Mental Health Advocacy Program for Kids

Report of Baseline and Follow Up Evaluation Data

March 2017-November 2024

March 25, 2025

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 November 14, 2024. 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 five main sections (1) Program Details, (2) Youth and Family Baseline Characteristics, (3) Engagement in Academic and Mental Health Services, (4) Family Experiences of Barriers, and (5) Evidence of Program Impacts.

1. **Program Details (pages 4-6).** 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 mid-November 2024. Data used are from the MHAP for Kids administrative data. Key questions include:
    - What is the design of the MHAP for Kids Program?
    - What are the patterns for program enrollment?
    - What organizations or agencies are referring youth to the MHAP for Kids program?

2. **Youth and Family Baseline Characteristics (pages 6-9).** 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 and family and youth risk profiles. 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?
    - What are the family risks at baseline, specifically those related to adult depression, family conflict, stress, and employment status?

3. **Baseline Engagement in Academic and Mental Health Services (pages 9-11).** 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?

4. **Family Experience with Barriers to Care (page 11).** Understanding the barriers that families face is important in the analysis of the impact of MHAP for Kids' ability to improve access to mental health care. To assess this the following key question is asked:
    - What types of barriers have families faced trying to access services prior to their work with MHAP for Kids?

5. **Evidence of Program Impacts (pages 11-14).** 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?
    - 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?
    - 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 and questionnaires were conducted with a subset of families (n=284 and n=292, respectively). (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

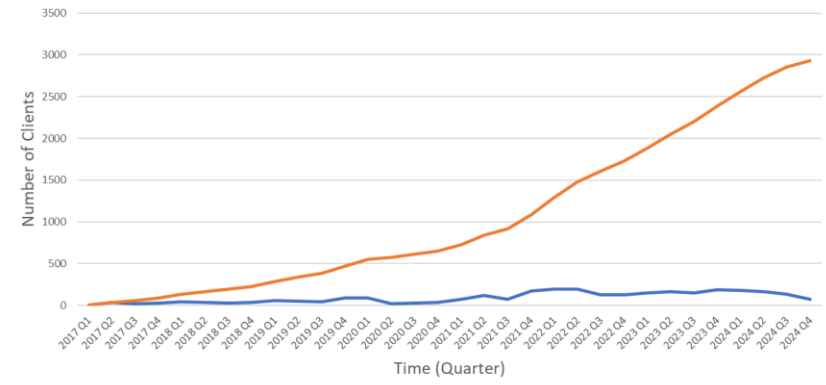
The Mental Health Program for Kids (MHAP for Kids) serves families whose youth are in need of access to appropriate mental health services and are court-involved or at-risk for court involvement. MHAP for Kids began providing services for youth in Massachusetts on March 1, 2017, when it opened its first 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. The physical location of the sites include: Salem, Lynn, and Lawrence (Essex County), Lowell and Everett (Middlesex County), Boston (Suffolk County), New Bedford (Bristol County), Holyoke and Springfield (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).

PROGRAM ENROLLMENT

Since the last evaluation report, the enrollment in MHAP for kids has doubled. As of November 14, 2024, 3282 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) when enrollment dipped due to the COVID-19 pandemic and its impact on schools and systems of care for youth.

Figure 1. MHAP Enrollment Over Time, Cumulatively and by Quarter



Note: Data are from March 1, 2017 through November 14, 2024. Therefore, only half of 2024 Q4 is represented here.

Figure 1 depicts the cumulative enrollment of the program over time. The bottom line (blue, if in color) represents each new case that opened within a given quarter, and the top line (orange, if in color) represents the total number of cases ever opened to date. Looking back over the past three years of data (2022-2024), enrollment has been steady with an average of 161 new cases opening each quarter. This is depicted in the slope of the top line in Figure 1. There appears to be seasonality to enrollment, with quarter 3 always having the least number of new cases each year. This is to be expected given that schools are closed during that time and school-related

difficulties are often what initiate program referrals. It is also important to note that Figure 1 includes data through the first half of quarter four of 2024. The slight dip at the end of the figure does not represent a decline in enrollment rates. Also, during the seven and a half years of data represented here, approximately 10% of cases (n=348) have missing enrollment data and are not included in Figure 1.

REFERRING AGENCY

In our first baseline report of data collected on youth enrolled Spring of 2017 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 which ran from March, 2015 through February, 2017. Subsequent analyses of program data up to 2022 showed a noticeable shift with healthcare organizations providing the most referrals to MHAP for Kids. This remains the same through our analyses of data collected through mid-November 2024, where across all sites, 27% of youth were referred from a healthcare organization. It is likely some of this is driven, in party, by MHAP for Kids' relationships with several Accountable Care Organizations (ACOs). A forthcoming report will provide additional analyses specifically detailing the outcomes of youth referred into the program by ACOs compared to those who find their way to MHAP for Kids through other sources.

Table 1. MHAP Participants by Referring Agency	
Healthcare Organization	27.1%
Community Organization	15.3%
Court/Legal System	11.2%
Word of Mouth	11.2%
Family Resource Center	10.7%
Previous MHAP Client	9.1%
Unknown/Missing	5.2%
State Agency	4.5%
HLA	2.4%
Client	2.1%
School District	1.1%

Community organizations and the court system have remained the second and third most common referral sources with 15% and 11% respectively. Word of mouth has emerged as a strong source of referrals with the same overall as the total percentage from the court system. This recent shift is a key indicator both of the successes of the program that there would be spread of its usefulness through social networks; as well as possible indication of growing community awareness as MHAP for Kids sites become part of the fabric of family support services imbedded within Family Resource Centers (FRC) across the Commonwealth.

Family Resource Centers themselves account for nearly 11% of actual referrals into the program. Anecdotal evidence from individual conversations suggest that FRC staff have benefited from the co-location of MHAP for Kids in the sites beyond direct referrals. For example, FRC staff have reported in several administrative meetings that they appreciate being able to walk over and ask a question of the staff attorney and then provide support to a family member themselves. Future data collection efforts should invite FRC personnel to provide qualitative feedback on their experiences with MHAP for Kids to investigate this anecdotal observation and other research questions about the program's implementation and impact on overall FRC capacity.

The evolving pattern of referrals at a program level is an indication of the meaningful integration of MHAP for Kids into the Family Resource Centers, the ability to partner with healthcare providers and

ACOs, the efforts toward building and nurturing relationships with community-based organizations, and the positive experiences of clients. More information on the qualitative experiences of families can be found in our companion report entitled *Family Voices A Report of Client Experiences with the Mental Health Advocacy Program for Kids*.

SECTION 2: YOUTH AND FAMILY BASELINE CHARACTERISTICS

Staff attorneys work closely with each client 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 (3282 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=284), and via self-administered questionnaires provided to parents/guardians at enrollment and closure (n=292). 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. Though, given the large number of families with Spanish-speaking members (Table 2) it is time to revisit data collection protocols to better understand differences for those who do not speak English.

Table 2. Youth Demographic Characteristics of MHAP for Kids Youth

Demographic	MHAP for Kids (n=3282)
Age (mean (min, max))	11.8 (3, 23)
Preschool (3-5)	5.8%
Middle Childhood (6-11)	31.8%
Teens (12-17)	48.2%
Young Adults (18-23)	2.6%
Unknown	11.6%
Gender Identity	
Male	58.1%
Female	30.8%
Trans	1.5%
Nonbinary	1.0%
Unknown/Missing	8.5%
Race/Ethnicity	
White	37.1%
Latino/Hispanic	24.9%
Biracial	13.3%
Black	11.6%
Asian	2.1%
Other/Missing	1.8%
Native American	.5%
Missing/Unknown/Refused	10.6%
Household Primary Language	
English Only	75.1%
Spanish Only	8.4%
Other Only	2.7%
English + Spanish	1.8%
English + Other	1.4%
Unknown/Missing	10.8%

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

Consistent with what has been reported previously, youth in MHAP for Kids were mostly male (58%) from English-speaking households (75.1%) (Table 2). On face value, this appears to be decreasing from than our last reporting in 2022 where youth were 64.2% male, 39.8% white, and 82.9% English-only speaking. However, due to the increased amount of missing or refused data in each demographic category (8.5-11.6%) no conclusions can be drawn about trends at this time. When compared to the original pilot program that operated within the court system from 2015-2017, even assuming current MHAP for Kids missing data were all comprised of the dominant group, MHAP for Kids does continue to show much greater diversity in age, gender identity, race, and language (Table 3). These demographic shifts can be attributed to moving the program from the courts to community-based organizations in 2017 (i.e. the FRCs), facilitating self-referrals or referrals from systems beyond courts, like healthcare organizations, that interface with eligible youth and families.

Table 3. Select Demographic Characteristics of J-MHAP Pilot and MHAP for Kids

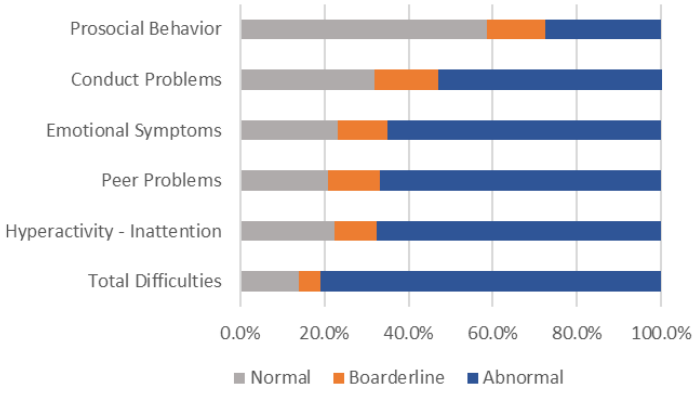
Demographic	Pilot (N=152)	MHAP for Kids (N=3282)
Age (mean (min, max))	15.7 (8, 22)	11.8 (3, 23)
Male	60.9%	58.1%
White	66.5%	37.1%
English Only	92.8%	75.1%

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 7.7 reflecting very good levels of physical health. The average mental health score was 5.0, 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. High levels of abnormal scores appear for the total difficulties (80%) and every subscale, as depicted in Figure 2. More than 50% of youth scored in an "abnormal" category on the subscales: 67.7% for hyperactivity – inattention, 66.8% for peer problems, 65.0% for emotional symptoms, and 53.1% for conduct problems (Figure 2).

Figure 2. Strengths and Difficulties Baseline Scores



These high abnormal scores reported by families indicate 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 remained stable since our first evaluation report five years ago, indicating the consistency of

severity of MHAP for Kids youth, overtime. In other words, MHAP for Kids has a long track record of enrolling youth with a high level of need and that the need in the community for MHAP for Kids services has not diminished.

PARENT/GUARDIAN AND FAMILY RISK PROFILES

In Table 3, family 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 indicates severe risk factors across all domains when compared to general community data. Also provided are the percent of the overall general population expected to score lower, or better, than the average MHAP for Kids score. For a pictorial representation of these data, please see Appendix B, Figure A.

Table 3. MHAP for Kids Family Functioning Compared to Norms[3,4,5]

	Number of standard deviations from community norms	% of general population who score better than MHAP for Kids Families
Parent Perceived Stress	+1.2	84%
Parent Depression Symptoms	+1.5	91%
Family Conflict	+2.4	99%
+ indicates the mean score is higher or worse than the norm		

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 20.8 (sd = 7.5) (Appendix A, Table C). This is 1.2 standard deviations above the published norm, representing greater than normal stress among MHAP for Kids parents (Table 3). This equates to being a worse score than would be expected in 84% of the general population.

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 (sd = 13), which is 1.5 standard deviations higher than the published norms, indicating that 91% of the population would be expected to score better. 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 (65.7%), indicating the mental health needs of caregivers in this program. Thirty-seven 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 families in the pilot 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 = 9.2, sd = 6.1) among MHAP for Kids parents was 4 times higher than published norms meaning a much higher average level of conflict in these families' homes, as represented in Table 3.

Finally, families were asked about the impact of their child's mental health problems on their family's income and their ability to work. A majority (59.4%) of respondent shared that family income was impacted. Among a subset (n=82) who answered about their own paid work, 58.5% said they were either unable to work or had lost their jobs due to their youth's needs. An additional 35.4% indicated that they lost time at work or their hours were reduced to manage their youth's needs. Only 6% said their own paid work was not disrupted.

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. As shown in Table 1., nearly half (48.2%) of youth enrolled in MHAP for Kids were in adolescence (age 12-17 years). About one-third (31.8%) were in middle childhood or elementary school age (6-11 years). Pre-school aged (3-5 years) children accounted for 5.8% of MHAP cases and young adults (18-23 years) were 2.6%. Within the subset of families who completed evaluation data collection at baseline, 88.0% were attending school full-time with over half (52.3%) in a special class for children with learning problems, 30.0% in a special class for children with behavioral problems, and 32.4% in a special class for children with emotional problems. Twenty-three 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 29.8% having been suspended in the year prior, with the same percent having been sent home because of their behavior in school in the past year. This is an increase from what we previously reported in the data collected through the summer of 2022 where 19.3% of youth had been suspended in the year before enrolling in MHAP for Kids, and 21% of youth having been sent home for their behavior.

Table 4. Baseline MHAP for Kids Education Service Use in 12 prior to MHAP for Kids Enrollment

	n=284 %
School Engagement	
School Suspensions	29.8%
Sent home for behavior	29.8%
Type of Service/Placement	
In-school therapy or counseling	56.8%
Special classroom for: learning	52.3%
behavioral	30.0%
emotional needs	32.4%
Special school for youth with emotional or behavioral needs	22.5%

YOUTH SCHOOL SERVICES USE

Many youths who participated in MHAP for Kids received services to address behavioral or mental health problems through their school. In addition to specialized classroom or school placements, over half of youth (56.8%) had received individual psychological counseling in their school prior to working with a MHAP for Kids staff attorney. Twenty-one percent of youth received medications for problems with concentration, behavior, or emotions that were taken at school. 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 services from mental health

professionals (78.5%), pediatricians or family doctors (35.2%), counselors or family preservations workers (44.4%), or mentors (36.2%) (Appendix A, Table E). Like with much of the data presented in this report, this pattern of health service use has remained very stable throughout the entirety of MHAP for Kids. Nearly two thirds (63%) of youth were on psychiatric medications at baseline. Among the youth whose parent/guardian filled out baseline data, 29.4% had ever received services from a social services agency. This is a decrease compared to 50% among the 182 families that provided data presented in the fall 2020 report, and 36.7% among the 150 families who had complete baseline and follow up data in the 2022 report. Complete data on outpatient behavioral health services can be found in Appendix A, Table E.

MHAP for Kids youth have also needed care from higher-level outpatient providers, like those in the emergency department or accessed through a mobile crisis service. In fact, approximately 40% of youth reported receiving emergency room (43.2%), or in-home crisis services (42.4%). Both are costly and indicative of mental health issues that are not stabilized and result in urgent care.

Table 5. Mental Health Service Use	
	n=284
Outpatient Services:	
Mental Health Provider	78.5%
Emergency Room	43.2%
Mobile Crisis	42.4%
Partial Hospital or Day Treatment	25.7%
Overnight Services:	
Hospital	33.3%
Residential Treatment Facility	17.9 %
Drug/Alcohol Treatment Unit	<5
Other Out-of-Home Placement:	
Group Home	3.7%
Detention center/prison/jail	1.5%
Emergency Shelter	2.2%
Foster Home	3.7%

Thirty-five percent of families engaged with community mental health centers or outpatient services. Partial hospitalization or day treatment programs were used by 25.7% of youth, both of which are consistent in MHAP for Kids data over time. Probation or juvenile corrections officers were involved with 14.0% 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 encounter youth in need of services outside of the court system. It also may point to reaching youth earlier in their trajectory prior to court involvement. Fourteen percent or fewer youth ever received services from a telephone hotline (14.1%), an educational tutor (11.4%), spiritual advisor (5.6%), or other healers (3.2%).

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. One third of youth in the evaluation sample had an overnight hospital stay. Residential treatment centers were used by approximately 17.9% of youth. Fewer youth lived in a group (3.7%) or foster (3.7%) home. Hospital and residential treatment stays among MHAP for Kids youth have been stable over time; however, there may be a trend of decreasing proportions of youth residing in group or foster homes. For example, in a report of data through October, 2020 with a sample of 182 families who had completed baseline data, 8.8% of youth were in a group home and 7.7% in a foster home placement. One year later, with a sample of 405 families who had completed baseline data, 6.2% had been in group homes and 6.2% in foster homes. In a later report with data through September, 2022 among a sample of families with both baseline and follow up data, 5.2 youth had been in group homes and 4.7% had been in foster homes. This may be

indicative of MHAP for Kids successful intervention earlier in youth's trajectories prior to, and perhaps in prevention of, out-of-home placements. Continued follow-up over time will yield more information on the ability of the program to interrupt outplacements for youth.

SECTION 4. 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.

Facing barriers to accessing care was a near universal (97.2%) experience of MHAP for Kids families, who reported that the barriers impacted mental health services for their youth. Again, this has been consistently reported over time. 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, remains the most frequently identified bothersome (81.6%) barrier. Over sixty percent of families rated incomplete information (65.0%), and time (63.6%) as important barriers to accessing services. Since our last report, we observe a decrease in the percent of parents reporting the unavailability of services as a barrier from 49.1% to 42.4% . Cost and transportation were also commonly reported (36.0%, and 32.9% respectively).

MHAP for Kids families also experienced substantial barriers related to the social consequences of seeking care. Consistent with past reports, 47.7% reported having a previous negative experience while seeking care for their child. Parents and guardians reported experiencing fear, dislike, or distrust of professionals as a bothersome barrier (45.9%). Others indicated that self-consciousness (24.7) and anticipation of a negative reaction from others (21.6%) were perceived as barriers. Concerningly, we observe an increase in the percent of families reporting the anticipation of an out-of-home placement, and anticipation of losing parental rights since our last report, from 17.0% to 24.4%, and 15.1% to 20.1%, respectively. A full table of all barriers can be found in Appendix A, Table G.

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 engagement in services, and experience of barriers are presented here, with full data tables found in the appendix as indicated below. A note of caution when interpreting these data. During baseline data collection, families are asked to report on the previous year. Given that MHAP for Kids aims to only work with families for six-months or less, the follow-up questions ask families to report on the past six months. Therefore, the data points have two different "look-back" periods.

YOUTH AND FAMILY FUNCTIONING AT FOLLOW UP

Consistent with our last report, 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 (Table 6). Additionally, while our last analysis of data through September of 2022 showed only a signal of effect for improvement in youth physical health, this measure was statistically significant in our current analysis. More detail on these values can be found in Appendix A, Table E.

Table 6. Statistically Significant Improvements in Youth and Family Profiles

	Improvements in Youth Mental Health
⇩	Total Difficulties
⇩	Emotional Symptoms
⇩	Conduct Problems
⇩	Hyperactivity – Inattention
⇩	Peer Problems
⇧	Prosocial Behavior
	Improvements in Family Functioning
⇩	Conflict
⇧	Ability to earn income
	Improvements in Parent Mental Health
⇩	Meets criteria for depression
⇩	Meets criteria for major depression

For example, at baseline, 80.8% of youth were rated with an "abnormal" level of difficulties, compared to only 59.9% at follow-up ($p<0.001$). This is driven by the 20.9% 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 65.7% of parents met the threshold for depressive symptoms on the CES-D tool, only 52.7% did at follow up. This decrease was also seen in the higher scores indicating major depression which changed from 37% to 27.1% at follow up. 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 overall family functioning.

For family income, there was also a statistically significant positive shift. Where 59.4% of families reported that youth problems impacted their family's income, only 42.8% reported this at follow-up. No significant changes were found among the subset of people who answered questions about their own personal paid work. More details are presented in Appendix A, Table G.

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 (Table 7). Analyses also revealed that decreases in suspension and youth sent home are approaching significance. Continued monitoring of MHAP for Kids data will allow for a better understanding if this is a real trend or not. Other school services remained at or near their baseline levels. More details can be found in Appendix A, Table D.

Consistent with findings since the J-MHAP pilot evaluation, families experienced fewer emergency room visits (from 43.2% to 18.6%), in-home mobile crisis interventions (from 42.4% to 23.6%), and fewer hospital stays (33.3% to 15.3%), placements in residential treatment (from 17.9% to 8.0%), and use of emergency shelter (2.2% to 0%). There were also decreases in other supports like use of a counselor or family preservation worker, respite care, and social services. The use of self-help groups increased at a significant level. Other services remained the same. Full details are in Appendix A, Table D.

Table 7. Statistically Significant Changes in Service Use	
	School Services
⇧	Special Classroom
⇧	Specialized School
	Outpatient Services
⇩	Emergency Room Visit
⇩	In-home/Mobile Crisis
⇩	Partial Hospitalization or Day Program
⇩	Counselor or Family Preservation Worker
⇩	Respite Care Provider
⇧	Self-help Group
	Inpatient and Overnight Services
⇩	Hospitalization
⇩	Residential Treatment Center
⇩	Emergency Shelter

FAMILY EXPERIENCES OF BARRIERS TO CARE AT FOLLOW-UP

As presented earlier in this report, nearly all families encountered bothersome barriers to accessing care for their child. Following work with MHAP for Kids, there was a significant increase in people no longer experiencing barriers to care (from 2.8% to 10.3%). Additionally, we saw a reduction in barriers like bureaucratic delays, time, and incomplete information which were the top three most commonly experienced barriers at baseline. Table 8 summarizes the change in barriers over time. During our first look at follow-up data through September 2022 there were nine categories of barriers that showed significant change. In this report, our analysis identified eleven categories with significant change. The differences between the two analyses are as follows. Previously, transportation as a barrier saw a drop, where now the change is no longer significant. That is the only category that is no longer showing significance.

Three questions are now showing significant differences at baseline compared with follow-up. There was change in the percent of families responding that barriers impacted their youth's services (94.3% to 87.1%). The remaining categories were related to outplacement or loss of parental rights. In our last report, 17% of families were worried about out of home placement at baseline and at follow-up. In this sample, we saw an increase in families who noted outplacement as a barrier to care before working with MHAP for Kids (24.4%). This decreased to 15.6% at follow-up. Similarly, 15.1% of families identified loss of parental rights as a barrier to care in our last report at baseline and 13.2% at follow-up. In this analysis we found that 20.1% of families noted this as a barrier before working with MHAP for Kids and only 11.0% after their case had closed. These findings are particularly interesting in the context of a smaller proportion of families reported having their child in foster care or a group home at baseline. This likely indicates MHAP for Kids is intervening earlier in youth's trajectories, possibly preventing the need for outplacement among families who view that as a threat or barrier to accessing mental health care for their youth.

The seven remaining categories of barriers did not show a difference. 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. Expanded data collection to those who speak Spanish (the next most commonly spoken language among MHAP for Kids families) may allow us to better understand 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 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 13.1% to 22.6%). 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.

Table 8. Comparison of Family Experience of Barriers at Baseline and Follow-Up

	Bothersome Barrier	Baseline %	Follow-up %	p-value
Significant change	Any Services Affected by Barriers	94.3	87.1	0.041
	Bureaucratic Delay	81.6	62.9	<0.001
	Incomplete Information	65.0	39.6	<0.001
	Time	63.6	55.8	0.047
	Fear, Dislike, or Distrust of Professionals	45.9	34.3	0.003
	Cost	36.0	20.1	<0.001
	Anticipation of Out-of-Home Placement	24.4	15.6	0.006
	Anticipated Loss of Parental Rights	20.1	11.0	0.003
	Child/Parent Refuses Treatment	13.1	22.6	0.002
	Other Barriers	3.2	13.8	<0.001
	No Barriers	2.8	10.3	<0.001
No significant change	Previous Negative Experience	47.7	43.5	0.299
	Service Not Available	42.4	39.2	0.456
	Transportation	32.9	30.4	0.543
	Self-Consciousness	24.7	24.7	1.000
	Anticipation of a Neg Reaction from Others	21.6	24.4	0.456
	Refusal to Treat	19.4	20.1	0.904
	Language	1.1	2.1	0.375

SUMMARY

This report presented data from the first 7.5 years of the MHAP for Kids program. There has been steady expansion and fairly consistent enrollment, particularly following the peak of the COVID-19 pandemic. The youth and families served by the program are younger and more racially and ethnically diverse than those in the pilot, J-MHAP. Further investigation into the data that are missing or unknown will better elucidate demographic trends in MHAP for Kids over time. 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 data continue to show that MHAP for Kids families are living under a great deal of stress. Despite accessing many services even before engaging with a staff attorney, 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. 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.

While much of this report shows a continued pattern of family profiles and impact of the program itself, several things stand out from this analysis. There appears to be a rise in families' experiences of school exclusion and suspension at baseline than we have seen in the past. Along with this increase, we are starting to see a signal of effect that there are significant changes by follow-up. It is important to continue to measure this. Additionally, family prior use of social services at baseline appears to be down, along with youth experiencing group or foster home placements. This is particularly interesting as we also saw an increase in parent perception of loss of parental rights and youth outplacement as more common barriers. Again, this may be another indicator that MHAP for Kids is reaching youth before families are as involved with state systems.

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.

APPENDIX A: DATA TABLES

Table A. MHAP for Kids Demographics

	Demographic	Total	
		%	(n)
Age at Intake			
	Preschool (3-5)	5.8	(189)
	Middle Childhood (6-11)	31.8	(1045)
	Teens (12-17)	48.2	(1582)
	Young Adults (18-23)	2.6	(84)
	Unknown	11.6	(382)
Gender			
	Female	30.8	(1011)
	Male	58.1	(1907)
	Trans	1.5	(50)
	Nonbinary	1.0	(34)
	Unknown/Missing	8.5	(280)
Ethnicity			
	White	37.1	(1216)
	Latinx/Hispapnic	24.9	(817)
	Black	11.6	(381)
	Asian	2.1	(69)
	Biracial	13.3	(435)
	Native American	0.5	(16)
	Mising/DK/Ref	10.6	(348)
Participant Language			
	English Only	75.1	(2463)
	English + Other	1.4	(45)
	Spanish	8.4	(274)
	English + Spanish	1.8	(58)
	Other Only	2.7	(88)
	Unknown/Missing	10.8	(354)

Table B. Referral Sources for MHAP for Kids

		%	(n)
Referral Source			
	Court/Legal System	11.2	(369)
	Healthcare Organization	27.1	(888)
	Community Organization	15.3	(503)
	State Agency	4.5	(148)
	Family Resource Center	10.7	(352)
	HLA	2.4	(80)
	Client	2.1	(69)
	Previous MHAP Client	9.1	(300)
	School District	1.1	(35)
	Word of Mouth	11.2	(369)
	Unknown/Missing	5.2	(169)

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)	9.2 (6.1)	2.4 (2.8)	2.4	Higher scores indicate more negative perceptions.
Parent Mental Health				
Parent Stress ➢ Perceived Stress Scale	20.8 (7.5)	13.0 (6.4)	1.2	Higher scores indicate more stress.
Parental Depression ➢ Center for Epidemiological Studies Depression Scale (CES-D)	22.0 (13.0)	9.3 (8.6)	1.5	Higher scores indicate greater depression symptoms.
At least mild depression (CES-D ≥ 16)	65.7%	19%	n/a	≥ 16 indicates any depression.

Table D. Comparison of School Engagement and Services at Baseline and Follow-up					
		Total	**Baseline**	**Follow-up**	
		(n)	**%**	**%**	**p-value**
Attending School		(283)			0.484
	No		12.0	9.5	
	Yes, full time		85.5	87.6	
	Yes, part time		2.5	2.8	
Special Class for Children with Learning Problems		(264)	52.3	53.4	0.841
Special Class for Children with Behavioral Problems		(250)	32.4	38.8	0.113
Special Class for Children with Emotional Problems		(247)	30.0	42.1	0.003
Special School for Children whose Problems Cannot be Handled by Regular School		(276)	21.5	30.9	<0.001
Individual Psychological Counseling or Therapy Delivered in School		(264)	56.8	60.2	0.407
Medications for Concentration, Behavior, or Emotional Problems Taken at School		(271)	21.0	21.4	0.903
Suspended in Previous 12/6 Months		(178)	29.8	22.5	0.060
Sent Home for Behavior in Previous 12/6 Months		(181)	29.8	22.1	0.098

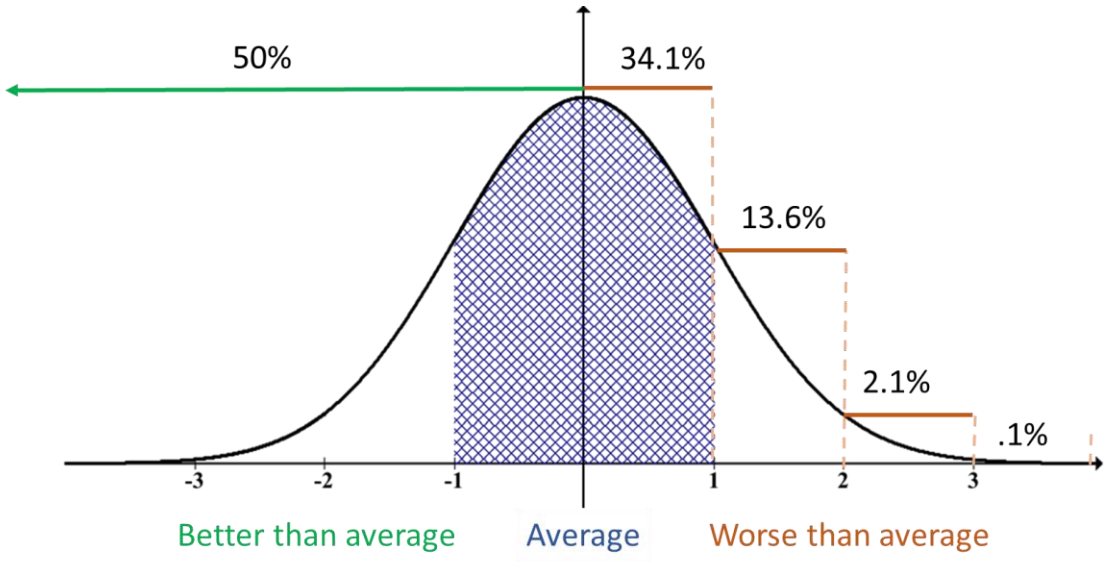
Table E. Comparison of Mental Health Service Utilization at Baseline and Follow-Up				
	Total (n)	Baseline %	Follow-up %	p-value
Outpatient Services				
Telephone Hotline	(276)	14.1	13.4	0.892
Self-help Group	(268)	6.7	12.7	0.023
Community Mental Health Center or Outpatient Mental Health Clinic	(274)	34.7	31.8	0.516
Mental Health Professional	(283)	78.5	76.8	0.640
Emergency Room	(283)	43.2	18.6	<0.001
In-home Crisis Services	(276)	42.4	23.6	<0.001
Pediatrician or Family Doctor	(281)	35.2	39.5	0.331
Partial Hospitalization or Day Treatment Program	(283)	25.7	11.3	<0.001
Drug or Alcohol Clinic	(283)	0.70	0.40	1.0000
Counselor or Family Preservation Worker	(279)	44.4	25.8	<0.001
Probation or Juvenile Corrections Officer	(283)	14.0	10.9	0.188
Spiritual Advisor	(283)	5.6	8.0	0.265
Respite Care Provider	(279)	6.1	2.2	0.027
Any Other Kind of Healer	(283)	3.3	0.7	0.2188
An Educational Tutor at Home	(282)	11.4	8.5	0.230
A Mentor	(276)	36.2	34.4	0.688
Social Services	(276)	29.4	22.5	0.061
Inpatient Services				
Hospital	(282)	33.3	15.3	<0.001
Drug or Alcohol Treatment Unit		sup	sup	n/a
Residential Treatment Center	(274)	17.9	8.0	<0.001
Group Home	(273)	3.7	3.7	1.000
Foster Home	(270)	3.7	1.5	0.179
Detention Center, Prison, or Jail	(273)	1.5	2.6	0.508
Emergency Shelter	(271)	2.2	0.0	0.031

Table F. Description of Barriers from Child and Adolescent Services Assessment[6]	
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	Baseline			Follow-up			
		(n)	%	$\bar{x}$	(sd)	%	$\bar{x}$	(sd)	p-value
Strengths and Difficulties Questionnaire									
Total Difficulties		(292)							<0.001
	Normal		14.0			24.0			
	Borderline		5.1			16.1			
	Abnormal		80.8			59.9			
Emotional Symptoms		(294)							<0.001
	Normal		23.1			37.4			
	Borderline		11.9			9.9			
	Abnormal		65.0			52.7			
Conduct Problems		(294)							<0.001
	Normal		32.0			44.2			
	Borderline		15.0			15.3			
	Abnormal		53.1			40.5			
Hyperactivity - Inattention		(294)							<0.001
	Normal		22.5			39.1			
	Borderline		9.9			11.9			
	Abnormal		67.7			49.0			
Peer Problems		(292)							0.0001
	Normal		20.9			26.4			
	Borderline		12.3			21.6			
	Abnormal		66.8			52.1			
Prosocial Behavior		(292)							0.049
	Normal		58.6			64.4			
	Borderline		14.0			16.1			
	Abnormal		27.4			19.5			
Parent Functioning									
Parental Stress Scale		(280)		20.8	(7.5)		17.3	7.9	<0.001
CES-D Depressive Symptoms		(262)		22.0	(13.0)		17.7	12.6	<0.001
	Clinical Cutoff(>=16)	(262)	65.7			52.7			<0.001
	Clinical Cutoff(>=27)	(262)	37.0			27.1			0.005
Family Functioning									
Conflict Behav. Questionnaire		(215)		9.2	(6.1)		7.2	(6.0)	<0.001
Child's problem- family income		(276)	59.4			42.8			<0.001
Child's prob impacting paid work		(82)							0.822
	No		6.1			4.9			
	Time lost, hrs reduced		35.4			41.5			
	Can't work, lost job		58.5			53.7			
Child Health									
Physical Health		(272)		7.7	(2.2)		8.0	(1.9)	0.021
Mental Health		(242)		5.0	(2.2)		5.9	(1.8)	<0.001

APPENDIX B: DATA FIGURES

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



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