused to allow the youth's participation.
Quality of services	1. Concern or discomfort with using services caused by subject's fear, dislike, or distrust of talking with professionals; or 2. Concern or discomfort with using services caused by subject's previous negative experience with professional(s).
Stigma	1. Reluctance to use services caused by self-consciousness about admitting having a problem or about seeking help for it. Also inability to talk with anyone about such sensitive issues; or 2. Reluctance to use services caused by anticipation of a negative reaction from family, friends, or others to seeking treatment for an emotional or mental problem.

Table G. Comparison of Baseline and Follow-Up Family Risk Scores

	Total (n)	Baseline		Follow-up			p-value	
		%	\bar{X}	(sd)	%	\bar{X}		(sd)
Strengths and Difficulties Questionnaire								
Total Difficulties	(164)		21.2	(6.7)		17.8	(6.8)	<0.001
Normal		14.0			25.6			
Borderline		5.5			15.2			
Abnormal		80.5			59.2			
Emotional Symptoms	(164)		5.2	(2.6)		4.3	(2.6)	<0.001
Normal		25.0			42.1			
Borderline		12.2			9.2			
Abnormal		62.8			48.8			
Conduct Problems	(164)		4.1	(2.6)		3.2	(2.4)	0.0012
Normal		31.7			45.1			
Borderline		14.0			14.0			
Abnormal		54.3			40.9			
Hyperactivity - Inattention	(164)		7.3	(2.4)		6.4	(2.6)	<0.001
Normal		21.3			37.2			
Borderline		9.2			14.0			
Abnormal		69.5			48.8			
Peer Problems	(164)		4.6	(2.2)		3.8	(2.1)	0.0001
Normal		18.9			24.4			
Borderline		12.8			25.0			
Abnormal		68.3			50.6			
Prosocial Behavior	(164)		6.1	(2.6)		6.6	(2.3)	0.0204
Normal		57.9			65.2			
Borderline		11.0			15.9			
Abnormal		31.1			18.9			
Parent Functioning								
Parental Stress Scale	(155)		20.3	(7.5)		16.5	(7.6)	<0.001
CES-D Depressive Symptoms	(147)		22.1	(12.9)		17.0	(11.8)	<0.001
Clinical Cutoff(>=16)	(147)							0.0051
No		34.0			46.3			
Yes		66.0			53.7			
Clinical Cutoff(>=27)	(147)							0.0011
No		61.2			75.5			
Yes		38.8			24.5			
Family Functioning								
Conflict Behavior Questionnaire	(121)		9.3	(6.1)		6.6	(5.7)	<0.001
Child Health								
Physical Health	(148)		7.9	(2.1)		8.2	(1.9)	0.0617
Mental Health	(132)		5.2	(2.1)		6.0	(1.8)	<0.001

Table H. Comparison of DCF and Police Engagement by Race/Ethnicity					
		Total (n)	Baseline %	Follow-up %	p-value
Placed Child Outside of Home					
Overall		(154)			0.0088
	No		80.5	73.4	
	Yes		4.6	10.4	
	Considered but Haven't Done it		14.9	16.2	
White Race		(76)			0.1692
	No		75.0	75.0	
	Yes		4.0	11.8	
	Considered but Haven't Done it		21.1	13.2	
Latinx/Hispanic		(29)			0.1250
	No		89.7	69.0	
	Yes		0.0	6.9	
	Considered but Haven't Done it		10.3	24.1	
Black		(22)			0.7500
	No		81.8	90.9	
	Yes		13.6	4.6	
	Considered but Haven't Done it		4.6	4.6	
Asian		(2)			<5
	No		<5	<5	
	Yes		<5	<5	
	Considered but Haven't Done it		<5	<5	
Bi-racial		(25)			0.1250
	No		84.0	56.0	
	Yes		4.0	16.0	
	Considered but Haven't Done it		12.0	28.0	
Called/Considered Calling the Police					
Overall		(156)			<0.001
	No		64.1	82.7	
	Yes		28.9	12.8	
	Considered but Haven't Done it		7.0	4.5	
White Race		(76)			0.0004
	No		59.2	82.9	
	Yes		32.9	14.5	
	Considered but Haven't Done it		7.9	2.6	
Latinx/Hispanic		(29)			1.0000
	No		75.9	82.8	
	Yes		17.2	10.3	
	Considered but Haven't Done it		6.9	6.9	
Black		(22)			0.2500
	No		63.6	81.8	
	Yes		31.8	13.6	
	Considered but Haven't Done it		4.6	4.6	
Asian		(2)			sup
	No		sup	sup	
	Yes		sup	sup	
	Considered but Haven't Done it		sup	sup	
Bi-racial		(27)			0.0313
	No		63.0	81.5	
	Yes		29.6	11.1	
	Considered but Haven't Done it		7.4	7.4	

Table I. Comparison of Open Court Cases at Baseline and Follow-Up					
		Total	Before Intake	After Case Closure	p-value
		(n)	%	%	
Care and Protection		(1421)			0.0215
	No		99.4	98.9	
	Yes	(9)	0.6	1.1	
CRA		(1421)			<0.001
	No		93.8	97.1	
	Yes	(88)	6.2	2.9	
Delinquency		(1421)			0.1153
	No		97.5	98.1	
	Yes	(36)	2.5	1.9	
Other		(1421)			0.0043
	No		98.2	99.2	
	Yes		1.8	0.8	

Table J. Demographic Comparison of Youth Referred by an ACO or not by an ACO						
		Enrolled in ACO				p-value
		Not an ACO		ACO		
		%	(n)	%	(n)	
Total		94.1	(1386)	5.9	(87)	
Age						0.053
	Preschool (3-5)	5.1	(65)	12.1	(10)	
	Middle Childhood (6-11)	33.8	(433)	27.7	(23)	
	Teens (12-17)	55.7	(714)	55.4	(46)	
	Young Adults (18-23)	3.8	(49)	4.8	(4)	
	Unknown	1.6	(21)	0.0	(0)	
Gender						0.089
	Female	31.3	(402)	43.4	(36)	
	Male	65.0	(834)	51.8	(43)	
	Other	2.1	(27)	3.6	(3)	
	Unknown/Missing	1.6	(20)	1.2	(1)	
Ethnicity						0.253
	White	39.8	(510)	39.8	(33)	
	Latinx/Hispanic	30.2	(388)	22.9	(19)	
	Black	12.0	(154)	19.3	(16)	
	Asian	2.4	(31)	1.2	(1)	
	Biracial	13.8	(177)	13.3	(11)	
	Mising/DK/Ref	1.8	(23)	3.6	(1)	
Participant Language						0.175
	English Only	83.2	(1068)	78.3	(65)	
	English + Other	2.7	(34)	4.8	(4)	
	Spanish	10.4	(134)	9.6	(8)	
	Other Only	2.1	(27)	2.4	(2)	
	Unknown/Missing	1.6	(20)	4.8	(4)	

Table K. Family Risk Measures by Referral Source (Not ACO and ACO)										
		Not Referred by ACO				Referred by ACO				p-value
		(n)	%	\bar{x}	(sd)	(n)	%	\bar{x}	(sd)	
Strengths and Difficulties Questionnaire										
Total Difficulties										0.504
	Normal	(57)	12.9			(2)	13.3			
	Borderline	(37)	8.4			(0)	0.0			
	Abnormal	(349)	78.8			(13)	86.7			
Emotional Symptoms										0.238
	Normal	(115)	25.8			(1)	6.7			
	Borderline	(54)	12.1			(2)	13.3			
	Abnormal	(277)	62.1			(12)	80.0			
Conduct Problems										0.932
	Normal	(131)	29.4			(5)	33.3			
	Borderline	(71)	16.0			(2)	13.3			
	Abnormal	(243)	54.6			(8)	53.3			
Hyperactivity - Inattention										0.304
	Normal	(104)	23.4			(2)	13.3			
	Borderline	(33)	7.4			(0)	0.0			
	Abnormal	(308)	69.2			(13)	86.7			
Peer Problems										0.082
	Normal	(86)	19.4			(1)	6.7			
	Borderline	(64)	14.5			(0)	0.0			
	Abnormal	(293)	66.1			(93)	14.0			
Prosocial Behavior										0.319
	Normal	(264)	59.5			(6)	40.0			
	Borderline	(57)	12.8			(3)	20.0			
	Abnormal	(123)	27.7			(6)	40.0			
Parent Functioning										
Parental Stress Scale		(426)		20.6	(7.6)	(15)		22.9	(5.7)	0.2476
CES-D Depressive Symptoms		(415)		21.5	(13.4)	(14)		26.2	(14.6)	0.1958
	Clinical Cutoff (≥ 16)									0.194
	No	(160)	38.6			(3)	21.4			
	Yes	(255)	61.5			(11)	78.6			
	Clinical Cutoff (≥ 27)									0.238
	No	(271)	65.3			(7)	50.0			
	Yes	(144)	34.7			(7)	50.0			.
Family Functioning										
Conflict Behavior Questionnaire		(374)		9.8	(6.2)	(9)		11.8	(5.2)	0.3293

Table L. Comparison of DCF and Police Engagement by Referral Source (Non-ACO, ACO)						
		Not Referred by ACO		Referred by ACO		p-value
		%	(n)	%	(n)	
Placed Child Outside of Home			(479)			0.063
	No	72.9	(349)	100.0	(15)	
	Yes	7.1	(34)	0.0	(0)	
	Considered but Haven't Done it	20.0	(96)	0.0	(0)	
Called/Considered Calling the Police						0.357
	No	57.4	(275)	73.3	(11)	
	Yes	35.1	(168)	26.7	(4)	
	Considered but Haven't Done it	7.5	(36)	0.0	(0)	
Advised to File a CRA						0.277
	No	72.6	(350)	85.7	(12)	
	Yes	27.4	(132)	14.3	(2)	
	Considered but Haven't Done it	0.0	(0)	0.0	(0)	
You or Another Guardian Filed a CRA						0.370
	No	85.7	(408)	93.3	(14)	
	Yes	10.5	(50)	0.0	(0)	
	Considered but Haven't Done it	3.8	(18)	6.7	(1)	
Child's School Filed a CRA						0.721
	No	86.7	(409)	93.3	(14)	
	Yes	11.4	(54)	6.7	(1)	
	Considered but Haven't Done it	1.9	(9)	0.0	(0)	

Table M. Mental Health Service Use by Referral Source (Non-ACO, ACO)					
	Not Referred by ACO		Referred by ACO		p-value
	%	(n)	%	(n)	
Outpatient Services					
Telephone Hotline	10.4	(48)	6.7	(1)	0.642
Self-help Group	8.1	(37)	13.3	(2)	0.467
Community Mental Health Center or Outpatient Mental Health Clinic	36.0	(170)	20.0	(3)	0.202
Mental Health Professional	83.4	(397)	78.6	(11)	0.633
Emergency Room	45.7	(218)	40.0	(6)	0.662
In-home Crisis Services	45.6	(216)	40.0	(6)	0.670
Pediatrician or Family Doctor	41.4	(197)	0.0	(0)	0.002
Partial Hospitalization or Day Treatment Program	27.1	(128)	13.3	(2)	0.236
Drug or Alcohol Clinic	0.8	(4)	0.0	(0)	0.722
Counselor or Family Preservation Worker	49.8	(235)	33.3	(5)	0.210
Probation or Juvenile Corrections Officer	18.4	(87)	6.7	(1)	0.246
Spiritual Advisor	6.4	(30)	7.1	(1)	0.909
Respite Care Provider	5.8	(27)	6.7	(1)	0.894
Any Other Kind of Healer	4.3	(20)	6.7	(1)	0.650
An Educational Tutor at Home	14.2	(67)	6.7	(1)	0.406
A Mentor	40.6	(189)	26.7	(4)	0.280
Social Services	36.9	(174)	20.0	(3)	0.179
Inpatient Services					
Hospital	39.2	(186)	40.0	(6)	0.948
Drug or Alcohol Treatment Unit	0.9	(4)	0.0	(0)	0.720
Residential Treatment Center	18.8	(88)	0.0	(0)	0.063
Group Home	6.0	(28)	0.0	(0)	0.329
Foster Home	6.8	(32)	0.0	(0)	0.295
Detention Center, Prison, or Jail	1.7	(8)	0.0	(0)	0.609
Emergency Shelter	3.9	(18)	0.0	(0)	0.437

APPENDIX B: DATA FIGURES

Figure A. Normal distribution with expected % of the population within each standard deviation in a community-based sample

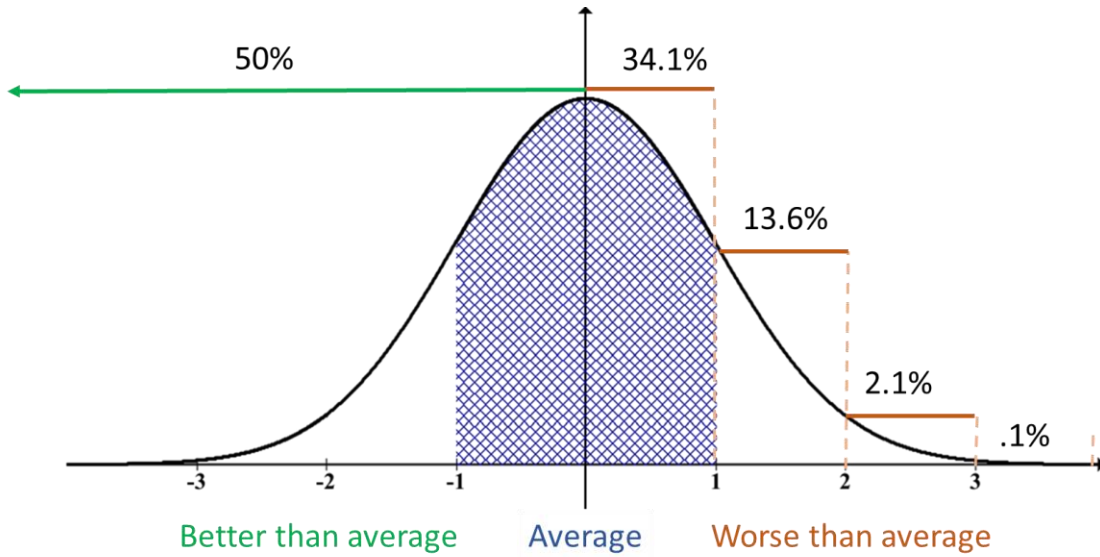
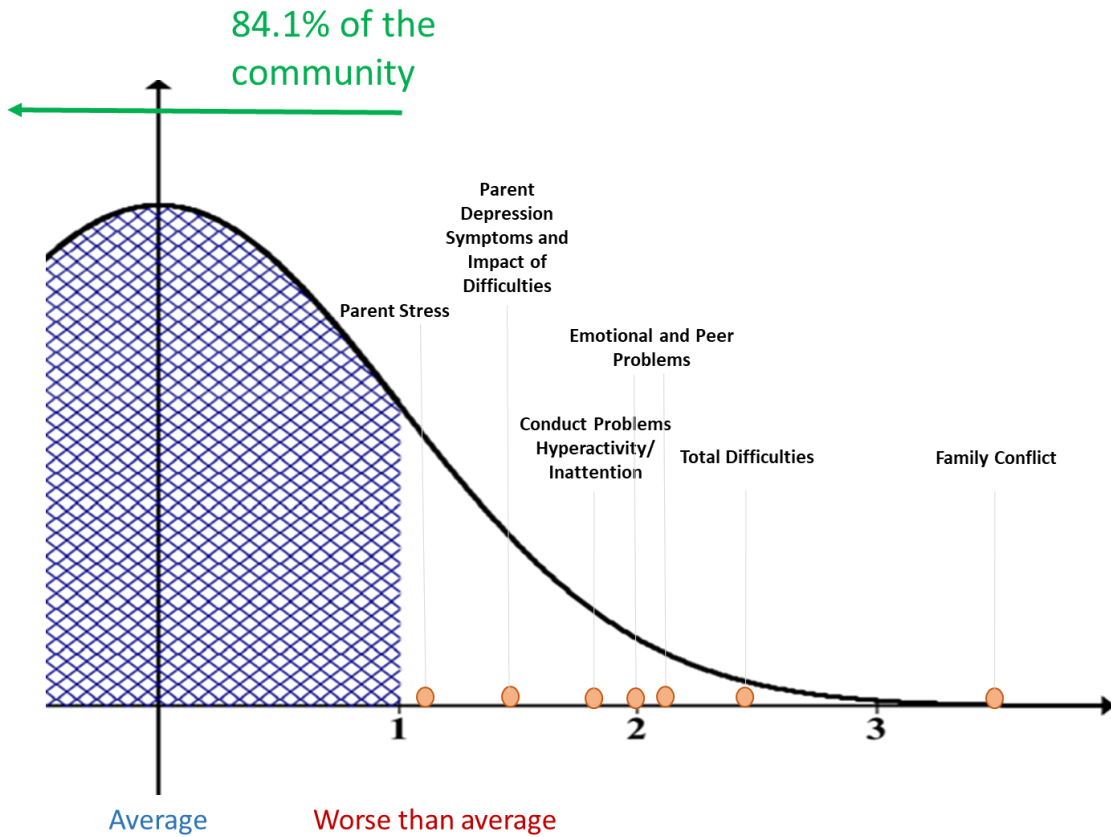


Figure B. Average MHAP for Kids Baseline Youth and Family Risk Scores Plotted as number of standard deviations from community norms^{3,4,5}



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