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October 29th, 2024

Steven T. James
House Clerk
State House Room 145
Boston, MA 02133

Michael D. Hurley
Senate Clerk
State House Room 335
Boston, MA 02133

Dear Mr. Clerk,

Pursuant to Chapter 24 of the Acts of 2021, please find enclosed a report from the Department of Public Health entitled "School Telebehavioral Health Pilot Program."

Sincerely,

Robert Goldstein, MD, PhD
Commissioner
Department of Public Health

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School Telebehavioral Health Pilot Program

October 2024

Legislative Mandate

The following report is hereby issued pursuant to Chapter 28 of the Acts of 2023 as follows:

The Department of Public Health "in consultation with the department of mental health and the department of elementary and secondary education, shall expend not less than $3,532,000 for a pilot program to increase student access to telebehavioral health services in schools; provided further, that not later than June 28, 2024, the department of public health shall report to the joint committee on mental health, substance use, and recovery and the house and senate committees on ways and means detailing the: (i) number of students participating in the program; (ii) frequency with which students use the program; (iii) cost of the services provided, including the use of support staff; and (iv) manner in which costs have been supported by third party reimbursement"

Executive Summary

The School Telebehavioral Health (TBH) Pilot Program is a state-funded initiative to increase access to quality youth mental health and substance use services by leveraging technology in the delivery of care and building the capacity of schools and providers. In fiscal year 2024, the pilot expanded services to 20 schools/districts and generated interest among an additional 5 districts that hope to join in FY25 (see Tables 1 and 2 for additional details). Participating and prospective districts have been primarily identified through the pilot's 2022 needs assessment.

Across participating districts, the pilot has served 940 students over the last two fiscal years, offering a total of 11,103 TBH sessions to those students. In FY24, the pilot served 658 students, offering a total of 6,739 sessions. This number reflects data collected through March 31, 2024, and is expected to increase before the close of FY24 as several newly onboarded districts ramp up service delivery. In addition to providing direct access to clinical care, the pilot also supported over 2,400 referrals for health-related social needs, peer support, and accessing higher-levels of behavioral health care.

The program expanded the number of service providers in FY24, bringing on two Community Behavioral Health Centers (CBHCs)– High Point Treatment Center and the Brien Center – to further expand access to care. The Brookline Center for Community Mental Health (BCCMH), the pilot's implementation vendor, is working with these agencies to build their TBH capacity in service of school districts in their catchment areas. Engaging CBHCs in the delivery of school-based TBH has highlighted an opportunity to integrate these services into the full continuum of behavioral health care, providing timelier referral and access to higher levels of care, such as Youth Mobile Crisis Intervention and Youth Community Crisis Stabilization supported by the EHS Behavioral Health Roadmap. Strengthening collaboration between the CBHCs and school TBH sites would possibly create a stronger pathway to financial sustainability and statewide expansion that will be further explored in FY25.

BCCMH provided ongoing training and technical assistance to both schools and providers in FY24. This included supporting the development of sustainable partnerships and workflows, training clinical and school staff on topics such as telehealth technologies, cultural responsiveness, trauma-informed care, and process improvement. BCCMH also developed new training and onboarding materials to support TBH providers in onboarding Community Health Workers (CHWs) to support service delivery in schools and supported districts in increasing access to services for newcomer students and their families.

In FY24, BCCMH and Brandeis University made significant strides in data collection and evaluation, working with provider agencies and school districts to ensure access to quality data. Although larger sample sizes are needed to assess trends over time, the evaluation has started to capture important themes related to service initiation, implementation, and outcomes with a focus on health equity. Data tables highlighting student and workforce demographics, service engagement, and outcomes are available in the appendix.

Current funding levels present a significant challenge heading into FY25 as the pilot does not have sufficient funds to support the expansion of services to additional districts, including those that have already expressed interest (several of which are larger, high-need districts according to the [pilot needs assessment](#)). A key focus of FY25 will be identifying additional funding to support ongoing expansion of pilot services, including grant funding and improved MassHealth reimbursement. Other FY25 activities will include expanding participation among CBHCs, leveraging funding to support smaller group practices that provide more culturally responsive and linguistically appropriate care, ongoing training and technical assistance, data collection and evaluation, and initial development of a replication guide.

Introduction

The Brookline Center for Community Mental Health (BCCMH) was awarded the contract to implement the school telebehavioral health (TBH) pilot on October 1, 2021. This third legislative report captures the second year of service delivery, covering the period of July 1, 2023 through March 31, 2024.

The goals of the 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 TBH service delivery and other elements necessary for success in schools.

As the lead implementation vendor, BCCMH has been charged 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.

To date, BCCMH has completed the needs assessment to identify priority districts for school TBH service delivery and is in the second year of program implementation and evaluation. In compliance with the legislative mandate, the Massachusetts Department of Public Health, in collaboration with BCCMH, is reporting on the progress of the fiscal year 2024. In addition to the metrics required by legislative mandate, the report includes information on the project infrastructure, capacity-building activities, evaluation, and ongoing and proposed activities for fiscal year 2025.

Report

During this reporting period (July 1, 2023 – March 31, 2024), activities focused on expanding of school TBH service delivery, engaging additional behavioral health providers, continuing capacity building, and identifying pathways toward financially sustaining ongoing expansion of school TBH.

Number of students participating in the program during the reporting period: 658

The program is currently being implemented in collaboration with 20 schools/districts. For grade levels and demographic characteristics of students engaged in the pilot program, see the data tables available in the appendix.

Table 1. School Districts Active in School TBH Pilot and Clinical Provider Organizations

Current Districts	Clinical Provider	Implementation Start Date[1]	Total Enrollment	Needs Assessment Score
Athol-Royalston Regional School District	Heywood Hospital / Cartwheel Care	July 2022 / September 2023	1,596	2
Ayer Shirley Regional School District	Cartwheel Care	January 2024	1,687	2
Berkshire Hills Regional	Cartwheel Care	January 2023	1,179	N/A*
Boston Arts Academy	Cartwheel Care	October 2023	473	5
Fall River Public Schools	Cartwheel Care	Pending	10,656	5
Fitchburg Public Schools	Cartwheel Care	June 2023	5,124	3
Gardner Public Schools	Heywood Hospital	July 2022	2,472	2
Lowell Public Schools	Cartwheel Care	April 2023	14,274	4
Methuen Public Schools	Cartwheel Care	September 2023	6,532	N/A*
Narraganset Public Schools	Heywood Hospital	January 2023	1,453	N/A*
North Adams Public Schools	Cartwheel Care + The Brien Center[2]	March 2023	1,207	4
Pittsfield Public Schools	Cartwheel Care	September 2023	4,876	3
RC Mahar Regional School	Heywood Hospital	January 2023	504	N/A*
Salem Public Schools	Cartwheel Care	January 2023	3,811	2
Marlborough Public Schools	Cartwheel Care	Feb 2024	4,729	2
Haverhill Public Schools	Cartwheel Care	March 2024	7,882	2
Greater Lawrence Regional Vocational Technical	Cartwheel Care	June 2023	1,774	2
Greater New Bedford Regional Vocational Technical	Cartwheel Care	Pending	2,147	2
Lawrence Family Development Charter	Cartwheel Care	Pending	879	2
Wareham Public Schools	High Point Treatment Center[3]	Pending	1,950	2

During FY24, between July 1 and March 31, the pilot provided TBH services to 658 students in selected schools across the Commonwealth. We expect this number to increase by the end of the fiscal year. The pilot has the opportunity for ongoing expansion in FY25 given expressed interest of schools identified in Table 2. However, with current funding, the pilot will not be able to expand to these sites immediately. The Massachusetts Department of Public Health (MADPH) will continue outreach to CBHCs to increase their awareness of the SBTH pilot, identify priority schools within their catchment area, and leverage the CBHC bundled reimbursement rate for sustainability. Further, MDPH will explore grant funding to support ongoing expansion of pilot sites, and will continue to work with BCCMH, other state agencies, participating schools, and providers to maximize third party reimbursement and explore pathways toward financially sustaining school TBH services.

Table 2. School Districts Interested in FY25 School TBH Pilot Engagement (as of March 31, 2024)

Current Districts	Clinical Provider	Projected Referrals	Total Enrollment	Needs Assessment Score
Boston Public Schools	Cartwheel Care	750	45,742	5
Brockton Public Schools	High Point Treatment Center	200	14,954	5
Lawrence Public Schools	Cartwheel Care	200	13,008	4
Framingham Public Schools	Cartwheel Care	100	9,134	2
Randolph Public Schools	Codman Square Health Center	75	2,685	2

Frequency with which students use the program: 6,739 sessions completed during the reporting period.

The frequency with which students use the program varies based on individual clinical need and the provider agency. Some students receive weekly individual therapy sessions while others receive sessions once or twice a month. The number of sessions per student ranges from one to thirty-five (1-35) sessions. Preliminary data suggests that the average number of TBH sessions for students receiving care from Cartwheel Care is just over six sessions, with a range of one session to twenty-two (1-22) sessions. For students engaged in Heywood Healthcare's services, the average number of TBH sessions is just over fourteen (14) sessions, with a range of one session to thirty-five (1-35) sessions. Because these samples include students who are still actively in care, it is expected that the average number of sessions per student is higher than

reported here. MDPH does not yet have this data from the Brien Center or High Point Treatment Center as those agencies are in earlier stages of service initiation and delivery.

Cost of the services provided, including the use of support staff:
The total cost of the services provided varies by site based on student enrollment, the needs of each district, and the partnering TBH provider. Costs include:

- **Clinical service delivery and care coordination**, including direct care provided by behavioral health clinicians, intake processes, care coordination, student and family engagement, and other services provided by Community Health Workers and clinician extenders. For schools working with Cartwheel Care, this also includes clinical care with "rapid access" which applies an additional cost to reserve clinical capacity as a strategy to reduce waitlists and expedite a connection to care for students.
- **Administrative and general operating costs**, including clinical supervision, project management, licensing, credentialing, billing, supplies, technology, training and local travel for on-site support staff.
- **Capacity building activities**, including partnership development between schools and TBH providers as well as training, technical assistance, and professional development offered to schools and provider agencies that support TBH service implementation and quality of care with a focus on health equity.

Tables 3 and 4 break-down costs per student for both Heywood Healthcare and Cartwheel Care. 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 and local education agencies. Please note that the cost estimates provided below are not comparable between the provider agencies because of the different service models. Students receiving services from Cartwheel Care are typically seen for two to six (2-6) months whereas Heywood Healthcare often provides longer-term services for students who need them as well as referrals for mental health-related social needs through the Community Health Worker (a role that is not reimbursed by insurance). As of March 31, 2024, the pilot does not yet have cost data from High Point Treatment Center or the Brien Center. The cost calculations provided below are general estimates and could change as the pilot collects additional data from participating providers.

Table 3. Cost Estimate: Cartwheel Care*

Average cost for MDPH grant per student	$434.49
Average cost for LEA per student	$658.95
Total average cost per student	**$1,093.44**

*This estimate is based on the maximum number of students expected to be served during FY24. For districts providing TBH services in partnership with Cartwheel Care, both DPH and the Local Education Agencies (LEA) are making contributions to costs that are not covered by third-party reimbursement. The amount of DPH funding is 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.

Table 4. Cost Estimate: Heywood Healthcare*

Service providers cost for MDPH per student	$2,020.11
Clinical services only	*$589.37*
CHW services only	*$1,430.73*
Administrative, cost for MDPH per student	$189.74
Training/PD, cost for MDPH per student	$7.73
General Operations, cost for MDPH per student	$43.71
Organization Indirect, cost for MDPH per student	$225.19
Total average cost per student	**$2,486.47**

* This estimate is based on the number of students served, prorated for July 2023-March 2024. The costs for DPH at districts partnering with Heywood Healthcare are currently significantly higher due to the use of Community Health Workers which are not reimbursable through third-party payors and the lack of contribution from participating districts. BCCMH has been working with Heywood Healthcare to increase revenue generated from third-party reimbursement and has started to explore LEA contributions.

Administrative costs=supervision, project management.
Training costs=CEUs, Certification, Conferences
General operations=supplies, technology, local travel

The manner in which costs have been supported by third-party reimbursement: A portion of the costs are being reimbursed through third-party billing. The program is only contracting with clinical service vendors that are credentialed to secure reimbursement through third-party payers, such as MassHealth, MassHealth managed care organizations, and commercial insurance companies. Over 63 percent of students engaged in the pilot are covered by MassHealth, another 4.8 percent are un/under-insured, and the remaining are covered by commercial insurance. Given the focus on health equity and expanding access to care, pilot funding supports access to care for students who are un/under-insured. As of March 2024, a total of $22,680.00 of FY24 pilot funding has been utilized to assist with service delivery for un/under-insured students, including those with MassHealth Limited, which does not include coverage for outpatient behavioral health care. Schools can also access these funds when out-of-pocket costs (e.g., weekly copays) present a financial barrier to care for students and families.

MDPH is working in collaboration with BCCMH, MassHealth, and school TBH providers to identify which costs are and are not covered by third party reimbursement and to support providers in maximizing revenue generated from third party reimbursement. Project costs that are not reimbursable by third-party payors include general operating costs associated with provider licensing, billing, credentialing; clinical supervision, training and technical assistance for both school districts and providers; and the rapid access offered by Cartwheel Care to reserve clinical capacity and reduce waitlists.

Due to reimbursement limitations, costs specific to care coordination and collateral calls are also being covered by grant funding. For students with MassHealth, only clinicians can be reimbursed for care coordination. However, provider agencies often use clinician extenders (e.g., Community Health Workers, care coordinators, and other paraprofessionals) to support this work. This allows clinicians to work at the top of their license by focusing on providing

clinical care to patients. This includes coordination with school-based providers, families, and other community behavioral health providers and social service agencies.

Clinical services delivered through the pilot are reimbursed by public and private insurance. However, reimbursement rates can vary by payor, and some providers have reported that rate variance makes it more difficult to manage costs, coordinate services, and meet demand. Many providers have reported that outpatient rates, especially MassHealth rates, do not cover the full costs of care delivery. MDPH is currently working with MassHealth and BCCMH to explore opportunities to better sustain and expand school TBH service delivery by reducing the reliance on grants and local educational agency contributions.

Service providers engaged in the pilot shared that the following changes would further support financially sustaining school TBH:
- Reimburse care coordination across payors that is provided by clinician extenders, including Community Health Workers and other paraprofessionals. As described above, current opportunities for reimbursement of care coordination goes underutilized given only clinicians can be reimbursed for these activities.
- Expand coverage for outpatient behavioral health care for youth with MassHealth Limited and enhance monitoring and enforcement of parity laws to ensure equitable coverage for behavioral health services across payors.
- Shorten and simplify processes for new providers to enter networks with payors, including a faster path to delegated credentialing at the group level. The current credentialing process requires agencies to dedicate significant resources per clinician. This is more burdensome for smaller provider groups and individual practitioners.
- Develop payment models to fund services provided by Community Health Workers in schools and community settings.
- Increase insurance payment for outpatient telebehavioral health services delivered in schools by multidisciplinary care teams.

Infrastructure and Capacity Building Activities

BCCMH conducts comprehensive needs assessments for schools engaged in the pilot. The needs assessment engages school administrators and staff to identify existing resources, gaps, and needs of each district. This assessment is implemented at the time of engagement with school districts and clinical providers and informs partnerships in planning, development, and implementation of TBH services at each site. BCCMH also provides technical assistance and training on telehealth technologies, cultural responsiveness, trauma-informed care, care coordination, and facilitates a learning collaborative website. In FY24, BCCMH hosted a symposium to bring together partners from across the state for shared learning and dissemination of best practices. In FY24, BCCMH also utilized one-time funding to support participating sites in welcoming newcomer students and their families by offering additional training and supports specific to immigrant and refugee communities. The goal is to remove barriers to TBH in school districts and improve access to clinical care and social services.

Learning collaborative

BCCMH has established a virtual learning collaborative website that aims to:
- Augment and enhance training and technical assistance with pilot sites and encourage sharing of best practices, creating a virtual learning community among pilot sites,
- Host specific learning opportunities via webinars, online modules, and discussion boards to support ongoing capacity building and collaboration,
- Be responsive to pilot sites' unique and shared needs by highlighting relevant best practices, and
- Include technical troubleshooting, an events calendar, a resource center, a spotlight on new ideas, and quick links.

Training

In FY24, BCCMH provided 30 trainings that were offered to clinical providers and school staff, including synchronous trainings as well as asynchronous trainings that were conducted through the learning collaborative website. Table 5 illustrates in aggregate the impact of these trainings on participants.

List of FY24 Training and Professional Development Opportunities:

- Telebehavioral Health Essentials, Parts 1 - 4
- Introduction to the Behavioral Health Helpline
- Problematic Interactive Media Use: Screen Addiction or the New Normal?
- Understanding & Supporting Youth with Cell Phone & Social Media Usage
- Early Psychosis: Symptoms, Identification, and Treatment
- Working with Family Systems: Relational & Transgenerational Lenses
- Working with Family Systems: Structural & Experiential Lenses
- Trans-Theoretical Model: Stages of Change
- Supporting Youth with Substance Use Disorders

- School Based Community Health Worker Module
- Cultural responsiveness topics:
  - Introduction to Cultural Responsiveness
  - Acculturation
  - Cultivating a Multicultural Perspective Parent Voice
  - Cultivating a Multicultural Perspective Youth Voice
  - Microaggressions
  - Cultural Elements in Working with Hispanic/Latino/a/e Communities
  - Facilitated Discussion on Immigrants and Newcomers: Sessions 1-3
  - Supporting Transgender and Non-Binary Students
  - Supporting Students & Families with LGBTQ+ Youth from a Culturally Responsive Latine Perspective
  - Leading with Cultural Humility
  - Connect, Accept, Respond, Empower (CARE) LGBTQ+ Suicide Overview
  - Creating LGBTQ+ Inclusive Secondary Schools
- Trauma related topics:
  - Trauma Informed Care 101
  - Racial Trauma in Schools for Educators
  - Racial Trauma in Schools for Behavioral Health Staff: Modules 1-5
  - Burnout and Secondary Traumatic Stress for Staff
  - Understanding and Interrupting the School-to-Prison Pipeline for School Staff
  - Understanding and Interrupting the School-to-Prison Pipeline for Behavioral Health Staff
- Conflict resolution skill-building topics:
  - Dealing with Conflict: A Mediator's Perspective
  - Understanding the Dynamics of Conflict
  - Conflict Skills Workshop
- Evaluation & data collection topics:
  - Evaluating the School-based TBH Pilot Project: Data Collection and Reporting for Schools
  - Process Improvement (PDSA) Module

To further promote participation in the FY24 trainings, BCCMH began offering continuing education credits and professional development points to further incentivize participation.

Table 5. Workforce Training Data for SFY24 and Since Pilot Launch

Metric	FY24	July 1, 2022 to current
Learning Management Trainings		
Course Enrollments	N=104*	N=130*
Course Evaluations Completed	N=31	N=45
Participants Reporting Agreement That They Can Immediately Apply What Learned	80.6% (N=31)	68.9% (N=45)
Participants Reporting Knowledge/Skill of Content Area as 'Quite a Bit' or 'A Great Deal' *BEFORE* Trainings	41.9% (N=31)	35.6% (N=45)
Participants Reporting Knowledge/Skill of Content Area as 'Quite a Bit' or 'A Great Deal' *AFTER* Trainings	93.5% (N=31)	77.8% (N=45)
Synchronous Trainings		
Synchronous Trainings Offered	13	24
Synchronous Attendees	188*	292*
Synchronous Evaluations	77	112
Participants Reporting Agreement That They Can Immediately Apply What Learned	92.2% (N=77)	Not Applicable**
Participants Reporting Knowledge/Skill of Content Area as 'Quite a Bit' or 'A Great Deal' *BEFORE* Trainings	34.7% (N=72)	41.6% (N=106)
Participants Reporting Knowledge/Skill of Content Area as 'Quite a Bit' or 'A Great Deal' *AFTER* Trainings	78.1% (N=73)	77.0% (N=107)

*Not unique users.
 **Evaluation questions were revised mid-year to meet the Department of Elementary & Secondary Education's post-training question requirements. Therefore, aggregate numbers are not available

Although BCCMH has focused on building the capacity of school TBH providers to offer more culturally competent and identity affirming care to students of historically marginalized identities, behavioral health workforce demographics make it difficult for many provider agencies to match students and families with clinicians of shared identities and experiences. Data collected from Cartwheel Care and Heywood Healthcare (shown in Appendix A, Table 9) suggests a current school TBH workforce that is largely white, heterosexual, and cisgender. Ongoing data collection is needed to ensure representative data across all participating provider agencies. However, BCCMH has heard from current and prospective provider agencies that recruiting a diverse workforce is an ongoing challenge. Broader workforce demographics in the behavioral health field suggest a need for policies that address structural racism and remove barriers to entry for populations under-represented in the current workforce. One significant barrier to entry is the requirement of unpaid clinical field placements during masters-level programs. These field placements create a significant financial burden on individuals who hope to become masters-level clinicians. Because of the relationship between

structural racism and economic opportunity, this barrier has a more significant impact on BIPOC individuals and contributes to the lack of workforce diversity in the behavioral health field overall. Provider diversity and linguistic capacity within the school TBH pilot program is further described in the evaluation section.

FY24 School TBH Symposium
BCCMH hosted their inaugural School TBH Symposium on November 17, 2023, bringing together a group of 67 stakeholders from across the state. Attendees came from a variety of backgrounds, including school districts, state agencies, federal agencies, and service providers. The audience heard from BCCMH staff, Commissioner Robbie Goldstein from the Massachusetts Department of Public Health, Rebecca Butler from the Executive Office of Health and Human Services, Omar Irizarry from the Massachusetts Department of Mental Health, and Captain Christopher Bersani from the Health Resources and Services Administration. Participants also engaged in the following learning sessions:
- Mutually Beneficial Partnerships to Support School-Based Behavioral Health. Presented by: Behavioral Health Integrated Resources for Children (BIRCh) Project
- The Role of Evaluation in Advancing Equitable School-Based Telebehavioral Health. Presented by: The Heller School for Social Policy and Management Brandeis University & John Crocker
- Leading with Equity and Eliminating Disparities: Developing Equitable Practices and Policies Utilizing a Social Justice Framework. Presented by: Dr. Haner Hernández, PhD, CPS, CADCII, LADCI
- Telebehavioral Health Initiatives in MA and the US. Presented by: Massachusetts Association for Mental Health (MAMH)
- Collaborative Implementation of School-Based Telebehavioral Health: Strengths, Strategies, and a Collective Response. Presented by: The Brookline Center for Community Mental Health School-Based Telebehavioral Health Pilot, Parent Voice, Heywood Hospital, Cartwheel Care, and Salem Public School District

Workforce Investments
In addition to the training outlined above, the pilot is making several investments in the behavioral health workforce. This includes building clinics' capacity for TBH service delivery, supporting new service partnerships between schools and community providers, especially CBHCs, and recruiting and training CHWs to enhance TBH service delivery in schools.

In FY24, BCCMH continued outreach to and engagement of behavioral health clinics across the state, bringing on two Community Behavioral Health Centers: The Brien Center and High Point Treatment Center. BCCMH meets monthly with these providers to build their TBH service capacity and support data collection. BCCMH is working with all engaged providers to address the insurance/financial challenges. A key objective of this support is to make TBH service expansion more financially feasible for both school districts and providers. This work will continue into FY25 as BCCMH collaborates with MDPH and MassHealth to explore opportunities to maximize Medicaid reimbursement.

BCCMH is also working to expand the use of Community Health Workers in TBH service delivery. In November 2023, the Brien Center hired a CHW to support North Adams Public Schools in collaboration with Cartwheel Care. High Point Treatment Center will also utilize CHWs in their TBH service delivery model. In the pilot, CHWs help bridge the gap between students and TBH clinical providers and are essential components to supporting the implementation of TBH services in schools. They contribute to the outreach, triage, service engagement and implementation within sites. Most importantly, CHWs serve as a point of contact and resources for the student and their family. In addition to facilitating onsite logistics, the CHW is often the student's onsite support person before and after TBH sessions and makes critical connections to address health-related social needs.

In FY24, BCCMH worked with Heywood Healthcare to develop a strategy for training and recruiting additional CHWs for the program. This work included developing sample job descriptions and providing training to newly hired CHWs at the Brien Center and High Point Treatment Center to improve familiarity with the school TBH model and build best practices related to student engagement and care coordination.

Partnership Development
As part of the pilot's capacity building efforts, BCCMH is working to establish sustainable partnerships between schools and provider agencies to support care coordination and referrals. This includes outlining clear roles and responsibilities, developing memoranda of understanding, establishing planning meetings, and setting up of custom workflows that integrate the pilot into the existing system of care. These efforts ensure that schools, TBH providers, and community-based agencies are working together to meet student needs.

Evaluation

BCCMH is contracting with Brandeis University to conduct a robust evaluation of the pilot program that includes a start-up, process, outcomes, and an adaptation evaluation. The evaluation aims to identify key elements needed for successful implementation of school TBH services and to study the effectiveness of those services. All aspects of the evaluation are being driven through an equity lens to assess equity in service access, service utilization and experience, and outcomes.

In FY24, Brandeis implemented ongoing data collection and evaluation. Preliminary process and outcome metrics are available in Appendix A. Data is not yet available for sites supported by the Brien Center and High Point Treatment Center as those sites only recently began service implementation. Brandeis also updated the evaluation logic models in FY24 to articulate expected impact by both student outcomes and provider outcomes.

Start-Up Evaluation

The start-up evaluation aims to capture the capacity of school districts to provide TBH services, including strengths and opportunities within districts, barriers to implementation and differences in pathways to or models of school-based TBH that are responsive to the unique needs and resources of each school district and their communities. The start-up evaluation also captures school/district level characteristics of the student population, workforce demographics, and start-up costs.

As of March 31, 2024, the capacity assessment has been administered to two schools and 13 school districts. An analysis of district-level responses indicates four districts with a high degree of school-based TBH capacity, including on-site staffing, dedicated physical spaces in schools, policies and procedures that are FERPA and HIPAA compliant, and dedicated processes for collaboration with school staff. The remaining nine districts report significant opportunities to build school-based TBH capacity, in some cases across all areas, while others identify specific areas for support. Responses are pending from the following districts, most of which are newly onboarded: Ayer-Shirley, Fall River, Greater New Bedford Vocational Tech (GNBVT), Haverhill, Marlborough, and Wareham.

Process Evaluation

The process evaluation uses a mixed-methods design, utilizing multiple data sources (e.g., providers' electronic record management systems, meeting notes, contract information, key informant interviews, focus groups, and surveys from providers, student participants, and their parents/guardians). One component of the evaluation is to differentiate and define the different models of school-based TBH as well as to investigate aspects of service uptake and delivery. Currently, there are 3 main models of school-based TBH services:

- **Model 1:** Remote TBH clinician + in-person/on-site Community Health Worker, both employed by the same provider agency and working in collaboration with school districts. Most students engaged in this model receive clinical care at school, during the school day.

- **Model 2:** Remote TBH clinicians + remote care coordinator that are both employed by the same provider agency and working in collaboration with school districts. Most students engaged in this model are receiving clinical services after school in a location that is not the school.
- **Model 3:** Remote TBH + in-person/on-site Community Health Worker, employed by two different community agencies working in collaboration with each other and the school district.

Early findings from the process and outcomes evaluation suggest effectiveness across all three models in expanding access to care, coordinating necessary referrals with other community agencies, and improving behavioral health outcomes. More data is needed to thoroughly assess these outcomes and to better understand equity-related implications as it relates to access to culturally and linguistically appropriate services, outcomes, and quality of care. Furthermore, Model 3 (the newest model) presents an opportunity to enhance provider partnerships to maximize clinical capacity, reduce waitlists, and increase access to care. However, more data is needed to capture best practices related to this model and to better understand its impact on access.

Other metrics captured by the process evaluation include:
- Client/family demographics and language needs
- Number of students served
- Number of unique referrals
- Number of repeat referrals
- Number of pending referrals
- Reason for referral (i.e., anxiety, depression, substance use, etc.)
- Source of referrals
- Number of referred but not accepted
- Number of additional needs referrals by type
- Number of intakes completed
- Number of closed cases with no services
- Number of sessions completed
- Time spent waiting for intake
- Mean and range of sessions per client
- Variation/range in frequency of visits
- Location of sessions
- Costs of running the program, including third party billing/claims data and costs to schools/districts
- Key themes of any focus groups or surveys with youth, clinicians, and schools
- Student satisfaction with services received, disaggregated

The process evaluation allows for demographic comparison between student populations at each district and the students served by the pilot at those districts. This comparison allows the project team to identify disparities in referrals, intakes, sessions completed, and other process

metrics. Larger sample sizes are still needed to monitor trends over time and to assess for equity in access to quality care via the school TBH models. This work will continue in FY25.

Heywood Healthcare and Cartwheel Care are utilizing various strategies to ensure language access for students and families. If a parent/guardian has limited English or does not speak any English, Heywood Healthcare utilizes Global Interpreters services to provide 24/7 telephone and video remote interpreting (VRI) services. The interpreter joins the intake session via Zoom because intakes are mainly conducted remotely. Ongoing communication with the parent/guardian following the intake is often facilitated via email or using an interpreter. Some districts served by Heywood Healthcare utilize staff to assist families whose preferred language is not English. For example, Athol has two "Bi-lingual Parent Liaisons" and Gardner has a "Family Services & Translations Coordinator." A medical interpreter would also be part of the intake. Families working with Cartwheel Care who speak a primary language other than English are paired with a Care Coordinator with this language capacity (e.g., Portuguese families are paired with a Coordinator who speaks Portuguese fluently).

If a student has limited English or does not speak any English, Heywood Healthcare uses the Community Health Worker to assist in connecting students to clinicians that speak their preferred language through partnerships with the Gandara Center and local community health clinics. For students and families accessing services through Cartwheel Care, the Care Coordinators use a language filter to find a clinician who can speak the family's primary language. Given workforce demographics and student/family need, there are times when families speak a language that Cartwheel Care does not have capacity to meet internally. In these cases, Cartwheel Care utilizes interpreter services through all phases of the care journey. These language line services enable students to receive services in their preferred language regardless if the clinician speaks the language or not. At other times, Cartwheel Care may have an available clinician with language capacity, but the available appointment times may not align with the family's needs. In these cases, they may be offered another clinician at a preferred time, or the option to wait a couple of weeks to begin care.

Beyond language needs, there is not a definitive way to assess the degree to which students can be matched with clinicians who reflect their identities and cultures. Cartwheel Care has built capacity to ensure students are matched with providers with the appropriate expertise, and when preferred, similar demographic characteristics. Given workforce demographics and student need, it is not always possible to match students with a clinician with expertise in their area of need, preferred time of appointment, and preferred demographic characteristics. In these cases, Care Coordinators provide families with options based on their preferences and prioritized needs. For Heywood Healthcare, there are even more limited opportunities for BIPOC and LGBTQ students to be served by providers reflecting their identities, language, and/or culture. Heywood Healthcare has made concerted efforts to recruit a more diverse workforce but has faced challenges with rural provider shortages.

In FY24, the evaluation team also developed and disseminated a student/family satisfaction survey. Preliminary findings should be available by the close of FY24.

Outcome evaluation

The outcome evaluation also relies on multiple data sources, including publicly available data from Massachusetts Department of Elementary and Secondary Education and Brandeis University's Child Opportunity Index, as well as data obtained from participating provider organization's electronic health record system. Key metrics include:

- Behavioral health screening data at intake
- Behavioral health screening data at discharge
- Differences in pre/post screening data
- Changes in absences, tardies, in-school suspensions, out-of-school suspensions, expulsions, grades
- Disparities in outcome across provider agencies

In January 2024, the evaluation team fielded a survey of participating districts to establish data points that schools will provide at the student level to track the impact of school TBH services on individual student outcomes. These data include attendance and discipline data. The evaluation team hopes to collect this data across six semesters (2 before and 4 during/after school TBH services), which can be linked with the student's service data from providers. The evaluation team will begin collecting this data from districts at the end of this school year.

In FY24, the evaluation team also launched an interagency working group sub-committee that will focus exclusively on supporting evaluation data collection and analysis.

Ongoing and Proposed FY2025 activities

BCCMH, in collaboration with the MDPH's Division of Child/Adolescent and Reproductive Health, Brandeis University, and the interagency working group, will continue the pilot implementation and evaluation process in FY25 with the following goals:

- Increasing funding available to the pilot to allow for ongoing service expansion to priority district
- Identifying opportunities to maximize revenue from third-party reimbursement by working with provider agencies and payors, including MassHealth
- Educating relevant parties on the importance of reimbursing for CHW activities
- Increasing engagement of additional CBHCs to better integrate school TBH services into the full continuum of care
- Supporting new and stronger partnerships between behavioral health provider agencies to better maximize clinical capacity, reduce waitlists, and improve care coordination
- Ongoing expansion of CHWs and other clinician extenders at pilot sites
- Enhance comprehensive data collection and ongoing evaluation
- Observe changes in absences, tardies, suspensions, expulsions, and grades
- Work on a sustainability year over year model to decrease costs across sites
- Develop an initial draft replication guide

Conclusion

In conclusion, the Fiscal Year 2024 School Telebehavioral Health Pilot Program was successful in expanding services to additional districts identified in the FY22 needs assessment. The project increased access to mental health services for students in these school districts, built the capacity of schools and provider agencies to support quality and sustainability, and continued to capture data needed to evaluate the impact of school TBH services. Furthermore, through the evaluation and engagement of provider agencies, the program began capturing barriers and opportunities to financial sustainability and ensuring equity in access to quality, culturally/identity affirming care.

Thank you for your support and for the opportunity to implement this important initiative.

Appendix A: Evaluation Data Tables
Table 1. TBH Service Launch (July 1, 2022) and FY24[a]

Metric	FY24	Total to Date
Referrals (approved)	1,055	1,552
New Students Intaked	658	940
TBH Sessions (students)	6,739	11,103
Closed without Services	385	510
'No Shows' Student TBH Sessions	1,317	1,984
Parent Guidance Sessions	322	322
Discharges	309	442
Waitlist (Heywood Healthcare)	74	*
Pending Intake (Cartwheel Care)	227	*
Active Caseload	438	438

[a] Data are up to March 31, 2024.

Table 1 Summary: To date, there have been 940 unique students served (defined as completing an intake) through the pilot since July 1, 2022, and 658 for FY24 to date. Since TBH service launch, 70% of referrals from Cartwheel Care have completed an intake and 66% of Heywood Healthcare referrals have completed an intake. As of March 31, 2024, the number of waitlist students for Heywood Healthcare sites was 74 students. Heywood Healthcare has dedicated clinicians assigned to each school, and waitlists indicate caseloads are full. Students on the waitlist can transition to care once another student moves out of care, either by transitioning to another school or completing services, for example. Waitlist students may engage with the Community Health Worker for non-clinical resources and also find another avenue for care and pursue that. As of May 1, 2024, Heywood Healthcare will be indicating the referral date as well as the intake date, so the evaluation team will be able to track this with more specificity. Cartwheel Care operates a different model, without the use of waitlists and specific clinicians assigned to schools. Rather than a waitlist, students are placed in queue and are pending intake. As of March 31, 2024, the number of students pending intake was 227. For students engaged in Cartwheel Care from July 1, 2023 through March 31, 2024, time from referral to intake ranged from 4 to 103 days, with a mean of 29.3 days and a median of 26 days. Factors involved in the length of time from referral to intake include obtaining parental/caregiver consent (i.e., signatures) and scheduling issues with caregiver or youth.

Table 2. Referrals for Additional Needs FY24[a]

Referral Type	Heywood*	Cartwheel**
Clothing/Personal Care	563	NA
Education	202	NA
Employment/Volunteer	68	NA
Food	451	NA
Fuel/Utility	11	NA
Health Insurance	16	NA
Housing	16	NA
Legal	6	NA
Peer Support (for students)	165	NA
Recreation	272	NA
Support Groups (for caregivers/families)	195	NA
Behavioral Health	241	71
Psychiatry	Combined with Behavioral Health	75
Other	113	NA
TOTAL	**2,319**	**146**

[a] Data are up to March 31, 2024.

*Note: Additional referrals for Heywood include both individual referrals for SBTBH students and families as well as school-based community wide events. These events have included 'Thrift Store' clothing drives as well as Back to School Breakfasts and School Supplies Drive (categorized as 'Other'). These events provide an opportunity to outreach about SBTBH and provide for basic needs in an unobtrusive way.

**Note: Cartwheel is developing EMR capacity to track additional referrals made beyond those for community-based behavioral health needs as well as in-house psychiatry referrals.

Table 3. Student-level Data for Cartwheel Clients Completing an Intake: Age, Grade, and Primary Insurance Status for FY24[a] (N=548)

Characteristic	Value
Age (n=547)	Mean (14 years); Range (5-20 years)
Grade (n=548)	
K	0.4%
1	2.2%
2	1.6%
3	6.9%
4	10.9%
5	10.4%
6	8.6%
7	9.7%
8	6.6%
9	10.9%
10	14.2%
11	8.8%
12	8.8%
Primary Insurance Status (n=294)*	
MassHealth	65.3% (n=192)
Uninsured	4.8% (n=14)
Private insurance (e.g. Blue Cross Blue Shield, Tufts, Aetna)	29.9% (n=88)

[a] Data are up to March 31, 2024.

*As reported from the referral form. Cartwheel is in the process of fully integrating their billing tool which will provide more complete data on health insurance status for future reports.

Table 3 Summary: Students from kindergarten through twelfth grade received services from Cartwheel, with an average age of 14. From third grade onwards, a similar number of students in each grade received services. Two-thirds of students had MassHealth as their primary insurance (65.3%), and few were uninsured (4.8%).

Table 4. Student-level Data for Cartwheel Clients Completing an Intake: Race, Ethnicity, Preferred Language, Disability Status, Substance Use, and Bullying for FY24[a] (N=548)

Characteristic	Value
Race (n=348)*	
Asian	4.6% (n=16)
Black/African American	12.4% (n=43)
Native Hawaiian/Pacific Islander	0.9% (n=3)
White	67.5% (n=235)
More than One Race	19% (n=66)
Prefer Not to Say	1.1% (n=4)
Ethnicity (n=348)*	
Hispanic or Latino/a/e	32.2% (n=132)
Not Hispanic or Latino/a/e	67.8% (n=278)
Preferred Language on Referral Form (n=548)	
English	90% (n=493)
Spanish	7.3% (n=40)
Portuguese	2.7% (n=15)
Gender Identity*	
Cisgender male	39.9% (n=139)
Cisgender female	44.5% (n=155)
Transgender Male	1.1% (n=4)
Transgender Female	0.9% (n=3)
Non-binary/genderqueer	2.3% (n=8)
Another gender identity	11.2% (n=39)
LGBQ Status** (n=548)	
Identified as Clinical Area in Records	4% (n=22)
Disability Status	Not Yet Available
Sense of Belonging	Not Yet Available
Intake 'Areas of Concern' Checked	
Suicidality (n=410)	

Thoughts, Intent, or Plan	20.2% (n=83)
Self Harm	19.5% (n=80)
Suicide Attempt(s)	3.9% (n=16)
Bullying (n=348)	
Yes	32.5% (n=113)
Substance Use (n=430)	
No	87.9% (n=378)
Cannabis	9.5% (n=41)
Nicotine	3% (n=13)
Alcohol	1.4% (n=6)
Other	2.3% (n=10)

[a] Data are up to March 31, 2024.

*Race, Ethnicity and Gender Identity are reported from intake forms. Less missing data is anticipated moving forward as EMR and administrative systems have been streamlined.

**There is not yet a data element capturing student sexual orientation. As a proxy, the Cartwheel Team reviewed records/clinical notes and flagged cases indicating concerns related to sexual orientation. There is broad agreement that this approach significantly underestimates the number of LQBQ+ students in the pilot working with this provider. Conversations are ongoing to address this limitation.

Table 4 Summary: Over two-thirds of SBTBH students through Cartwheel are white (67.5%), non-Hispanic or Latino/a/e (67.8%), and cisgender (84.4%). Gender minority (transgender, genderqueer, non-binary) students comprise 4.3% of the sample. A significant minority (11.2%) reported 'other' on intake, which requires additional follow-up. One possible explanation is that respondents were not familiar with the terms 'cis-male' or 'cis-female.' Nearly a third indicate bullying as an area of concern at intake. Of the small minority reporting issues with substance use (12.1%), cannabis misuse is endorsed by the greatest number of students (nearly 10% of student). A reliable and valid measure of sexual orientation is pending, and conversation to capture disability status and sense of belonging are ongoing as well.

Table 5. Student-level Data for Cartwheel Clients Completing Intake: Behavioral Health Data for FY24[a] (N=548)

Characteristic	Value
Average Sessions for Students Attending a First Session* (n=459)	6.5 sessions (range: 1-22 sessions)
Behavioral Health Screeners	
GAD Intake Mean Score (n=207)	7.8 (range: 0-20)
GAD Discharge Mean Score (n=67)	6.6 (range: 0-17)
PHQ-8 Intake Mean Score (n=207)	8.8 (range: 0-22)
PHQ-8 Discharge Mean Score (n=67)	8.3 (range 0-22)
Reason for Discharge (n=243)	
Graduated (Services Completed)	21.4% (n=117)
Services Ended by Client	42.4% (n=103)
Services ended by Cartwheel	9.5% (n=23)
Diagnoses (n=429)	
Severe Stress and Adjustment	59.9% (n=257)
Anxiety	15.9% (n=63)
Behaviors and Emotions, Childhood and Adolescent Onset	11.4% (n=49)
Mood	10% (n=43)
Adult Personality and Behavior	2.3% (n=10)
Obsession and Compulsions	0.5% (n=2)
Prescribed Medication (n=459)	
Yes	6.1% (n=28)

[a] Data up to March 30, 2024.
* Includes Students discharged and currently in care.

Table 5 Summary: The average number of TBH sessions for Cartwheel students is just over six sessions, with a range of one session to twenty-two sessions. Because this sample includes students still actively in care, it is expected that the average number of sessions per student is higher than reported here. In this model, GAD score drops on average 1.2 points from the first session (7.8) until discharge (6.6). In terms of the PHQ-9, scores dropped from an average of 8.8 at the first session, to 8.3 at discharge. More

rigorous analyses are planned as the sample size of discharged students increases. Over three-quarters of students presented with anxiety or stress-related disorders, with 10 percent receiving a diagnosis of a mood disorder. Less than a quarter of students (21.4%) completed treatment as defined by graduation from services. However, Cartwheel reports that many students complete their treatment plan but choose to forgo their final 'graduation' session.

Table 6. Student-level Data for Heywood Clients Completing an Intake: Grade and Primary Insurance Status for FY24[a] (N=110)

Characteristic	Value
Grade (n=99)	
5	9.2% (n=9)
6	11.2% (n=11)
7	15.3% (n=15)
8	19.4% (n=19)
9	14.3% (n=14)
10	15.3% (n=15)
11	9.2% (n=9)
12	6.1% (n=6)
Primary Insurance Status (n=98)*	
MassHealth	60.2% (n=59)
Private insurance (e.g. Blue Cross Blue Shield, Harvard Pilgrim, Tufts)	41.8% (n=41)
Insurance not accepted by Heywood	4.1% (n=4)
Uninsured	1.0% (n=1)

[a] Data are up to March 31, 2024.
*N values add to more than 98, because some students had multiple insurance categories.

Table 6 Summary: Students from fifth through twelfth grade received SBTBH from Heywood. A similar number of students received services in each grade, but more students received services in seventh through tenth grade. The majority of students had MassHealth (60.2%), followed by private insurance (41.8%).

Table 7. Student-level Data for Heywood Clients Completing an Intake: Race, Ethnicity, Preferred Language, Gender, Sexuality, Disability Status, Substance Use, and Bullying for FY24[a] (N=110)

Characteristic	Value
Race (n=98)*	**NOTE SOURCE**
White	92.9% (n=91)
Black/African American	6.1% (n=6)
More than One Race	5.1% (n=5)
American Indian or Alaska Native	2.0% (n=2)
Asian	1.0% (n=1)
Ethnicity (n=95)	NOTE SOURCE
Not Hispanic or Latino/a/e	89.5% (n=85)
Hispanic or Latino/a/e	10.5% (n=10)
Preferred Language on Referral Form (n=97)	
English	100% (n=97)
Gender Identity (n=97)	
Cisgender female	59.8% (n=58)
Cisgender male	33.0% (n=32)
Non-binary/gender queer	6.2% (n=6)
Questioning or unsure	1.0% (n=1)
Sexuality (n=86)	
Straight, or heterosexual	86.0% (n=74)
Bisexual	8.1% (n=7)
Questioning or unsure	2.3% (n=2)
Lesbian or gay	2.3% (n=2)
Queer	1.2% (n=1)
Disability Status	
Has IEP (n=93)	17.2% (n=16)
Has 504 (n=92)	10.9% (n=10)
Feels Sense of Belonging at School (n=96)	
Agree	76.0% (n=73)
Disagree	24.0% (n=23)

Reports being Bullied (n=95)	17.9% (n=17)
Has History of Suicide Attempts (n=97)	3.1% (n=3)
Columbia Suicide Severity Scale Screener (n=94)	
Yes**	20.2% (n=19)
Substance Use	
None (n=94)	76.6% (n=72)
Marijuana (n=94)	22.3% (n=22)
Tobacco / nicotine (n=91)	15.4% (n=14)
Vaping (n=91)	12.1% (n=11)
Alcohol (n=90)	81.8% (n=10)
Other (n=82)	3.7% (n=3)

[a] Data are up to March 31, 2024.
*Though there were 110 youth served, data were not available for all youth. Values (n) indicate the number of students for whom there are data. **Answered at least one question affirmatively, indicating at passive suicidal ideation to high risk for attempts.

Table 7 Summary: The vast majority of SBTBH students through Heywood are white (92.9%), non-Hispanic or Latino/a/e (89.5%), and cisgender (92.8%). Non-binary or genderqueer students comprise 7.2% of the sample; lesbian, gay, bisexual, queer, or questioning students account for 14.0% of students served. Students with either an IEP or 504 plan encompass over a quarter of students served since July 1, 2023. Three-quarters report a sense of belonging at school; less than a fifth report experiencing bullying. The vast majority report no substance use (76.6%), though the most often misused substance is marijuana (22.3%).

Table 8. Student-level Data for Heywood Clients Completing Intake: Behavioral Health Data for FY24[a] (N=110)

Characteristic	Value
Average Sessions for Students Attending a First Session* (n=105)	12.4 sessions (range: 1-35)
Behavioral Health Screeners	
GAD Intake Mean Score (n=92)	9.7 (range: 0-21)
GAD Discharge Mean Score (n=12)	6.6 (range: 3-13)
PHQ-8 Intake Mean Score (n=92)	10.0 (range: 0-23)
PHQ-8 Discharge Mean Score (n=12)	9.7 (range: 3-17)

Reason for Discharge (n=12)	
Services Completed as Planned	25.0% (n=3)
Student stopped showing up	41.7% (n=5)
Seeing another therapist	25.0% (n=3)
Student didn't want therapy	8.3% (n=1)
Diagnoses (n=110)**	
Non-psychotic mental disorders (i.e. anxiety, dissociative, stress-related, somatoform, and others)	65.5% (n=72)
Attention-deficit hyperactivity disorders	20.0% (n=22)
Major depressive disorder	11.8% (n=13)
Cannabis use	4.5% (n=5)
Pervasive and specific developmental disorders	3.6% (n=4)
Conduct disorders	2.7% (n=3)
Tic disorder	1.8% (n=2)
None	11.8% (n=13)

[a] Data are up to March 31, 2024.

*Includes both students discharged and currently in care.

**N values add to more than 110 due to multiple diagnoses per client.

Summary: The average number of TBH sessions for Heywood students is just over twelve sessions, with a range of one session to thirty-five sessions. Because this sample includes youth still actively in care, it is expected that the average number of sessions per student is higher than reported. In this model, GAD score drops on average three points from the first session (9.7) until discharge (6.6). In terms of the PHQ-9, scores were similar during the first session, with an average of 10.0, and at discharge, with an average of 9.7. More rigorous analyses are planned as the sample size of discharged students increases. Two-thirds of students presented with anxiety or stress-related disorders, with just over ten percent receiving a diagnosis of depression. A quarter of students (25.0%) completed treatment as planned. Others who discharged did not complete treatment: many stopped showing up, while others began seeing another therapist or decided they did not want therapy.

Table 9. SBTBH Workforce Demographic Characteristics as of March 2024 (N=31)

Characteristic		Total SBTBH Workforce (N=31)	Heywood Healthcare (N=18)	Cartwheel Care (N=13)
Race				
	Asian	0	0	0
	Black/African American	6.5% (n=2)	0	14.3% (n=2)
	White	83.9% (n=26)	100% (n=18)	57.1% (n=8)
	More than One Race	3.2% (n=1)	0	7.1% (n=1)
	Other	6.5% (n=2)	0	14.3% (n=2)
	Prefer Not to Say	3.2% (n=1)	0	7.1% (n=1)
Ethnicity			0	
	Hispanic or Latino/a/e	19.4% (n=6)	0	46.2% (n=6)
	Not Hispanic or Latino/a/e	80.6.0% (n=25)	100% (n=18)	53.9% (n=7)
Gender Identity				
	Cisgender male	6.5% (n=2)	5.6% (n=1)	7.7% (n=1)
	Cisgender female	93.5% (n=29)	94.4% (n=17)	92.31% (n=12)
Identify as LGBQ Status				
	Yes	29.0% (n=9)	16.7% (n=3)	46.2% (n=6)
	No	70.1% (n=22)	83.3% (n=15)	53.9% (n=7)
Identify as Having a Disability				
	Yes	9.7% (n=3)	11.1% (n=2)	7.7% (n=1)
	No	77.4% (n=24)	88.9% (n=16)	61.5% (n=8)
	Don't Know	3.2% (n=1)	0	7.1% (n=1)
	Prefer Not to Say	9.7% (n=3)	0	23.1% (n=3)
Language Capacity				
	Speaks Any Language Other than English*	22.6% (n=7)	*	53.8% (n=7)_

*Five respondents speak Spanish, one speaks Portuguese, and one speaks both Spanish and Portuguese

Table 9 Summary: A total of thirty-one respondents completed the SBTBH workforce survey, though not every respondent answered each question. The vast majority of the SBTBH workforce is identifies as white (83.9%), non-Hispanic or Latino/a/e

(80.6%), cisgender women (93.5%). Nearly 30% identify as lesbian, gay, bisexual, or queer and nearly a quarter of the workforce is fluent in a language other than English.

Table 10. SBTBH Workforce Job-Related Characteristics as of March 2024 (N=31)

Characteristic	Value
SBTBH Workforce Role (n=31)	
Clinician	61.3% (n=19)
Care Coordinator/Community Health Worker	35.5% (n=11)
Other	3.2% (n=1)
Length of Practice (n=31)	
Any Clinical Practice (Both In-Person and Tele)	
Less Than One Year	6.5% (n=2)
One to Three Years	32.2% (n=10)
Three to Five Years	12.9% (n=4)
Five Years to Ten Years	22.6% (n=7)
Ten Years+	25.8% (n=8)
Telebehavioral Health Practice	
Less Than One Year	16.1% (n=5)
One to Three Years	41.9% (n=13)
Three to Five Years	35.5% (n=11)
Five Years to Ten Years	6.5% (n=2)
Specialty Practice/Certification Areas	
Any	67.7% (n=21)
Trauma-Informed Practice	67.7% (n=21)
Substance Use	32.3% (n=10)
Culturally Responsive Practice	32.3% (n=10)
Social Determinants of Health	16.1% (n=5)
Anti-racism/Implicit Bias Training	35.5% (n=11)
Disability/Neuro-divergence	9.7% (n=3)
Gender and Queer Affirming Practice	22.6% (n=7)
Other	9.7% (n=3)

Job Satisfaction (n=31)	
Satisfied	90.4% (n=28)
Neutral	6.5% (n=2)
Dissatisfied	3.2% (n=1)

Table 10 Summary: Over two-thirds of the SBTBH workforce have certification/practice specialty in trauma-informed practice. Over a third endorse certification/specialty practice in anti-racism/implicit-bias training, with nearly a third reporting expertise in treating substance use, and in culturally responsive practice. Finally, over 90% of respondents are 'satisfied' or 'very satisfied' with their jobs as part of the SBTBH workforce.