Mental Health Advocacy Program for Kids

Report of Baseline Evaluation Data

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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 process data for the Mental Health Advocacy Program for Kids (MHAP for Kids). The information presented includes data for all families receiving staff attorney services except where specified that the data are only from the subset of families who provided survey and questionnaire information prior to staff attorney assignment. Throughout all main sections of this report, data are described for specific sub-populations of interest including sex, race, and ethnic categories. Data are also described by whether or not the youth had an open court case at the time of enrollment in MHAP for Kids. For these data, only youth who are 13-years-old or older are used, as the jurisdiction of the juvenile courts is restricted to this age range.

This report is broken down into five main sections. The first, focuses on program details including the flow of youth referrals to each of the ten MHAP for Kids sites opened between March 2017 and August 2021. The second section describes youth and family characteristics like the demographics of the youth, family and youth risk profiles, and youth court-involvement at baseline. The 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. The fourth section details the ways in which the COVID-19 pandemic and related remote schooling impacted families through youth school engagement and behavior at home. The fifth and final section details the work of the staff attorneys.

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 ten sites in counties across the Commonwealth. Represented in Figure 1, the sites include: Lynn (Essex County), Lowell (Middlesex County), Boston (Suffolk County), New Bedford (Bristol County), Holyoke (Hampden County), Worcester (Worcester County), Quincy (Norfolk County), Brockton (Plymouth County), Cape Cod and Islands (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 August 10, 2021, 910 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. As three new sites opened in quarters one and two of 2021 the enrollment rates return to a steep slope as is expected, even with pandemic challenges. (Note: The site in Barnstable County was closed in quarter 3 of 2021 and consolidated with the New Bedford site in Bristol County which continues to serve both regions.)

Figure 1. Enrollment in MHAP for Kids by Quarter and Year

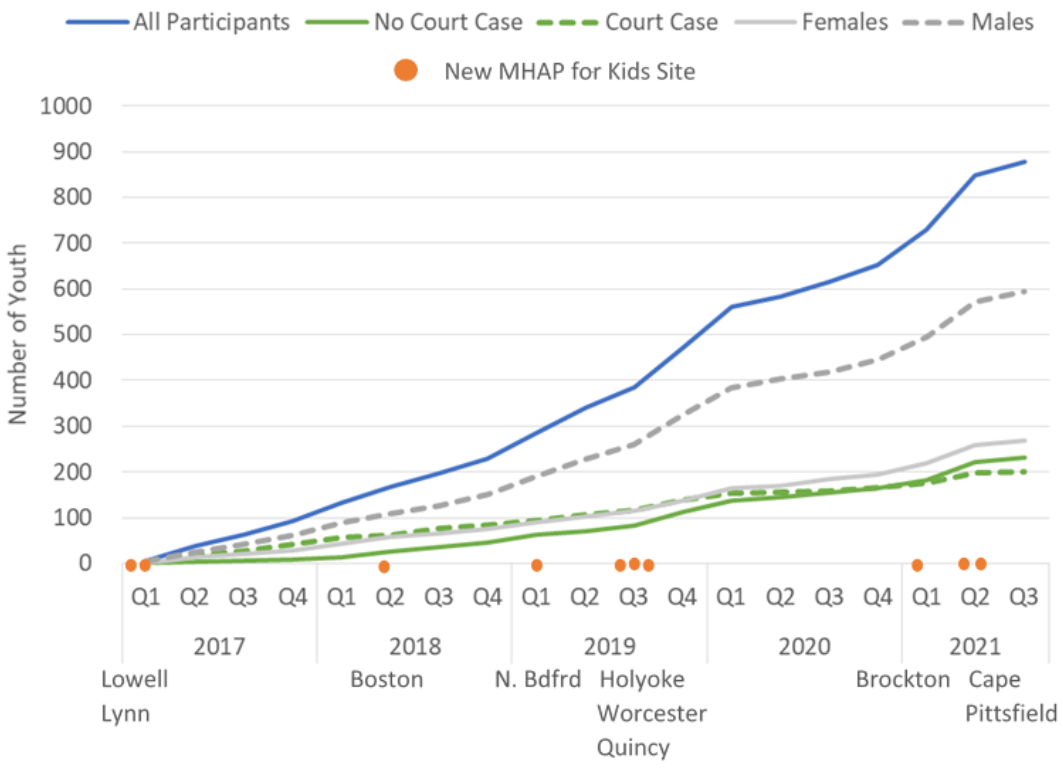


Figure 1 depicts the cumulative enrollment of the program over time, inclusive of when new sites opened. The solid bottom line (green if in color) represents any youth 13-years-old or older with 'no court case' at baseline. The dotted line above this (green if in color) shows youth in that age range with open court cases. As the program has evolved, the proportion of youth who enter into MHAP for Kids without any existing court involvement has changed over time. In quarter one of 2021 these youth began to outnumber their court-involved peers. The very top line of the figure shows the total number of youth enrolled of all ages. The middle grey solid and dotted lines represent female and male youth enrollees of all ages over time. Though the program has primarily enrolled male youth the rates of enrollments of both males and females has been fairly steady over the years. For nearly each quarter, the female enrollment has consistently been approximately 30% of the total number of youth enrolled in that quarter.

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: 24.6%, Lynn: 20.8%) (Table 1). Boston, Holyoke, and New Bedford were the non-J-MHAP counties with the largest MHAP for Kids populations following the expected pattern related to the duration of time the sites have been operational.

Table 1. % Youth Participants by MHAP Site and Racial/Ethnic Category

	Total	White	Latinx/Hispanic	Black	Biracial	Asian	Missing
Middlesex	24.6%	47.8%	25.5%	8.5%	8.5%	5.8%	4.0%
Essex	20.8%	47.1%	32.8%	6.4%	12.7%	<5	<5
Worcester	12.4%	47.8%	23.0%	8.0%	15.9%	<5	<5
Hampden	11.9%	14.8%	57.4%	13.0%	13.0%	<5	<5
Suffolk	11.4%	14.4%	29.8%	42.3%	11.5%	<5	<5
Bristol	9.6%	50.6%	24.1%	9.2%	13.8%	<5	<5
Norfolk	4.4%	55.0%	<5	15.0%	<5	<5	<5
Unknown/Missing	1.8%	--	--	--	--	--	--
Plymouth	1.3%	75.0%	<5	<5	<5	<5	<5
Berkshire	1.2%	63.6%	<5	<5	<5	<5	<5
Barnstable	0.7%	<5	<5	<5	<5	<5	<5

Participant age at intake and gender by site show similar patterns, overall, with most youth being male and aged 12-17 at enrollment. However, Essex was less likely than others to enroll preschool age children (3%) compared to a range 6-8% in other sites, including Middlesex. This may be due to differences in referral sources, as discussed in the next section. Hampden county is the only site with over half (52.8%) of youth enrolled during middle childhood, when other sites ranged from 27-40% for children aged 6-11-years.

Most sites predominantly enrolled white youth with the exception of Suffolk and Hampden counties (white = 14.87% for both). Racial breakdown is provided in Table 1. For the purposes of privacy, any cell with fewer than five people is suppressed.

REFERRING AGENCY

In our first baseline report of data through Fall of 2020, most youth were referred to MHAP for Kids via the court/legal system (31.9%). Which 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% (32.6% and 32.3%, respectively), compared to lower rates within other counties (Suffolk = 22.1%, Hampden = 15.7%, Bristol = 14.9%, and Worcester = 7.1%).

Table 2. MHAP Participants by Referring Agency	
Healthcare Organization	23.1%
Court/Legal System	22.6%
Community Organization	18.1%
Family Resource Center	17.4%
State Agency	5.3%
Previous MHAP Client	3.6%
HLA	3.1%
Unknown/Missing	3.0%
Client	2.9%
School District	1.0%

With program data through August of 2021 (Table 2), there is a noticeable shift with healthcare organizations providing a significant, and now the most, referrals to MHAP for Kids. Across all sites, 23.1% of youth were referred from a healthcare organization. Essex had the highest referral rate with nearly a third of youth (31.8%). Suffolk county had the next highest with 25% of referrals coming from healthcare. In all other sites, healthcare referrals ranged from 16-22% (Middlesex = 22.3%, Hampden =21.3%, Worcester = 19.5%, Bristol = 16.5%). Worcester, Norfolk, and Hampden counties appear to have strong connections to community organization-based referrals (37.2%, 32.5% and 32.4% respectively), compared to a range of 4.2%-23.0% in other counties. Family Resource Centers comprised 17.4% of referrals across all sites but 29.9% of Bristol, 22.1% of Worcester, 21.2% of Suffolk, and 20.0% of Norfolk referrals. The changing pattern of referrals 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.

Youth referred to MHAP for Kids from community-based organizations were more likely to be female (38.8%) than those from the other top four leading referral sources (court/legal system = 33.5%, healthcare = 25.2%, FRC = 27.9%). With the exception of court/legal system referrals who were likely to be older, no differences in age were apparent across referral sources. Other race/ethnicity patterns across referral sources were very similar with 25%-33% Latinx/Hispanic, and 11-16% Black. Among the top four referral sources, healthcare organizations, the court/legal system, and community-based organizations each referred over 40% white youth, compared to FRCs who referred 36.1% white youth.

To better understand referral source and youth court-involvement we also looked only at youth at or over the age of 13 years. Among these youth with open court cases at baseline, 55.2% were referred by the court, 13.9% by FRCs, and 12.4% by community-based organizations. Across all youth in this age range, there were no apparent differences by age, gender, ethnicity, or primary language compared to the group as a whole.

SECTION 2: YOUTH AND FAMILY 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 (910 youth). Other information was collected via an enrollment interview with a paralegal or other program staff (n=405) or via self-administered questionnaires provided to parents/guardians (n=327). Due to resource constraints, interview and questionnaires were administered 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 were selected because of their wide use among youth and their families, as well as the existence of published norms for each measure, which were established using community or national samples. The selection of measures allows for the comparison of MHAP for Kids participants and the broader population. Youth details described in this report are all based off of 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 (66%) from English speaking households (83.2%) (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 youth of color. Youth in MHAP for Kids were on average younger than youth in J-MHAP. 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 that interface with eligible youth and families. The comparison of demographic data between the pilot and the existing program are summarized in Table 3.

Table 3. Youth Demographic Characteristics of MHAP for Kids Youth and Pilot (J-MHAP) Youth

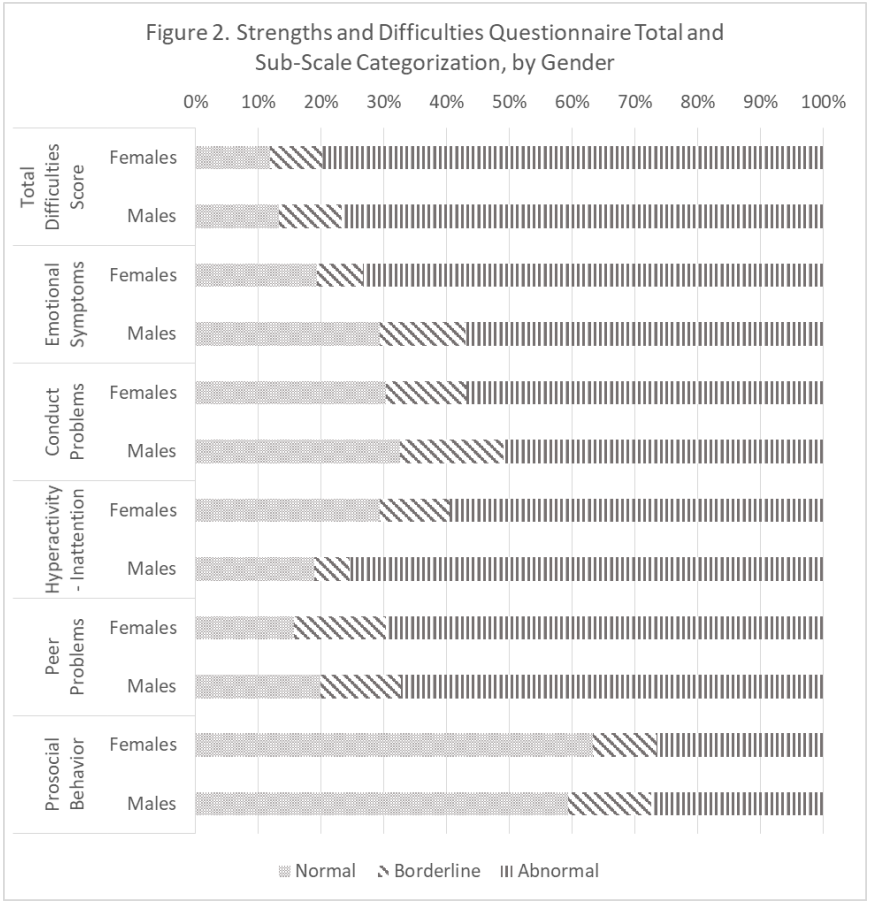
Demographic	J-MHAP pilot (n=152)	MHAP for Kids (n=910)
Age (mean (min, max))	15.7 (8, 22)	12.1 (3, 22)
Male (%)	60.9%	66.5%
Race/Ethnicity (%)		
White	66.5%	40.4%
Latino/Hispanic	20.4%	29.6%
Black	5.9%	12.5%
Biracial	4.6%	11.9%
Asian	.6%	2.4%
Other/Missing†	1.9%	3.2%
Household Primary Language, English (%)	92.8%	83.2%

†Other J-MHAP: Brazilian 1.3%, Cape Verdean .6%
†Other MHAP for Kids: Missing/Don't know 3.2%

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 the "best possible" health. The mean physical health score was 8.1 (median = 9) reflecting very good levels of physical health. The average mental health score was 5.0 (median = 5), representing fair or poor mental health. Youth aged 13-years or older had slightly lower average ratings of mental health among youth who were not court-involved (4.7 = not court-involved, 4.9 = court-involved).

On the self-administered questionnaire, 387 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 every day functioning. The measure contains 5 subscales: prosocial behavior, peer problems, hyperactivity, conduct problems, and emotional 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 = 6.8), 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. Difficulties were reported to impact the youth's functioning with a score 7.3 (sd = 2.5), a level 18 times higher than reported for 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.



In table 4, participant scores were averaged and compared to a published community sample, or "norm." Scores are reported based on the number of standard deviations (presented as an absolute number) 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 indicate severe risk-factors across all domains when compared to general community data.

More than 50% of youth scored into an "abnormal" category on the subscales: 69.9% for hyperactivity – inattention, 68% for peer problems, 62% for emotional symptoms, and 55% for conduct problems (Figure 2). Based on the total difficulties score, a full 78% of the MHAP for Kids participants are categorized as "abnormal" and an additional 9.3% are categorized as "borderline." Males were more likely than female to have difficulty with hyperactivity or inattention (75.5%, 69.6% respectively).

Among youth aged 13-years or older, those without open court cases were more likely to have emotional (77.4% compared to 61.8%) or peer problems (73.9% compared to 63.6%) compared with their counterparts with open court cases. Youth with court-involvement were more likely to have conduct (61.8% compared to 55.9%), or hyperactivity (67.3% compared to 60.2%).

Overall, 86.6% of MHAP for Kids youth were reported to have "definite" or "severe" difficulties with emotions, concentration, behavior, or getting along with others. For 87.8% of youth, these difficulties last for more than 1 year.

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 (35.8%) to very good (26.9%), accounting for two-thirds of all respondents, with the remaining third reporting fair or poor physical health. Twenty-eight percent reported limitations in moderate activities and 34.3% reported difficulties climbing several flights of stairs. Physical health also caused 40% of respondents to accomplish less than they would have liked and 11% 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 36.9% of respondents reporting accomplishing less than they would have liked and 39.3% reporting they did not do work or activities as carefully as usual most or all of the time during the past 4 weeks. Thirty-one percent of respondents reported that pain interfered with their normal activities more than a little bit during the past 4 weeks. Twenty-eight percent of adults reported that their physical health was much worse compared to 1 year ago; this proportion increased to 36.5% for emotional problems.

Table 4. MHAP for Kids Youth Functioning on the Strengths and Difficulties Questionnaire Compared to Norms[3,4,5]

Measure	Number of standard deviations from norm
Youth Measures	
Emotional Symptoms	2.1
Conduct Problems	1.8
Hyperactivity – Inattention	1.8
Peer Problems	2.1
Prosocial Behavior	-1.4
Total Difficulties Score	2.5
Impact of Difficulties	+5.31
Family Measures	
Parent Perceived Stress	+1.2
Parent Depression Symptoms	+1.4
Family Conflict	+2.7
+ indicates the mean score is higher or worse than the norm	

The Perceived Stress Scale was completed by 341 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 20.4 (sd = 7.6) (Appendix A, Table A). This is 1.2 standard deviations above the published norm, representing greater than normal stress among MHAP for Kids parents.

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 21.4 (sd = 13.3), which is 1.4 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 (62.5%), indicating the mental health needs of caregivers in this program. These results are very similar to what was measured among parent/guardians at baseline among J-MHAP families.

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 = 9.9, sd = 6.2) among MHAP for Kids parents was 4 times higher than published norms indicating a much higher average level of conflict in these families' homes.

Additionally, to understand the impact of youth challenges, data were collected on whether parents/guardians ever considered using outside 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 quarter of families considered out-placing their youth (25.9%). Parents of female youth were less likely to consider out-placement (22.5%) than parents of males (25.7%). Of those who considered it and followed through there were no differences based on the sex of the youth. Parents of White youth were least likely to consider calling the police (23.7%), and parents of Biracial youth were most likely to consider it, but less likely to do it.

Forty-one percent of parents have ever considered calling the police for help with their youth. When parents considered calling the police but decided not to do it the most common reported reasons were fear of consequences (33.3%) and not wanting to do it (30%). Among parents who considered calling, and did call the police, there were no differences in these responses based on the sex of the child. Data related to race show similar patterns for actually calling the police across the racial categories of White (35.6%), Black (34.1%), and Biracial (37.1%), with those categorized as Latinx/Hispanic having the lowest percentage (27.1%). It is important to note that these data were collected from parents/guardians using a questionnaire and interview tool delivered in English which limits our ability to know about the experiences of non-English speaking families.

Table 5. Parents/Guardians Consideration and Use of Court-Related Services to Get Help with Youth

Court-Related Service	Ever Considered But Did Not Use	Ever Used
Out-of-home placement	18.8%	5.4%
Calling the police	6.7%	32.8%
Filing a CRA case	2.7%	8.4%

One quarter of MHAP for Kids families were advised to file a Child Requiring Assistance (CRA) case, and of those 8.4% filed. Among families who received advice to file a CRA case, there were no real differences based on the child's sex. Parents of biracial youth were most likely to be advised to file a CRA (30.7%), compared to White (26.8%), Latinx/Hispanic (23.5%), and Black families (20.5%). The vast majority of youth were over the age of 13-years, however, 29 youth were younger than 13 when their parents were advised to file a CRA case on their behalf.

Data show that 201 youth had an open court case when they began working with MHAP for Kids. Primarily (67%) they were for status offenses which are before the court as a Child Requiring Assistance

case or CRA. Approximately 9% of these youth had both a CRA and a delinquency matter at the same time, and 15% had just delinquency charges. 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.

SECTION 3: ENGAGEMENT IN ACADEMIC AND MENTAL HEALTH SERVICES

YOUTH ACADEMIC ENGAGEMENT

Among the 910 youth who have received services from MHAP for Kids, in-depth baseline data was collected on 405 youth. Forty-two percent of youth were in elementary school (Kindergarten to grade 5), 32% were in middle school (grades 6-8), 19% were in high school or college, and 6% did not report a grade. Approximately 89% of youth were attending school full- (82.7%) or part- (5.9%) time. Ages of youth receiving services from MHAP for Kids varied by sex, with female youth spread across elementary, middle school and high school groups nearly in thirds (34.1%, 31.8%, and 29.5%, respectively). Male youth were more likely to receive MHAP for Kids services at a younger age, with 47.5% in grades 1-5, and less likely (13.2%) in high school. Across racial groups, engagement with MHAP for Kids was similar for all grade levels, with the exception of Biracial youth who were more likely to be in elementary school or middle school (50%, 37.1%) compared to high school (9.7%).

Nearly 16% of youth were ever held back or repeated a grade (Table 6). Among youth who were held back, the average numbers of years held back was 1.9 (median = 1), with a maximum of 11 years held back. Thirty-four percent of youth were ever suspended and 28.6% ever sent home, with approximately 20%of youth suspended (19.8) or sent home (21.1%) in the 12 months prior to becoming involved with MHAP for Kids. Youth enrolled in the pilot, J-MHAP, were over twice as likely to have been suspended in the year before becoming part of the program (46.2%) than youth enrolled in MHAP for Kids. This is likely explained by the larger proportion of pilot youth in court for open CRA cases. Among youth in MHAP for Kids with an open court case at baseline, 31.9% had been suspended in the year prior to enrollment. Males were over twice as likely to have been suspended in the year leading up to working with MHAP for Kids (females = 10.1%, males = 22.6%). Biracial youth were less likely to have been suspended (12.9%) compared to White (18.0%), Latinx/Hispanic (23.5%) or Black youth (25.0%). Among youth who were suspended, the average number of suspensions in the 12 months before enrolling in MHAP for Kids was 4, with one youth experiencing the maximum of 25 suspensions. The average number of times sent home in the 12 months before receiving MHAP for Kids services was 10.8, with a maximum reported of 220. Interestingly, both means for having been sent home or suspended in the last 12 months have decreased considerably since our preliminary baseline report in the fall of 2020 (suspended from 34.1% to 19.8%, and sent home from 38.5% to 21.0%). More data can be found in Appendix A, Table B.

Table 6. Baseline School Engagement for MHAP for Kids Youth (n=420)

	Total	Avg. # of times
	%	$\bar{X}$
Ever Held Back or Repeated Grade	15.9	1.9
Ever Suspended	34.3	6.3
Suspended in last 12 mo	19.8	3.9
Ever Sent Home	28.6	10.8
Sent Home in last 12 mo	21.0	8.5

YOUTH SCHOOL SERVICE USE

Many youth 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. Complete details on school service use can be found in (Appendix A, Table C). On average, these services began when the child was between the ages of 6 and 8 (median = 6 to 7) and had been received for 4 to 5 (median = 3 to 4) years. When asked to think about the year before engaging with MHAP for Kids, parents reported these services were received for an average of 7 to 8 (median = 9 to 9.5) months which reflects nearly the entire length of a school year.

Twenty-three percent of youth attended a special school for children with problems that cannot be handled by regular schools. These services began at a mean age of 10.5 (median = 10) years old, were received for 3.1 (median = 2) years, and were received for 7 (median = 8) of the last 12 months.

Across all special school placements, female youth were more likely to be older on average when they first received special classroom or school placements with a range of 6 months to 1-year difference from their male counterparts across categories. This difference is partially explained by the younger average age of males enrolled in MHAP for Kids. Across racial categories, Black youth were also more likely to be 1 to 2-years older on average than other youth to receive special school placements. When looking at all youth 13-years of age or older, those with an open court case were an average of 2 years older when they first received services in a special class for children with learning problems (8.7 years compared to 6.7 years), services in a special class for behavioral problems (9.3 years compared to 7.3 years), and in a special class for emotional problem (9.9 years compared to 7.6 years).

Approximately 58% of MHAP for Kids youth received school-based counseling. This percentage is higher among kids with an open court case (68.1%), and among youth who are Black (65.9%) or Biracial (62.9%). Twenty-eight percent of youth received medications for problems with concentration, behavior, or emotions that were taken at school. Forty-four percent of parents reported that a teacher or other adult had encouraged them to visit a professional for the youths' problems with emotions, behaviors, or substance use. Youth were an average of 8 (median = 7) years old at the time of encouragement. Black youth were more likely to take medication at school (36.4%) and to have an adult recommend professional intervention (47.7%) at an average age of 9.7-years of age (median = 8). No differences were seen across sexes.

YOUTH OUTPATIENT BEHAVIORAL HEALTH SERVICES UTILIZATION

The majority of youth received mental health services from mental health professionals (81.2%), pediatricians or family doctors (42.5%), counselors or family preservations workers (52.6%), or mentors (41.0%) (Appendix A, Table D). On average, these services began when the youth was between the ages of 7 and 10 (median = 7 to 10), some beginning during early childhood. Among youth ever receiving these services, the average number of visits was 24.0 (median = 13.8) to mental health professionals, 2.5 (median = 1.0) to pediatrician or family doctors, 10.6 (median = 3.0) for counselors or family preservation workers, and 18.2 (median = 5) for mentors. Among the 405 youth whose parent/guardian filled out baseline data, 38.8% 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. The average age at which social services began providing services was 6.8 (median = 6) and youth had an average of 7.5 (median = 4) visits during the previous 12 months. Complete data on outpatient behavioral health services can be found in Appendix A, Table D.

Table 7. 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	19.8
Type of Service/Placement		
In-school therapy or counseling	70.83	58.0
Special classroom for learning, emotional or behavioral needs	50.98	62.5
Special school for youth with emotional or behavioral needs	31.11	22.7
Mental Health Services Received		
Outpatient Services:		
Mental Health Provider	92.16	84.2
Crisis or Emergency Services (emergency room, in-home crisis services)	69.57	57.8
Received a prescription for medication for emotional, behavioral, or substance use reasons	91.18	71.9
Took medication for emotional, behavioral, or substance use reasons during past year (at least 1 week)	88.89	72.2
Partial Hospital or Day Treatment	16.33	30.1
Overnight Services:		
Hospital	44.00	40.0
Residential Treatment Facility	35.42	19.3
Drug/Alcohol Treatment Unit	5.77	<5
Other Out-of-Home Placement:		
Group Home	13.46	6.2
Detention center/prison/jail	13.73	2.2
Emergency Shelter	10.00	4.2
Foster Home	<5	6.2

Between 40 and 50% of youth reported receiving emergency room (45.9%), in-home crisis services (44.2%), and community mental health center or outpatient services (35.8%). These reportedly began when the youth was an average of 8 to 10 (median = 7 to 10) years old. During the year prior to working with a MHAP for Kids staff attorney, emergency services were used an average of 2.7 (median = 2) times, in-home crisis services were used 5.3 (median = 2) times, and community mental health centers or outpatient services were used 21.3 (median = 12) times. Use of outpatient services is lower than recorded at baseline for the pilot (Table 7).

Partial hospitalization or day treatment programs were used by 30.1% of youth, which is a much higher percentage than observed in the J-MHAP pilot (Table 7). Probation or juvenile corrections officers were

involved with 17.0% of youth, compared to nearly a quarter of youth included in the fall 2020 baseline report. This shift is likely indicative of the expanding referral sources for MHAP for kids that are encountering youth in need of services outside of the court system. Fewer than 20% of youth ever received services from an educational tutor (13.1%), telephone hotline (10.4%), spiritual advisor (6.2%), self-help group (7.4%), other healer (4.7%), or respite care provider (5.2%).

Overall, since the initial baseline report published in 2020 (n=182), outpatient behavioral health services utilization is down across all measures with the exception of crisis or emergency services. Based on baseline data collected through October 2020, 45.6% of youth had baseline crisis or emergency services, compared to 57.8% of all youth enrolled through August 2021 with baseline data (n=405). This was highest among MHAP for Kids youth who had an open court case at baseline (72.2%), and even higher than what was recorded during the J-MHAP pilot among all court-involved youth (69.6%).

YOUTH INPATIENT BEHAVIORAL HEALTH SERVICES UTILIZATION

Use of inpatient services was also queried. Forty-four percent of youth had an overnight hospital stay, up from 42% in the 2020 report. Hospitalizations were lowest among Latinx/Hispanic youth (30.6%), with little significant differences across sex or court-involvement. Residential treatment center use is the same as the preliminary report, at approximately 20%, with the highest use among youth with an open court case (34.7%) and no observed differences across racial or sex categories. Group (6.2%) and foster (6.2%) homes were used by fewer than 10% of youth. Hospital stays among MHAP for Kids youth are similar to youth from the J-MHAP pilot (Table 7); however few 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.

YOUTH MEDICATION USE

Seventy-one 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 (Table 7). The average age when this medication was first prescribed was 8.1 (median = 7) and youth received the prescription for an average of 3.7 (median = 3) years. Nearly 83.9% of these youth received this prescription in the past 12 months, up from 70% reported in the preliminary report. Complete baseline medication use data presented in Appendix A, Table E.

Seventy-two percent of youth took this medication regularly for at least 1 year. This prescription was first received at an average age of 7.6 (median = 7) and was taken for an average of 4.2 (median = 4) years. At baseline, 81.6% of youth had received this prescription in the past 12 months, compared to 61% reported in the 2020 report.

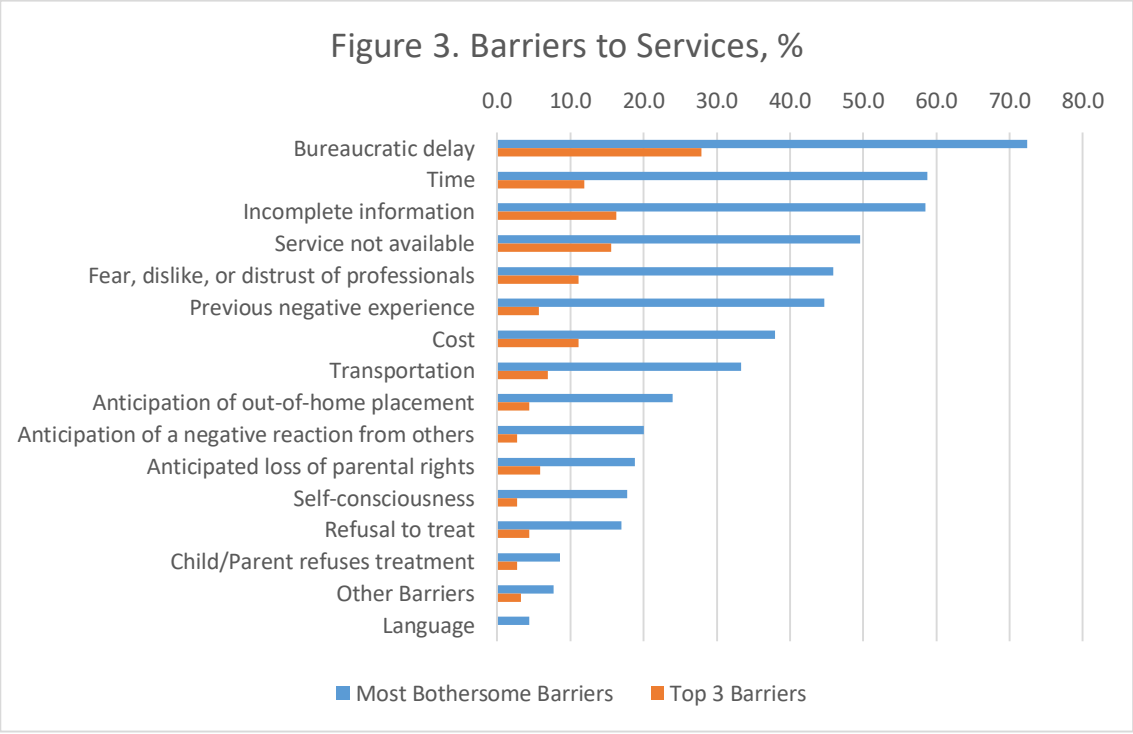
FAMILY EXPERIENCE WITH BARRIERS TO SERVICES

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 was the most bothersome (in blue), as well as the top 3 barriers they faced (in orange) (Figure 3). This full list of barriers is provided in Appendix A, Table F.

Of those who experienced barriers, 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 most bothersome (72.4%) barrier and a top 3 (27.9 %) barrier. Approximately 60% rated their most bothersome barriers as time (58.8%), and incomplete information (58.5%), and 50% rated the unavailability of services (49.5%)as the most bothersome barriers. The unavailability of services and incomplete information were rated among the top 3 barriers to services by 16.3% and 16.3% of persons respectively. Across racial categories, parents of White youth were more likely to indicate experiencing bureaucratic delays as the most bothersome (77.3%), followed by parents of Biracial youth (75.8%). There were no differences by sex of the youth.

Parents of youth aged 13 years or older with an open court case at baseline, repeated the same pattern of barriers as the group as a whole with bureaucratic delays (76.4%), time (61.1%), and incomplete information (59.7%) as most common barriers viewed as bothersome, and tended to have higher percentages across most barriers. Among all the barriers, these parents reported ten or more percentage points higher experiences of fear, dislike, or distrust of professionals (56.9%), transportation (45.9%), and child/parent refuses treatment (19.4%) compared to the group as a whole (45.9%, 33.3%, and 8.6%, respectively). Similarly, self-consciousness (26.4% vs 17.8%), previous negative experience (51.4% vs 44.7%), and anticipation of out-of-home placement (30.6% vs 24%) were higher in this group.

There were no noticeable differences in experiences with barriers within sex or racial categories, with the exception of the responses from parents of Biracial youth. For this group, the third most common barrier reported was not incomplete information (54.8%), but rather fear, dislike, or distrust of professionals (58.1% compared to 45.9% for the group as a whole). Tied with incomplete information, previous negative experience (54.8% compared to 44.7%) was a significant barrier.



SECTION 4: 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 from 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 but 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 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 8. 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 9.

Table 8. Youth Social/Emotional/Behavioral Challenges Observed During Remote Learning March-June 2020

	%
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 9. 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 a 53.5 with a median of 50. Families reported that 69% of youth had their own laptop or tablet for their work from home, and 71% had reliable WiFi to facilitate connection to school, and 54% had a quiet study space. This is similar to what parents reported at the beginning of remote learning in 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 school work, 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 10).

Table 10. 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> *"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…"* *"School was physically abusive in the past…"* *"I am worried about the abuse of power the School system is using to call DCF and Get the Juvenile court system involved."* *"The staff actually does more to try and trigger him into having behaviors…"* *"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."* <u>Lack of appropriate services</u> *"My child's IEP has not been followed and he has been excessively disciplined."* *"Child getting denied appropriate services again"*	30%

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 10).

The weekly data showed that overtime, 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 the reasons include 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.

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 and IEP (52.2%). Of those, only 45% received services in 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 11). The vast majority of parents reported on the weekly log that their child exhibited at least one of these challenges (93.3%).

Table 11. 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

SECTION 5: THE WORK OF STAFF ATTORNEYS

MHAP for Kids has provided services for 910 youth in its first three and a half years. The average length of a completed case was 247 days or 8.2 months with a minimum of less than one month and maximum of 2.3 years. We did not observe significant variation across gender, race/ethnicity, or court-involvement categories (Appendix A, Table G).

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, as the MHAP for Kids staff attorneys serve as their legal representation. Data on goals is available for 684 MHAP for Kids participants. The average number of goals per participant were 4.4 (median = 4.0) and ranged from 1 to 35 goals. The majority of goals (55%) focused on assessing, obtaining, and maintaining educational services. Goals related to accessing appropriate mental health services comprised 17.7%, obtaining educational or mental health evaluations were 13.6%, and general case coordination and insurance goals were 8.0% of all stated goals. Staff attorneys also had goals related to court (5%), and accessing other services like physical health care, transportation, and housing (.7%).

STAFF ATTORNEY EFFORT WITHIN VARIOUS SYSTEMS

Staff attorneys tracked their work by documenting all the contacts they made on behalf of families. For the 910 youth receiving MHAP for Kids services 46,643 contacts were recorded. From the 42,120 contact entries that also included the amount of time spent, staff attorneys spent just over half of their accounted time communicating with family members (52%) and 30% of their time with people and agencies involved with the youth's schooling. This is not unexpected given the attorney-client relationship and the focus on youth academic goals. The rest of their tracked time was spent communicating with health practitioners in both inpatient and outpatient settings (7%), state agencies including Department of Mental Health, Department of Children and Families and Department of Elementary and Secondary Education (2.3%), and court-related contacts including probation officers and other attorneys (3.7%). This is different from the data collected about contacts during the pilot program where most of the time was spent working within the court (30%). Staff attorneys also had contact with residential programs, community-based organizations and insurers, each comprising less than 1% of the tracked time. In their documentation very little was documented about administrative time necessary to work with other program staff or accomplish day to day tasks of MHAP for Kids. This speaks to the possibility that other tasks may also be underreported during the course of the attorneys' work.

The most frequent modes of contact were telephone calls (16.3% of time spent working on the case) and emails (14.8% of time spent working on the case). Staff attorneys had phone contact on behalf of 94.3% of youth; the average number of phone calls per youth was 17.4 (median = 10) and a maximum of 148. Among staff attorneys who made phone contact on behalf of youth, the average duration of calls per youth was 5.3 hours (median = 3.0 hours) and a maximum of 47.5 hours. Staff attorneys also sent emails (85.0%) and letters (72.1%) on behalf of youth. Full details on contacts are summarized in Appendix A, Table H.

CASE KEY EVENTS

Staff attorneys track *key events* or pivotal moments in a case. As of August, 2021 there are 653 key events recorded for 221 youth (range 1-10 events). These data highlight the complexities of these cases and documents both challenges and successes faced by families during their work with MHAP for Kids. Some examples of challenging key events include suicide attempts, youth hospitalizations, and illness or death in the family. Some cases successes include youth discharge from inpatient program with follow up plan, a school district agreeing to cost sharing a residential placement, and newly qualified services obtained within the existing school. More about case key events will be explored in future reports with outcomes data.

SUMMARY

The first three years of MHAP for Kids has 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. The racial diversity of youth enrolled in the program has illuminated differential experiences of barriers in navigating systems of care, as well as parents' thoughts and behaviors related to outplacement and calling the police, among others. MHAP for Kids has persistent disparities in enrollment by sex. Data from referral sources show that community-based organizations and courts are most likely to refer female youth compared with other sources. Female participants are also more likely to be enrolled at older ages than their male counterparts, which reflects a pattern of female youth with mental health needs accessing services at older ages, as well.

Youth and families have 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 largely 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. Compared to the 2020 preliminary baseline report, there has been a decrease in the average utilization of all outpatient and out of home behavioral health services with the exception of mobile crisis utilization and hospitalization, which remains high.

Program goals and staff attorney recorded time suggests that their work is focused primarily on schools and agencies related to school services and are spending much less time with court-related activities. The COVID-19 pandemic has impacted youth mental health as indicated qualitatively by parents in weekly logs during the past two school years. Data from the 2020-2021 school year have highlighted important parental concerns about the ability of schools to provide sufficient services and youth experiences of abuse of power. Future reports will continue assess the ongoing impact of COVID-19 and the experience of families with the program, along with outcome data of youth whose cases have closed.

APPENDIX A: DATA TABLES

Table A. Parent and Family Functioning from Parent Self-Administered Survey Characteristics								
		MHAP for Kids All				Published Norm		
		%	$\bar{x}$	(sd)		%	$\bar{x}$	(sd)
Parent Functioning								
	Perceived Stress Scale		20.4	(7.6)			13.0	(6.4)
	CES-D Depressive Symptoms		21.4	(13.3)			9.3	(8.6)
	CES-D Clinical Cutoff (≥16)	62.5				19.0		
Family Functioning: Conflict Behavior Questionnaire			9.9	(6.2)			2.4	(2.8)

Table B. Baseline School Characteristics for MHAP for Kids (n=182)					
	Total	If Yes, Number of Times:			
	%	$\bar{x}$	(sd)	min	max
Ever Held Back or had to Repeat Grade	15.9	1.9	(2.2)	1	11
Ever Suspended	34.3	6.3	(8.6)	1	50
Suspended in last 12 months	19.8	3.9	(4.7)	1	25
Ever Sent Home	28.6	10.8	(15.4)	1	100
Sent Home in last 12 months	21.0	8.5	(24.5)	1	220

Table C. Baseline School Services Received by MHAP for Kids Participants (n=182)							
	Received Services %		Among Participants who Received Services				
			$\bar{X}$	(sd)	median	min	max
Special Class for Children with Learning Problems	54.3						
Age when 1st Received Services			6.7	(3.2)	6.0	2.0	18.0
#Years Received Services			5.1	(3.8)	4.0	0.0	18.0
#Months of Services in the Past 12 Months			7.1	(4.6)	9.0	0.0	12.0
Special Class for Children with Behavioral Problems	33.3						
Age when 1st Received Services			7.3	(3.4)	7.0	2.0	18.0
#Years Received Services			4.3	(3.7)	3.0	0.0	18.0
#Months of Services in the Past 12 Months			7.2	(4.4)	9.0	0.0	12.0
Special Class for Children with Emotional Problems	28.6						
Age when 1st Received Services			7.6	(3.7)	7.0	2.0	18.0
#Years Received Services			4.2	(3.6)	3.0	0.0	18.0
#Months of Services in the Past 12 Months			8.1	(4.0)	9.5	0.0	12.0
Special School for Children with Problems that Cannot be Handled by Regular School	22.7						
Age when 1st Received Services			10.5	(3.7)	10.0	2.5	18.0
#Years Received Services			3.1	(3.5)	2.0	0.0	18.0
#Months of Services in the Past 12 Months			6.8	(4.6)	8.0	0.0	12.0
Individual Psychological Counseling of Therapy Delivered in School	58.0						
Age when 1st Received Services			8.4	(3.2)	8.0	3.0	18.0
# Years Received Services			3.7	(3.0)	3.0	0.0	18.0
#Months of Services in the Past 12 Months			6.4	(4.5)	6.5	0.0	12.0
Medications for Problems with Concentration, Behavior, or Emotions Taken at School	28.6						
Age when 1st Received Services			8.2	(3.5)	7.0	0.0	16.0
#Years Received Services			3.6	(3.1)	3.0	0.0	18.0
#Months of Services in the Past 12 Months			5.4	(4.9)	5.0	0.0	12.0

Table D. Baseline Outpatient Behavioral Services Used by MHAP for Kids Participants (n=182)							
	Received Services		Among Participants who Received Services				
	%		$\bar{x}$	(sd)	median	min	Max
Mental health professional	81.2						
Age (years) at 1st services			7.5	(3.6)	7.0	1.0	16.0
# Visits in past 12 months			24.0	(22.6)	13.8	0.0	96.0
Pediatrician or family doctor	42.5						
Age (years) at 1st services			7.8	(4.3)	7.0	0.1	17.0
# Visits in past 12 months			2.5	(5.2)	1.0	0.0	50.0
Counselor or family preservation worker who came to your home	52.6						
Age (years) at 1st services			6.9	(4.5)	6.0	0.0	17.0
# Visits in past 12 months			10.6	(17.5)	3.0	0.0	80.0
A Mentor	41.0						
Age (years) at 1st services			9.5	(3.0)	9.0	4.0	17.0
# Visits in past 12 months			18.2	(23.8)	5.0	0.0	96.0
Social services	38.8						
Age (years) at 1st services			6.6	(4.6)	6.0	0.0	16.0
# Visits in past 12 months			6.4	(9.6)	2.5	0.0	50.0
Emergency Room	45.9						
Age (years) at 1st services			10.0	(3.9)	10.0	2.5	17.0
# Visits in past 12 months			2.7	(3.9)	2.0	0.0	25.0
In-home crisis services	44.2						
Age (years) at 1st services			9.3	(3.7)	9.0	1.0	17.0
# Visits in past 12 months			5.3	(11.8)	2.0	0.0	72.0
Community mental health center or outpatient mental health clinic	35.8						
Age (years) at 1st services			8.1	(3.8)	7.0	0.0	16.0
# Visits in past 12 months			21.3	(22.0)	12.0	0.0	96.0
Partial hospitalization or day treatment program	30.1						
Age (years) at 1st services			10.4	(3.8)	11.0	1.0	17.0
# Visits in past 12 months			1.6	(2.8)	1.0	0.0	20.0
Probation or juvenile corrections officer or court counselor	17.0						
Age (years) at 1st services			13.2	(2.5)	13.0	8.0	22.0
# Visits in past 12 months			3.4	(5.7)	2.0	0.0	32.0
An educational tutor at home	13.1						
Age (years) at 1st services			11.4	(3.0)	11.0	6.0	17.0
# Visits in past 12 months			12.1	(18.7)	4.0	0.0	90.0
Telephone hotline	10.6						
Age (years) at 1st services			9.9	(3.5)	10.0	4.0	16.0
# Visits in past 12 months			5.5	(11.3)	2.0	0.0	52.0

Spiritual advisor	6.2						
Age (years) at 1st services			9.1	(4.4)	10.0	0.0	15.0
# Visits in past 12 months			13.6	(22.7)	3.0	0.0	76.0
Self-help group	7.4						
Age (years) at 1st services			10.7	(3.5)	11.0	4.0	16.0
# Visits in past 12 months			11.1	(16.7)	3.0	0.0	50.0
Any other kind of healer	4.7						
Age (years) at 1st services			8.4	(3.9)	9.0	0.0	15.0
# Visits in past 12 months			11.4	(19.0)	2.0	0.0	64.0
Respite care provider	5.2						
Age (years) at 1st services			9.6	(3.8)	10.5	3.0	15.0
# Visits in past 12 months			8.8	(15.2)	1.0	0.0	50.0

Table E. Baseline Medication Use for Emotional, Behavioral, or Substance Use Problems by MHAP for Kids Participants (n=141)

	Total		Among Participants with Prescriptions				
	%		$\bar{x}$	(sd)	median	min	max
Took medication regularly for at least 1 week	95.2						
Age when prescription first received			8.1	(3.8)	7.0	1.5	17.0
# Years received prescription			3.7	(2.8)	3.0	0.0	13.0
Took medication regularly for at least 1 year	72.2						
Age when prescription first received			7.6	(3.4)	7.0	1.5	16.0
# Years received prescription			4.2	(2.6)	4.0	1.0	13.0

Table F. Description of Barriers from Child and Adolescent Services Assessment[6]	
Barrier	**Description**
Systems barriers	
Bureaucratic delay	Bureaucratic hurdles such as excessive pre-visit paperwork or authorizations, difficulty getting an appointment in a timely fashion or being put on a waiting list, or offices where the phone is not answered or calls are not returned.
Transportation to treatment/services	Reluctance to use services caused by difficulty getting to treatment site.
Incomplete information	Difficulty in getting services caused by lack of information about where to get services or how to arrange them.
Time	Reluctance to use services caused by lack of time to get treatment or to make arrangements for treatment.
Service not available	Non-availability of a particular service desired by a subject (such as counseling or drug rehab) because it does not exist in the area where the subject lives.
Cost of treatment/services	Inability to use services or underutilization of services caused by perception that services could not be afforded or paid for; insurance would not cover cost
Refusal to treat	Being refused by the service for various reasons: lack of space/beds, problematic history of subject, fear of liability, etc.
Fear of consequences	1. Reluctance to use services caused by fear that subject's children might be at greater risk of out-of-home placement; or 2. Reluctance to use services caused by fear that subject might be seen as an unfit parent and lose parental rights.
Child or parent refuses treatment	1. Youth refused to go for treatment; or 2. Parent refused to allow the youth's participation.
Quality of services	1. Concern or discomfort with using services caused by subject's fear, dislike, or distrust of talking with professionals; or 2. Concern or discomfort with using services caused by subject's previous negative experience with professional(s).
Stigma	1. Reluctance to use services caused by self-consciousness about admitting having a problem or about seeking help for it. Also inability to talk with anyone about such sensitive issues; or 2. Reluctance to use services caused by anticipation of a negative reaction from family, friends, or others to seeking treatment for an emotional or mental problem.

Table G. Youth Demographic Characteristics of MHAP for Kids Youth and Pilot (J-MHAP) Youth

		MHAP for Kids Participants		Subsection 1: Court (>=13 years old)			Subsection 2: Gender	
				No Court Case	Court Case		Females	Males
		(n=910)		(n=88)	(n=201)		(n=277)	(n=605)
		%		%	%		%	%
Age (mean (min, max))		12.1 (3, 22)		14.7 (13, 20)	15.0 (13, 22)		12.5 (3, 21)	11.8 (3, 22)
	Preschool (3-5)	4.7		-	-		3.6	5.5
	Middle Childhood (6-11)	33.6		-	-		27.1	37.9
	Teens (12-17)	52.2		95.5	94.5		60.3	49.4
	Young Adults (18-23)	3.7		4.6	5.5		4.0	3.8
	Unknown	5.7		0.0	0.0		5.1	3.5
Gender (%)								
	Female	30.4		39.8	31.3		-	-
	Male	66.5		58.0	67.7		-	-
	Other	1.1		2.3	1.0		-	-
	Unknown/Missing	2.0		0.0	0.0		-	-
Ethnicity (%)								
	White	40.4		43.2	44.8		44.4	39.7
	Latinx/Hispapnic	29.6		28.4	28.9		28.2	30.7
	Black	12.5		12.5	14.9		11.2	13.7
	Biracial	11.9		14.8	10.0		12.3	12.1
	Asian	2.4		1.1	1.5		1.8	2.5
	Mising/DK/Ref	3.2		0.0	0.0		2.2	1.3
English		83.2		85.2	88.6		84.5	85.0

Table H. Staff Attorney Contacts on Behalf of MHAP for Kids Youth							
		All Youth					
		Overall					
		%	$\bar{X}$	sd	median	min	max
Phone		94.3	17.4	(20.2)	10.0	1.0	148.0
	Duration (hours)		5.3	(6.4)	3.0	0.1	47.5
Email		85.0	28.3	(40.6)	14.0	1.0	513.0
	Duration (hours)		7.3	(10.5)	3.5	0.0	128.5
Fax		28.7	2.2	(1.8)	2.0	1.0	10.0
	Duration (hours)		0.7	(0.7)	0.5	0.3	5.3
Letter		72.1	2.5	(1.7)	2.0	1.0	13.0
	Duration (hours)		0.8	(0.7)	0.8	0.3	4.3
Meeting		68.8	4.0	(4.2)	3.0	1.0	47.0
	Duration (hours)		5.3	(5.8)	3.5	0.3	41.5
Draft		28.6	2.8	(3.0)	2.0	1.0	26.0
	Duration (hours)		2.9	(5.6)	1.0	0.3	40.3
Texts		15.5	3.6	(4.0)	2.0	1.0	22.0
	Duration (hours)		0.9	(1.0)	0.5	0.1	5.8
Prep/Research		38.1	2.8	(2.7)	2.0	1.0	20.0
	Duration (hours)		2.1	(4.6)	1.0	0.3	65.8
Record Request/Review		58.7	3.2	(2.8)	3.0	1.0	26.0
	Duration (hours)		1.8	(2.0)	1.3	0.1	21.5
Court		8.9	1.8	(1.7)	1.0	1.0	10.0
	Duration (hours)		3.5	(4.3)	2.5	0.3	33.0
Key Event		24.8	3.0	(2.9)	2.0	1.0	19.0
	Duration (hours)		1.1	(1.7)	0.5	0.3	12.0
Supervision		25.3	3.4	(4.0)	2.0	1.0	32.0
	Duration (hours)		0.9	(1.1)	0.5	0.1	9.5
Data Collection		19.1	1.6	(0.5)	2.0	1.0	3.0
	Duration (hours)		0.9	(0.4)	1.0	0.3	2.3
In-Person		11.8	1.6	(1.1)	1.0	1.0	9.0
	Duration (hours)		1.0	(1.0)	0.5	0.3	5.3
Other		13.7	1.3	(0.7)	1.0	1.0	5.0
	Duration (hours)		0.5	(0.5)	0.3	0.3	4.0
Unknown		9.6	1.3	(0.6)	1.0	1.0	5.0
	Duration (hours)		0.6	(0.4)	0.5	0.1	1.5

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