The MA School-Based Telebehavioral Health Pilot

2025 ANNUAL REPORT

the brookline center
SCHOOL-BASED TELEBEHAVIORAL HEALTH

Brandeis | THE HELLER SCHOOL FOR SOCIAL POLICY AND MANAGEMENT

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I. Executive Summary

The Massachusetts Department of Public Health (MDPH) has partnered with the Brookline Center for Community Mental Health (BCCMH) to implement the School-Based Telebehavioral Health (SBTBH) Pilot Program to address the youth behavioral health crisis in the Commonwealth. This initiative aims to leverage technology, advance workforce training, and foster collaboration between schools and behavioral health providers, with an emphasis on serving students most in need. The pilot project was launched on October 1, 2021, and has concluded its fourth fiscal year (FY).[1] The goals of the SBTBH Pilot are to:

- Expand access to mental health and substance use services for school-age youth,
- Evaluate the impact of services and capture any needed adaptations, and
- Demonstrate feasibility for statewide replication, including pathways to financially sustain school telebehavioral health (TBH) service delivery and other elements necessary for success in schools.

As the lead implementation vendor, BCCMH is tasked with:

- Designing a pilot program after conducting a thorough needs assessment and investigation of past successful projects,
- Implementing the pilot program, including site selection, funding, and support to sites to achieve sustainability in the provision of services,
- Providing a rigorous evaluation of the program, and
- Producing a replication guide to support further expansion of school TBH across the Commonwealth.

During FY25, there were 22 participating districts and schools – 18 public school districts, two regional vocational technical schools, one charter school, and one Boston Public School. Together, the pilot enabled 2,280 referrals for students to receive SBTBH services, resulting in 1,266 completed intakes and 18,693 telebehavioral health sessions. Since the pilot began providing direct services to students in July 2022, over 2,400 students have received TBH services.

Implementation and outcomes data show that services are having a positive impact:

- The pilot offered over 60 free training opportunities to providers, school personnel, and other stakeholders during FY25.
- Students' scores on scales of depression (PHQ-9) and anxiety (GAD-7) were significantly lower at discharge than intake, across all providers.
- The pilot's focus on Social Determinants of Health supported providers in making over 1,050 referrals for additional services in FY25.

[1] The report uses the term "fiscal year," which covers July 1 through June 30.

- Students at participating school sites with in-person Community Health Workers (CHWs) had a lower session no-show rate (9%) than those sites without a CHW (15%), suggesting the importance of this role in service uptake.
- The majority of youth and caregiver survey respondents (85%) reported being satisfied with TBH services.
- District personnel who were interviewed about their feedback on the SBTBH pilot praised the initiative for increasing access, particularly for students facing language, transportation, privacy, or insurance barriers, and for helping to reduce stigma around mental health issues among students and staff.

During FY25, the pilot's evaluation incorporated new data from school districts, providing additional information on the characteristics of pilot participating students and a baseline on indicators of school engagement (i.e., attendance, academic performance, and disciplinary actions). These data showed that:

- Students from high-priority groups (e.g., BIPOC students, LGBTQ+ students) were referred for TBH services at higher rates than their overall percentage in participating schools and districts.
- Students from low-income households, those in foster care, and students with a disability were referred to the pilot at higher rates than their overall prevalence in Massachusetts.
- Referred students had higher rates of school discipline and absenteeism than the Massachusetts average.

Findings indicate that, overall, the SBTBH pilot is meeting its goal to increase access to behavioral health care for students in high-priority groups and to enhance workforce capacity to provide culturally resonant and affirming care. Behavioral health services for youth continue to be in high demand, emphasizing the need for the expansion of pilot services. Important priorities for the upcoming fiscal year will be to continue building partnerships between school districts and Community Behavioral Health Centers (CBHCs) to ensure sustainable services and to conduct additional analyses including data submitted by school districts to begin to monitor student outcomes.

The SBTBH Pilot projects planned for Fiscal Year 2026 include:

- Initiate services with three new school districts and one new provider organization.
- Launch a new care pathway for students with substance use challenges.
- Implement a Youth Advisory Board to center student voice and promote a participatory role for students in the pilot.
- Finalize a Financial Sustainability Framework aimed at maximizing reimbursement, securing new funding streams, setting district-based referral targets, and expanding to new pilot sites.
- Update the Needs Assessment to ensure the pilot is reaching the highest-priority districts.

- Ensure integration of Culturally and Linguistically Appropriate Services (CLAS) Standards and Community Health Equity Initiative (CHEI) data into processes across the project.
- Formalize SBTBH workflows under all models to clarify referral criteria, referral process, wraparound support, and expected service location and duration.
- Set benchmarks and targets for future implementation using data collected across the previous pilot years to drive quality improvement goals.

II. Background of Behavioral Health Issues Among Youth

Youth mental health challenges are well documented as a leading cause of disability and poor life outcomes (CDC, 2024; McGorry et al., 2025), with about 1 in 4 children (27.7%) ages 3 to 17 in the U.S. having a reported mental, emotional, developmental, or behavioral disorder in 2021 (Leeb et al., 2024). Disruptions caused by the COVID-19 pandemic brought a sharper focus to the ongoing mental health crisis among youth (U.S. Surgeon General, 2021). In Massachusetts, high school students reporting depressive symptoms[2] increased from 30.4% to 34.3% between 2019 and 2023. The prevalence of suicidal ideation[3] increased from 2019 to 2021 (12.8% and 14.5%, respectively), then decreased in 2023 (12.7%). Massachusetts middle school students who reported depressive symptoms also increased from 2019 to 2023 (24.3% and 26.6%, respectively) and the prevalence of suicidal ideation increased from 2019 to 2021 (11.3% and 12.6%, respectively) and then decreased in 2023 (11%) (MDPH, 2024).

One positive trend in the youth behavioral health landscape, however, is the decrease in reported substance use among Massachusetts high school students from 2019 to 2023. The most recent data from 2023 show that 22.4% of high school students reported drinking alcohol, 16.0% reported using a vape product, and 16.8% reported using marijuana in the past 30 days. These figures are lower than those reported in 2021, when 29.9% reported drinking alcohol, 32.0% reported vaping, and 30.2% reported marijuana use (MDPH, 2024).

Addressing longstanding inequity in youth behavioral health burden is a critical component of any intervention to address the youth behavioral health crisis. Historically, behavioral health challenges have been more prevalent among marginalized populations, including those who are Black, Hispanic/Latine, Indigenous, LGBTQ+, individuals with a disability, and/or low-income (Mongelli et al., 2020; Shim, 2021). These disparities persist today. Among racial groups, symptoms of depression remain highest among Black, Brown, and Indigenous youth (West et al., 2023). LGBTQ+ youth are disproportionally impacted by anxiety and depression and report significantly higher rates of suicidal thoughts, plans, and attempts than their cisgender and heterosexual peers (Nath et al., 2024). Transgender and non-binary youth are especially at risk; approximately 13% made a suicide attempt in the past year (Gaylor et al., 2023; Health Survey Program, 2024; Nath et al., 2024). For youth with multiple minoritized identities (e.g., LGBTQ+ Students of Color from low-income families), the risks increase.

Despite higher rates of behavioral health needs, access to care is more difficult for student populations most in need of behavioral health care. Among racial groups, Black and Hispanic/Latine youth are less likely than their White non-Hispanic/Latine counterparts to receive treatment for mental health conditions (SAMHSA, 2023). Recent

[2] The MA Youth Health Survey asked: “During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?”
[3] The MA Youth Health Survey asked: “During the past 12 months, did you ever seriously consider attempting suicide?”

data show that 50% of LGBTQ+ youth who wanted mental health care were not able to access it (Nath et al., 2024). This ongoing crisis highlights the need for available, accessible, effective interventions and support.

Offering tailored behavioral health supports within school settings has emerged as a promising pathway to ensure greater, more equitable access to behavioral health care for youth (Hilty et al., 2020; Orsolini et al., 2021; Reese & Ramtekkar, 2022; Stephan et al., 2016). An increasing number of schools have leveraged teleconferencing software to offer school-based telebehavioral health (SBTBH) services (National Center for Education Statistics, 2024). Through SBTBH services, schools can readily connect students to individualized behavioral health care with a licensed clinician, even in the context of the behavioral health provider shortage. Through virtual consultations, students can access appropriately trained behavioral health professionals sooner, reducing the risk of their needs requiring crisis-level care in an acute setting. Moreover, the virtual platform creates an opportunity to match students with clinicians with relevant specialized training and/or lived experience (Hilty et al., 2020; Orsolini et al., 2021; Reese & Ramtekkar, 2022).

Emerging evidence indicates that students, parents/caregivers, and clinicians have been highly satisfied with SBTBH. A 2025 review of youth telebehavioral health from the Massachusetts Association of Mental Health (MAMH) found that telehealth is an important service option to have available, as it can lower the burden on families to get to appointments and increase the selection of available clinicians (Stolyar & Larochelle, 2025). These findings are supported in other literature, which show telehealth has increased access for students who face barriers with transportation or health care coverage (Mayworm et al., 2020; Sowa et al., 2024; Stephan et al., 2016). Recent literature report that students engaged in telebehavioral therapy are equally satisfied and have the same level of connection with their clinician during telepsychiatry appointments as compared to in-person appointments (Sowa et al., 2024), although the MAMH report finds that many youth would prefer in-person appointments were they available. Reassuringly, research on outcomes of telebehavioral health has been favorable, showing decreases in anxiety and depression scores at the same rates as in-person care (McCord et al., 2022). Areas for consideration when providing telebehavioral therapy include concerns about privacy in some situations, such as finding a private space at home, as well as challenges with engaging some students in a virtual format (Sowa et al., 2024; Stephan et al., 2016; Villalobos et al., 2023). The MAMH report notes that these same challenges in providing services at home apply when they are provided in school, especially if the school does not have a dedicated room for telebehavioral health sessions. Overall, the literature on youth telebehavioral health services indicate a promising, rapidly expanding intervention, with more research needed to define the groups for whom and situations in which it is best used.

III. Service Models, Program Reach & Community Engagement

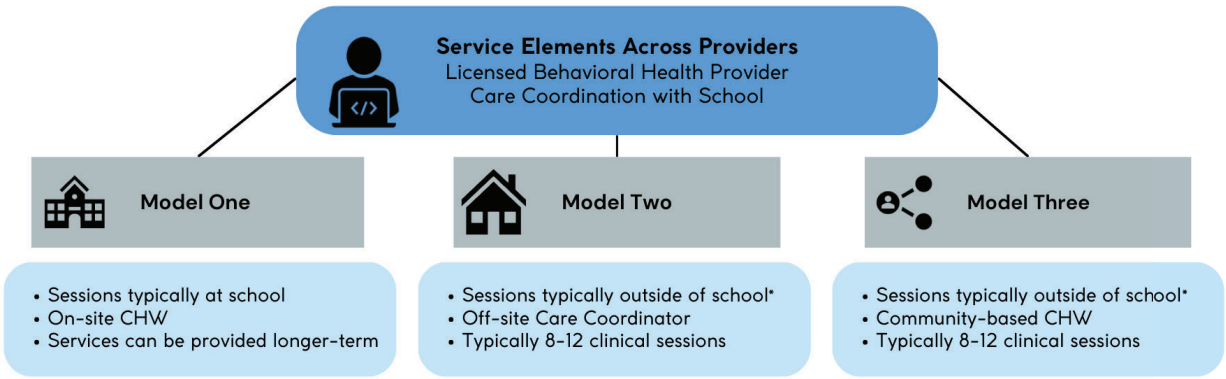
FY25 Highlights

- The pilot consisted of two primary service models, with a third that was discontinued at the end of the fiscal year.
- Services were provided in 22 participating sites, including public school districts, regional vocational schools, and charter schools. Three provider organizations offered SBTBH services. One additional provider organization was in a planning phase to implement services.
- The pilot delivered over 18,500 TBH sessions to over 1,250 students; nearly 2,500 students have been served since pilot launch.
- BCCMH remained focused on workforce training, partnership development, careful stewardship of fiscal resources, and data-driven programmatic improvements.

A. Service Models

The heart of the SBTBH pilot is the partnership between districts and provider organizations to deliver telebehavioral health services to students. As the implementation lead, BCCMH facilitates and monitors these relationships and provides ongoing support and resources. Models 1 and 2, described below, were the primary service models during FY25. Model 3 was piloted across FY24 and FY25 but has been discontinued.

Figure 1. SBTBH Service Models



Model 1, delivered by Heywood Healthcare, consists of telebehavioral health (TBH) services provided, in general, at school during school hours, with the support of an in-person Community Health Worker (CHW) for a wide range of services (e.g., psychoeducation, access to Social Determinants of Health [SDoH] resources, care coordination, and follow-ups on referrals to additional services). Students under Model 1

have access to longer-term TBH sessions from a clinician and in-person support from a CHW.

Model 2, delivered by Cartwheel Care, consists of TBH services provided primarily outside of school and school hours, likely at home, with the support of a remote Care Coordinator. Students served under Model 2 typically have access to 8-12 TBH sessions (lasting 45-60 minutes per session) over 2-4 months from a clinician, with extensions when clinically indicated, and virtual care coordination services. Over the course of the pilot, Model 2 has adapted its approach to provide greater flexibility, enabling students to access care at school when it is deemed appropriate.

Model 3 was intended to describe a hybrid model offering TBH services similar to Model 2, delivered by Cartwheel Care both in and outside of school with the support of a virtual Care Coordinator and a remote CHW housed at The Brien Center. However, this model applied to one school district and will be discontinued in FY26. It was discovered that the remote CHW role was underutilized and coordination between the local CHW provider and the school district proved challenging during FY25. Therefore, this report combines Models 2 and 3 when presenting data by model.

An additional service site was introduced in FY25 at the Salem YMCA with sessions conducted on site. Referrals for these services were funded separately from the SBTBH pilot and through the YMCA. BCCMH worked with Cartwheel Care to establish a reporting process for this partnership to replicate the model in Haverhill Public Schools.

By the end of FY25, these models became more nuanced as districts adapted to what works best for their students. For example, some districts that originally thought to offer TBH services mostly outside of school (i.e., home) began to offer TBH services at school, either during school hours or after school, to better meet their students' needs regarding privacy, technology, or other access issues. Additionally, students in Models 2 and 3 were observed to be receiving similar core services (i.e., 8-12 clinical TBH sessions); therefore, the pilot can be viewed as having two main service models (i.e., Model 1 and Model 2). It is important to note that these models should not be directly compared when assessing indicators of the pilot's impact due to the differences in services and interventions provided. As the pilot continues and expands, understanding the changes in the implementation of services will be important to further refine the Models.

Data to track students who were referred for services more than once began to emerge in FY25. Ten students (about 6%) referred for services in Model 1 schools were repeat referrals, while just six repeat referrals were recorded for Models 2 and 3 (less than 0.5%). Referral source is not routinely reported in the clinical data. Monthly Metrics allow for reporting of referral sources, but providers do not submit these data consistently, resulting in limited referral source data. Model 1 reports referral sources by distinguishing between TBH and non-TBH referrals.

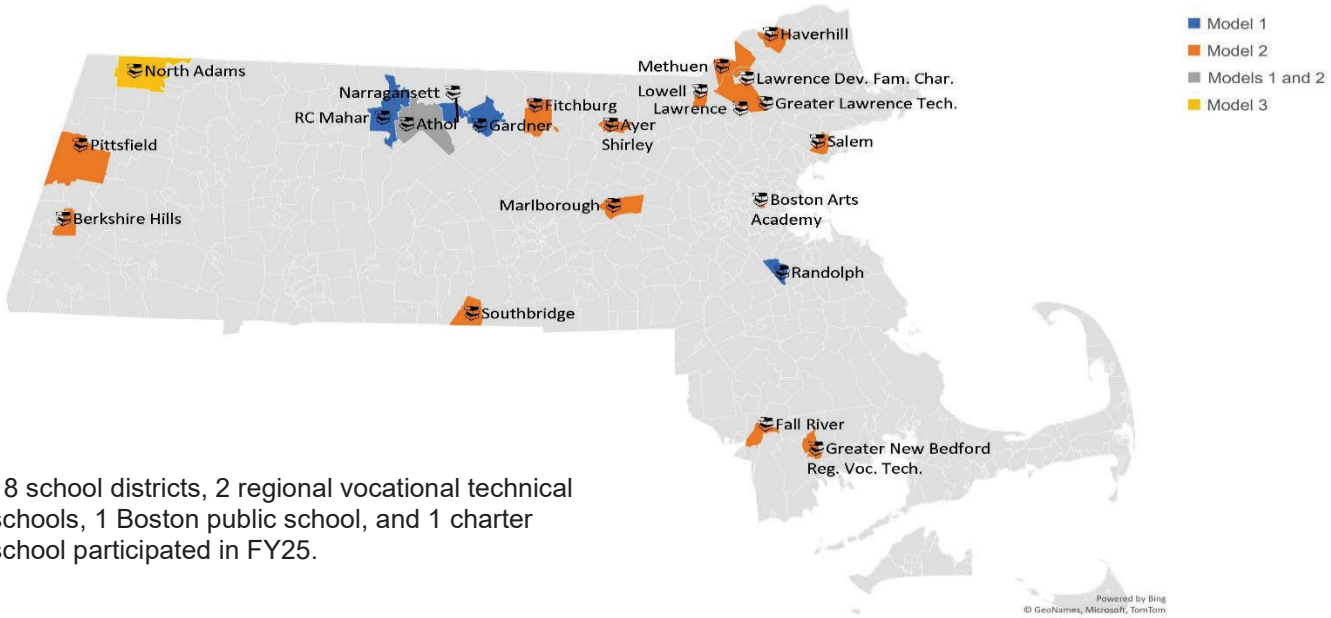
B. Participating Districts and Providers

In FY25, students from 18 public school districts, 2 regional vocational technical schools, 1 Boston public school, and 1 charter school (a total of 22 sites) participated in the SBTBH pilot to provide services to their students in need of behavioral health resources. Four provider organizations participated in the SBTBH pilot during FY25. New school district partnerships in FY25 included Randolph, Lawrence, and Southbridge Public Schools. Southbridge and Lawrence Public Schools began services in Fall 2024. Randolph Public Schools will begin to provide services in the second quarter of FY26; FY25 activities at this site focused on capacity-building.

In FY26, the pilot will include six new partnerships: Framingham Public Schools, Chelsea Public Schools, Boston Public Schools, Springfield Empowerment Zone, Brockton Public Schools, and Franklin County Tech School. Athol Royalston, which previously participated in both models, will continue with only Model 1 in FY26. Two partners – Greater Lawrence Regional Vocational Technical School and The Brien Center – opted to exit the pilot beginning this year. The Brien Center withdrew from the pilot after determining that the remote CHW position was not widely utilized and that collaboration between the local CHW provider and the school district was difficult to sustain during FY25.

Details of participation by district, including FY25 referrals and rates of service penetration, are available in Table A1 in Appendix A. Interested and onboarding districts are listed in Appendix A in Table A2.

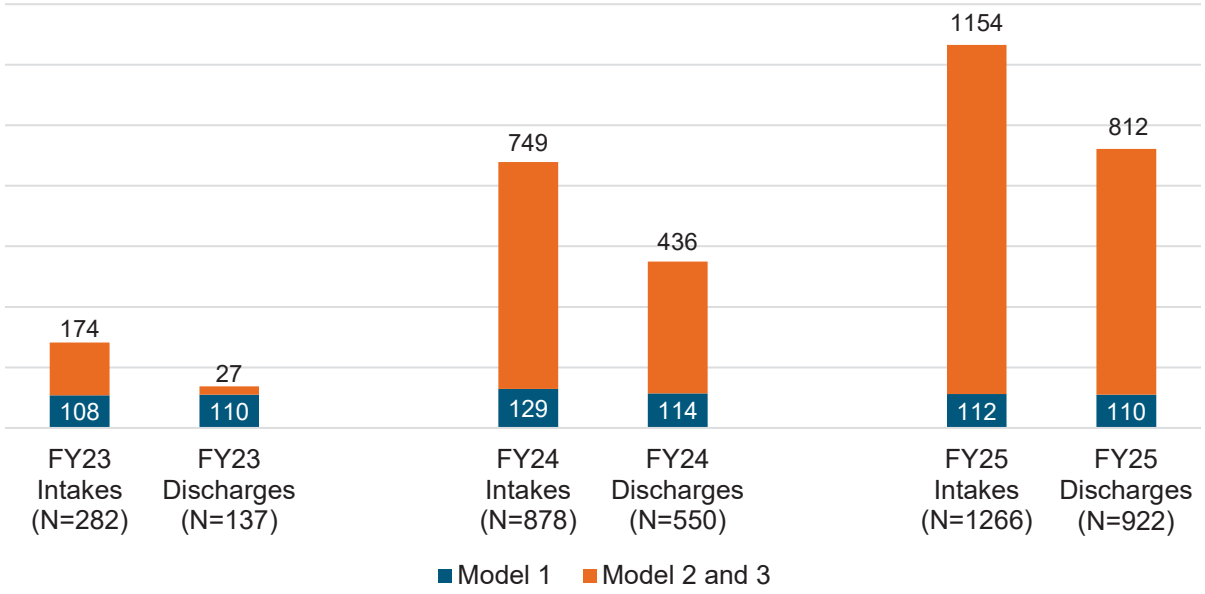
Figure 2. Map of Participating School/District Sites, FY25



18 school districts, 2 regional vocational technical schools, 1 Boston public school, and 1 charter school participated in FY25.

The number of students who participated in services provided by the SBTBH pilot has grown substantially across the three years of implementation. During FY25, 18,693 telebehavioral health (TBH) sessions were delivered. Since the pilot began providing services in FY22, 2,426 students have completed an intake. During FY25 alone, there were 2,280 new referrals, resulting in 1,266 completed intakes.

Figure 3. Intake and Discharge Metrics from Providers, FY23-FY25[1]



[1] Data source: Monthly Service Metrics from SBTBH provider organizations.

C. Expanding the Pilot's Reach

The increase from 20 to 22 participating sites from FY24 to FY25 reflected thoughtful, equity-driven expansion rather than a linear scaling model. Each participating district presented unique behavioral health disparities and service gaps, which influenced both the structure of services delivered and the associated costs.

The cost per site varied significantly depending on the clinical provider selected by the district. For instance, established for-profit providers with existing infrastructure tend to have lower per-student costs, while community-based or nonprofit providers often require upfront capacity-building investments, including support for staff onboarding, technology, and supervision. Hence, the pilot covers services and costs that are not reimbursable by third party payors. These include Community Health Worker (CHW) services currently and an Equitable Care Fund set aside to ensure students in any participating district who were uninsured or underinsured could access care. These start-up and non-reimbursable costs raised initial expenditures but were critical to achieving long-term service equity across under-resourced areas.

The total SBTBH budget has remained flat year-over-year, which limited the pace of expansion until provider costs stabilize. To address this, BCCMH began working with partners to implement predictive financial models that identify opportunities for sustainable budget reductions in future years as programs mature. More detailed cost breakdowns can be found in Section X.

Partnership development is an ongoing focus for BCCMH. During FY25, the BCCMH team met with each school/district partner monthly to learn about and document their implementation processes, adaptations, and challenges, and to assist in problem-solving for any barriers that arose. Similarly, the BCCMH met biweekly or monthly with provider organizations to ensure alignment on pilot goals and to provide support for quality improvement processes. The BCCMH team facilitated collaborative problem solving across local education agency (LEA) and provider organization partners to improve those relationships when needed.

To guide partnership planning, development, and implementation at each site, BCCMH utilizes a comprehensive Capacity Assessment tool with schools participating in the pilot. The assessment is administered at the time of engagement with school districts and clinical providers and is intended to be repeated at least annually to identify existing resources, gaps, and needs within each district. Areas of identified support included language capacity and substance use disorder (SUD) pathways. These findings continue to inform BCCMH's strategic priorities. During FY25, efforts were underway to refine and streamline the Capacity Assessment and associated data collection processes to reduce the burden on LEAs while generating targeted, actionable information to support quality improvement.

IV. Capacity Development & Service Flow

FY25 Highlights

- BCCMH utilized a comprehensive Capacity Assessment to support participating sites' readiness to deliver SBTBH services and identify targets for priority growth areas.
- Focus groups with school district personnel revealed strong support for TBH service offerings. They also identified areas for further development, including technology support and enhancing outreach to caregivers.
- Overall, 56% of youth referred to the pilot completed an intake. This is likely because of consent delays, caregiver hesitancy, and provider capacity limitations. Improving intake completion rates across participating sites will be a focus of FY26 quality improvement efforts.
- Students with access to an in-person Community Health Worker had lower no-show rates (9%) than those without access to this resource (15%).

A. Capacity Development, Process Implementation and Focus Groups

1. Capacity Assessment

Capacity building was strengthened through meetings with district personnel, information shared by Interagency Work Group (IWG) members, and collaboration with other partners (e.g., Department of Elementary and Secondary Education [DESE] and the Massachusetts Association for Mental Health [MAMH]; see Table G1 in Appendix G). In FY25, ten districts completed the Capacity Assessment, a tool used to evaluate readiness and resources for implementing telebehavioral health (TBH) services. BCCMH streamlined the assessment to improve accessibility and increase response rates, resulting in more consistent and actionable data collection to assist the SBTBH team in assessing feasibility of service implementation.

Capacity Assessment findings in FY25 indicated that four districts had dedicated on-site spaces for telebehavioral health, while six had partial on-site services. Five districts were working to enhance WiFi and technology infrastructure and to update Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) requirements to better meet student needs within the pilot. These findings provided a clearer understanding of current strengths and areas requiring targeted support.

Using the Capacity Assessment, BCCMH worked with districts to strengthen capacity across relevant domains and identify priority areas for growth, including for newly onboarding districts. While securing sustainable funding remained an ongoing

consideration, the progress achieved through targeted capacity-building efforts positioned districts to better deliver high-quality, accessible telebehavioral health services to students. Data improvements in FY26 may include tracking the frequency and location of sessions, which will help to better understand how students interact with services in each model and what adaptations may be needed to support full engagement.

2. Process Implementation

Process evaluation data are regularly collected and analyzed, including monthly metrics from provider organizations, capacity assessment data, and training evaluation data. During FY25, clinical data collection protocols were refined and tailored to each provider organization, and implementation data were analyzed to describe the intervention design and populations served. Ongoing quality improvement efforts led by the BCCMH team have also enhanced these data collection protocols, with clearer guidelines for provider organizations to facilitate consistency across organizations and data quality within organizations, and to improve outcomes for youth. For example, one provider organization transitioned from using the Patient Health Questionnaire-8 (PHQ-8) to the PHQ-9 paired with the Columbia Suicide Severity Rating Scale (C-SSRS), allowing for better screening for suicidality among youth. In addition, the adaptations to Social Determinants of Health (SDoH) identification processes and sexual orientation and gender identity (SOGI) data collection, mentioned above (see Data Collection Processes section on p. 26), will improve clinicians' ability to support youth and families.

3. Focus Groups with School Districts

For the first time in FY25, the Brandeis evaluation team facilitated one-hour focus groups with five districts (one in the pilot since FY23, three since FY24, and one since FY25) while BCCMH coordinated recruitment and scheduling. Discussions explored how districts implemented services, TBH processes, data collection, successes, areas for improvement, and future directions. Across sessions, participants often described a streamlined referral process led by Student Adjustment Counselors (SACs), with two of the three groups highlighting the Model 2 as a valuable tool for managing care, while also suggesting enhancements such as school-level visibility into all referrals and notifications when dashboard updates occur.

> "Offering SBTBH services has had a transformative impact on the mental health of our population, particularly for those who were previously underserved. This collaboration has made a real difference in addressing critical needs."
> - District Partner

School-based TBH services were praised for increasing access, particularly for students facing language barriers, lack of transportation, or limited insurance coverage, and for helping reduce stigma around mental health among students and faculty. District personnel appreciated the convenience of in-

school sessions, especially for high-priority populations such as students in foster care, who often face challenges with in-home stability and privacy.

At the same time, participants noted persistent challenges, including space limitations in school buildings, technology issues, and caregiver hesitancy or lack of engagement. While many caregivers (e.g., parents, foster parents, grandparents, other guardians) were receptive once outreach began, others needed additional education and support to feel comfortable with the offered services for their children. Some students were also identified by school or clinical providers as better suited for in-person care.

Overall, the district personnel focus groups provided valuable insights into the evolving implementation of SBTBH services and underscored both strengths and areas needing further support to ensure equitable access to behavioral health services across districts.

> "[The TBH Pilot] has been instrumental in expanding our reach, enabling us to provide essential mental health care while breaking down barriers like transportation, insurance complexities, and limited multilingual support."
>
> - District Partner

B. Service Utilization Metrics

Overall, there were 2,280 new referrals for SBTBH services in FY25, resulting in 1,266 completed intakes and 18,693 telebehavioral health sessions. Over half of referrals resulted in completed intakes (56%). The low rate of conversion from referral to intake may be explained by delays in obtaining consent for treatment, caregiver hesitancy, and provider capacity limitations. Understanding and addressing the barriers will be a focus for FY26.

Model 1 recorded 230 referrals in FY25, compared with 2,050 across Models 2 and 3. A smaller share of Model 1 referrals completed intake (48.7%) relative to Models 2 and 3 (56.3%). However, Model 1 reached a larger proportion of its enrolled population, with a 5.6% penetration rate, in comparison to a 2.5% penetration rate for Models 2 and 3.

Table 1. Referral to Intake by Model in FY25

Model	Total Enrollment of Participating Schools	Contracted Referrals	Referrals for FY25	% Completed Intake	Penetration Rate[1]
Model 1	4,126	–	230	48.7%	5.6%
Models 2 & 3	82,849	2,335	2,050	56.3%	2.5%

[1] Penetration Rate=The percentage of students enrolled in participating schools who were referred to SBTBH services.

By the end of FY25, a total of 454 students were awaiting care. Model 1 reported a waitlist of 34 students, while Models 2 and 3 had 420 students in queue for an intake. These numbers varied based on the number and size of districts and schools. For

students on a waitlist under Model 1, treatment typically began once another student transitioned out of care. Students engaged with Models 1 and 3 were also able to access support from a Community Health Worker (CHW) to address SDoH needs and explore alternative care options. Model 2 does not maintain a traditional waitlist, as clinician time is reserved to accommodate incoming referrals; as such, the time from referral to intake was generally influenced by the process of obtaining parental or caregiver consent and coordinating scheduling. Analysis of data from districts indicates that those who had access to an in-person CHW (Model 1) had lower no-show rates for TBH sessions (9% compared to 15% in districts without in-person CHWs).

Table 2 highlights overall monthly metrics for SBTBH service delivery in FY25.

Table 2. Service Utilization Metrics from Provider Organizations in FY25[1]

	Model 1 (n)	Models 2 and 3[2] (n)	Total (N[4])
Referrals Received	230	2,050	2,280
Intakes Completed	112	1,154	1,266
TBH Sessions, Non-intake (students)	5,046	13,647	18,693
Closed With No Services	70	1,055	1,126
No Shows (students)	525	2,387	2,912
Discharges	110	812	922
Discharges With Graduation[3]	–	342	–
Discharges Without Graduation[3]	–	470	–
Waitlist/Referrals Pending (as of June 30)	34	420	454
Active Caseload at End of Month (as of June 30)	154	541	695
Caregiver Guidance Referrals	–	219	219
Caregiver Guidance Sessions	–	1,358	1,358
Community Referrals	660	106	766

[1] Data are up to June 30, 2025; data from Monthly Metrics.
[2] Model 3, currently operating in one school district, is similar to Model 2 except with the addition of a community-based CHW who primarily supports families remotely. Due to the small sample size for this district, and the limited integration of this CHW within the school, Models 2 and 3 are combined for this annual evaluation report.
[3] Not reported for Model 1.
[4] N is the sample of students.

V. Overall Student Demographics & Equity Impact

FY25 Highlights

- For the first time, participating schools and districts provided data on students referred to the pilot, including demographic, behavioral, and academic characteristics than were previously unavailable. These data serve as a baseline for benchmark metrics to assess the pilot's impact in future years.
- Data show that the pilot is meeting its goal of serving youth from high-priority populations, including BIPOC, gender diverse, and English Language Learner students, and those from low-income households.
- Data indicates that students referred to the pilot have higher rates of chronic absenteeism and disciplinary action than the average across Massachusetts or within their districts.
- BCCMH worked to integrate Culturally and Linguistically Appropriate Services (CLAS) standards established by the Massachusetts Department of Public Health (MDPH) as a guiding framework for service delivery to advance racial and health equity which will continue in FY26.

A. Participating Student Demographics and Characteristics

Demographic information for students participating in the pilot comes from two data sources. First, clinical providers report demographic data that are collected during the time of the student's referral and intake. Second, student-level data from schools/ districts were collected for the first time during Fall 2024 for all students referred to TBH services during the 2023-2024 school year (FY24), which represent the most current data available. These data shed light on different aspects of participant demographics, and in slightly different ways.

Compared to data from clinical providers, district-provided demographic data are more complete for students who were referred to the pilot but did not complete an intake, as demographics are not universally collected by providers before intake. The student-level data provided by districts also contain metrics on students' attendance, behavior, and academic performance, which provide a baseline understanding of students' school performance in this report, and may be utilized in future years to monitor longer-term outcome measures.

In contrast, the clinical data are likely more complete on topics such as sexual orientation and gender identity, as students are more likely to disclose non-cisgender or non-heterosexual status to clinicians than in a school record. The clinical data also include baseline information on student language preference, insurance coverage, and experiences such as bullying and sense of belonging. This report leverages the

strengths of each data source to consider equity in access as appropriate. More details on the district data collection are provided below (p. 26).

Taken together, these data provide an illuminating picture of students who were referred to and served through the pilot. Data from both clinical and district data sources indicate that students from high-priority groups (e.g., BIPOC students, LGBTQ+ students) were referred for TBH services at rates higher than their overall percentage in Massachusetts school enrollment data. Students from low-income backgrounds, those in foster care, and students with a disability were also referred to the pilot at higher rates than their prevalence in the full Massachusetts student body. Further, students referred to the pilot had much higher rates of absenteeism and disciplinary actions than their peers. These data show that, overall, the pilot is meeting its goals of serving youth from high-priority populations.

1. Demographics: Race/Ethnicity

Table 3 below shows the reported race of students referred to the pilot and those who completed an intake using district-submitted data for FY24. Hispanic/Latine and Multiracial students were served at rates above their enrollment prevalence in the state, while White and Asian students were referred to and served by the SBTBH program at rates below their prevalence. Differences in reporting categories among clinical providers, the Massachusetts Department of Elementary and Secondary Education (DESE), and the schools/districts make it difficult to conclusively state whether Black/ African American students were served at rates above their enrollment prevalence, as many students who are Black/White Multiracial may identify as Black but be classified as Multiracial in this analysis. The district data show no significant difference between referral and intake rates by race, indicating equitable access after referral for all students. Racial/ethnic breakdowns of youth by model can be seen in Table C2 through Table C6 in Appendix C.

Table 3. Race in District-Submitted Data, Following DESE Categories
Students referred to the pilot vs. those completing an intake vs. MA enrollment, FY24[1]

Category	Referred (N[3]=1,433)		Completed Intake (N[3]=799)		MA Enrollment[2]	Sig. (Referred vs. Enrollment)
	n	%	n	%		
White	601	41.9%	365	45.7%	38.0%	*
Black/African American	76	5.3%	37	4.6%	7.1%	*
Asian	37	2.6%	16	2.0%	7.1%	*
Hispanic/Latine	604	42.2%	325	40.7%	43.1%	*
American Indian/Alaska Native	4	0.3%	2	0.3%	0.2%	*
Native Hawaiian or Pacific Islander	1	0.1%	0	0.0%	0.1%	
More Than One Race	110	7.7%	54	6.7%	4.8%	*

[1] Because provider organizations do not routinely collect demographic data at referral, these demographic comparisons are drawn from student-level data provided by the districts and so are only available for FY24.
[2] Categories are based on DESE. DESE lists all race and ethnicity categories together; categories are mutually exclusive. SBTBH data were recoded so that each student only had one race. Note that because of this recoding, some students who may primarily identify as Black/African American may have been assigned to the More Than One Race category.
[3] N is the sample of students.
* Statistically significant difference at p<.05; significance is between referrals and MA enrollment.

2. Demographics: Gender Identity and Sexual Orientation

District data indicate that cisgender female students comprised 53% of students referred for SBTBH services, a higher proportion than the overall Massachusetts enrollment (49%). Students who do not identify as cisgender (i.e., non-binary, transgender, or another gender identity) comprised between 2.0% (an estimate from district-provided data) and 9.6% (an estimate from clinical provider data) of referrals. Because of the sensitive nature of gender data, DESE only collects the categories "male," "female," and "non-binary," and not all schools/districts reported student gender beyond the binary categories. The evaluation team therefore leaned toward the clinical provider data as being more accurate about students' identity. These estimates indicate that the pilot served gender minoritized students at rates at or above their estimated prevalence in the Commonwealth (0.1% of middle school and 0.4% of high school students in Massachusetts reported their gender as non-binary) (Massachusetts Department of Public Health, 2024). Please see Table 4 below. Data from clinical providers also indicate that between 15-20% of youth who provided sexual orientation information identified as LGBTQ+ (see Table C2 in Appendix C).

Table 4. Gender Identity, FY24
Students referred to the pilot vs. MA enrollment[1]

	Provider Est. (N[6]=1,494)		District Est. (N[6]=1,394)		MA Enrollment[2]	Sig.[3]
	n	%	n	%		
Cisgender Female	745	49.9%	736	52.8%	48.6%	*
Cisgender Male	605	40.5%	627	45.0%	51.3%	*
Non-binary or Gender Queer	35	2.3%	14	1.0%	0.1%	*
Transgender	21	1.4%	11	0.8%	ND[4]	
Questioning, Unsure, or Other[5]	88	5.9%	3	0.2%	ND[4]	

[1] Provider estimates based on clinical data from 2024 and 2025. District estimates based on 2023-2024 school year (FY24).
[2] Based on DESE data. MA enrollment statistics do not include transgender and questioning. MA enrollment figures may include transgender male or transgender female students within the male and female categories.
[3] Significance is compared to district estimates.
[4] ND=No data available.
[5] Data from FY24 indicate an unexpectedly high number of youth reporting an "other" gender; data from FY25 do not reflect the same trend. Therefore, this number should be treated with caution.
[6] N is the sample of students.
* Statistically significant difference at p<.05.

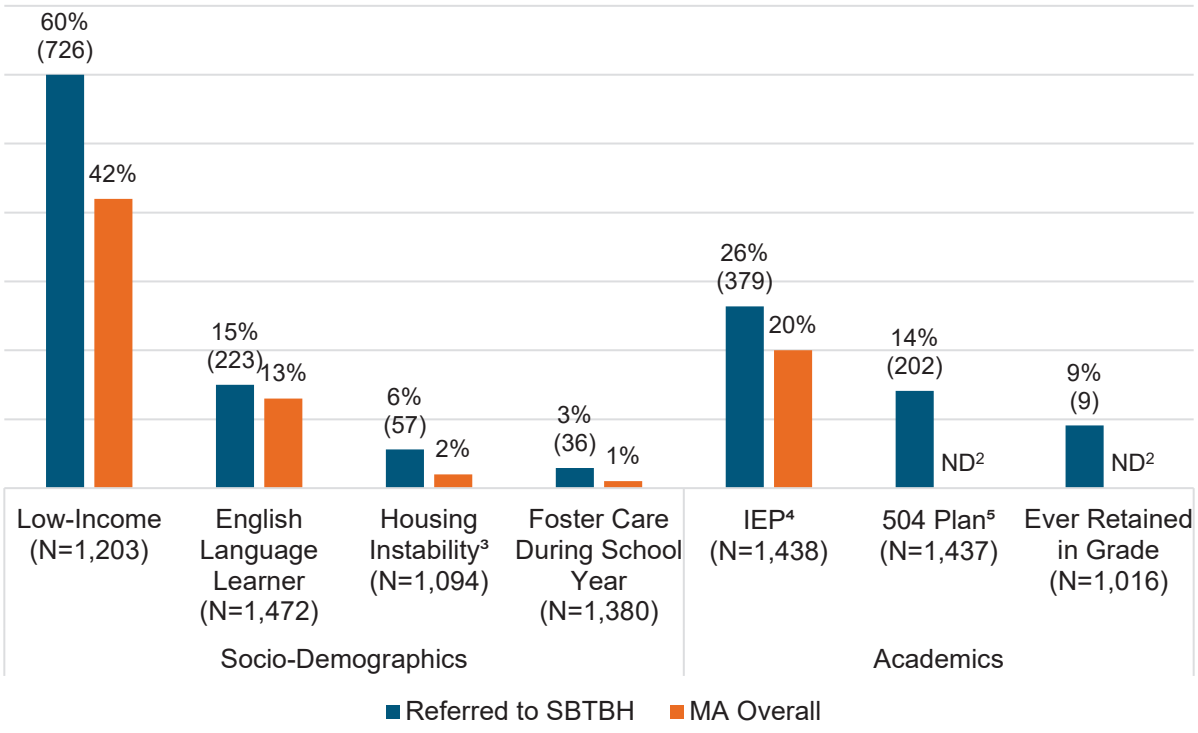
3. Other Student Characteristics

District-provided data show that students from low-income households, those with Individualized Education Programs (IEPs) and 504 plans, English Language Learners and students who have a first language other than English, students who are housing unstable, and students who have been in foster care were referred at higher rates than overall Massachusetts enrollment for youth in these categories (see Figure 4 below).

District data provide estimates of the number of youth referred who had housing instability or had current or past services through foster care (see Table B1 in Appendix B). These data show that approximately 5.6% of referred youth were considered housing insecure and 2.9% had a known history in foster care. These metrics are not

reported by DESE. However, data from America's Health Rankings estimate that in 2021-2022, 2.3% of Massachusetts public school youth were living in an unstable housing situation, which is defined as lacking "a fixed, regular, and adequate nighttime residence" (America's Health Rankings, 2025). Data from the Massachusetts Department of Children and Families show that 8,464 children aged 0 to 17 were in foster care at the beginning of 2022, an overall rate of 0.7% of Massachusetts youth in this age range[4] (Massachusetts Department of Children and Families, 2022). By these standards, the pilot served these populations at or above statewide rates.

Figure 4. Referral Rates by Student Subgroup Compared to Statewide Benchmark[1]



[1] Data period: School year 2023-2024.
[2] ND=No data available.
[3] Comparison data for Low Income, English Language Learner, and IEP populations come from DESE. External sources were used for Housing Instability (America's Health Rankings, 2025) and Foster Care (Massachusetts Department of Children and Families, 2022) comparisons.
[4] An IEP (Individualized Education Program) outlines specialized instruction and support services to be provided to a student with a disability.
[5] A 504 plan outlines accommodations to be provided to a student with an impaired major life activity for them to access the same instruction, school activities, and school building as students without disabilities.

Data from clinical providers offer additional insights about youth characteristics (see Appendix C). Almost two-thirds of youth clients were Medicaid beneficiaries (65.8%), while 22.4% had commercial/private insurance coverage as their primary insurance. Analysis showed that students completed an intake at about the same rate, regardless of insurance type.

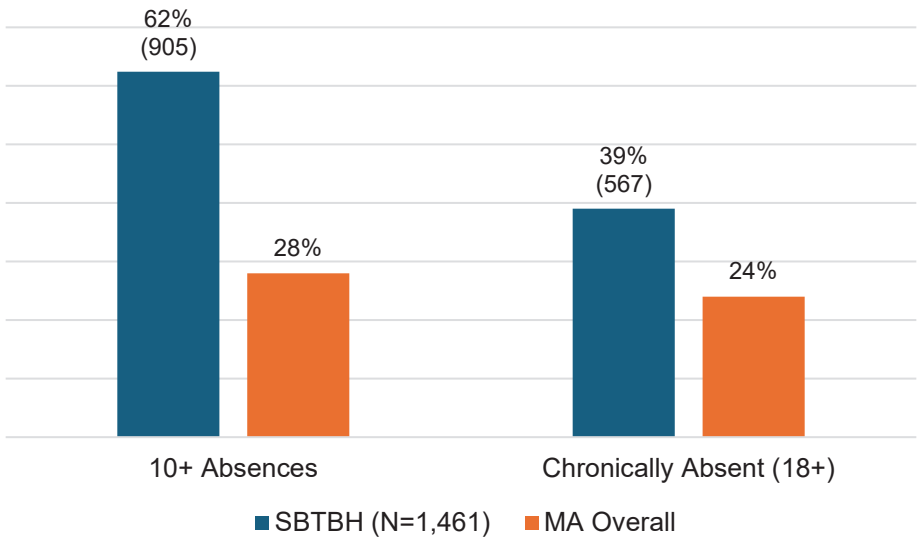
[4] 2022 MA population aged 0-17 estimated at 1,279,086 (census).

4. School Indicators: Attendance, Discipline, Academics

District-provided data indicate that, compared to state averages, students referred to the pilot had much higher rates of absenteeism (24% chronically absent[5] in MA, compared to 39% referred for TBH services) and disciplinary actions (4% assigned one or more out of school suspensions in MA, compared to 18% of those referred for TBH) (see Figure 5 and Figure 6).

Students referred to the pilot missed an average of 21 days of school across the 2023-24 school year, compared to an average of 12 days in Massachusetts overall. Of note, although absenteeism and disciplinary actions were higher among students in the pilot compared to state averages, students who completed an intake with a provider organization had lower rates of absenteeism and discipline than those who were only referred for TBH services. This may be indicative of the challenge of reaching a student struggling with chronic absenteeism to engage them in services and could be a place for additional training and assistance to districts.

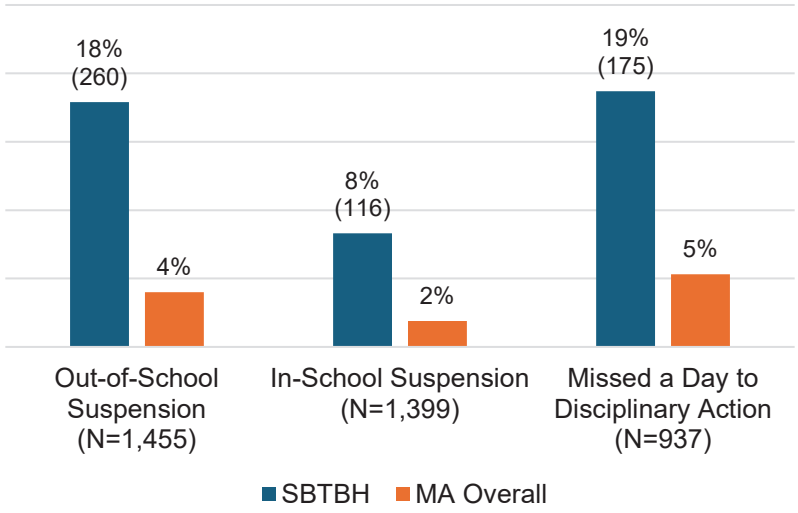
Figure 5. School Absenteeism Among Referred Students Compared to MA Overall[1]



[1] Data period: School year 2023-2024.

[5] This report used DESE's definition of chronic absenteeism as 18 or more days (10%+) missed in a school year.

Figure 6. Disciplinary Actions Among Referred Students Compared to MA Overall[1]



[1] Data period: School year 2023-2024.

Data provided by participating sites on students' academic performance indicate that a lower percentage of students referred to the pilot may have been working at or above grade level compared to the average for all Massachusetts students. For this reporting period, MCAS (Massachusetts Comprehensive Assessment System) scores for those students who were referred to or served through the pilot were not available due to the timing of the data collection period; instead, schools/districts reported on whether the student was working at or above grade level for reading or math. Therefore, data on academic performance should be interpreted with caution due to varying methods across schools/districts for assigning students' grades or measuring whether they are working at or above grade level. See Table B3 in Appendix B.

B. Responding to Data with an Equity Lens

Across FY24 and FY25 data provided by provider organizations, approximately 13% of students referred to the pilot had a need for services in a language other than English. Of these, 53% completed an intake, which was on par with the intake rate for the pilot overall. To serve students with language needs besides English, provider organizations implement a range of language access and demographic matching strategies – including 24/7 interpreter services, bilingual staff and Community Health Worker (CHW) support, language-matched clinician pairing, and flexible scheduling options – while actively working to expand a diverse provider workforce despite rural staffing challenges. Because individual provider organizations approach this differently, some of their specific strategies are listed below.

Model 1's provider organization offers the following:

- The organization partners with Global Interpreters, a company that provides 24/7 telephone and video interpreting services during intake sessions and ongoing communication and uses medical interpreters for intakes if needed.
- CHWs connect students with preferred-language clinicians through partnerships with the Gandara Center and local clinics. Some districts participating in this model (e.g., Athol-Royalston and Gardner) have bilingual liaisons or coordinators to assist non-English-speaking families.
- The organization conducts ongoing efforts to recruit a more diverse provider workforce, but faces rural staffing shortages that impact matching for BIPOC and LGBTQ+ students.

Models 2 and 3's provider organization offers the following:

- Language filters are used to pair families with Care Coordinators and clinicians who speak their primary language whenever possible. If the internal language capacity is not sufficient, interpreter services are used throughout the care journey. If language-matched clinicians are unavailable at the client's preferred times, families are offered the choice of a different clinician sooner or a language-matched clinician with a wait list.
- The organization attempts to match students with providers of similar demographic backgrounds, when possible.

1. Integrating CLAS Standards and Equity Data

BCCMH strengthened the application of the Culturally and Linguistically Appropriate Services (CLAS) standards established by the Massachusetts Department of Public Health (MDPH) as a guiding framework for service delivery. CLAS standards are a Performance Management Quality Improvement (PMQI) tool to advance racial and health equity. This tool provides guidance on reviewing data for inequities, understanding their root causes, and updating policies to ensure diverse staffing, equitable language access, and authentic community engagement. The CLAS framework promotes cultural competence, builds community partnerships, and ensures services are accessible to all, including racially and ethnically minoritized groups, people with disabilities, LGBTQ+ individuals, and rural populations. This framework provides actionable strategies aligned with the goals of the pilot to serve high-priority populations. BCCMH is working with provider organizations to more deeply integrate CLAS into the SBTBH program to facilitate consistent data collection on race, ethnicity, and language, which will be used to inform targeted, equity-driven interventions. These data will help identify and address disparities in service access, ensure culturally and linguistically appropriate care, and ultimately improve outcomes for all students.

Alongside the CLAS standards, data from the Community Health Equity Initiative (CHEI) will provide additional insights into all evaluation components. This data resource will allow for additional benchmarking around Social Determinants of Health (SDoH) needs, behavioral health, access to health care, social support, and experiences of discrimination of youth in Massachusetts, including youth from high-priority populations. The purposive sampling design of the CHEI allows for the

exploration of the experiences of youth with multiple marginalized identities. These data will help inform future updates to the Needs Assessment and serve as an important reference for process and outcome evaluation findings during FY26.

Through its trainings, the pilot offers a wide range of learning opportunities to clinical providers and school personnel on providing culturally and linguistically responsive care. However, trainings are voluntary and data do not include detailed demographic information on training participants. In FY26, the BCCMH team plans to implement a required learning collaborative for all providers and schools/districts participating in the pilot.

2. Data Collection Processes

Data collection processes and elements are regularly examined as new data become available to align with current best practices for health equity. For example, during FY25, provider organizations were asked to collect gender information in a two-part format (gender identity and sex assigned at birth) to better identify gender minoritized students receiving services through the pilot. In addition, the pilot continued to monitor data from the youth/family survey to assess their satisfaction with services. While sample sizes do not yet support cross-tabulating service satisfaction by high-priority subgroups, responses were monitored for evidence of inequities and potential strategies to address them. Another data improvement effort included provider organizations beginning to assess students' sense of belonging at school beyond the initial referral and intake process to assess change over time.

BCCMH and the Brandeis evaluation team collaborated during FY25 to produce provider recommendations documents that leveraged clinical and implementation data to help provider organizations bridge gaps in their processes and services, maintain focus on health equity, and proactively resolve potential areas of inequity. In addition, the evaluation team created data summary presentations for each school/district that the BCCMH team will use as feedback to district representatives. These presentations were designed to support districts' understanding of pilot service users, highlight areas of inequity, and be proactive in tailoring solutions.

During FY25, significant work went into the school/district data collection process. Building on groundwork laid in FY24, data collection protocols and training materials for both providers and participating schools/districts were developed and refined. BCCMH worked closely with each district to support the establishment of Data Use Agreements (DUAs) and Memoranda of Understanding (MOUs) to ensure student privacy and Family Educational Rights and Privacy Act (FERPA) compliance. Ultimately, the process led to data submissions from 16 of 19 participating schools/districts that were expected to share data as part of the pilot, covering 84% of youth referred to the pilot in FY24. These data from schools/districts were collected in Fall/Winter 2025 and covered the 2023-2024 academic year, which served as a baseline.

Collecting data across schools/districts proved complex. Districts use different data systems and have varying levels of expertise in accessing and providing specific data,

particularly when it is being requested outside of the current school year. These variabilities made it difficult to provide technical assistance to schools/districts. In addition, DUAs with schools/districts were being completed during the same timeframe as the data collection, leading to some delays related to ensuring student confidentiality and privacy. Despite these challenges, most districts used the provided data collection tools (e.g., data templates, protocols, and informational videos) and support sessions (e.g., virtual office hours) to submit standardized data that were not available through other sources.

Of the 22 participating sites in FY25, three were not yet eligible for the data collection, and three did not submit usable data. Two districts did not respond to requests for data clarification after they submitted their data. One school district had a more complex DUA process that requires submitting a research proposal to the district; this process is only open at specific times of year and was not made known to BCCMH or the evaluation team until the application window was closed. Once the application is submitted and approved, the missing FY24 data can be obtained. Finally, three sites had not been participating in the pilot long enough to request data for the FY24 period.

VI. Clinical Outcomes & Quality

FY25 Highlights

- Across both primary models of care, services obtained through the overall SBTBH pilot were associated with significant improvement in depression and anxiety.
- Students served by Model 1 reported an average decreased of 3 points for depression and an average of 3.2 points for anxiety from intake to discharge which were statistically different.
- Students served by Model 2 reported an average decrease of 3.7 points for both depression and anxiety between intake and discharge which were statistically different.
- Leveraging data across FY24 and FY25 showed that improvements in clinical scores were relatively consistent across subpopulations. In both primary models of care, cisgender male students had lower clinical scores at baseline than their other-gender peers. Additionally, in Model 1, Hispanic/Latine students demonstrated larger score decreases than their peers, while in Model 2 Multiracial students had smaller score changes than their peers. These findings will be monitored as the sample size increases.
- Data on session count and service duration show that White students had higher session totals, shorter wait times to intake, and longer time in care than their peers in Models 2 and 3. Students who did not report race had lower session totals, longer wait times to intake, and shorter times in care. These data will be monitored and further investigated in FY26.

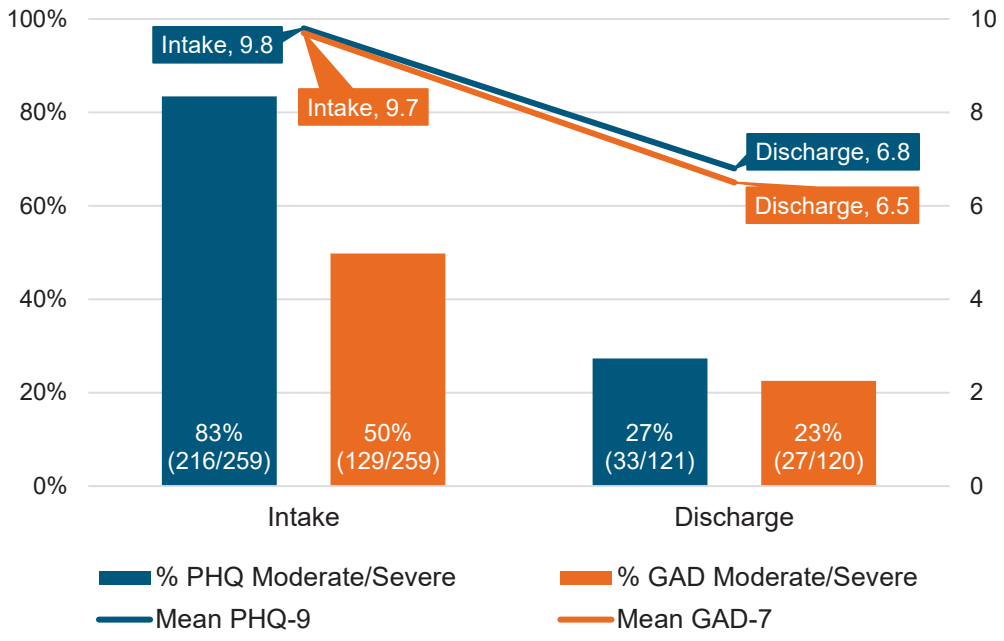
Stress and anxiety were the most common issues for students who completed an intake for services through the pilot. For students who had an intake for Model 1, 79% had a stress/anxiety diagnosis. Additionally, 25% had a diagnosis related to attention or conduct disorders, and 11% had a mood disorder diagnosis. Among youth who completed an intake for Model 2 services, 72% had a stress/anxiety diagnosis,12% had a diagnosis related to attention and conduct disorders, and 11% had a mood disorder diagnosis. Across the United States, these are the most common three diagnoses among youth (CDC, 2025). Please see Table C1 in Appendix C for breakdown of diagnoses by model.

Behavioral health data for anxiety, depression, and suicidal ideation are a key component of evaluating the pilot's impact. Services obtained through the overall SBTBH pilot were associated with significant improvement in these symptoms. As

shown in Figure 7 and Figure 8, students served during FY24 and FY25 through Model 1 saw an average decrease of 3.0 points in their scores on the General Anxiety Disorder-7 (GAD-7), a measure of anxiety, and a 3.2 point decrease on the Patient Health Questionnaire-9 (PHQ-9), a measure of depression. Among students served under Models 2 and 3, students reported a 3.7-point decrease on both the GAD-7 and the PHQ-9; these decreases were statistically significant. Notably, students served under Model 1 entered services with higher scores on both measures, which may indicate that these students had more acute clinical needs.

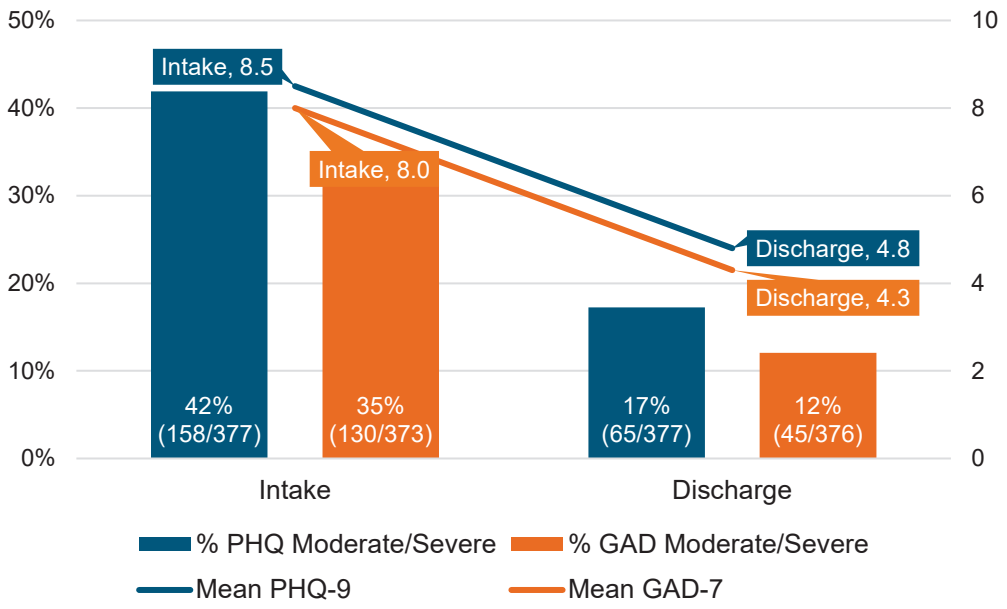
During FY25, the evaluation team conducted a rapid review of clinically significant change in the PHQ-9 (measure of depression) and the GAD-7 (measure of anxiety) for SBTBH-engaged students. Based on this review, two methods for determining clinically significant change from intake to discharge were chosen. These are: 1) a discrete change of 5 or more points on either measure and 2) a categorical change indicating a reduction in symptom severity when the baseline score was in the moderate-severe range. On these measures, 34% of students served under Model 1 experienced a reduction of 5 or more points on the GAD-7 and 25% on the PHQ-9. Among Model 1 students entering services with moderate-severe scores, 45% and 36% reported a categorical reduction on the GAD-7 and PHQ-9, respectively. For students under Models 2 and 3, 37% reported a 5+ point reduction on the GAD-7 and 38% on the PHQ-9. Sixty-five percent reported a categorical reduction on each measure.

Figure 7. Model 1: Mean depression and anxiety scores fell, as did the percent of students scoring moderate or severe[1]



[1] Percent moderate/severe is only among students who had at least one session post-intake.

Figure 8. Models 2 & 3: Mean depression and anxiety scores fell, as did the percent of students scoring moderate or severe[1]



[1] Percent moderate/severe is only among students who had at least one session post-intake.

Each method for determining clinically significant change has strengths and limitations and may be highly influenced by the baseline score, number of sessions, and length of care. Categorical change is only calculated for those who scored moderate-severe for either depression or anxiety. In the FY25 data, many students' baseline scores were at or just above a scoring category threshold. Because of this, about 50% met the criterion of categorical change with just a two- or three-point decrease. Conversely, only about a third met the threshold for a discrete change of five points. To mitigate these limitations, findings reported here utilize both the discrete change and categorical change methods of measuring clinically significant change.

Additionally, no method can fully capture the complexities faced by historically marginalized populations, who often experience higher behavioral health needs and systemic barriers to care. Factors such as unaddressed Social Determinants of Health (SDoH) needs, limited access to culturally competent providers, and ongoing experiences of stigma and discrimination contribute to disparities in treatment outcomes.

Other clinical indicators include screenings for suicidal ideation and reports of substance use. Both provider organizations for Model 1 and Models 2 and 3 use the Columbia Suicide Severity Rating Scale (C-SSRS) but report their screenings in different ways. Model 1 reports risk or no risk for all students, while Models 2 and 3 report low, moderate, and high risk only for students who answer "yes" to the final question on the PHQ-9, which asks if, in the past two weeks, students have had "Thoughts that you would be better off dead or of hurting yourself in some way?" Table C1 in Appendix C shows responses by model. For students under Model 1, 16%

screened positive for suicidal ideation. For students in Models 2 and 3, 101 students (approximately 21%) were screened for suicidality based on their PHQ-9 response. Of those screened, 19% (n=19) were considered high risk. The data do not currently support analysis of follow-up C-SSRS scores.

Students reported relatively low rates of substance use. For all students receiving services in FY25, 89% reported no substance use. Among the 11% (n=124) with reported substance use, 75% (n=90) reported using cannabis and 43% (n=51) reported using nicotine. See Table C2 in Appendix C for a complete breakdown of substance use patterns by model.

Although substance use rates are low, care for substance use disorder (SUD) is a priority focus for the pilot. BCCMH worked in FY25 to develop a comprehensive substance use disorder referral pathway through a partnership with the Adolescent Substance Abuse Program (ASAP) through the Boston Children's Hospital Center for Addiction Medicine for students presenting with substance use concerns that require more intensive care. This includes ensuring access to specialized SUD services, comprehensive and universal assessments, and coordinated treatment planning. The pilot is also in the process of replicating this model with other local hospitals and payors to expand access to high-quality, youth-focused SUD services in additional school districts. A key feature of the model is the integration of a CHW who leads the care coordination and health system navigation. The CHW supports the student and caregiver throughout the referral journey – providing psychoeducation, facilitating warm handoffs, maintaining ongoing contact with the student/caregiver, and coordinating across all providers involved in the student's care. This ensures a seamless, supportive experience that honors cultural and linguistic needs while improving engagement and certain outcomes such as reducing missed appointments. While this model was not implemented in FY25, development is ongoing, with implementation planned for FY26.

A. Outcomes by Subpopulation

By leveraging data on behavioral health scores across FY24 and FY25, it is now possible to examine outcomes by high-priority populations. There were few significant differences by subpopulation in Model 1. Notably, cisgender male students had significantly lower intake GAD-7 and PHQ-9 scores as compared with cisgender female students and those with another gender identity. Additionally, those who did not have insurance had significantly higher intake scores along with a significantly larger change in scores as compared with students with other insurance types. Finally, Hispanic/Latine students had significantly larger changes in PHQ-9 scores, a larger percentage with a 5+ point change on the PHQ-9, and more students with a reduction in severity on the PHQ-9 as compared with non-Hispanic/Latine students. Although there were some significant changes by subpopulation, Model 1 has a relatively small sample size, which may impact these tests.

For Models 2 and 3, there were also relatively few differences by subpopulation. Cisgender male students had lower screener scores at baseline and reassessment compared to cisgender female students and students with another gender identity. However, significantly fewer cisgender male students reported a 5+ point reduction in score on either screener compared to their peers of other genders. Students with disabilities had higher baseline scores on both the GAD-7 and the PHQ-9, but the differences were not significantly different by discharge. Finally, Multiracial students had smaller score changes and were less likely to have clinically significant change on either measure. These differences were not statistically significant, except for the change in PHQ-9 score, perhaps due to small sample size (see Figure 9, Figure 10, and Figure 11).

Figure 9. Models 2 &3: GAD-7 scores decreased less for Multiracial students compared to students of other races

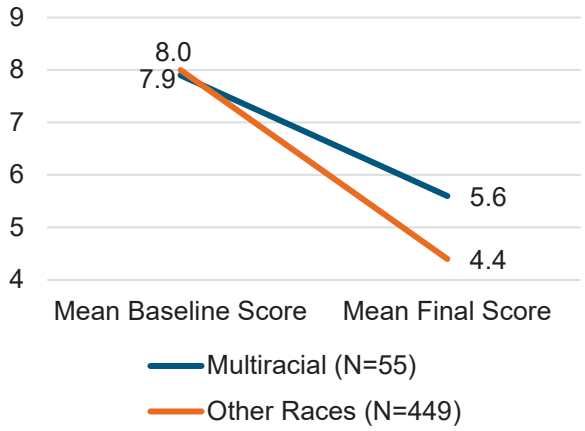


Figure 10. Models 2 &3: PHQ-9 scores decreased less for Multiracial students compared to students of other races

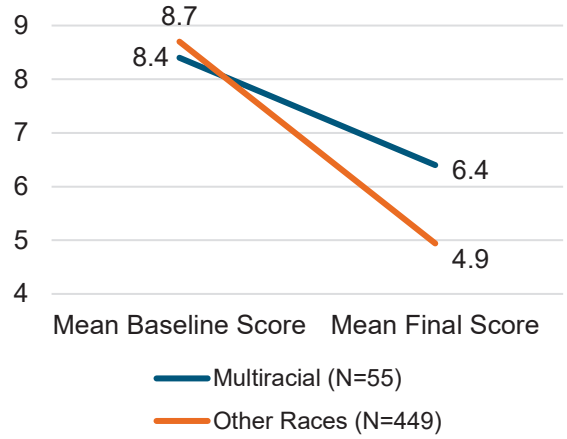
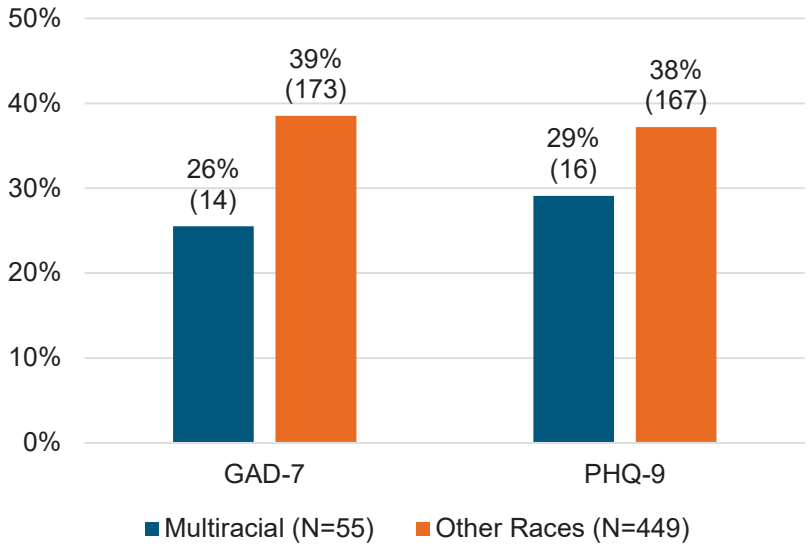


Figure 11. Models 2 & 3: Fewer Multiracial students had clinically significant changes in GAD-7 and PHQ-9 scores compared to students of other races (5+ point reduction)



B. Session Count, Wait Time to Intake, and Service Duration

Clinical quality and outcomes can be associated with intake speed, session uptake, and length of service. Although most students, particularly in Models 2 and 3, complete care within a single school year, many students do remain in services and have sessions over the summer months. As seen in Table 5 below, students under Model 1 had an average of 20 sessions over 235 days. The average wait time for intake was 61 days. Students under Models 2 and 3 had an average of 12 sessions over 112 days. The average time between the referral and intake appointment was 30 days. Notably, White students in Models 2 and 3 had significantly higher session totals, shorter wait times to intake, and longer time in care than their counterparts. Conversely, students who did not report race had significantly smaller session totals, longer wait times to intake, and the shortest time in care of any subgroup (see Table C6 in Appendix C).

Table 5. Session Information, All Models, Students Served in FY25

	Model 1			Models 2 & 3[1]		
	N[2]	Range	Mean	N[2]	Range	Mean
Session Count	168	1 - 52	19.7	833	1 - 73	12.2
Days Referral to Intake Appointment	126	0 - 533	60.8	909	3 - 132	30
Days Intake to Discharge	59	0 - 626	234.9	909	0 - 587	112.3

[1] Data available only after discharge.
[2] N is the sample of students.

VII. Social Determinants of Health

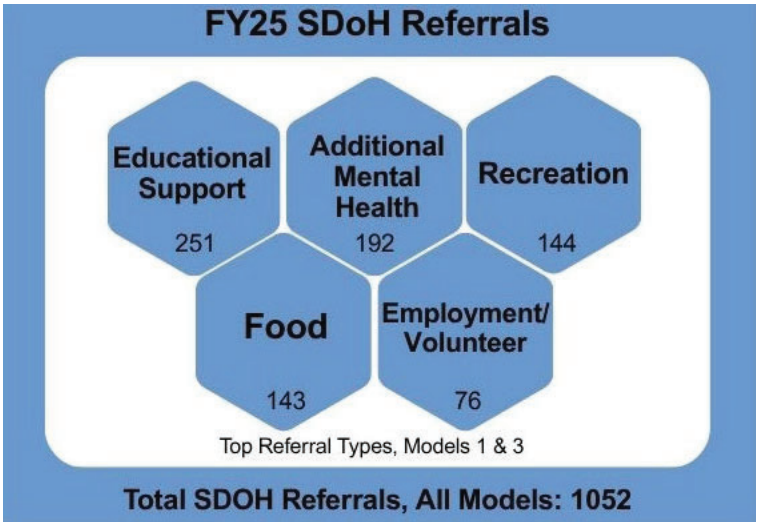
FY25 Highlights

- Providers made over 1,050 referrals for Social Determinants of Health needs.
- BCCMH developed a CHW onboarding and monthly training program, supported school personnel in understanding and collaborating with CHWs more effectively, and disseminated materials and resources to improve the quality of care.
- With support from BCCMH, Model 2's provider adopted an SDoH screener and began making appropriate referrals. BCCMH expects to standardize SDoH referral processes in FY26 across all provider organizations.

Social determinants of health (SDOH) have been recognized as a core driver of access to healthcare and have a great impact on individuals' quality of life, health, and well-being, with telehealth specifically being highlighted as an important factor in helping to improve access to care for many communities (Office of Disease Prevention and Health Promotion, n.d.). Recent research has shown that there is a causal link between SDOH factors and mental health outcomes (Kirkbride et al., 2024) and there is promising evidence for the efficacy of interventions such as case management and trauma-focused psychotherapy, highlighting the importance of addressing SDOH in behavioral health treatments (Jeste et al., 2025). BCCMH has therefore worked to center SDOH services in the pilot's approach to care.

Schools and districts operating under Models 1 and 3 received support from Community Health Workers (CHWs) to address Social Determinants of Health (SDoH) needs (see Figure 9). As shown in Table D1 in Appendix D, the range of additional referrals reflected the wide variety of SDoH needs across communities and underscored the importance of individualized attention to students' and caregivers' specific circumstances. Examples of SDoH needs included access to nutritious food, clothing and personal care items, educational support, mental health services outside of the SBTBH pilot, and recreational activities. Data from Model 1, where students receive in-person CHW support, seem to indicate that these services and referrals support sustained engagement: students with access to an in-person CHW had lower no-show rates (9%) than those without access to this resource (15%).

Figure 12. Referrals for Social Determinants of Health



All provider organizations made important strides in strengthening SDoH referral and tracking processes in FY25, with approaches tailored to each model's structure. The pilot focused on building CHW capacity and strengthening CHWs' integration into school settings. BCCMH developed a CHW onboarding and monthly training program, supported school personnel in understanding and collaborating with CHWs more effectively, and disseminated materials and resources. For example, Heywood Healthcare's School-Based Services Professional Development team contributed to efforts in designing and enhancing onboarding resources and technical assistance to further support CHW integration.

As part of process improvement efforts, the SBTBH team requested that Model 2 adopt this screener and use it to make appropriate referrals to resources. Cartwheel Care incorporated screening questions into caregiver intake forms to identify needs and connect families to relevant resources, as well as launching a referral and tracking system using the Find Help platform.[6] These coordinated efforts across provider organizations reflect a more intentional and sustainable approach to addressing students' SDoH needs alongside behavioral health services.

During FY25, BCCMH developed and piloted a universal SDoH screening tool to help clinical providers identify and address unmet needs. The CHW or clinical provider can then ensure that students and families are connected to services beyond those directly offered through the SBTBH pilot. Beginning in FY26, this screening and referral process will be standardized across all models.

[6] See https://www.findhelp.org/.

VIII. Provider Capacity & Training

FY25 Highlights

- Focus groups with providers highlighted the strengths of telebehavioral health in expanding access, particularly for students and families facing barriers such as transportation, scheduling, or stigma, and emphasized the value of meeting students where they were during the school day to address daily challenges and prevent potential crises.
- Workforce training was provided as synchronous, asynchronous, and in-person modalities. Over 850 enrollments were recorded across 60 free courses and the online learning platform enrolled 190 new users.
- BCCMH invested in strategic efforts to strengthen the behavioral health workforce, regardless of pilot participation. This was done through a learning collaborative, partnerships to expand capacity and highlight the role of CHWs, and targeted communication to SBTBH stakeholders to better serve high-priority populations.
- Training participants reported high levels of knowledge and skills gained, finding the trainings immediately applicable to their work. BCCMH will incorporate feedback from training evaluations into planning for FY26.
- BCCMH emphasized capacity building for provider organizations with data-informed recommendations to improve service delivery and technical assistance in implementing best-practice frameworks.

A. Workforce Demographics

One goal of the SBTBH pilot program is to achieve a diverse workforce. However, the FY25 workforce demographic survey indicated that the racial and ethnic composition of the two main provider organizations' staff was relatively homogenous. Over 70% of Model 2 respondents and all Model 1 respondents identified as White, with 21% of Model 2 and 6% of Model 1 respondents identifying as Hispanic/Latine. Workforce experience varied widely, with 12% of Model 2 and 6% of Model 1 respondents practicing therapy for less than one year and 21% of Model 2 and 29% of Model 1 respondents practicing for more than ten years.

Clinicians and therapists were more racially and linguistically diverse than Community Health Workers (CHWs). While Model 1 and 3 CHWs were 100% White and 9.1% Hispanic/Latine, clinicians across models were 78% White and 17.1% Hispanic/Latine. CHWs reported speaking only English, whereas clinicians reported additional

languages, including Spanish, Portuguese, and Haitian Creole. Overall job satisfaction was high across provider organizations and by roles: 76% of Model 2 staff and 100% of Model 1 staff, or 80.4% of clinicians and 90.1% of CHWs, reported being extremely satisfied or satisfied with their job. Detailed tables about workforce demographics by role are included in Appendix E.

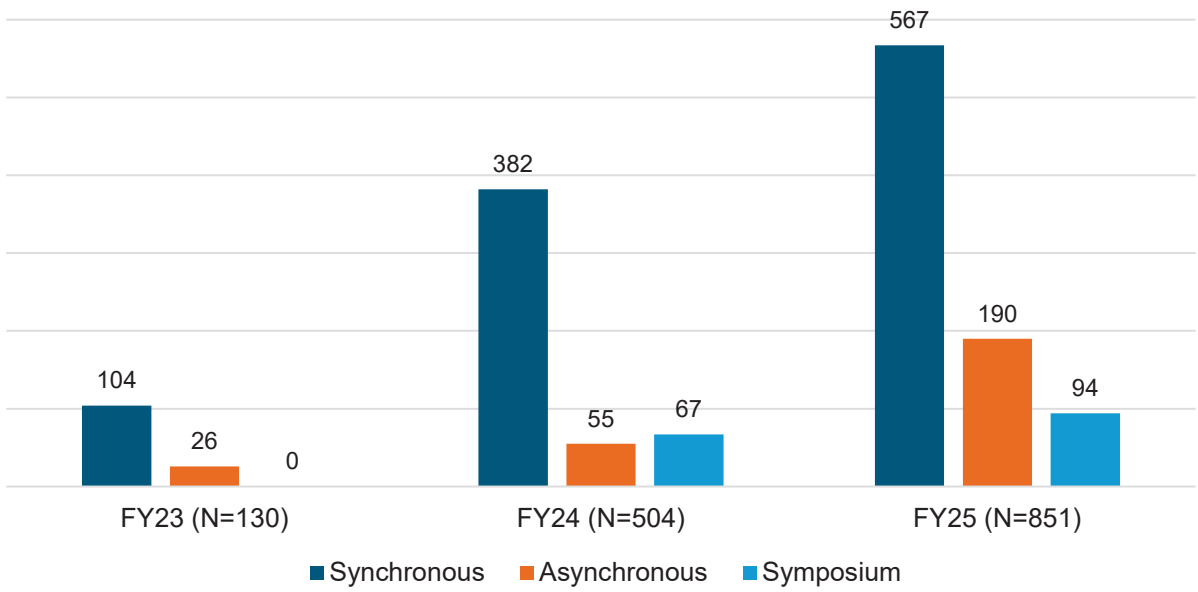
B. Provider Focus Groups

In FY25, focus groups were held with behavioral health providers across all three service delivery models to better understand their experiences implementing SBTBH services. Participants highlighted the strengths of telebehavioral health in expanding access, particularly for students and families facing barriers such as transportation, scheduling, or stigma, and emphasized the value of meeting students where they were during the school day to address daily challenges and prevent potential crises. Participants in Models 1 and 3 noted the critical role of CHWs in engaging families, coordinating logistics, and connecting households to essential resources like food assistance, fuel support, and childcare. However, challenges were also identified across models, including caregiver hesitancy, technology limitations, capacity constraints, and the reality that telebehavioral health is not always appropriate for students with higher acuity or attention-related needs. Participants also expressed the need for clearer communication around procedural and administrative changes both within their organizations and with participating school districts and emphasized the need for sustainable support of CHW roles.

C. Workforce Training

Workforce training is a core component of pilot activities to improve behavioral health outcomes. Since FY23, data have been analyzed to evaluate the effectiveness of trainings in building capacity for evidence-based telebehavioral health care, trauma-informed approaches, and culturally and gender-affirming practices. Results consistently show increased knowledge and competency among participants, with over 90% reporting that they could immediately apply what they learned. BCCMH offers synchronous, asynchronous, and in-person sessions on topics such as cultural responsiveness, trauma-informed care, conflict resolution, and telebehavioral health best practices. Between July 1, 2024, and June 30, 2025, over 850 enrollments were recorded across all modalities, including over 60 free courses available to provider organizations, school districts, and other stakeholders. Training access expanded through the Learning Management System (LMS), which added seven new courses and enrolled 190 new users in FY25.

Figure 13. Workforce Training Enrollment, FY23-FY25



Notes: Synchronous trainings include in-person and live virtual sessions. Asynchronous trainings are prerecorded sessions for participants to view at their convenience. The Symposium was first held in FY24; FY25 Symposium data are based on registration data.

1. Learning Collaboratives for Local Education Agencies and Clinical Providers

Workforce training was a key component of the SBTBH pilot, encompassing synchronous (real-time virtual) and asynchronous (self-directed via the LMS) training, as well as in-person training via the annual SBTBH Symposium, a day-long assembly held by BCCMH to examine and reflect on the SBTBH pilot project and the intersections of education, technology, and behavioral health service provision. Trainings addressed a wide range of topics; for example, clinical provider topics included behavioral health theoretical models, trauma-informed care, equity-based best practices, cultural diversity and responsiveness, conflict resolution and mediation, and general telebehavioral health best practices. Figure 10 presents enrollment by modality, and Table E2 and Table E3 in Appendix E list all trainings offered through the pilot.

2. Training Investments

BCCMH prioritized workforce investment through strategic efforts to train and strengthen the behavioral health workforce, regardless of pilot participation. This included a rigorous learning collaborative offering no-cost training to all youth-serving professionals in the Commonwealth, targeted communications to SBTBH stakeholders to enhance skills in serving high-priority populations via telebehavioral health, and partnerships to expand capacity and highlight the role of CHWs. A key highlight in FY25 was a joint presentation by Heywood Healthcare and the Massachusetts Association of Community Health Workers at the Second Annual SBTBH Symposium, which emphasized CHWs' role in advancing health equity through community-based outreach, education, and care coordination. The presentation also addressed CHW certification, workforce development, and policy advocacy to strengthen and sustain the profession statewide.

Training sessions currently cost approximately $2,500 each, which includes speaker honorariums for live events such as the annual SBTBH Symposium. This estimate does not include asynchronous LMS modules, which were paid for at the time of initial development, nor does it reflect BCCMH staff support time, which is estimated at 10 hours per training. These sessions are seen as highly valuable by participants. During FY25, there were 567 attendees to 29 live training events. The pilot intends to explore alternative formats or funding sources to continue and expand access to high-quality professional development opportunities.

3. Training Evaluation Results

The vast majority (over 90%) of participants indicated that they felt they could immediately apply what they learned. After training, 85% reported that their level of knowledge/skills in the given area was either “A Great Deal” or “Quite a Bit,” compared to less than half (44%) reporting the same prior to the training. This difference was statistically significant ($p<.05$), and this finding was consistent across all training modalities. Table E4 in Appendix E provides a breakdown of evaluation data by training type.

Participant evaluations also included suggestions for improving training, such as incorporating more opportunities to hear from people with lived experience. Participants expressed interest in learning more about supporting students from specific populations, such as students with disabilities who have experienced trauma. Following some trainings, participants had the opportunity to identify action steps they would take moving forward in their professional roles. Some of these included using more gender-neutral terminology with students, working with administrators to develop supportive policies, and facilitating safe spaces for students.

4. Capacity Building for Provider Agencies

BCCMH emphasized capacity building for provider organizations not only through professional development opportunities, but also with data-informed recommendations to improve service delivery and technical assistance in implementing best-practice frameworks. Provider agencies and school districts were engaged in identifying training needs to shape a no-cost professional development curriculum. Many courses offered Continuing Education Units (CEUs) at no cost, increasing accessibility and appeal for educators, psychologists, mental health counselors, social workers, and CHWs.

A set of overarching recommendations for provider organizations was compiled into an executive summary, including: 1) integrating Social Determinants of Health (SDoH) screening and referrals into clinical practice, 2) participating in trainings that support workforce development and equity-driven clinical practices, and 3) collecting high-quality data to strengthen SBTBH implementation and outcomes evaluation. BCCMH planned to meet with each provider organization to review these recommendations and establish SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) goals for tracking progress on each metric.

IX. Youth & Family Voice

FY25 Highlights

- Respondents of the youth and family survey reported high levels of satisfaction with service: 86% of caregivers and 85% of youth were satisfied with the services they received.
- Over 80% of youth and caregivers agreed that the student had built a strong relationship with their provider and that they had learned skills to help them manage their feelings or behavioral health needs.

Beginning in Spring 2024, providers disseminated a satisfaction survey to all SBTBH pilot participants at discharge. In FY25, 112 youth and caregivers responded to the survey. The data presented here are the results from FY25. Most survey respondents (88.4%) were caregivers. Most respondents were White (83.5%). Nearly all respondents or their children received care through Model 2 (93.8%). Most Model 2 clients participated in telebehavioral health sessions from home (79.8%). In contrast, though the FY25 sample size from Model 1 is small, data from FY24 and FY25 combined indicate that most clients participated in telebehavioral health sessions from school (n=21, 84.0%).

Overall, in FY25, 85.7% of caregivers and 84.6% of youth were satisfied with the services they received, as seen in Figure 11 below.[7] They had positive perceptions of the relationship the youth had with the staff supporting them, as well as the effectiveness of the care provided. Respondents agreed that the child was included in the treatment planning process (91.7% caregivers, 92.3% youth), that services were sensitive to the child's cultural background (94.1% caregivers, 100% youth), and that the child felt heard and understood by their clinician (93.9% caregivers, 92.3% youth). Caregivers of students who were

> "The therapist was professional, compassionate, intelligent and deeply kind. The bond with my child was strong and my child always felt heard and understood. When the program ended, my child's therapist knew that my child needed a therapist locally to continue working with them. My child's therapist helped us find someone local and followed up to make sure that connection was working."
>
> - Caregiver

[7] Some survey questions were asked differently for youth than for caregivers to make sure the questions were understandable to youth.

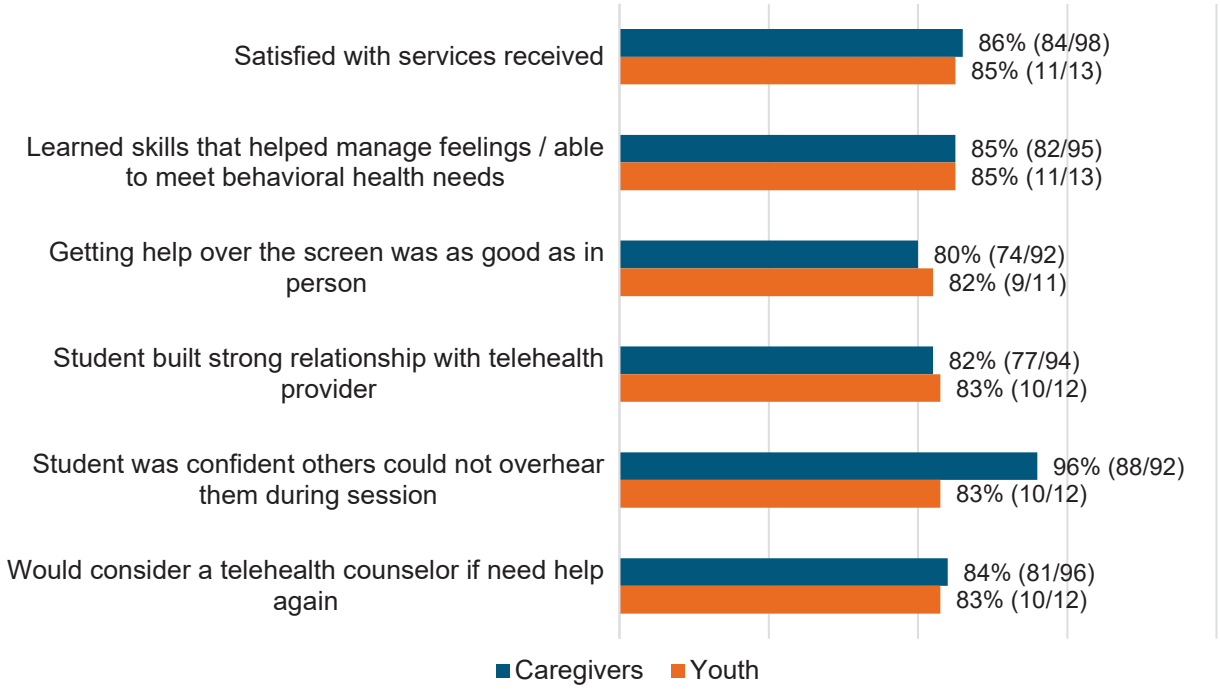
White were slightly more likely than caregivers of students who reported a Non-White race to agree that services were sensitive to the child's cultural background (95.6% of White only vs. 88.2% of Non-White). This difference was not statistically significant.[8] Most youth reported that they had learned skills that helped them to manage their feelings (84.6%). Their caregivers agreed, with 84.5% reporting that their child was better able to meet their own emotional and behavioral health needs after services.

> "Being able to talk about your emotions and everything going on in your life is important… There are a lot of kids who have nobody, or nobody trusted, to talk to."
>
> - Youth

Nearly all respondents indicated that the youth had easy access to the technology needed for their appointments (96.9% caregivers, 100% youth) and that youth and their telebehavioral health providers could hear each other easily (95.8% caregivers, 91.7% youth). Most felt that they built a strong relationship with their telebehavioral health provider (81.9% caregivers, 83.3% youth). The majority also agreed that getting help over the screen was as good as in person (80.4% caregivers, 81.8% youth). A similar number were confident that they would not be overheard during a session (95.7% caregivers, 83.3% youth). Almost all caregivers (84.4%) and youth (83.3%) reported that if the student needed help again, they would consider a telebehavioral health counselor. A full breakdown of the satisfaction survey is available in Appendix F.

[8] An analysis by race is not done among student respondents because only one student respondent was Non-White.

Figure 14. SBTBH Satisfaction[1]



[1] Items from the surveys are paraphrased for clarity. Some survey questions were asked differently for youth than for caregivers to make sure the questions were understandable to youth. Responses were recoded: "Agree"="Strongly Agree" and "Slightly Agree"; "Disagree"="Slightly Disagree" and "Strongly Disagree." All questions were worded as "I…" or "My child…".

X. Fiscal Summary

FY25 Highlights

- Costs vary for several reasons. Both school districts and provider organizations have start-up costs that may support varying degrees of planning, capacity building, and recruitment activities.
- Costs to the pilot are higher for Model 1 than Model 2. This is in large part because of the on-site CHW services provided under Model 1, which is not reimbursable by third-party payors.
- The pilot incurs many non-reimbursable costs that are essential to the goals of ensuring equity and increasing access to services. For example, the pilot allocated over $110,000 in the Equitable Care Fund to facilitate access for un- or under-insured students. In addition, maintaining coordination and collaborations across the many partners in the pilot requires significant personnel and level of effort.
- BCCMH is working closely with their provider network and school district partners to integrate cost-sharing models and explore braided funding strategies that will support long-term continuation of services beyond the pilot.

The cost of SBTBH services varied across the participating sites. Factors included the school district's student enrollment, the needs and capacity of each district, and the partnering TBH provider. Participating districts also had unique behavioral health disparities and service gaps which influenced both the structure of service delivery and the associated costs. This section offers additional information on program costs, including start-up costs for districts and provider organizations as well as costs associated with running the program. The program costs are based on the type of service model that is associated with the TBH provider organization.

A. Start-up Costs to School Districts

An example of start-up costs to school districts was based on one district located in south-central Massachusetts that is currently in receivership[9] and had a Needs Assessment score of 3, indicating moderately high needs (see Table 6; for a description of the Needs Assessment process, see Appendix Table A1, note 6). With a contract agreement to provide SBTBH services that went into effect on July 1, 2024, this district served students under the SBTBH Model 2, which typically provides access to 8-12 TBH sessions (lasting 45-60 minutes per session) over 2-4 months, with extensions when clinically indicated, and virtual care coordination services through the provider

[9] School districts placed in receivership are appointed a receiver by the state to plan for and address issues typically related to financial instability or academic performance.

organization. The district contributed 70% of the average cost per student while the SBTBH initiative contributed 30%.[10]

Table 6. Cost to One School District	
Item	**Estimate Based on Referrals Made[1]**
Average Cost for SBTBH Pilot per Student	$263.16
Average Cost for LEA[2] per Student	$601.32
Total Average Cost per Student	$864.47
[1] This estimate is based on the number of referrals made for SBTBH services during FY25 (N=95). [2] LEA=Local education agency.	

B. Start-up Costs to Provider Organizations

An example of start-up costs for a provider organization was based on Model 1 (see Table 7). This organization's contract with the SBTBH pilot went into effect on October 1, 2024, to conduct a planning and capacity-building phase that included recruiting and onboarding staff (clinical and community health worker [CHW] roles). The capacity-building phase also involved support of a clinician's salary for a limited time to allow time to build their caseload and prepare for reimbursable services by third-party payors. Direct clinical services for students are expected to begin during FY26.

Table 7. Cost for Model 1 Provider Organization	
Item	**Estimate**
Service Provider Cost	$65,896.74
Clinical Provider Only	$32,760.00
CHW Services Only	$33,136.74
Administrative Cost	$17,043.27
General Operations Cost	$8,800
Organization Indirect Cost	$8,259.99
Total Cost	**$100,000**
Notes: Budget was for 9 months (October 2024-June 2025). Service Provider Cost=Salary, tax, and fringe benefits; Administrative Cost=Supervision, project management; General Operations Cost=Supplies, technology, local travel; Organization Indirect Cost=Agency overhead costs including program supplies, facilities, and IT.	

C. Costs of Running the Program (for School Districts and Provider Organizations)

The costs per student for each service model are associated with the following provider organizations: The Brien Center, Cartwheel Care, and Heywood Healthcare. These cost estimates were calculated separately for each provider organization based on available data and do not include costs reimbursed by health insurance. The cost estimates only reflect the contributions made by the pilot for each service model and by local education agencies (LEAs) for Model 2. Please note that the cost estimates provided below for each model are not directly comparable.

[10] The pilot's contribution for SBTBH services for school districts depends on multiple factors (e.g., total student enrollment, budget constraints, and needs of the school). For reference, during FY24, the pilot's contribution ranged from 37-76% of service costs to LEAs. These costs are not reimbursable by third-party payors.

Students in Model 1, who typically received longer-term clinical services (e.g., more than 6 months) from a community-based organization (Heywood Healthcare) and had access to an in-person CHW at the participating school site, had an estimated average cost of $2,650.31 per student (see Table 8). This estimated cost included staff recruitment and onboarding, supervision, technology needs, as well as the CHW role, which is not reimbursable by third-party payors. These start-up and non-reimbursable costs may raise initial expenditures but are critical to achieve long-term equity by increasing availability and access to services across under-resourced areas.

Table 8. Cost Estimate: Model 1 (Heywood Healthcare)[1]	
Item	**Estimate**
Service Providers Pilot Cost per Student	$2,074.64
Clinical Services Only	$348.41
CHW Services Only	$1,726.24
Administrative, Pilot Cost per Student	$334.74
General Operations, Pilot Cost per Student	$56.28
Organization Indirect, Pilot Cost per Student	$240.93
Total Average Cost per Student	**$2,650.31**

[1] This estimate is based on the number of students served (N=199) during FY25. The costs to the pilot for those districts partnering with Heywood Healthcare included the use of CHWs, a role that is not reimbursable through third-party payors nor subsidized by the LEA.
Notes: There were no training costs to the provider organization during FY25 because BCCMH provided free training opportunities, many of which offered Continuing Education Units (CEUs). Service Providers Cost=Salary, tax, and fringe benefits; Administrative Cost=Supervision, project management; General Operations Cost= Supplies, technology, local travel.

Students served under Model 2 typically received clinical services for 2-4 months and care coordination services virtually from a for-profit organization (Cartwheel Care). The estimated average cost was $1,172.80 per student (see Table 9). This provider organization had an established infrastructure (i.e., technology, business, and operational workflows) and had clinical staff who were already onboard.

Table 9. Cost Estimate: Model 2 (Cartwheel Care)[1]	
Item	**Estimate**
Average Pilot Cost per Student	$640.98
Average Cost for LEA per Student	$531.82
Total Average Cost per Student	**$1,172.80**

[1] This estimate is based on the number of students served during FY25 (N=1,463). For districts providing TBH services in partnership with Cartwheel Care, both the Massachusetts Department of Public Health (MDPH) and the LEA made contributions to costs that were not covered by third-party reimbursement. The amount of MDPH funding was determined based on total student enrollment, expected referral volume (which can range between 2.5-5% or total enrollment depending on district needs), and other available LEA grants.

Students served under Model 3 received non-clinical support and services from a community-based CHW through the SBTBH pilot and TBH services from Cartwheel Care, separately from the pilot. Therefore, the cost was related primarily to the CHW position; the average cost was estimated at $1,152.60 per student (see Table 10).

Table 10. Cost Estimate: Model 3 (The Brien Center)[1]	
Item	**Estimate**
CHW Services Only per Student	$731.82
Administrative, Pilot Cost per Student	$159.57
Training/Professional Development, Pilot Cost per Student	$3.37
General Operations, Pilot Cost per Student	$116.29
Organization Indirect, Pilot Cost per Student	$141.55
Total Average Cost per Student	**$1,152.60**

[1] The Brien Center provided services from a CHW to a public school district serving grades K-12 located in northwestern MA. Clinical services (TBH sessions) were provided by Cartwheel Care, separately from the pilot. The costs during FY25 are for students referred to the pilot (N=89).

D. Costs Covered by Third-Party Reimbursement

Clinical services (i.e., TBH therapy sessions) delivered through the pilot are reimbursed by public and private insurance. During FY25, about two-thirds of students (64%) engaged in the pilot were covered by MassHealth, another 5% were uninsured or underinsured, and the remaining were covered by commercial insurance. However, provider organizations reported that third-party reimbursements did not cover the actual cost of the TBH sessions provided, nor the cost associated with cancelled/no-showed sessions. For example, Cartwheel Care estimated that a TBH session costs about $130 per session (costs that include clinician's time, credentialing, care coordination, maintaining open slots to avoid a waitlist, and administrative tasks), of which about $70-$80 was reimbursed per session across all payors. BCCMH is working to have data on specific codes for reimbursement for later reports.

E. Costs Not Covered by Third-Party Reimbursement

Services provided through the pilot that were not covered by third-party reimbursement included the following:

- Caregiver engagement and psychoeducation that were typically provided by CHWs and in some cases by clinicians. Stretching beyond traditional care coordination, these services may include CHW outreach to the family to schedule appointments, coordinate care across providers, provide education about services, address caregiver concerns/hesitations, and screen for and engage caregivers to address family Social Determinants of Health (SDoH) needs. The aim of these services is to initiate and sustain family engagement beyond clinical sessions to address gaps in care and mitigate risk. During FY25, the pilot provided $361,263 in direct cost coverage (i.e., salaries) for CHWs, providing a total of 7.12 FTEs ($281,575 for Heywood Healthcare, $51,366 for The Brien Center, and $28,322 for Codman Square Health Center).
- General operating costs associated with provider licensing, billing, and credentialing. For example, Heywood Healthcare allocated 8% of their FY25 budget serving four school districts ($44,593) for overall project management, including data submissions; The Brien Center allocated 13.8% ($14,202) for project and staff supervision serving one school district; and Codman Square Health Center allocated 2% ($2,000) for project management serving one school district.
- Supervision of CHWs and clinical staff. For example, Heywood Healthcare allocated 2% of their FY25 budget ($10,819) for clinical

supervision; Codman Square Health Center allocated 15% ($15,054) for clinical supervision.

- Training costs, oversight of data collection and submission for SBTBH evaluation, administrative tasks (e.g., documentations), and management of project-related services and activities (e.g., Memoranda of Understanding [MOUs], Data Use Agreements [DUAs], project meetings).
- Associated costs to families who were uninsured or underinsured. During FY25, the pilot allocated $110,500 to assist un/under-insured students to access and utilize TBH services. This included those with MassHealth Limited, which does not include coverage for outpatient behavioral health care. Schools were able to access these funds when out-of-pocket costs (e.g., weekly copays or high deductibles) presented a financial barrier to care for students and families. BCCMH reserved pro bono referral slots in every district to ensure students who are uninsured or underinsured were able to access care. Cartwheel Care automatically provides pro bono care for 5% of referrals. If Cartwheel Care districts utilized more than 5%, BCCMH provided support at $1,000 per referral case. For Heywood Healthcare, where services are more long term, BCCMH provided support at the MassHealth Reimbursement rate.
- SBTBH pilot activities that involved collaboration and coordination with participating school staff and provider organizations. For example, BCCMH staff spent an average of 11 hours per month meeting with school district personnel and, on average, 9 hours per month meeting with provider organizations. At these meetings, BCCMH reviewed the current status of implementation, identified successes for replication, identified pain points and implemented timely solutions to prevent service disruption, and collaborated on training and technical assistance (TTA) needs. School district personnel also met independently with their respective provider organization to ensure quality care coordination for youth clients.

F. Barriers/Challenges Related to Third-Party Reimbursement or Financial Sustainability

BCCMH is working closely with their provider network and school district partners to integrate cost-sharing models and explore braided funding strategies that will support long-term continuation of services beyond the pilot. This includes local grants, municipal contributions, and alignment with MassHealth and school-based Medicaid pathways. Dialogue has been ongoing with state partners around structural and policy supports to sustain school-based behavioral health access. The pilot will continue to engage payors to partner with the SBTBH initiative for a more sustainable financial model that addresses SDoH and potentially to cover non-reimbursable costs related to care navigation and the CHW role.

XI. Summary & Future Directions

The SBTBH pilot program consisted of multiple partners providing services to students in need of behavioral health care: 22 schools/school districts, 3 provider organizations, and 1 provider organization that was in a planning phase. During FY25, the pilot enabled 2,280 referrals for students to receive TBH services, resulting in 1,266 completed intakes and 18,693 TBH sessions. Since the pilot began in FY23, over 2,400 students have received behavioral health services because of this initiative.

Two primary service models have emerged. Model 1 provided telehealth services mostly at school during the school day, with the support of an on-site Community Health Worker. These services could be long-term, with an average of 20 sessions across 235 days in care. Model 2 provided telehealth services mostly outside of school hours and off campus, with the support of a remote Care Coordinator. These services were designed to be short-term, with an average of 12 sessions across 112 days in care. Clinical data from FY25 indicate that students who received care through the SBTBH pilot experienced positive clinical outcomes across both models of care. For example, students demonstrated statistically significant improvements in anxiety and depression scores from intake to discharge within each model of care. Approximately 85% of youth and caregivers indicated that they were satisfied with the services they received.

In FY25, the pilot's evaluation included data from school districts that provided insights into the academic and behavioral backgrounds of students referred to the pilot. Data from both clinical and district data sources indicate that students from high-priority groups (e.g., BIPOC students, LGBTQ+ students) were referred for TBH services at rates higher than their overall percentage in Massachusetts school enrollment data. Students from low-income backgrounds, those in foster care, and students with a disability were also referred to the pilot at higher rates than their prevalence in the overall Massachusetts student population. Further, students referred to the pilot had much higher rates of absenteeism and disciplinary actions than their peers. These data indicate that, overall, the pilot is achieving its goal of serving youth from high-priority populations.

The pilot invested heavily in workforce training and development. In FY25, the pilot offered over 50 courses across synchronous, online, and in-person training modalities; these garnered over 850 enrollments. Participants reported high levels of engagement and knowledge acquisition, with a 40-point increase in participants' reports of having a "a great deal" or "quite a bit" of knowledge on the training topic (44% to 85% before and after the training, respectively). In addition, the BCCMH team worked closely with provider organizations and school and district partners to ensure alignment on goals for service delivery improvement and to identify areas of opportunity for additional trainings.

The cost of SBTBH services varied across the participating sites. Factors included the school district's student enrollment, the needs and capacity of each district, and the partnering TBH provider. Participating districts also had unique behavioral health disparities and service gaps that influenced both the structure of service delivery and

the associated costs. It is important to note that the pilot's capacity to scale and enhance services is constrained by flat funding levels across fiscal years. BCCMH has been working closely with their provider networks and school district partners to integrate cost-sharing models and explore braided funding strategies that will support long-term continuation of services beyond the pilot. This includes local grants, municipal contributions, and alignment with MassHealth and school-based Medicaid pathways.

Exciting work is planned for FY26. BCCMH, in collaboration with the Massachusetts Department of Public Health (MDPH) Division of Child/Adolescent and Reproductive Health, the evaluation team, and the Interagency Work Group, will continue to enable TBH services and Social Determinants of Health (SDoH) resources for school districts while refining the implementation and evaluation processes. Highlights of this work are expected to include:

- Initiating services with three new school districts and one new provider partner;
- Rolling out a new SUD referral care pathway for students with substance use challenges;
- Implementing a Youth Advisory Board to center student voice and promote a participatory role for students in the pilot;
- Finalizing a Financial Sustainability Framework aimed at maximizing reimbursement, securing new funding streams, setting district-based referral targets, and expanding to new pilot sites;
- Updating the Needs Assessment to ensure the pilot is reaching the highest-priority districts;
- Implementing a standardized SDoH referral process for all clinical providers;
- Ensuring integration of Culturally and Linguistically Appropriate Services (CLAS) Standards and Community Health Equity Initiative (CHEI) data into processes across the project;
- Formalizing SBTBH workflows under all models to clarify referral criteria, referral process, wraparound support, and expected service location and duration;
- Collecting a second year of student-level data from district partners to provide insight into pilot impacts on academic and behavioral indicators;
- Streamlining the Capacity Assessment to promote more consistent data collection and better understanding of school/district partner readiness and adaptations to services.

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A. Appendix A. SBTBH Contracted and Interested School Districts

Table A1. List of Participating School Districts and Models in FY25

School/District	Entered Pilot	Model(s)	Needs Assessment Score[6]	Total Enrollment of Participating Schools	Contracted Referrals	Referrals for FY25	% Completed Intake	Penetration Rate[1]
Athol-Royalston[2]	FY23	Model 1	2	877	–	84	60.7%	9.6%
	FY24	Model 2		1,015	125	77	58.4%	7.6%
Ayer Shirley	FY24	Model 2	2	1,687	50	81	67.9%	4.8%
Berkshire Hills	FY23	Model 2	–	1,179	80	59	61.0%	5.0%
Boston Arts Academy	FY24	Model 2	5	473	50	51	51.0%	10.8%
Fall River	FY24	Model 2	5	10,453	200	226	40.2%	2.2%
Fitchburg	FY23	Model 2	3	5,234	100	63	54.0%	1.2%
Gardner	FY23	Model 1	2	1,292	–	62	27.4%	4.2%
Greater Lawrence Regional Vocational Technical[3]	FY23	Model 2	2	1,774	75	44	52.3%	4.8%
Greater New Bedford Regional Vocational Technical	FY24	Model 2	2	2,147	100	44	61.4%	1.3%
Haverhill	FY24	Model 2	2	7,581	130	190	62.1%	2.5%
Lawrence	FY24	Model 2	2	13,313	200	90	57.8%	1.7%
Lawrence Family Development Charter	FY24	Model 2	2	879	50	110	57.3%	12.5%
Lowell	FY23	Model 2	4	14,274	375	245	54.7%	1.7%
Marlborough	FY24	Model 2	2	4,729	200	141	58.9%	3.0%
Methuen	FY24	Model 2	1	6,389	50	96	55.2%	1.5%
Narragansett	FY23	Model 1	1	1,453	–	37	64.9%	2.5%
North Adams[4]	FY23	Model 3	4	1,207	75	65	60.0%	5.4%
Pittsfield	FY24	Model 2	3	4,876	150	199	54.8%	4.1%
R.C. Mahar	FY23	Model 1	–	504	–	47	42.6%	9.3%
Randolph[5]	FY25	Model 1	2	2,875	–	–	–	–
Salem	FY23	Model 2	2	3,811	200	177	68.9%	4.6%
Southbridge	FY25	Model 2	3	1,828	125	92	47.8%	5.0%

Table A1 Notes:
[1] Penetration rate calculations based on number of students enrolled at schools where the pilot was operating. The calculation does not capture enrollment per grade, so if services were only available to some grades, the penetration rate is an under-estimation.
[2] Athol-Royalston signed a tri-party agreement with BCCMH and Cartwheel Care to access Cartwheel Care services beginning September 2023. Initially, Athol-Royalston offered services only through Heywood Healthcare, and will only offer services through Cartwheel Care in FY26.
[3] Greater Lawrence Regional Vocational Technical ended services with the SBTBH pilot beginning FY26.
[4] North Adams signed a tri-party agreement with Cartwheel Care and The Brien Center to add support services from a CHW. Initially, North Adams offered only Cartwheel Care clinical services and will resume services only through Cartwheel Care in FY26, as The Brien Center exits the pilot.
[5] Randolph will begin offering services in FY26.
[6] The Needs Assessment (NA) Score is a composite measure ranking MA districts by behavioral health needs and resources using five weighted indicators: Community mental health status (from Behavioral Risk Factor Surveillance System), child opportunity (from Child Opportunity Index), school needs (from DESE), Race/ethnicity (from DESE), and school district resources (from BIRCh High Needs Tech Report). The top 10% of districts were coded "1" for measures of poor mental health status, students with high needs, and students of color. Schools identified by the BIRCh report with high need and low resources were coded "1", and the bottom 10% of school districts with the lowest COI were also coded "1." The purpose of the Needs Assessment was to inform the identification of potential school districts across Massachusetts in which telebehavioral health services in a school-based setting would be the most appropriate.

Table A2. List of Onboarding and Interested School Districts and Providers in FY26

School/District	Model	Needs Assessment Score	Total Enrollment
Boston Public Schools	Model 2	5	46,094
Framingham Public Schools	Model 2	2	9,124
Chelsea Public Schools	Model 2	4	6,094
Springfield Empowerment Zone	N/A	5	4,907
Brockton Public Schools	N/A	5	15,280
Franklin County Tech School	N/A	1	643

Note: The Needs Assessment Score is a composite measure ranking MA districts by behavioral health needs and resources using five weighted indicators. See note 6 to Table A1 for a more complete description of the Needs Assessment process.

B. Appendix B. District Student Demographics and Equity Impact Tables

Table B1. Other Student Characteristics: District-Provided Data				
Students Referred to the Pilot vs. MA Enrollment	**n Referred**	**% Referred**	**MA Enrollment[1]**	**Sig.**
IEP[2] (N[5]=1,438)	379	26.4%	21.1%	*
504 Plan (N=1,437)	202	14.1%	ND[3]	
English Language Learner (N=1,472)	223	15.2%	19.3%	*
First Language Other Than English (N=1,471)	355	24.1%	34.0%	*
Low-income (N=1,203)	726	60.4%	64.0%	*
Students Referred to the Pilot vs. MA Estimate	**n Referred**	**% Referred**	**MA Estimate[4]**	**Sig.**
Immigrant (N=1,051)	76	7.2%	5.7%	*
Housing Unstable (SY23-24 only) (N = 1,094)	57	5.6%	2.3%	*
Has Known History in Foster Care (N=1,380)	36	2.9%	0.7%	*

[1] Based on DESE data.
[2] IEP=Individualized Education Program.
[3] ND=No data available.
[4] MA estimates for Immigration (Migration Policy Institute, 2024), Housing Instability (America's Health Rankings, 2025) and Foster Care Involvement (Massachusetts Department of Children and Families, 2022) drawn from external sources, as DESE does not report these.
[5] N is the sample of students.
* Statistically significant difference at p<.05.

Table B2. Number and Percent of Referred Students with Absences, Tardies, and Disciplinary Incidents (School Year 2023-2024)					
	SBTBH Referred			**MA Enrollment[2] (SY23-24)**	**Sig.**
	N[3]	**n**	**%**		
1+ Absences	1,265	1,165	92.1%	ND[1]	
10+ Absences	1,265	789	62.4%	45.5%	*
18+ Absences	1,265	511	40.4%	19.7%	*
1+ Tardies	1,201	921	76.7%	ND[1]	
10+ Tardies	1,201	464	38.6%	ND[1]	
18+ Tardies	1,201	331	27.6%	ND[1]	
1+ Out of School Suspensions	1,259	227	18.0%	2.4%	*
1+ In School Suspensions	1,203	102	8.5%	1.4%	*
1+ Days Missed to Disciplinary Action	741	140	18.9%	3.4%	*
1+ Office Disciplinary Referrals	645	272	42.2%	ND[1]	
Ever Retained in Grade	849	86	10.1%	ND[1]	
Ever Been Expelled/Excluded from School for 45+ Days	819	9	1.1%	ND[1]	
Ever Arrested on Campus	817	1	0.1%	ND[1]	

[1] ND=No data available.
[2] Based on DESE data.
[3] N is the sample of students.
* Statistically significant difference at p<.05.

Table B3. Academic Indicators (SY 2023-24) Students referred to the pilot vs. MA enrollment			
	Working at or Above Grade Level		MCAS[1]
	n	%	MA Enrollment[2]
Reading (N=438)	133	30.4%	39% (Grades 3-8) 57% (Grades 10)
Math (N[3]=408)	123	30.2%	41% (Grades 3-8) 48% (Grades 10)

[1] MCAS=Massachusetts Comprehensive Assessment System.
[2] State figures from MCAS: https://educationtocareer.data.mass.gov/stories/s/MCAS-Data-Trends/qagd-r9iy/
[3] N is the sample of students.

C. Appendix C. Clinical Data Tables

Table C1. Clinical Outcomes Among Students Receiving Services, FY25[1]						
	Model 1			Models 2 & 3		
	N[1]	n (Range)	Value	N[1]	n (Range)	Value
GAD-7 (Anxiety)						
First Score Mean (Among All Students)	180	(0-21)	10.1	471	(0-21)	7.9
First Score Mean (Among Students Who Had at Least One Session Post-Intake)	170	(0-20)	10.1	377	(0-21)	8.0
Last Score Mean	58	(0-21)	6.3	377	(0-21)	4.3
Average Difference (Among Students Who Had at Least One Session Post-Intake)	56	–	-3.0	377	–	-3.7
% 5+ Point Reduction	56	19	33.9%	377	139	36.8%
% Severity Reduction	55	25	45.5%	283	184	65.0%
PHQ-9 (Depression)						
First Score Mean (Among All Students)	180	(0-24)	9.9	471	(0-26)	8.7
First Score Mean (Among Students Who Had at Least One Session Post-Intake)	169	(0-24)	10.0	377	(0-25)	8.5
Last Score Mean	59	(0-24)	6.7	377	(0-22)	4.8
Average Difference (Among Students Who Had at Least One Session Post-Intake)	56	–	-1.8	377	–	-3.7
% 5+ Point Reduction	56	14	25.0%	377	142	37.7%
% Severity Reduction	56	20	35.7%	287	186	64.8%
C-SSRS (Suicidality)						
High Risk	–	–	–	101	19	18.8%
Moderate Risk	–	–	–	101	24	23.7%
Low Risk	–	–	–	101	58	57.4%
Screen Positive	183	29	15.6%	–	–	–
Screen Negative	183	154	84.2%	–	–	–
Health Insurance						
Medicaid	196	138	70.4%	909	589	65.3%
Commercial	196	52	26.5%	909	196	21.7%
Uninsured / Insurance Not Accepted	196	6	3.1%	909	124	13.6%

[1] Models should not be directly compared.
[2] N is the sample of students.

Table C2. Youth Client Demographics, All Who Received Services, FY25[1]				
Characteristic	**Model 1**		**Models 2 & 3**	
	n	**Percent**	**n**	**Percent**
Race	N[2]=199		N[2]=909	
American Indian/Alaska Native	3	1.5%	1	0.1%
Black/African American	10	5.0%	39	4.3%
East Asian/Pacific Islander	0	0.0%	2	0.2%
Hispanic/Latine	–	–	218	24.0%
More Than One Race	7	3.5%	98	10.8%
South Asian	–	–	5	0.6%
White	174	87.4%	309	34.0%
Prefer Not to Say	–	–	32	2.4%
Missing	5	2.5%	301	22.1%
Ethnicity	N=193		N=693	
Hispanic/Latine	29	15.0%	284	41.0%
Not Hispanic/Latine	164	82.4%	409	59.0%
Gender Identity	N=193		N=702	
Cisgender Male	61	31.6%	292	41.6%
Cisgender Female	117	60.6%	357	50.9%
Transgender	3	1.6%	6	0.9%
Non-binary	7	3.6%	14	2.0%
Another Gender Identity	5	2.6%	30	4.3%
Unknown/Undeclared	–	–	3	0.4%
Sexual Orientation	N=199		N=563	
Straight/Heterosexual	129	64.3%	181	32.2%
Gay/Lesbian	5	2.5%	12	2.1%
Bisexual	8	4.0%	14	2.5%
Pansexual/Queer/Other	1	0.5%	9	1.6%
Questioning	8	4.0%	12	2.1%
Undisclosed/Not Asked	49	24.6%	335	59.5%
Disability Status	N=197		N=909	
Yes	66	33.5%	300	33.0%
Experienced Bullying	N=182		N=599	
Yes	59	32.4%	214	35.7%
Feels Accepted at School	N=190		N=250	
Yes (Mostly/Always True)	152	76.4%	216	86.4%
Substance Use	N=180		N=897	
Cannabis	33	18.3%	57	6.4%
Nicotine	26	14.4%	27	3.0%
Alcohol	12	6.7%	16	1.8%
Vape	23	12.8%	–	–
Other	4	2.2%	8	0.9%
None	138	76.7%	819	91.3%
Among Those with Any Use:	*N=42*		*N=78*	
Cannabis	33	78.6%	57	73.1%
Nicotine	26	61.9%	25	32.1%
Alcohol	12	28.6%	16	20.5%
Vape	23	54.8%	–	–
Other	6	13.0%	8	10.3%

[1] Models should not be directly compared.
[2] N is the sample of students.

Table C3. Model 1: Change in Behavioral Health Screener Scores, by Subpopulation																	
Subgroup		Mean Baseline Score			Mean Final Score			Mean Change in Score			5+ Point Reduction				1-Level (or More) Reduction			
		N[1]	Value	Sig.	N[1]	Value	Sig.	N[1]	Value	Sig.	N[1]	n	%	Sig.	N[1]	n	%	Sig.
GAD-7 (Anxiety)																		
Race	All Race	255	9.7		117	6.6		115	-2.0		115	29	25.2%		111	39	35.1%	
	White	231	9.7		105	6.7		103	-1.7		103	23	22.3%		99	33	33.3%	
	Non-White	24	9.9		12	5.1		12	-4.4	*	12	6	50.0%	*	12	6	50.0%	
Ethnicity	All Ethnicity	252	9.7		117	6.4		115	-2		115	29	25.20%		111	41	39.90%	
	Hispanic/Latine	38	10.3		18	5.9		18	-3.7		18	7	38.9%		18	11	61.1%	*
	Not Hispanic/Latine	214	9.6		99	6.5		97	-1.7		97	22	22.7%		93	30	32.3%	
Gender	All Gender	257	9.7		120	6.5		118	-2.0		118	29	24.6%		114	41	36.0%	
	Cisgender Male	85	7.3	*	40	5.3	*	39	-1.9		39	9	23.1%		13	37	35.1%	
	Cisgender Female	156	10.8	*	73	7.2	*	72	-1.9		72	19	26.4%		25	70	35.7%	
	Other Gender	16	11.7		7	6.4		7	-3.6		1	7	14.3%		3	7	42.9%	
Disability	All Ability	246	9.8		110	6.6		108	-2.1		108	29	26.9%		104	39	37.5%	
	Disability	76	9.6		28	6.7		27	-2.9		27	9	33.3%		24	10	41.7%	
	No Disability	170	9.9		82	6.5		81	-1.9		81	20	24.7%		80	29	36.3%	
Insurance	All Insurance	251	9.7		115	6.5		113	-2.0		113	28	24.8%		109	40	36.7%	
	Medicaid	170	9.8		79	6.8		78	-2.3		78	21	26.9%		76	31	40.8%	
	Commercial	27	9.0		31	6.0		30	-0.4	*	30	4	13.3%		28	6	21.4%	
	Uninsured	9	14.2	*	5	5.8		5	-6.4	*	5	3	60.0%		5	3	60.0%	
PHQ-9 (Depression)																		
Race	All Race	255	9.8		118	6.8		115	-1.7		115	27	23.5%		112	37	33.0%	
	White	231	9.9		106	7.0		103	-1.5		103	22	21.4%		100	32	32.0%	
	Non-White	24	9.2		12	5.1		12	-3.3		12	5	41.7%		12	5	41.7%	
Ethnicity	All Ethnicity	252	9.7		118	6.5		115	-1.6		115	27	23.5%		112	37	33.0%	
	Hispanic/Latine	37	9.7		18	6.1		18	-4.1	*	18	8	44.4%	*	18	10	55.5%	*
	Not Hispanic/Latine	215	9.7		100	6.6		97	-1.2		97	19	19.6%		94	27	28.7%	
Gender	All Gender	257	9.7		121	6.8		118	-1.6		118	27	22.9%		115	38	33.0%	
	Cisgender Male	85	7.8	*	40	5.4	*	39	-1.5		39	10	25.6%		37	10	27.0%	
	Cisgender Female	156	10.4	*	74	7.4	*	72	-1.3		72	13	18.1%		71	24	33.8%	
	Other Gender	16	13.8	*	7	8.4		7	-4.7	*	7	4	57.1%	*	7	4	57.1%	
Disability	All Ability	246	9.8		111	6.8		108	-1.7		108	25	23.1%		105	36	34.2%	
	Disability	75	10.2		28	7		27	-2.3		27	8	29.6%		24	11	45.8%	
	No Disability	171	9.7		83	6.8		81	-1.5		81	17	21.0%		81	25	30.9%	
Insurance	All Insurance	251	9.8		16	6.7		113	-1.7		113	27	23.9%		110	36	32.7%	
	Medicaid	170	9.8		80	7.0		78	-1.7		78	19	24.4%		77	26	33.8%	
	Commercial	72	9.2		31	6.0		30	-1.0		30	5	16.7%		28	7	25.0%	
	Uninsured	9	14.1	*	5	5.6		5	-4.8	*	5	3	60.0%		5	3	60.0%	

[1] N is the sample of students.
* Statistically significant difference at p<.05.

Table C4. Model 1: Session Counts, Intake Time, and Days in Care, by Subpopulation										
Subgroup		Session Count			Days Referral to Intake			Days Intake to Discharge		
		N[1]	Value	Sig.	N[1]	Value	Sig.	N[1]	Value	Sig.
Race	All Race	225	17.7		150	64.8		118	237.5	
	White	202	17.7		133	64.5		106	231.8	
	Non-White	23	13.6		17	67.1		12	287.6	
Ethnicity	All Ethnicity	223	17.3		149	61.7		119	236.9	
	Hispanic/Latine	33	15.8		24	60.8		29	247.4	
	Not Hispanic/ Latine	190	17.5		125	61.9		100	234.9	
Gender	All Gender	227	17.1		153	65.5		120	239.2	
	Cisgender Male	78	17.6		48	54.5		40	266.7	
	Cisgender Female	137	16.8		97	70.8		74	217.9	*
	Other Gender	12	16.3		8	63.0		6	317.5	
Disability	All Ability	224	17.4		143	66		111	226.2	
	Disability	70	18.6		45	65.1		30	250.0	
	No Disability	154	16.8		98	66.4		81	217.5	
Insurance	All Insurance	222	17.4		148	64.2		116	238.6	
	Medicaid	152	17.6		105	65.2		79	242.9	
	Commercial	62	17.2		41	62.9		32	227.3	
	Uninsured	8	14		2	39.5		5	242.6	

[1] N is the sample of students.
* Statistically significant difference at p<.05.

Table C5. Models 2 & 3: Change in Behavioral Health Screener Scores, by Subpopulation																		
Subgroup		Mean Baseline Score			Mean Final Score			Mean Change in Score			5+ Point Reduction				1-Level (or More) Reduction			
		N[1]	Value	Sig.	N[1]	Value	Sig.	N[1]	Value	Sig.	N[1]	n	%	Sig.	N[1]	n	%	Sig.
GAD-7 (Anxiety)																		
Race	All Race	652	7.9		504	4.5		504	-3.5		504	187	37.1%		383	243	63.5%	
	White	237	7.9		184	4.1		184	-3.8		184	70	38.0%		141	92	65.3%	
	Hispanic/Latine	154	7.5		124	3.9		124	-3.8		124	50	40.3%		97	64	66.0%	
	Black	31	6.7		27	4.2		27	-2.6		27	8	29.6%		16	11	68.8%	
	Multiracial	72	7.8		55	5.6		55	-2.3		55	14	25.5%		39	20	51.3%	
	Other	8	10.9		6	4.2		6	-6.3		6	4	66.7%		5	4	80.0%	
	Unknown	150	8.5		108	5.6	*	108	-3.4		108	41	38.0%		85	52	61.2%	
Gender	All Gender	520	7.7		409	4.3		409	-3.5		409	148	36.2%		307	197	64.2%	
	Cisgender Male	180	6.0	*	141	3.1	*	141	-2.9		141	40	28.4%	*	90	56	62.2%	
	Cisgender Female	291	8.8	*	231	5.1	*	231	-3.7		231	94	40.7%	*	191	125	65.5%	
	Other Gender	49	7.6		37	3.8		37	-3.9		37	14	37.8%		26	16	61.5%	
Disability	All Ability	652	7.9		504	4.5		504	-3.5		504	187	37.1%		383	243	63.5%	
	Disability	234	7.3	*	177	4.4		177	-3.2		177	64	36.2%		132	83	63.9%	
	No Disability	418	8.3		327	4.6		327	-3.7		327	123	37.6%		251	160	63.8%	
Insurance	All Insurance	644	7.9		498	4.5		498	-3.5		498	184	37.0%		377	240	63.7%	
	Medicaid	410	7.9		320	4.7		320	-3.3		320	115	36.0%		243	152	62.6%	
	Commercial	157	7.8		121	4.1		121	-3.7		121	46	38.0%		88	59	67.1%	
	Uninsured	58	8.6		43	3.8		43	-5.0		43	20	46.5%		37	26	70.3%	
PHQ-9 (Depression)																		
Race	All Race	652	8.7		504	5.1		504	-3.6		504	183	36.3%		394	241	61.2%	
	White	237	8.4		184	4.7		184	-3.4		184	59	32.1%		136	83	61.0%	
	Hispanic/Latine	154	8.6		124	4.7		124	-4.2		124	53	42.7%		98	68	69.4%	
	Black	31	7.8		27	4.9		27	-2.8		27	7	25.9%		18	10	55.6%	
	Multiracial	72	8.3		55	6.4		55	-2.0	*	55	16	29.1%		45	20	44.4%	*
	Other	8	14.4	*	6	6.0		6	-7.7		6	4	66.7%		6	4	66.7%	
	Unknown	150	9.5		108	5.7		108	-4.0		108	44	40.7%		91	56	61.5%	
Gender	All Gender	520	8.5		409	5.0		409	-3.5		409	145	35.5%		314	191	60.8%	
	Cisgender Male	180	6.6	*	141	3.5	*	141	-3.0		141	41	29.1%	*	192	115	59.9%	
	Cisgender Female	291	9.6	*	231	6.0	*	231	-3.6		231	87	37.7%		93	53	57.0%	
	Other Gender	49	9.6		37	4.7		37	-4.6		37	17	46.0%		29	23	79.3%	*
Disability	All Ability	652	8.7		504	5.1		504	-3.6		504	183	36.3%		394	241	61.2%	
	Disability	234	7.8	*	177	4.7		177	-3.2		177	67	37.9%		132	85	64.4%	
	No Disability	418	9.2		327	5.4		327	-3.8		327	116	35.5%		262	156	59.5%	
Insurance	All Insurance	644	8.7		498	5.1		498	-3.6		498	181	36.4%		389	239	61.4%	
	Medicaid	410	8.8		320	5.2		320	-3.6		320	119	37.2%		251	154	61.4%	
	Commercial	157	8.3		121	4.8		121	-3.5		121	41	33.9%		92	60	65.2%	
	Uninsured	58	9.5		43	4.3		43	-4.9	*	43	19	44.2%		36	22	61.1%	

[1] N is the sample of students.
* Statistically significant difference at p<.05.

Table C6. Models 2 & 3: Session Counts, Intake Time, and Days in Care, by Subpopulation										
Subgroup		**Session Count**			**Days Referral to Intake**			**Days Intake to Discharge**		
		N[1]	**Value**	**Sig.**	**N[1]**	**Value**	**Sig.**	**N[1]**	**Value**	**Sig.**
Race	All Race	1233	10.7		1362	30.9		1362	97.2	
	White	435	12.3	*	478	29.9		478	108.1	*
	Hispanic/Latine	305	10.6		327	31.5		327	100.2	
	Black	51	11.5		55	23.5	*	55	110.1	
	Multiracial	146	10.3		155	26.9	*	155	104.7	
	Other	13	17.1	*	14	25.1		14	127.6	
	Unknown	283	8.0	*	333	35.1	*	333	71.5	*
Gender	All Gender	992	11.3		1073	29.6		1073	104.5	
	Cisgender Male	416	10.9		454	30.5		454	98.9	
	Cisgender Female	479	11.7		515	28.1	*	515	109.6	
	Other Gender	97	11.1		104	33.0	*	104	103.2	
Disability	All Ability	1233	10.7		1362	30.9		1362	97.2	
	Disability	442	10.5		491	31.3		491	95.0	
	No Disability	791	10.8		871	30.7		871	98.4	
Insurance	All Insurance	1221	10.7		1349	30.8		1349	97.4	
	Medicaid	803	10.1		893	31.3		893	93.6	
	Commercial	254	12.8		281	28.2		281	108.0	
	Uninsured	128	9.9		137	33.3		137	93.5	

[1] N is the sample of students.
* Statistically significant difference at p<.05.

D. Appendix D. Social Determinants of Health Referrals

Table D1. Referrals for Additional Needs in FY25[1]		
Referral Type[2]	**Models 1 and 3[3] (n)**	**Model 2[4] (n)**
Clothing/Personal Care	9	–
Education	251	–
Employment/Volunteer	76	–
Food	143	–
Fuel/Utility	14	–
Health Insurance	23	–
Housing	12	–
Legal	7	–
Support Groups	38	–
Recreation	144	–
Behavioral Health	192	–
Psychiatry	Combined with Behavioral Health	–
Other	11	–
Total	**N=920**	**N=132**

[1] Data are up to June 30, 2025.
[2] Due to the small sample size for Model 3, and the limited integration of this CHW within the school, Models 1 and 3 were combined for SDoH reporting. This table includes only referral types shared between Models 1 and 3.
[3] Model 3 concluded participation in the pilot at the end of FY25. Beginning in FY26, Models 1 and 2 remain active in the pilot.
[4] Model 2 data are restricted to a binary indicator (Yes/No) of whether an external referral was received. As a result, data for other categories are not currently available for reporting in this model.

In FY25, five schools and districts operating under Models 1 and 3 received Community Health Worker (CHW) support and resources to address Social Determinants of Health (SDoH) needs. Prior to FY25, Model 2 provided only behavioral health referrals but, with support from BCCMH, developed SDoH referral processes and integration with Find Help in FY25. In FY26, Model 3 will conclude participation in the pilot, and Models 1 and 2 will remain active in the pilot.

E. Appendix E. Provider Capacity and Workforce Training Tables

Table E1. Workforce Demographics and Satisfaction				
Characteristic	**Therapists / Clinicians (N[1]=41)**		**Community Health Workers (N[1]=9)**	
	n	**Percent**	**n**	**Percent**
Time in Practice				
Less Than One Year	4	9.8%	1	11.1%
One to Two Years	6	14.6%	3	33.3%
Two to Three Years	7	17.1%	0	0.0%
Three to Five Years	5	12.2%	3	33.3%
Five to Ten Years	7	17.1%	2	22.2%
More Than Ten Years	12	29.3%	0	0.0%
Time in Telehealth Practice				
Less Than One Year	7	17.1%	1	11.1%
One to Two Years	11	26.8%	3	33.3%
Two to Three Years	6	14.6%	0	0.0%
Three to Five Years	14	34.2%	3	33.3%
Five to Ten Years	3	7.3%	2	22.2%
More Than Ten Years	0	0.0%	0	0.0%
Gender				
Cisgender Female	35	85.4%	9	100.0%
Cisgender Male	2	4.9%	0	0.0%
Non-binary or Gender Queer	4	9.8%	0	0.0%
Sexual Orientation				
LGBQ+	8	19.5%	2	22.2%
Heterosexual	31	75.6%	7	77.8%
Prefer Not to Say	2	4.9%	0	0.0%
Disability				
Yes	10	24.4%	0	0.0%
No	31	75.6%	8	88.9%
Prefer Not to Say	0	0.0%	1	11.1%
Race[1]				
White	32	78.0%	8	88.9%
Black/African American	3	7.3%	0	0.0%
Asian	2	4.9%	0	0.0%
More Than One Race	4	9.8%	0	0.0%
Other	1	2.4%	1	11.1%
Hispanic/Latine				
Yes	7	17.1%	1	11.1%
No	33	80.5%	8	88.9%
Prefer Not to Say	1	2.4%	0	0.0%
Language[1]				
English	40	97.6%	9	100.0%
Spanish	8	19.5%	0	0.0%
Portuguese	5	12.2%	0	0.0%
Haitian Creole	1	2.4%	0	0.0%
Cantonese	1	2.4%	0	0.0%
Ga	1	2.4%	0	0.0%
[1] N is the sample of students.				

Table E1. Workforce Demographics and Satisfaction				
Characteristic	**Therapists / Clinicians (N[1]=41)**		**Community Health Workers (N[1]=9)**	
	n	**Percent**	**n**	**Percent**
Job Satisfaction				
Extremely Satisfied	13	31.7%	3	33.3%
Satisfied	20	48.8%	5	55.7%
Neither Satisfied nor Dissatisfied	6	14.6%	0	0.0%
Dissatisfied	0	0.0%	0	0.0%
Extremely Dissatisfied	2	4.9%	1	11.1%
Trainings Attended[1]	**Therapists / Clinicians (N=35)**		**Community Health Workers (N=3)**	
	n	**Percent**	**n**	**Percent**
Trauma Informed Practice	32	91.4%	3	100.0%
Substance Use Disorder	19	54.3%	3	100.0%
Culturally Responsive Practice	21	60.0%	2	66.7%
Social Determinants of Health	12	34.3%	2	66.7%
Anti-racist Clinical and Community Practice / Implicit Bias Training	20	57.1%	2	66.7%
Disability and Neuro-Divergence	12	34.3%	2	66.7%
Queer and Gender-Affirming	12	34.3%	2	66.7%
Other	2	5.7%	1	33.3%

Note: N is the sample of students.
[1] Respondents could select all that apply, so may add up to more than 100%.

Table E2. List of Available Synchronous and Asynchronous Trainings	
Category	**Course / Session Title**
Tele-Behavioral Health & Clinical Topics	Adolescent Substance Use: What's the Deal?
	Building Authentic Youth Engagement & Partnership
	Building Collaborative and Trusting Relationships with Caregivers
	Co-Occurring Mental Health and Substance Use Disorders: Strategies for Managing Anxiety, Mood, and Psychosis in Adolescents and Young Adults
	Early Psychosis: Symptoms, Identification & Treatment
	Evaluating the School-Based TBH Pilot Project: Data Collection and Reporting for Schools
	How Do I Use Motivational Interviewing to Engage Caregivers?
	How Do I Use Motivational Interviewing to Engage Students?
	Introduction to the Behavioral Health Helpline
	Problematic Interactive Media Use
	Self-Compassion & Mindful Movement
	Self-Injurious Behavior
	Substance Use Screening, Brief Intervention and Referral to Treatment in Schools
	Supporting Youth with Cell Phones & Social Media 2.0
	Supporting Youth with Substance Use Disorders
	Tele-Behavioral Health Essentials, Parts 1 - 4
	Understanding & Supporting Youth with Cell Phone & Social Media Usage
	Understanding and Tackling Youth Mental Health Challenges
	Understanding Risks of Youth Vaping
ECHO Sessions	Promoting Mental Health ECHO Listening Session #1 & #2
	ECHO: Tackling Anxiety in Students Using Bottom-Up and Top-Down Strategies
	ECHO: Demystifying the MTSS Framework
	ECHO: Raising Concerns About Racism
	ECHO: Trauma-Informed Care for Promoting Behavioral Health at School
Family Systems & Behavioral Health Models	Clinical Leadership & Supervision to Establish & Support Comprehensive School Mental Health Systems
	Introduction to Family Engagement Training
	School Based Community Health Worker Module
	Transtheoretical Model of Change (Stages of Change)
	Working with Family Systems: Relational & Transgenerational Lenses
	Working with Family Systems: Structural & Experiential Lenses
Trauma-Informed & Equity-Based Practice	Burnout and Secondary Traumatic Stress (aka Secondary Traumatic Stress & Burnout)
	Racial Stigma, Policing, and Our Schools
	Racial Trauma in Schools for Behavioral Health Staff: Modules 1-5
	Racial Trauma in Schools for Educators
	Trauma 101 and Group Settings
	Trauma Informed Care 101
	Understanding and Interrupting the School-to-Prison Pipeline for Behavioral Health Staff
	Understanding and Interrupting the School-to-Prison Pipeline for School Staff
Cultural Diversity & Responsiveness	Acculturation
	Being Culturally Responsive
	Berkshire Hills LGBTQ+
	CARE (Connect, Accept, Respond, Empower) LGBTQ+ Suicide Overview
	Creating LGBTQ+ Inclusive Secondary Schools
	Cultivating a Multicultural Perspective: Parent Voice & Youth Voice
	Cultural Elements in Working with Hispanic/Latine Communities
	Immigrants and Newcomers: Sessions 1-4
	Introduction to Cultural Responsiveness
	Leading with Cultural Humility
	Microaggressions
	Session 1: Facilitated Discussion on Immigrants/Newcomers
	Supporting Students & Families with LGBTQ+ Youth from a Culturally Responsive Latine Perspective
	Supporting Transgender and Non-Binary Students
	The Mental Health Impact of Living in a Racialized Society

Conflict Resolution & Mediation	Conflict De-escalation Techniques
	Conflict Resolution to Prevent Bullying
	Conflict Skills Workshop
	Conflict Styles
	Dealing with Conflict: A Mediator's Perspective
	How to Lead Conversations About Conflict with Youth
	Introduction to Peer Mediation
	Understanding the Dynamics of Conflict
Other	Introduction to the Learning Collaboration Tutorial
	The Plan-Do-Study-Act (PDSA) Cycle Module

Table E3. List of Available FY25 Symposium Trainings
Session/Training Title
Understanding the Complexity of Chronic School Absenteeism
BIRCh: School and Community Partnerships to Enhance Behavioral Health and Wellness
Mental Health in Schools: Systems, Individuals, Professional Identity, and Implications for Students
Best Practices and Considerations for Delivering Tele-Behavioral Health in Schools in Massachusetts
FY24 Annual Report Findings in the Tele-Behavioral Health Project Evaluation
Mindfulness Meditation
Community Health Workers: Overview and Advocacy

Table E4. Training/Course Evaluation by Training Type (July 1, 2024 – June 30, 2025)[1]		
Asynchronous Learning (LMS site)		
Full or Partially Completed Evaluations	Pre-test	Post-test
Can Immediately Apply What Was Learned: "Agree" or "Strongly Agree" (N=134)	–	89% (n=119)
Level of Knowledge/Skill: "A Great Deal" or "Quite a Bit" (N=134)	45% (n=60)	87% (n=117)*
SBTBH Symposium		
Full or Partially Completed Evaluations	Pre-test	Post-test
Can Immediately Apply What Was Learned: "Agree" or "Strongly Agree" (N=27)	–	96% (n=26)
Level of Knowledge/Skill: "A Great Deal" or "Quite a Bit" (N=22)	50% (n=11)	96% (n=21)*
Synchronous Workforce Trainings		
Full or Partially Completed Evaluations (N=327)[2]	Pre-test	Post-test
ECHO Learning Session Has Improved My Confidence to Foster Students' Social, Emotional and Behavioral Skills: "Agree" or "Strongly Agree" (N=106)	–	90% (n=95)
Can Immediately Apply What Was Learned: "Agree" or "Strongly Agree" (N=221)[2]	–	93% (n=205)
Level of Knowledge/Skill: "A Great Deal" or "Quite a Bit" (N=221)[2]	43% (n=95)	84% (n=186)*
Totals across Workforce Training Modalities		
Full or Partially Completed Evaluations (N=488)	Pre-test	Post-test
Can Immediately Apply What Was Learned: "Agree" or "Strongly Agree" (N=375)[2]	–	91% (n=343)
Level of Knowledge/Skill: "A Great Deal" or "Quite a Bit" (N=375)[2]	44% (n=164)	85% (n=320)*

[1] While BCCMH-sponsored trainings utilized the same evaluation form across trainings (and matched those administered through the LMS site), evaluation questions were not always consistent when co-facilitating or co-sponsoring trainings with other organizations.
[2] Excludes ECHO data.
[3] N is the sample of students.
* Difference in level of knowledge/skills pre and post training is statistically significant (p<.05).

F. Appendix F. Preliminary Findings from Youth and Caregiver Satisfaction Surveys

Beginning in February 2024, the Youth and Family Satisfaction Survey was sent to all students and caregivers discharged from SBTBH services. The youth and caregiver versions of the survey were worded slightly differently to ensure accessibility to youth respondents. In FY25, 112 survey responses were received, of which the majority were caregivers (88%), with the remaining responses coming from students answering the survey on their own behalf (12%).

1. Respondent Demographics

Table F1 displays demographic characteristics of SBTBH-engaged students for whom responses were recorded, both overall and based on respondent category. Most respondents identified as White (83.5%), with just over a quarter (26.5%) identifying as Hispanic/Latine. The youth survey also asked about sexual orientation and gender identity, with 2 of 10 respondents identifying as LGBTQ+.

Table F1. SBTBH Youth Demographics, Among Satisfaction Survey Respondents[1]

Characteristic	Caregiver Responses	Youth Responses	Total Responses[2]
	Percent (n)	Percent (n)	Percent (n)
Age	N[4]=96	N=10	N=106
6-10	28.1% (27)	0.0% (0)	25.5% (27)
11-13	32.3% (31)	20.0% (2)	31.1% (33)
14-15	22.9% (22)	20.0% (2)	22.6% (24)
16-17	16.7% (16)	10.0% (1)	16.0% (17)
18+	0.0% (0)	50.0% (5)	4.7% (5)
Race[2]	N=92	N=11	N=103
White	82.6% (76)	90.9% (10)	83.5% (86)
Black	8.7% (8)	9.1% (1)	8.7% (9)
Hispanic/Latine[3]	9.8% (9)	0.0% (0)	8.7% (9)
More Than One Race	7.6% (7)	0.0% (0)	6.8% (7)
American Indian/Alaska Native	2.2% (2)	0.0% (0)	1.9% (2)
Asian	2.2% (2)	0.0% (0)	1.9% (2)
Hispanic/Latine	N=93	N=12	N=105
Yes	26.9% (25)	25.0% (3)	26.7% (28)

[1] Duplication of individual youth is possible, as a youth and their caregiver may have both responded to the survey.
[2] Total may add to more than 100% because respondents could select multiple race options.
[3] Some respondents selected that they were of an "other" race and specified their race as Hispanic/Latine.
[4] N is the sample of students.

Respondents were also differentiated by provider to deliver targeted feedback and recommendations to support service delivery. As shown in Table F2, nearly all reported receiving services through Model 2 (93.8%), while just seven respondents were served by Model 1 (6.3%). Most students engaged in Model 1 had sessions at school (83.3%), compared to less than a fifth of students engaged in Model 2 (19.2%). Though there were few Model 1 respondents, these data are consistent with the total sample from FY24 and FY25 combined, in which 21 out of 25 Model 1 respondents (84.0%) took sessions at school. While responses are reported by youth vs. caregiver in many

instances, caution is warranted in extrapolating findings with such a small sample of youth (N=13).

Table F2. Telebehavioral Health Provider and Session Location						
	Caregiver Responses		Youth Responses		Total Responses[1]	
	N[2]	Percent (n)	N[2]	Percent (n)	N[2]	Percent (n)
Provider						
Model 2	99	96.0% (95)	13	76.9% (10)	112	93.8% (105)
Model 1	99	4.0% (4)	13	23.1% (3)	112	6.3% (7)
Participated in Telebehavioral Health Sessions From:						
Home	98	78.6% (77)	12	58.3% (7)	110	76.4% (84)
School	98	20.4% (20)	12	41.7% (5)	110	22.7% (25)
Other	98	1.0% (1)	12	0.0% (0)	110	0.9% (1)
Model 2: Participated in Telebehavioral Health Sessions From:						
Home	94	81.9% (77)	10	60.0% (6)	104	79.8% (83)
School	94	17.0% (16)	10	40.0% (4)	104	19.2% (20)
Other	94	1.1% (1)	10	0.0% (0)	104	1.0% (1)
Model 1: Participated in Telebehavioral Health Sessions From:						
Home	4	0.0% (0)	2	50.0% (1)	6	16.7% (1)
School	4	100.0% (4)	2	50.0% (1)	6	83.3% (5)

[1] Duplication of individual youth is possible, as a youth and their caregiver may have both responded to the survey.
[2] N is the sample of students.

2. Areas of Strength for SBTBH Services

Overall, 86% of caregivers and 85% of students reported that they were satisfied with services (see Table F3). This included making progress towards treatment goals (86% of caregivers; 92% of students) and feeling heard and understood by the clinician (94% of caregivers; 92% of students), both supported by open-ended responses:

> *"My son had depression at the beginning of the year and the treatment he received was very good. Today he is doing very well. The services he received and the school's support were fundamental to his recovery." (Translated from Portuguese)*

Satisfaction with the technological aspects of service delivery was high. Both adult and youth respondents indicated that they had access to the technology needed to access services (97% of caregivers; 100% of students) and that the student could hear their clinician well (93% of caregivers; 92% of students). Most respondents would consider telebehavioral health again in the future (84% of caregivers; 83% of students).

Table F3. Youth and Caregiver Satisfaction with SBTBH Services[1]				
	Youth		Caregivers	
	N[2]	Percent (n)	N[2]	Percent (n)
Overall Care				
Felt Heard and Understood by Clinician	13	92.3% (12)	98	93.9% (92)
Felt Heard and Understood by CHW/Care Coordinator	12	91.7% (11)	79	96.2% (76)
Included in Treatment Planning Process	13	92.3% (12)	96	91.7% (88)
Made Progress Towards Treatment Goals	13	92.3% (12)	95	86.3% (82)
Better Able to Meet Own Emotional and Behavioral Health Needs	13	84.6% (11)	97	84.5% (82)
Services Sensitive to Cultural Background	13	100% (13)	68	94.1% (64)

Felt More Accepted and Supported at School After Services	13	92.3% (12)	84	85.7% (72)
Overall, Satisfied With Services Received	13	84.6% (11)	98	85.7% (84)
Technology				
Had Easy Access to Technology Needed for Telehealth Sessions	11	100% (11)	98	96.9% (95)
Telehealth Provider and Student Could Hear Each Other Easily	12	91.7% (11)	95	95.8% (91)
Student Built Strong Relationship With Telehealth Provider	12	83.3% (10)	94	81.9% (77)
Student Was Confident Others Could Not Overhear Them During Session	12	83.3% (10)	92	95.7% (88)
Getting Help Over the Screen Was as Good as In Person	11	81.8% (9)	92	80.4% (74)
Would Consider a Telehealth Counselor if Need Help Again	12	83.3% (10)	96	84.4% (81)

[1] Responses were recoded: "Agree"="Strongly Agree" or "Slightly Agree"; "Disagree"="Slightly Disagree" or "Strongly Disagree." All questions were worded as "I…" or "My child…". Some survey questions were asked differently for youth than for caregivers to make sure the questions were understandable to youth.
[2] N is the sample of students.

Respondents shared that SBTBH services led to improvements in their child's relationship with and performance at school, including in their communication, confidence, grades, behavior, attendance, and relationships with friends. They appreciated that the school was able to address their child's needs through SBTBH. Participation in SBTBH improved child-caregiver communication and led youth to see that their caregiver was also available for them when they need help. Sessions that included both the child and caregiver, or parent guidance sessions alone, were particularly helpful. Overall, caregivers and youth reported that the youth felt like they were being taken seriously by the school and their caregivers.

> *"I feel more confident that the school was able to identify an issue with my child and offer assistance that was accessible and useful."*

> *"We [child and caregiver] had some sessions together to talk about issues which helped us get along better."*

> *"My mom helped me understand that I can share feelings with my counselor that I didn't have to share with her. It showed me that my mom respects my privacy."*

3. Areas for Consideration for SBTBH Services

Though telehealth was effective for the majority of respondents, many students would prefer in-person sessions if they had a choice. Others did not find SBTBH services helpful because they were virtual.

> *"I like in person sessions better than telehealth but I do like the flexibility of telehealth if need be."*

> *"My child's issue are social-emotional and telehealth is not helpful with that. In person [services] would provide better access to emotional learning."*

While most respondents did not have any issues with the technology, this was a problem for a few. There were issues with the audio especially. One participant

expressed frustration with Zoom as well as the therapist's speaker and microphone every session. Another participant would have liked the option to have cameras off.

> *"Issues with hearing causing things to have to be spoken louder which lead to others hearing. My child felt weird especially with the hearing aspect of it because things were missed."*

Though the majority of respondents benefited from participation in SBTBH and built a strong relationship with their counselor, many reported that students were not very engaged in their sessions. Some felt that the therapist could have done more to attempt to engage the youth.

> *"[The] clinician needed to create an approach to connect with my child; sessions lasted much less than the allotted time. My child was reluctant and [the] clinician did not attempt to connect or keep sessions going."*

A few respondents mentioned that they had limited choice in which therapist they were assigned to. They noted that they would have preferred to be matched with therapists who had specific qualities, such as clinicians specializing in neurodivergence, play therapists, clinicians of color, or multilingual providers.

Constraints in the therapist's availability for appointments was another frequent challenge. Some respondents indicated that they needed to reschedule appointments because of the therapist's availability. Many appointment hours were in the morning, which was inconvenient for some. Additionally, participants would like more flexibility in their session location. One student who took sessions at school would have preferred to have them at home. Likewise, one caregiver whose child took sessions at home after school would have preferred that they have them at school during the day.

Some caregivers noted being unsure of to what extent they could and should be involved in their child's treatment. Some caregivers would have liked more communication with the clinician, while others reported feeling like "the middleman" between the clinician and the student. Additional guidance to caregivers from the provider organization on the treatment plan and how and when to be involved would better support parent engagement.

A minority of respondents felt that they were not taken seriously by the provider. One caregiver noted:

> *"My son is an 'A' student, he doesn't miss school, he has two parents who are married, and that's when people stop listening. They miss the part where he is [severely] depressed, has no friends, and experiences suicidal ideation. This [clinician], much like the [counselors] at our school, seem to feel that students who get good grades and come from intact family units can't suffer from mental health issues."*

Opportunities for growth and potential program adaptations also emerged from some of the feedback. Many participants would have preferred more continuity in care with a therapist. For students receiving care through Model 2, the limit on the time that a student could participate in SBTBH was disappointing for some people who needed continued therapy. Others reported that they needed services again after finishing their sessions with SBTBH and that it was difficult to re-enroll. Additionally, respondents noted that it would have been helpful to be able to have overlap or a warm transition between moving or graduating and finding a new therapist outside of SBTBH.

> *"The 6-month cut off was a bit of a surprise for us. We didn't realize that there was a stopping point. My child was honestly pretty upset to say goodbye to the therapist that they had developed such a strong bond with and start over with someone local. It's really too bad they couldn't have retained their therapist, even if it shifted out of the [provider's] program and into private pay."*

> *"It's unfortunate that they had to close due her going to a new school, it would be good to have overlap until she finds new therapist."*

4. Conclusion

The emerging data from the Youth and Family Satisfaction survey indicate a high level of satisfaction with the clinical care received, and an overall willingness to return to a telebehavioral health model in the future. Reassuringly, technological issues reported were very rare. Some respondents, however, shared that while telebehavioral health was effective, in-person therapy would be more effective for them.

G. Appendix G. Interagency Work Group (IWG) Members

Table G1. Interagency Work Group (IWG) Members	
Department of Public Health The mission of the Massachusetts Department of Public Health (DPH) is to promote and protect health and wellness and prevent injury and illness for all people, prioritizing racial equity in health by improving equitable access to quality public health and health care services and partnering with communities most impacted by health inequities and structural racism.	
Bureau of Community Health and Prevention	Manager, Behavioral Health Initiatives
	Director, Division of Child/Adolescent Health and Reproductive Health
	Behavioral Health Coordinator
	Director, School-Based Health Center Program
	Epidemiologist, Division of Child/Adolescent Health and Reproductive Health
	Program Coordinator
	Assistant Director, School-Based Health Center Program
	Director, School Health Services
Bureau of Substance Addiction Services	MA Statewide A-CRA Trainer, Office of Youth & Young Adult Services
Department of Elementary and Secondary Education The mission of the Massachusetts Board of Elementary and Secondary Education is to strengthen the Commonwealth's public education system so that every student is prepared to succeed in postsecondary education, compete in the global economy, and understand the rights and responsibilities of American citizens, and in so doing, to close all proficiency gaps.	
Office of Student and Family Support	Substance Use Prevention and Intervention Specialist
	Behavioral and Mental Health Specialist
Center for Educational Options	Safe and Supportive Schools Specialist
Department of Mental Health The Department of Mental Health (DMH), as the State Mental Health Authority, assures and provides access to services and supports to meet the mental health needs of individuals of all ages, enabling them to live, work, and participate in their communities.	
DMH	Director of Cross-Agency Initiatives
MassHealth MassHealth's mission is to improve the health outcomes of its members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life.	
MassHealth, EOHHS	Deputy Director, Office of Behavioral Health
Massachusetts Association for Mental Health The Massachusetts Association for Mental Health (MAMH) advances mental health and well-being by promoting prevention, early intervention, effective treatment, and research to address social, emotional, and mental health challenges. MAMH also works to eliminate stigma and discrimination and ensure full social, economic, and political inclusion in all aspects of community life.	
MAMH	Co-Director of Public Policy and Government Relations
	Senior Policy and Program Research Associate

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