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The School-Based Telebehavioral Health Pilot Project

Needs Assessment Report

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Introduction

The Brookline Center for Community Mental Health (BCCMH), in collaboration with the Massachusetts Department of Public Health's (MDPH) Division of Child/Adolescent and Reproductive Health, contracted with the Schneider Institutes for Health Policy and Research within the Heller School for Social Policy and Management at Brandeis University to evaluate a school-based telebehavioral health pilot initiative. The evaluation aims to understand the feasibility of implementing telebehavioral health services for students and families within school districts, identify key elements needed for successful implementation, and study the effectiveness of those services. This report contains the method and results of a preliminary needs assessment to identify the first cohort of school districts to partner on this initiative.

Background

Mental health issues have been well documented among school-aged children even prior to the COVID-19 pandemic. It is estimated that over 20% of all Massachusetts children aged 0-17 have a mental health disorder, and approximately half of all children with a mental health disorder do not receive formal care (Whitney & Peterson, 2019). Youth ages 11-17 have been found to be more likely to suffer from moderate to severe symptoms of anxiety and depression than any other age group (Mental Health America, 2021). Depression and suicidality among children and adolescents continue to be grave concerns, with over 1 in 3 Massachusetts youth reporting depressive symptoms in the past year and almost 1 in 5 seriously considering suicide (CDC, 2019). Additionally, the pandemic has exacerbated mental health issues for youth. A review of longitudinal studies on the effects of isolation during the pandemic indicates that there are detrimental effects on youth mental health (i.e., mood disorder, anxiety, attention-deficit hyperactivity disorder, and eating disorder) (Chadi et al., 2022).

Although mental health issues can affect youth of all groups, there are marked inequities in the burden of disease, namely among racial/ethnic minority and LGBTQ+ students. According to the 2019 Youth Risk Behavior Surveillance Survey (YRBSS), Hispanic/Latino students in Massachusetts reported elevated feelings of being sad or hopeless as compared to all youth. Asian and Hispanic/Latino students were almost twice as likely to report having attempted suicide than to White students (10.9% and 10.8%, respectively, compared to 5.7%). LGBTQ+ youth reported the highest rates of suicidal ideation and attempts (CDC, 2019). Nationally, there are also significant disparities between the mental health of Black youth and their White counterparts. The rate of suicide attempts rose significantly for Black youth from 1991-2017 while their White peers experienced significant decreases in attempts during the same period (Lindsey et al., 2019). Additionally, research has shown that behavioral health problems among racial and ethnic minority youth often leads to school punishment or even incarceration, but rarely leads to mental health care intervention (Marrast et al., 2016).

Despite the demonstrated need for behavioral health services tailored to school-aged youth in Massachusetts, there is a significant lack of access for many students. According to a 2021 survey by Mental Health America, Massachusetts ranked 39th out of 50 states in terms of youth with major depressive episodes who did not receive mental health services in the past year (61.2% of youth compared to 59.6% national average), indicating that many youths went

without care for their mental health. Although the survey found that the majority of Massachusetts youth have insurance coverage for their mental health needs, there are significant barriers to access services for school-aged youth (Mental Health America, 2021). These barriers, ranging from limited insurance coverage to lack of available treatment types, are more pronounced for youth of color and LGBTQ+ youth (Marrast et al., 2016; The Trevor Project, 2020).

One of the most impactful ways to increase access to behavioral health services for youth is to use telehealth methods in the educational setting. School-based telehealth is meant to expand access to doctors and other providers for students while reducing the time away from their course lessons (HHS, n.d., a). Telebehavioral health services can be a tool that can be accessed almost immediately in a crisis during school time and potentially divert students from disciplinary action (HHS, n.d., b). School-based telebehavioral health services have been found to be as effective as in-person appointments and parents, students, school clinicians, and psychiatrists have been highly satisfied with the intervention (Mayworm et al., 2020).

Since the start of the COVID-19 pandemic, telehealth services have played a critical role for maintaining the health of both patients and providers. At the same time, it required all involved to adjust to a newer method of delivering and receiving care. Youth in particular have been quick to adapt to this new framework of healthcare delivery because of their familiarity with technology and engagement with social media (Neavel et al., 2022). Therefore, by expanding the use of telebehavioral health services in Massachusetts schools, the Commonwealth has an opportunity to address the rising rates of mental health and substance use disorders among youth as well as reduce the high rates of youth who do not have access to care.

Purpose of Needs Assessment

The purpose of the preliminary needs assessment was to inform the identification of potential school districts across the Commonwealth of Massachusetts in which telebehavioral health services in school-based settings would be most appropriate and feasible. While the initiative focuses on providing services to school districts with relatively high need and low resources, the project also has a strong emphasis on addressing racial injustice and inequities in the service delivery system. The intent of the project evaluation is to study the feasibility and effectiveness of telebehavioral health services in school-based settings for potential widespread replication across the Commonwealth. The study will also focus on identifying key elements necessary for successful implementation.

To maximize innovation and apply lessons learned, three cohorts are planned for the pilot project, consisting of eight to 10 districts per cohort. Each cohort is expected to be diverse in school characteristics (e.g., school type, size, and geographic location). The first cohort will be conducted with a mix of school districts that may include both charter and non-charter schools, vary in student demographics and population size, and have community level indicators for high behavioral health needs (e.g., impacts from COVID-19 and drug overdose).

This report describes the methods, data sources, and list of school districts identified as having high-need for behavioral health services. This preliminary needs assessment is intended

to inform the final selection for the first cohort of school districts that will implement school-based telebehavioral health services for students.

Methods

The evaluation team participated in regular communications with staff at the BCCMH and the Massachusetts Department of Public Health (MDPH) who helped refine the inclusion and exclusion criteria to determine the list of potential school districts. The analyses to identify school districts with relatively high need for behavioral health services and limited resources were based on information from key informants (i.e., Interagency Work Group (IWG) members, the University of Massachusetts Behavioral Health Integrated Resources for Children (BIRCh) Project Director), and publicly available data. Data were available for a total of 400 school districts across Massachusetts. The needs assessment analysis was conducted in two parts: first, with 318 non-charter school (including vocational technical schools) and second, with 82 public charter and specialty schools (i.e., online and STEM focused schools).

The analysis consisted of five key indicators on which each of the school districts could be scored: 1) community mental health status, 2) child opportunity, 3) school needs, 4) race/ethnicity, and 5) school district resources (see Data Sources for more information). These five indicators were chosen based on previous literature on telebehavioral health, behavioral health needs, and available data. These indicators were drawn from data available through the Behavioral Risk Factor Surveillance System (BRFSS), Brandeis' Institute for Child, Youth, and Family Policy's Child Opportunity Index (COI), MA Department of Elementary and Secondary Education (DESE), and the University of Massachusetts BIRCh Project.

The analyses included four models using varying weights on the key indicators. The findings presented are based on equal weights because all four models returned similar lists of schools with the same top 14 school districts. Consequently, the decision was made to weight all five indicators equally for the assessment. Therefore, the top 10% of school districts were coded "1" for measures on poor mental health status, students with high needs, and students of color; schools identified by the BIRCh Project with high need/low resource were coded "1"; and the bottom 10% of school districts with the lowest COI were coded as "1."

Exclusion criteria was also considered when compiling the list of school districts. To ensure that each school could maximize the benefit of a school-based telebehavioral health program, the district-level population threshold was set to a minimum of 500 students. Additionally, to reach the target demographic for this initiative, selected school districts were required to serve middle and/or high school students. Therefore, districts that were listed as consisting of elementary schools only were excluded. Through these two exclusion criteria, four non-charter districts and three charter school districts were removed from the list of identified school districts.

Additional data were explored as descriptors alongside the five main indicators. These descriptors include geographic rurality, community's broadband access, community impact of COVID-19, school district's dropout rate, receivership status, and the number of other projects and/or commitments that the school or district has for the upcoming year. While these

descriptors were not used for the creation of the priority list of school districts, they will be considered when selecting the final list of schools with which to conduct the telebehavioral health pilot project.

Data Sources

The following data sources were used as the indicators in the needs assessment.

Table 1. (See Appendices B-D for more information on sources)

| Indicator | Source | Summary |
|---------------------------------|--|---|
| Community mental health status* | CDC BRFS | Percent of adults reporting 14+ days of poor mental health in past 30 days; provides profile of health among MA adults, reported at the zip code level |
| Child opportunity | COI 2.0 | Includes 29 variables scored as an index score of childhood health across three domains of education, health and environment, and social and economic factors |
| School needs | DESE High Needs | A student is considered high needs if they are designated as either low income (prior to 2015 and 2022-present), economically disadvantaged (2015-2021), English Learner (EL)/former EL, or a student with disabilities |
| Race/ethnicity | DESE Students of Color | Using enrollment by race/ethnicity, measure of percentage of all except white students. Includes African American or Black, Asian, Hispanic or Latino, Multi-race, Native American, or Native Hawaiian or Other Pacific Islander |
| School district resources | BIRCh High Needs (Tech Report) | 26 school districts considered to be high need and low resources based on mental / behavioral health staff to student ratio, percentage of "economically disadvantaged students," and access to school-based supports provided through DESE grants. NOTE: Only available for non-charter schools. |

*Note: Data on youth mental health status was only available at the state level therefore community level mental health status was used as a proxy measure.

Results: Identified School Districts

Using the five key indicators (community mental health status, child opportunity, school needs, race/ ethnicity, and school district resources) and the intention for equitable opportunities, 38 non-charter (Table 2A) and 5 charter (Table 2B) school districts located in 13 of the 14 counties were identified for the first cohort consideration. There was no school district in Duker County that met the needs assessment indicators. The list spans both rural and urban areas and includes regional vocational school districts. Additional information is provided on student population size, grade levels served, and the type of school-based health center in each district, if applicable.

Table 2A: Identified Non-Charter School Districts¹ Ranked by Full Weight Model

| | District | Needs Score | District Type ² | Enrollment | Grades Served | SBHC ³ | County |
|----|--|-------------|----------------------------|------------|---------------|-------------------|-----------|
| 1 | Boston | 5 | M | 46,169 | PK-12 | 2 | Suffolk |
| 2 | Brockton | 5 | M | 15,265 | PK-12 | 0 | Plymouth |
| 3 | Fall River | 5 | M | 10,268 | PK-12 | 0 | Bristol |
| 4 | Springfield | 5 | M | 23,799 | PK-12 | 5 | Hampden |
| 5 | Worcester | 5 | M | 23,735 | PK-12 | 2 | Worcester |
| 6 | Chelsea | 4 | M | 6,074 | PK-12 | 1 | Suffolk |
| 7 | Everett | 4 | M | 6,813 | PK-12 | 0 | Middlesex |
| 8 | Holyoke* | 4 | M | 5,102 | PK-12 | 2 | Hampden |
| 9 | Lawrence* | 4 | M | 12,786 | PK-12 | 1 | Essex |
| 10 | Lowell | 4 | M | 13,991 | PK-12 | 1 | Middlesex |
| 11 | Lynn | 4 | M | 15,727 | PK-12 | 2 | Essex |
| 12 | New Bedford | 4 | M | 12,504 | PK-12 | 0 | Bristol |
| 13 | North Adams ^R | 4 | M | 1,257 | PK-12 | 0 | Berkshire |
| 14 | Revere | 4 | M | 7,141 | PK-12 | 1 | Suffolk |
| 15 | Fitchburg | 3 | M | 5,187 | PK-12 | 3 | Worcester |
| 16 | Malden | 3 | M | 6,101 | PK-12 | 3 | Middlesex |
| 17 | Pittsfield | 3 | M | 4,953 | PK-12 | 0 | Berkshire |
| 18 | Southbridge* | 3 | M | 1,805 | PK-12 | 0 | Worcester |
| 19 | Webster | 3 | M | 1,697 | PK-12 | 4 | Worcester |
| 20 | Athol-Royalston ^R | 2 | R | 1,539 | PK-12 | 0 | Worcester |
| 21 | Ayer Shirley School District ^R | 2 | R | 1,622 | PK-12 | 0 | Middlesex |
| 22 | Framingham | 2 | M | 8,824 | PK-12 | 3 | Middlesex |
| 23 | Gardner | 2 | M | 2,251 | PK-12 | 0 | Worcester |
| 24 | Greater Fall River Regional Vocational Technical | 2 | RV | 1,421 | 9-12 | 0 | Bristol |
| 25 | Greater Lawrence Regional Vocational Technical | 2 | RV | 1,655 | 9-12 | 0 | Essex |

| | | | | | | | |
|----|--|---|----|-------|-------|---|------------|
| 26 | Greater New Bedford Regional Vocational Technical | 2 | RV | 2,110 | 9-12 | 0 | Bristol |
| 27 | Haverhill | 2 | M | 7,738 | PK-12 | 0 | Essex |
| 28 | Marlborough | 2 | M | 4,643 | PK-12 | 0 | Middlesex |
| 29 | Nantucket ^R | 2 | M | 1,672 | PK-12 | 0 | Nantucket |
| 30 | Northern Berkshire Regional Vocational Technical (North Adams) | 2 | RV | 523 | 9-12 | 0 | Berkshire |
| 31 | Randolph | 2 | M | 2,571 | PK-12 | 0 | Norfolk |
| 32 | Salem | 2 | M | 3,665 | PK-12 | 0 | Essex |
| 33 | South Hadley | 2 | M | 1,763 | PK-12 | 0 | Hampshire |
| 34 | Ware ^R | 2 | M | 1,124 | PK-12 | 0 | Hampshire |
| 35 | Wareham | 2 | M | 2,043 | PK-12 | 0 | Plymouth |
| 36 | Barnstable | 1 | M | 4,751 | PK-12 | 0 | Barnstable |
| 37 | Franklin County Regional Vocational Technical | 1 | RV | 583 | 9-12 | 0 | Franklin |
| 38 | Gill-Montague | 1 | R | 845 | PK-12 | 0 | Franklin |

Table 2B: Identified Charter School Districts¹ Ranked by Full Weight Model

| | District | Needs Score | District Type ² | Enrollment | Grades Served | County |
|---|---|-------------|----------------------------|------------|---------------|---------|
| 1 | Global Learning Charter Public | 2 | CH | 504 | 05-12 | Bristol |
| 2 | Alma del Mar Charter School | 2 | CH | 944 | K-08 | Bristol |
| 3 | Roxbury Preparatory Charter | 2 | CH | 1521 | 05-12 | Suffolk |
| 4 | Lawrence Family Development Charter | 2 | CH | 796 | PK-08 | Essex |
| 5 | UP Academy Charter School of Dorchester | 2 | CH | 653 | PK-08 | Suffolk |

Notations:

1. **Eligibility:** Identified school districts must serve 500+ students and offer middle and/or high school grades
2. **District Type:** Municipal, Regional, Regional Vocational, **CH**arter
3. **SBHC** (School Based Health Centers): **0** = no SBHCs in district; **1** = DPH funded, 1 high school only; **2** = DPH funded, multiple schools; **3** = Not DPH funded, 1 high school only; **4** = Not DPH funded, 1 middle school only; **5** = Not DPH funded, multiple schools (note: information not available for charter schools)

* **In Receivership**

^R **Rural**

=== Districts in lines 36-38 of Table 2A had a needs score of "1" but are included for county representation.

Next Steps

The lists containing a total of 43 school districts (38 non-charter and 5 charter) are intended for the BCCMH staff and collaborating partners to further assess for district's willingness, readiness, and capacity to participate in the first cohort for the telebehavioral health pilot program using pre-established measures of readiness assessment.

Concurrently, the Brandeis evaluation team will continue to track, monitor, and analyze additional data of interest for future cohort determination. The evaluation team will also develop the implementation and outcomes evaluation plans. The implementation evaluation will be designed to understand the feasibility of implementing telebehavioral health services within school districts and the key elements needed for successful implementation. The study will seek to understand the attitudes and behaviors of school professionals and support staff, including those in school-based health centers, as well as those of the students and family members in need of services. It will also seek to learn about the role of school administrators and school committee members in influencing the adoption, implementation, and sustainability of the telebehavioral health services. Overall, the aim will be to describe the implementation of this intervention and to identify the behaviors, strategies, and characteristics of school systems that support and impede the use of telebehavioral health services to improve students' health outcomes and to better address health disparities. Finally, the outcomes evaluation plan will identify proximal and distal outcomes based on feasible data access (e.g., school attendance and behavioral health assessments) and stakeholders' input that can be used in future phases of this initiative.

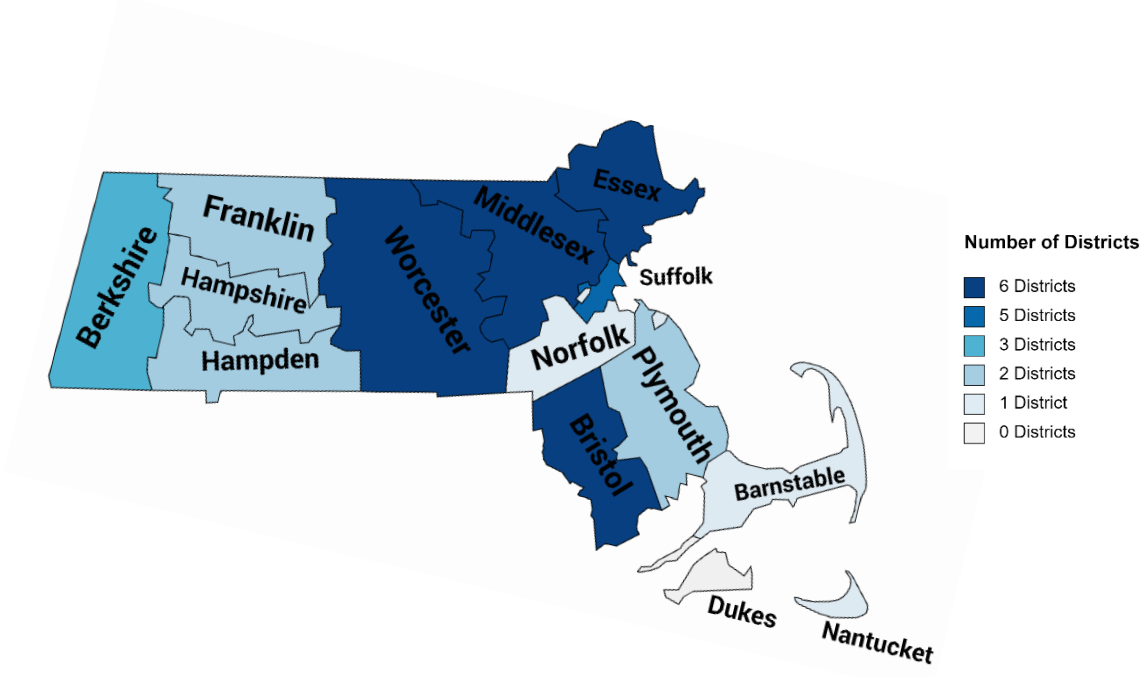
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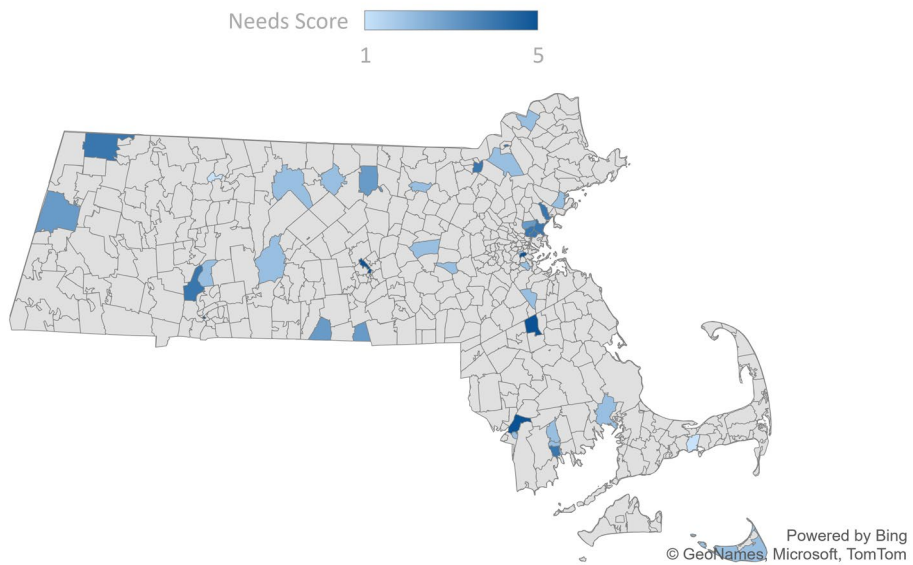
Appendices

Appendix A: Maps of School Districts

Identified School Districts (Charter and Non-Charter) by County (n=43)



Identified School Districts (Charter and Non-Charter) by Zipcode (n=43)



Appendix B: Full List of Child Opportunity Index (COI) Indicators

Education

Early Childhood Education (ECE)

ECE centers within five miles
 High quality ECE centers within five miles
 ECE enrollment

Primary School

Third grade reading proficiency
 Third grade math proficiency

Secondary and post-secondary

High school graduation rates
 AP enrollment
 College access / enrollment

Resources

School poverty
 Teacher experience
 Adult educational attainment

Health and Environment

Healthy Environments

Access to healthy food
 Access to green space
 Walkability
 Housing vacancy rates

Toxic Exposures

Superfund sites
 Industrial pollutants
 Micropollutants
 Ozone

Heat

Health care access

Health insurance access

Social and Economic

Economic Opportunities

Employment rate
 Commute duration

Economic resource index

Poverty rate, public assistance rate, high skill employment, median household income, home ownership

Family structure

Single parenthood

Source: Noelke, C., McArdle, N., Baek, M., Huntington, N., Huber, R., Hardy, E., & Acevedo-Garcia, D. (2020). Child Opportunity Index 2.0 Technical Documentation.

For more information: <https://www.diversitydatakids.org/child-opportunity-index>.

Appendix C: MA Department of Elementary and Secondary Education (DESE) Definitions

High Needs: Calculated based on the number of high need students, divided by the adjusted enrollment. A student is high needs if he or she is designated as either low income (prior to 2015, and from 2022 to present), economically disadvantaged (from 2015-2021), English learner (EL)/former English learner, or a student with disabilities. A former EL student is a student who is not currently an EL but had been at some point in the four previous academic years.

Low-income (prior to 2015): Indicates the percent of enrollment who meet ANY ONE of the following definitions of Low-income:

- The student is eligible for free or reduced-price lunch, or
- The student receives Transitional Aid to Families benefits; or
- The student is eligible for food stamps

Economically Disadvantaged (2015-2021): Calculated based on a student's participation in one or more of the following state-administered programs:

- The Supplemental Nutrition Assistance Program (SNAP)
- The Transitional Assistance for Families with Dependent Children (TAFDC)
- The Department of Children and Families' foster care program
- MassHealth (Medicaid)

Low-income (2022 to present): Calculated based on a student's participation in one or more of the following state-administered programs:

- The Supplemental Nutrition Assistance Program (SNAP)
- The Transitional Assistance for Families with Dependent Children (TAFDC)
- The department of Children and Families' (DCF) foster care program
- Expanded MassHealth (Medicaid) up to 185% of the federal poverty line

As well as students identified by the districts as homeless and students the district confirmed had met the low-income criteria through the supplemental process and collected the required supporting documentation.

English Learners: Indicates the percent of enrollment who are English learners, defined as "a student whose first language is a language other than English who is unable to perform ordinary classroom work in English."

Students with Disabilities: Indicates the percent of enrollment who have an Individualized Education Plan (IEP).

Enrollment by Race/Ethnicity:

- **African American or Black:** A person having origins in any of the black racial groups of Africa
- **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent
- **Hispanic or Latino:** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race
- **Multi-race, Non-Hispanic:** A person selecting more than one racial category and non-Hispanic
- **Native American:** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment
- **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

Appendix D: Behavioral Health Integrated Resources for Children (BIRCh) Project Technical Report Definitions

| Staffing Ratios & Student Economic Need |
|---|
| School Counselor (PreK-8; 5-12) |
| School Social Worker / School Adjustment Counselor (All levels) |
| School Psychologist (All levels) |
| School Nurse (All levels) |

| State and Regional Resources | Funding Agency |
|---|--|
| Safe and Supportive Schools Grant Programs (SaSS) | DESE |
| Improving Student Access to Behavioral and Mental Health Services | DESE |
| PBIS Academy | DESE & UConn Center for Education and Research |
| Systemic Student Support Academy (S3) | DESE & Boston College's Center for Optimized Student Support & Rennie Center for Education and Research Policy |
| SEL / MH Academy | DESE & Education Development Center & Transforming Education |

| High Need Districts | | | |
|----------------------------|--------------|-------------|--------------|
| Webster | Everett | Florida | Holyoke |
| Chelsea | Boston | Attleboro | Haverhill |
| Ware | Lynn | North Adams | Sunderland |
| Worcester | Brockton | Revere | Lowell |
| Rowe | Monomoy | Lawrence | Ayer-Shirley |
| Fall River | Springfield | Orange | Narragansett |
| Malden | South Hadley | | |

Source: Pearrow, M., Berkman, T., Walker, W., Gordon, K., Whitcomb, S., Scottron, B., Kurtz, K., Priest, A., & Hall, A. (2020). *Behavioral health capacity of Massachusetts public school districts: Technical report*. https://www.umb.edu/birch/research_evaluation

Appendix E: Prioritized Communities for COVID-19 Response in MA

From March 3, 2021 to July 30, 2021, the MDPH deemed 20 communities in the Commonwealth as “priorities” for COVID-19 vaccine distribution. This designation was based on the towns and cities that were hardest hit by COVID-19, as well as social determinants of health and the disproportionate impact of COVID-19 on Black, Indigenous, and People of Color (BIPOC).

Below are the 20 priority communities and their overlap with the identified school districts in the needs assessment.

| Community | In SBTBH Needs Assessment? | Community | In SBTBH Needs Assessment? |
|------------|----------------------------|-------------|----------------------------|
| Boston | Yes | Malden | Yes |
| Brockton | Yes | Methuen | No |
| Chelsea | Yes | New Bedford | Yes |
| Everett | Yes | Randolph | Yes |
| Fall River | Yes | Revere | Yes |
| Fitchburg | Yes | Springfield | Yes |
| Framingham | Yes | Worcester | Yes |
| Haverhill | Yes | | |
| Holyoke | Yes | | |
| Lawrence | Yes | | |
| Leominster | No | | |
| Lowell | Yes | | |
| Lynn | Yes | | |

SBTBH=School-based Telebehavioral Health

Source: Massachusetts Department of Public Health. <https://www.mass.gov/info-details/covid-19-vaccine-equity-initiative#:~:text=20%20prioritized%20communities,-The%20%20%20cities&text=The%20communities%20are%3A%20Boston%2C%20Brockton,Revere%2C%20Springfield%2C%20and%20Worcester.>

Appendix F: Exclusion Criteria and List of Excluded Districts

The following school districts were excluded from the final list although they had high needs scores due to the following reasons: 1 = serving fewer than 500 students or 2 = serving only elementary age students

| District | Needs Score | District Type ² | Enrollment | Grades Served | County | Exclusion Reason |
|--|-------------|----------------------------|------------|---------------|-----------|------------------|
| Amherst | 2 | M | 1,053 | PK-6 | Hampshire | 2 |
| Clarksburg ^R | 2 | M | 211 | PK-8 | Berkshire | 1 |
| Florida (Monroe) ^R | 3 | M | 104 | PK-8 | Berkshire | 1 |
| Orange ^R | 2 | M | 536 | PK-6 | Franklin | 2 |
| Phoenix Academy Public Charter High School Springfield | 3 | CH | 175 | 9-12 | Hampden | 1 |
| Phoenix Academy Public Charter High School Lawrence | 2 | CH | 138 | 9-12 | Essex | 1 |
| Libertas Academy Charter School | 2 | CH | 332 | 6-12 | Hampden | 1 |

^R Rural

Appendix G: Glossary

| | |
|--------------|--|
| BCCMH | Brookline Center for Community Mental Health |
| BIPOC | Black, Indigenous, and People of Color |
| BIRCh | Behavioral Health Resources for Children |
| BRFSS | Behavioral Risk Factor Surveillance Survey |
| COI | Child Opportunity Index |
| DESE | Department of Elementary and Secondary Education |
| IWG | Interagency Work Group |
| MDPH | Massachusetts Department of Public Health |
| YRBSS | Youth Risk Behavior Surveillance Survey |

Appendix H: List of Inter-Agency Work Group (IWG) Members

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|---------------------------|---|
| Jill Clark | Director, Division of Child/Adolescent Health and Reproductive Health, Bureau of Community Health and Prevention, MA Department of Public Health |
| Máireád Day Lopes | Director, School-Based Health Center Program, MA Department of Public Health |
| Jill Northrup | Assistant Director, School-Based Health Center Program, MA Department of Public Health |
| Beth Beatriz | Director of Data and Statistics, Division of Child/Adolescent Health and Reproductive Health, Bureau of Community Health and Prevention, MA Department of Public Health |
| Yves Singletary | Senior Advisor to the Commissioner, MA Department of Public Health |
| Brian Jenny | Director, Office of Youth & Young Adult Services, Bureau of Substance Addiction Services, MA Department of Public Health |
| Rebecca Butler | Assistant Director, Office of Youth & Young Adult Services, Bureau of Substance Addiction Services, MA Department of Public Health |
| Vanna Souksavath | MA Statewide A-CRA Trainer, Office of Youth & Young Adult Services, Bureau of Substance Addiction Services, MA Department of Public Health |
| Justine Egan | Epidemiologist, Division of Child/Adolescent Health and Reproductive Health, MA Department of Public Health |
| Karen Robitaille | Director, School Health Unit, Bureau of Community Health and Prevention, MA Department of Public Health |
| Dr. Estevan Garcia | Chief Medical Officer, MA Department of Public Health |
| Anne Gilligan | Safe and Healthy Schools Coordinator, Department of Elementary and Secondary Education |
| Margot Tracy | Manager, School Based Medicaid and Cross Agency Initiatives, MassHealth Office of Behavioral Health |
| Mi-Haita James | CYVPU Director, MassHealth Office of Behavioral Health |
| Melissa Threadgill | Director of Strategic Innovation, Office of the Child Advocate |