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Behavioral Health Capacity of Massachusetts Public School Districts: Technical Report

This report was developed by the Behavioral health Integrated Resources for Children Project (BIRCh), representing a collaboration between the University of Massachusetts Boston and the University of Massachusetts Amherst and funded by Boston Children's Hospital.

The mission of the BIRCh Project is to provide professional development and resources for schools and strengthen the coordination of behavioral health supports provided by school and community agencies. More information is available at **www.umb.edu/birch**, or contact us at **Birch.project@umb.edu**.

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Executive Summary

Access to critical school-based behavioral health services varies significantly across the state of Massachusetts. A central goal of the BIRCh Project is to increase the capacity of schools to promote and integrate behavioral health services. Understanding current behavioral health supports available to school districts across the Commonwealth is crucial to this mission. This technical report summarizes findings from the first phase of an ongoing resource mapping project focused on workforce capacity, state-funded grants, and Educational Collaborative membership.

Students in Massachusetts lack adequate access to **school-based behavioral health staff** according to national recommended ratios. Moreover, school districts serving students with high economic needs have less access to school-based behavioral health professionals, particularly Social Workers and School Psychologists. Priorities of the 25 **Educational Collaboratives** across the Commonwealth include sharing resources to provide direct services to students, professional development, technical assistance, and programs and services to improve district operations. Resource mapping suggests that 26.9% of identified high needs districts do not belong to a Collaborative, and there are no Collaboratives servicing the most western part of the state. Additionally, 34.6% of the school districts with high economic need and disproportionately low staffing of school-based behavioral health professionals did not access any **Department of Elementary and Secondary Education (DESE) behavioral health grants**.

Stakeholders representing state agencies, district administrators, Educational Collaboratives, school-based and community-based providers, and university trainers noted fragmented access across geographic regions and limited coordination of resources. The fragmented allocation of behavioral health resources reflects the lack of a state-driven coordinated plan for school-based prevention efforts. Without designated district leadership to focus on these efforts and with competing district-level priorities, schools and districts have limited access to quality and sustainable school-based behavioral health programming.

Our hope is that the current findings serve as a foundation to strengthen the coordination of behavioral health services available through school, community, and state agencies. The report offers strategies to address gaps in access to mental health services so that all students can benefit from high-quality services that emphasize prevention and promote positive education and life outcomes. It offers policy recommendations organized around the following five areas: **Consistent and Coordinated Professional Development; Workforce Development Opportunities; Supportive and Collaborative Partnerships; Incentivizing Collaboratives; and, Regional Technical Assistance Centers.**

Background

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The behavioral and mental health needs of children have been called a 'silent epidemic' with grave implications for families and communities (Anderson & Cardoza, 2016). **Despite the estimate that 20% of U.S. children meet criteria for behavioral health disorders, our nation's response continues to fall short with the vast majority (80%) of children identified as in need of services receiving no intervention** (Caldarella et al. 2008; Kataoka, Zhang, & Wells, 2002; Perou et al., 2013). Among children who do access services, schools played an integral role (Farmer, Burns, Philip, Angold, & Costello, 2003; Merikangas, He, Burstein, Swendsen, Avenevoli, Case, Georgiades, Heaton, Swanson, & Olfson, 2011). The school setting is a convenient location that reduces a variety of access barriers (Blake, Ledsky, Goodenow, & O'Donnell, 2001; Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Yet, even within the context of school settings, access to needed behavioral health services varies tremendously across geographic regions, states, and local communities.

The minimum standard for school-based services is established and enforced by the federal government (e.g., IDEIA), though the bulk of responsibility for ensuring quality education services is carried out at the state and local levels. State agencies maintain oversight of qualifications and licensing of professional staff; still, states delegate much of the authority for the management of public schools to local education agencies (LEA; Jacob, Decker, & Hartshorne, 2010). As such, the responsibility of staff appointments, employment expectations, and professional role configurations fall on local districts and leadership. Within these complex layers of governmental oversight, there remain tremendous gaps in access to school-based mental health services *across* states, as well as *within* states across local communities.

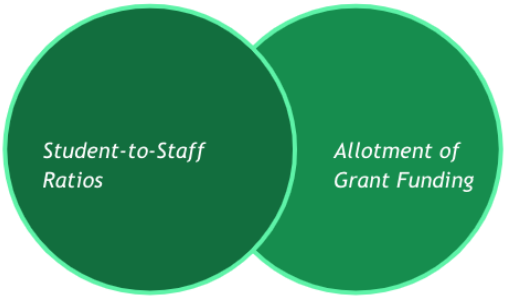
Throughout the Commonwealth, schools often struggle to effectively implement a continuum of student support initiatives that promote healthy development and address mental health needs of students. Numerous overlapping agencies support the development of the whole child, yet some of our most vulnerable children experience limited access to services due to fragmented organizational systems. Even though Massachusetts is the leader in academic achievement, the lack of integrated behavioral health services results in vast disparities and a failure to address the demonstrated needs of children.

Our hope is that the findings presented in this report serve as a foundation to strengthen the coordination of behavioral health services available through school, community, and state agencies. It merges findings from multiple data sources to better understand the disparities across the Commonwealth, and offers strategies and policy recommendations for more equitable access to school behavioral health services.

Purpose of Current Report

With the overarching goal of understanding the capacity of school districts in Massachusetts to address the behavioral health needs of students, the goals of the current project were threefold. First, the research team examined students' access to licensed Professional Support Personnel (e.g., school psychologists, school social workers, school counselors, school nurses), as reported by the Department of Elementary and Secondary Education (DESE). Student-to-staff ratios were calculated and then compared to the recommendations of each national, professional and credentialing organization. These findings on the current capacity were then compared across school districts, with a focus on equitable access based on student economic need.

In addition to sufficient staffing levels, schools and districts need access to high quality professional development and support to provide comprehensive school-based services. The second aspect of the study was to examine the dissemination of state education resources - specifically competitive funding to support social, emotional, and behavioral health. As such, grants provided by DESE to schools and districts that targeted students' social, emotional, mental, and behavioral health were explored.



Finally, this report highlights findings from state and community leaders and other experts, in the field of behavioral health, on the variability of districts' capacity - through staffing, professional development, and grants - to meet the behavioral health needs of students. In these interviews, factors that contribute to communities' access to services, and the impact of overlapping and competing priorities at the building, district, and state level were explored.

Procedures for the three studies, more specifically methodology, analysis procedures, and findings, are described in depth in the sections below. The consolidation of findings, strategies to ameliorate inequities, and policy recommendations for more equitable access to school behavioral health services are outlined in the final section of the report.

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Staffing Ratios & Student Economic Need

School-based behavioral health workforce was evaluated using publicly available data from DESE for the 2018-19 school year. The four fields credentialed through DESE as Professional Support Personnel licenses are as follows:

- School Counselor **(Levels: PreK-8; 5-12)**
- School Social Worker/School Adjustment Counselor **(All Levels)**
- School Psychologist **(All Levels)**
- School Nurse **(All Levels)**

Requirements for these professional licenses include graduate coursework accompanied by supervised field experiences and demonstrated competencies in the implementation of social, emotional, and behavioral health and/or health services. Only those employed by the **local education agencies (LEAs)** were included in the analysis.

The number of students in each LEA was also examined, including the percentage of students identified as economically disadvantaged. **"Economically disadvantaged students"** are defined by DESE as those who participate in one or more of the following state-administered programs: the Supplemental Nutrition Assistance Program (SNAP); the Transitional Assistance for Families with Dependent Children (TAFDC); the Department of Children and Families (DCF) foster care program; and eligible MassHealth program (Medicaid).

These data were calculated to determine staff-to-student ratios for each of the professional licenses. Staffing ratios of districts were organized into quartiles. Similarly, districts with the highest concentrations of economically disadvantaged students were organized into quartiles. Data were combined to identify districts with the highest economic need and poorest staffing ratios. These districts were then mapped using ArcGIS software and geospatial data available through MassGIS[1].

Findings

During the **2018-2019** school year, the **406 public school district**s employe**d 7,475 Professional Support Personne**l in schools to meet the needs of **951,631 students**. **2,048 school nurses** provide a range of health services, and the **remaining 5,427**

[1] MassGIS, Bureau of Geographic Information, Commonwealth of Massachusetts EOTSS; school-district data was last updated in June 2019

support personnel provide school-based counseling, academic guidance, health, and behavioral health services.

Overall, when compared to the staff-to-student ratios recommended by national associations from each of the professional fields, Massachusetts public schools are currently under resourced in the specializations of **School Social Worker/Adjustment Counselor, School Counselor, and School Psychologist.** Students in Massachusetts public schools have adequate access to services provided by School Nurses (see Table 1).

Table 1. Massachusetts Staff-to-student ratios

Professional Support Personnel License	Number of Professionals in MA Schools	Ratio of Staff: Student	National Recommended Ratios
School Social Worker/ School Adjustment Counselor	1777	1:536	1:250
School Counselor	2353	1:404	1:250
School Psychologist	1297	1:734	1:500
School Nurse	2048	1:465	1:750

Access to each of the Professional Support Personnel was organized into quartiles, based on the percentage of economically disadvantaged students, as defined above. These results were also compared to the nationally recommended ratios. Findings indicate that across all quartiles, students have adequate access to School Nurses. Students with the greatest economic need had the least access for School Counselors and School Psychologists, with twice the ratio between the lowest and highest quartile for access to School Psychologists. Students with the least economic need had the most limited access to School Adjustment Counselors/School Social Workers. The findings are demonstrated in **Figure 1**.

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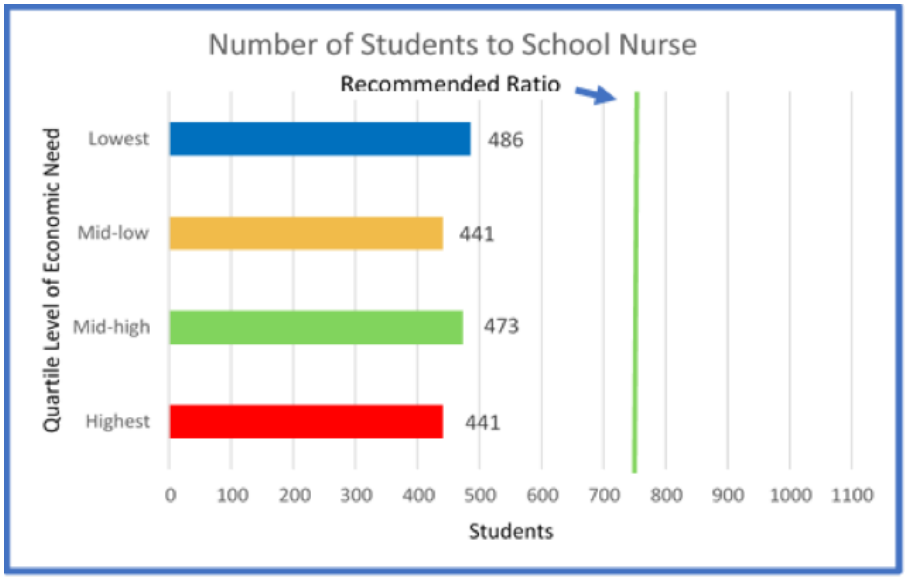
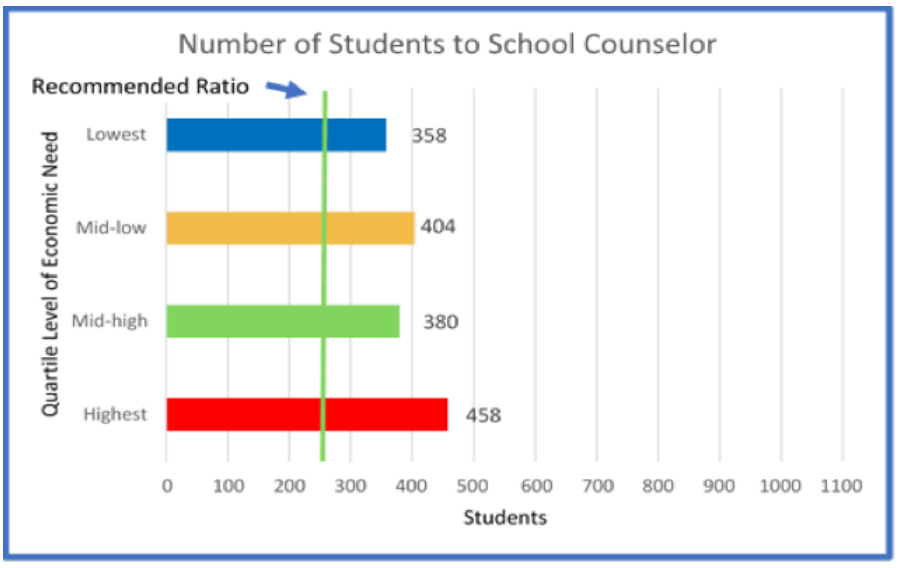
Figure 1. Staffing Ratios of Student Support Personnel in Massachusetts School Districts According to Economic Need of Students





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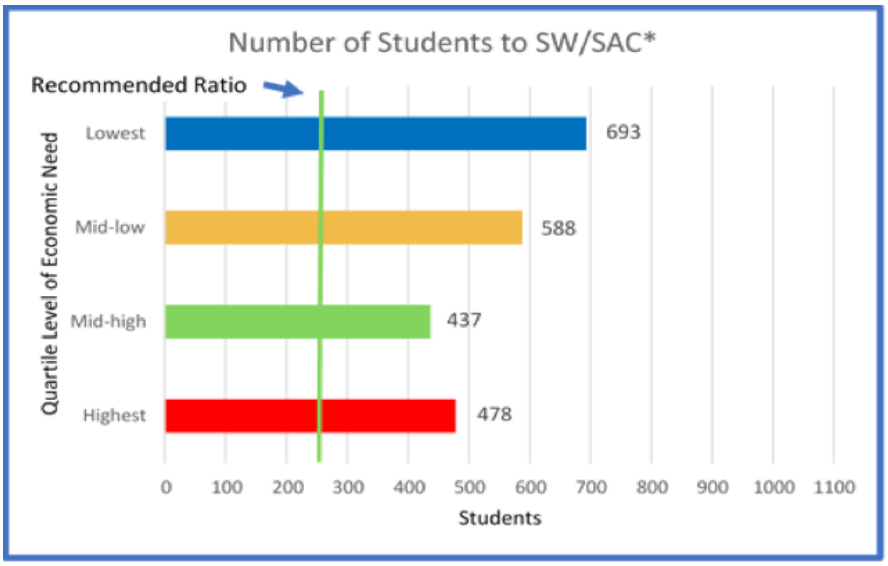
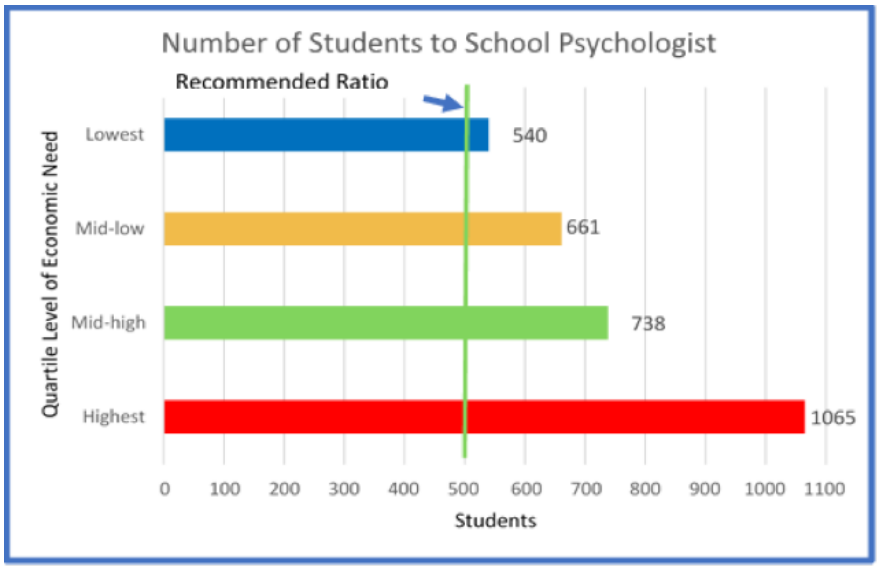


*School Social Worker/School Adjustment Counselor



Twenty-six Massachusetts school districts were identified as having both the highest level of student economic need and poorest staffing ratios (see Figure 2). These districts span every geographic region and county in Massachusetts (with the exception of Dukes, Nantucket, and Norfolk counties). **Districts near urban centers and in rural towns are overrepresented among districts with high economic need, and 54% of these districts are recognized as "Gateway Cities."** Among these districts, the proportion of Hispanic students in high needs districts is 11.4% higher than the state average and the proportion of students who speak a first language other than English is 7.2% higher than the state average.

Figure 2. Map of High Needs Districts

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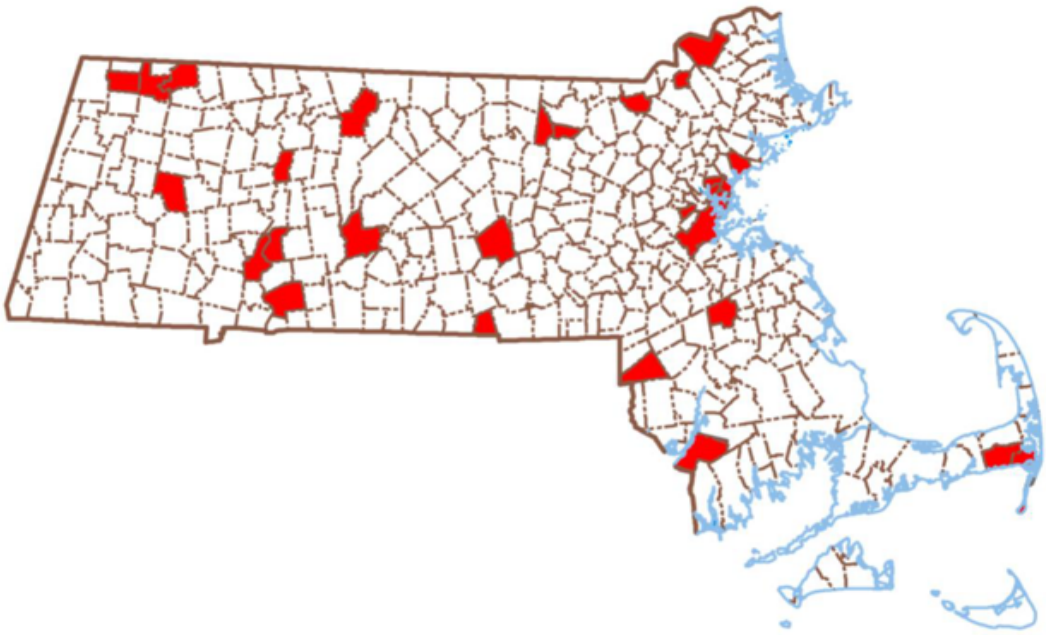


Table 2. List of High Needs Districts in MA

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

These findings suggest that students throughout the Commonwealth lack adequate access to school behavioral health staff - School Social Workers/ School Adjustment Counselors, School Psychologists, and School Counselors - based on national recommendations. Additionally, there is great variability in access to behavioral health supports and corresponding staff positions based on the level of student economic need, particularly in regard to Social Workers and School Psychologists. School districts serving students with high economic need disproportionately face barriers in access to quality behavioral health service delivery.

State and Regional Resource Maps

The second aspect of the study was to examine the dissemination of state resources - specifically competitive funding to support social, emotional, and behavioral health. As such, **grants** provided by DESE to schools and districts were explored. Grant resources included the **Safe and Supportive Schools Programs (SaSS)** and **Improving Student Access to Behavioral and Mental Health Services**. Multi-year training and support, also sponsored by DESE, included **PBIS Academy grant**, in partnership with the University of Connecticut Center for Behavioral Education and Research; **Systemic Student Support Academy (S3) grant**, in partnership with Boston College's Center for Optimized Student Support and the Rennie Center for Education and Research Policy; and, the **SEL/MH Academy grant**, in partnership with the **E**ducation Development Center and Transforming Education. Grant program descriptions are summarized below **(Table 3).**

Table 3. DESE Grant Program Descriptions

Grant Name	*Funder*	*Years Mapped*	*Grant Purpose*
Safe and Supportive Schools Grant Programs (SaSS)	DESE	2017-2020	Purpose is to organize, integrate, and sustain school and district-wide efforts to create safe and supportive school environments. Schools that receive funding through their district in this program will either convene a school team and use the Safe and Supportive Schools Self-Assessment Tool, determine areas to prioritize for improvement and finalize an action plan, or implement and assess progress on a previously created action plan. Grants last one year, and continuation funding is available. More information can be found at: http://www.doe.mass.edu/grants/2020/335/
Improving Student Access to Behavioral and Mental Health Services	DESE	2019-20	Purpose is to improve student behavioral and mental health outcomes and to address related barriers to student success. Goals include to develop comprehensive, integrated multi-tiered systems for student support and establish an infrastructure to facilitate integrated coordination of school and community-based resources. Projects are prioritized that forge partnerships and increase access between schools and community organizations. Grants last two years. More information can be found at: http://www.doe.mass.edu/grants/2019/336/
PBIS Academy	DESE & University of Connecticut Center for Education and Research	2013-2020	Purpose is to support district and school-based teams to implement PBIS. Academy includes training and networking opportunities, as well as on-site technical assistance and consultation. The grant program lasts three years. This program focuses on Tier 1 implementation, while some schools may qualify to participate in a Tier 2 Academy. Grants last three years. More information can be found at: http://www.doe.mass.edu/sfss/prof-dev/?section=pbis

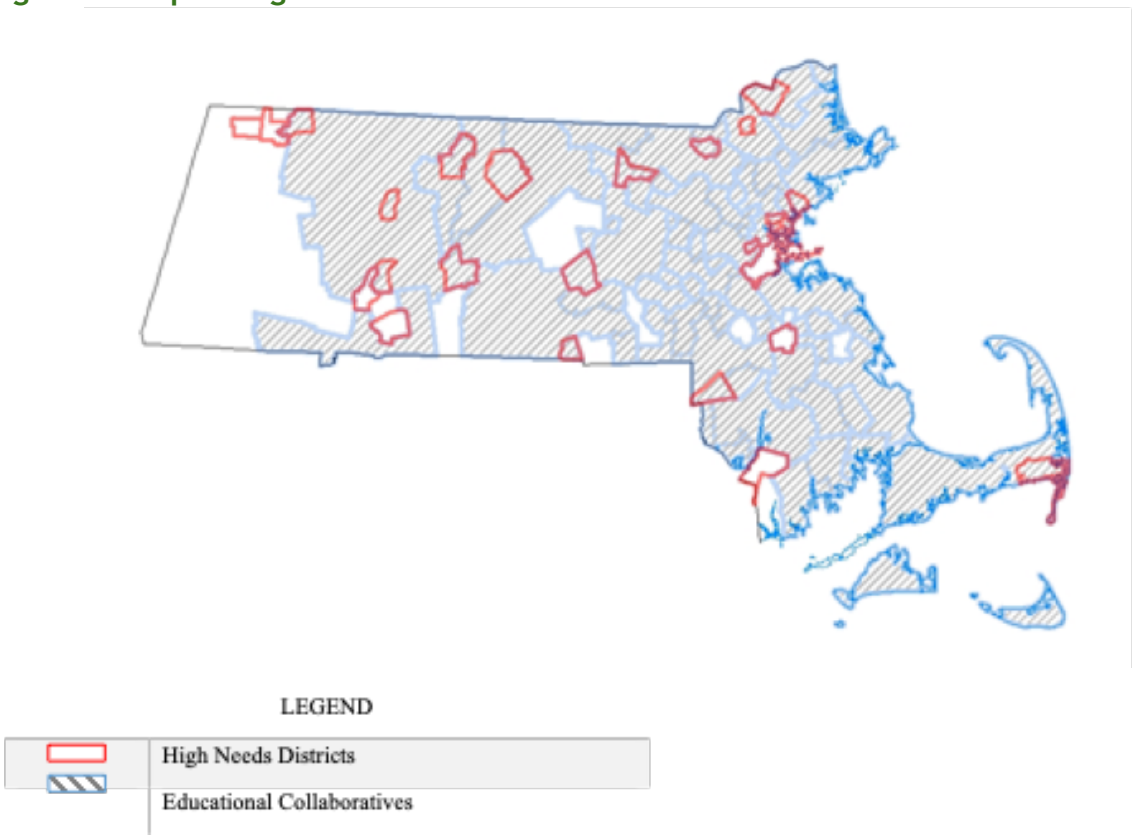
Systemic Student Support Academy (S3)	DESE & Boston College's Center for Optimized Student Support & Rennie Center for Education and Research Policy	2018-2020	Purpose is to support district-level teams in implementing integrated systems of student support. The S3 Academy is structured around a series of in-person workshops and supplemental webinars. This grant program lasts one year. More information can be found at: http://www.doe.mass.edu/sfss/prof-dev/?section=s3#accordion
SEL/MH Academy	DESE & Education Development Center & Transforming Education	2019-2020	Purpose is to help districts integrate SEL and mental health within an MTSS framework and align the work with existing priorities, systems, and practices. This program includes 3 years of professional development, coaching, networking, and technical assistance. More information can be found at: http://www.doe.mass.edu/sfss/prof-dev/?section=sel#accordion

Educational Collaboratives

In addition to the DESE funded grant programs, under **Massachusetts law (M.G.L. Chapter 40, Section 4E)**, local school committees can join together to develop Educational Collaboratives with the goals of jointly delivering services to build capacity and decrease the financial burden on individual school districts. Priorities of Educational Collaboratives include sharing resources to provide direct educational services to students (e.g., special education services), professional development, technical assistance, and programs and services to improve district operations. Collaboratives must be approved by all participating school committees, as well as by DESE. Collaboratives must report annually to the DESE on their ***1)*** programs and services provided, ***2)*** cost effectiveness of the services being provided as a collaborative as compared to the services being provided by individual school districts, and ***3)*** progress toward goals and objectives outlined in the collaborative agreement.

Massachusetts has 25 Educational Collaboratives that were included in the resource maps. Findings indicate that 26.9% of identified high needs districts do not participate in a Collaborative, and there are no Collaboratives servicing the most western part of the state. In addition to variability in membership, there is great variability in the services provided by Collaboratives to districts. While some provide therapeutic placements and services, and some provide robust professional development on behavioral health and social emotional challenges, others do not. Despite some degree of state oversight, the Collaboratives are locally-driven, with large geographical and regional disparities. Evidence of this variability across the Commonwealth is highlighted in **Figure 3**.

Figure 3. Map of High Needs Districts and Educational Collaboratives

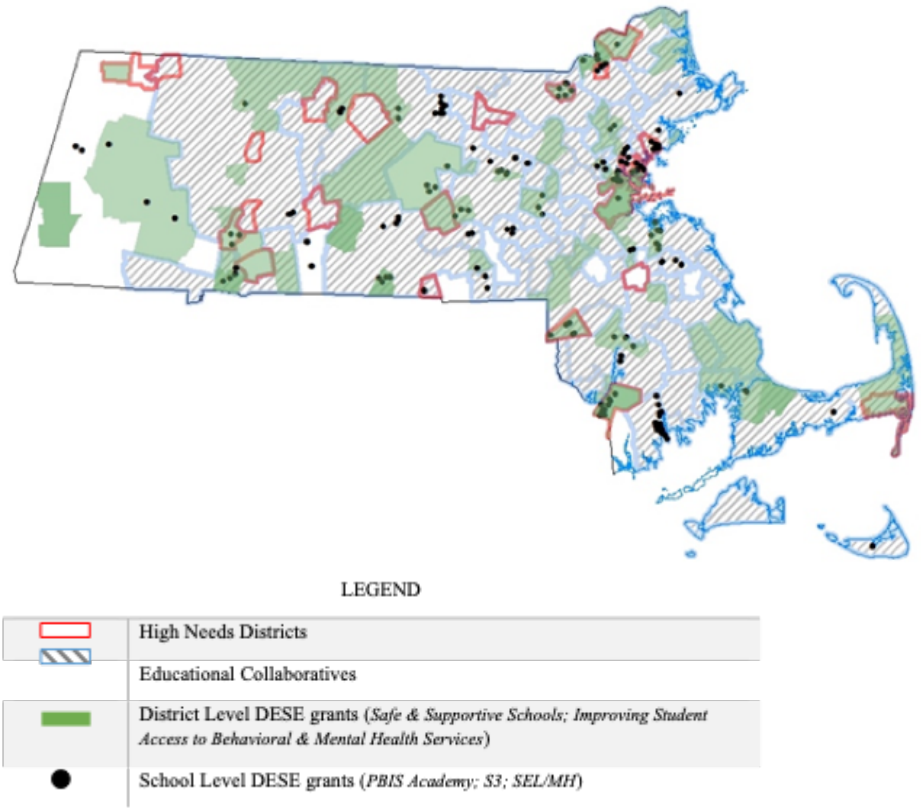


Behavioral Health Grants from the Department of Education

In addition to mapping the Educational Collaboratives, the DESE-funded, school- and district-level mental and behavioral health grant resources were mapped. Between 2017 and 2020 (including 2013-2020 for the PBIS Academy), 34.6% of the school districts with high economic need and disproportionately low staffing of Professional Support Personnel did not access any DESE resources targeting behavioral health. Many of these high needs districts are located in Western Massachusetts, which received DESE funded grant resources at a lower rate than in the eastern part of the state. This pattern indicates a discrepancy in resource allocation between rural districts with high levels of student poverty in the west, and urban districts with high levels of student poverty in the east. Similarly, "Gateway Cities"[2] are home to many vulnerable students. These cities, which account for 54% of the identified high needs districts, and did not receive many of the state-funded grants, often independently receive state funds, and may have internal personnel or systems for professional development.

[2] The Massachusetts Legislature defines 26 Gateway Cities across the state which are mid-sized urban centers and have historically served as economic hubs.

Figure 4. Map of High Needs School Districts, Educational Collaboratives, and DESE Funded Grant Resources



The fragmented grant allocation, as demonstrated in **Figure 4**, reflects the lack of a state-driven cohesive plan for school-based prevention efforts, leaving much of the responsibility to individual school districts. Without designated district leadership to focus on these efforts (e.g., Director of SEL or MH), and with competing district-level priorities and/or lack of buy-in, schools and districts have limited access to high quality and sustainable school-based behavioral health programming. There is some evidence that high need districts access funding external to Educational Collaboratives and DESE (i.e. other state agencies, philanthropic funding) and utilize community partners such as community health centers, community service agencies, or other behavioral health providers. Additional efforts are needed to understand how schools and districts are addressing these gaps.

Stakeholder Perspectives

In the final phase, more than 15 stakeholders representing state agencies, district administrators, Educational Collaboratives, school-based and community-based

providers, and university trainers were interviewed to explore their understanding of these Resource Maps. Stakeholders were asked a series of open-ended questions to critically examine and reflect on their understanding of the behavioral health needs and resources across Massachusetts schools. Additional questions included the following: ***How are DESE's resources used to support the work of school districts? What is noteworthy regarding patterns of resource allocation across schools in the Commonwealth? Which districts are accessing these resources and which are not?*** Notes from these interviews were reviewed and findings were compiled into themes.

Table 3. Themes from Stakeholder Interviews

Topic Area	Summary of Themes
Inequities in access to behavioral health resources across the state	• Many high needs school districts are not accessing state resources • Western part of the state is particularly devoid of resources • Resource allocation may be reflective of population density
"Key" to district access to behavioral health resources	• Assertive and savvy superintendents • Good grant writers • Past history of being grant recipient • Formation of a district consortium for pursuit of resources • Internal/district-level leadership, support, buy-in • Designated leadership to focus on behavioral health/SEL
Role of collaboratives in supporting districts' behavioral health efforts	• High levels of variability and diversity in the roles of collaboratives (locally-driven) • Lack of state guidelines for how to best structure and coordinate collaborative services • Service focus is often on behavioral/social-emotional challenges rather than professional development • Geographical/regional disconnects in collaborative-district partnerships • May be beneficial to leverage collaboratives as a leader in the distribution of behavioral health professional development resources • Unclear about how to best structure the role of collaboratives in supporting high needs districts across the state
Role of DESE in supporting districts' behavioral health efforts	• Siloed/fragmented efforts to support districts • Lack of critical understanding of universal framework/integrated model for supporting behavioral health • May not necessarily have the infrastructure to support high-quality efforts in schools (e.g., technical assistance and high-quality coaching) • State agency may function best in the role of an "arbiter" or "funder" of this work; rather than a central coordinating and organizing body

"Ideal" statewide infrastructure to best support building capacity of school districts to address the behavioral health needs of students	• More equitable distribution of collaboratives across the state to address the needs of low incidence populations of students; incentivization for collaborative membership • Formation of regional technical assistance centers • More efficient coordination and collaboration between school districts and state agencies (i.e. DESE, DMH, etc.) • Supporting high needs districts in building partnerships with community agencies while building capacity of school personnel • Collaboration with MassHealth • Designated behavioral health leadership in each school district • Clearer guidance regarding professional standards for behavioral health role utilization and staffing models
Envisioning the role of the BIRCh Project in supporting districts' behavioral health efforts	• Help districts understand how they can access resources and plan behavioral health efforts • Bring key stakeholders together (i.e. advocacy groups, district leaders) • Work alongside organizations such as the Children's Mental Health Campaign to foster shared alignment of goals • Continue to describe, explore, and define the roles that various stakeholders throughout the state are playing in building capacity to support student behavioral health • Continue mapping efforts (i.e., school-based health centers and Community Service Agencies) • Explore partnerships between community mental health agencies & schools • Collaborate with DESE in supporting school district access to state resources • Generate resources to help districts engage in targeted and intensive professional development (i.e., coaching, mentoring) • Spread awareness of inequities that exist in supporting student behavioral health throughout the state (e.g., creation and dissemination of fact-sheets about these issues and future action steps to address inequities)

In general, stakeholders noted the fragmented regional structures and coordinated resources for districts not part of any Educational Collaboratives. This was most noteworthy in the western part of the Commonwealth. They reported that many of the high needs districts were not accessing the training and resources provided by DESE, and again, the limited support for the western part of the Commonwealth. In fact, stakeholders reported that once districts receive one grant, they are often more likely to receive additional grants from DESE in the future. One stakeholder offered this summarizing statement on securing state-funded grants*, "it often depends on having a savvy superintendent and a good grant writer."*

Others noted that the poverty of staffing in urban communities varies from the areas of rural poverty. Urban areas have the potential to access community partners while areas of rural poverty are extremely limited in access to transportation and community resources. Some participants also noted that several districts have been known to pool resources together, forming consortiums, to better their odds of

securing grants. Due to the responsibility of individual districts in awareness of and pursuit of grants, internal district leadership and buy-in from school teams is essential for supporting student behavioral health.

Limitations of Findings

There are several limitations to this project. While the current mapping project focused exclusively on Educational Collaboratives and DESE funded grants, other state agencies also fund school-based behavioral health services and will be included in future mapping projects (i.e., Department of Mental Health). It should also be noted that data were collected from several publicly available databases and may not represent an exhaustive list of all grant funds allocated by DESE between 2017 and 2020 (note that PBIS Academy participants prior to 2017 were included in the current project).

Additionally, the findings do not reflect the myriad of community partnerships that exist between school and community agencies, including school-based health centers. These centers, which are supported by the Department of Public Health, tend to be located in Gateway Cities (e.g., Boston, Chelsea, Worcester, Springfield), which are densely populated with diverse communities that have unique needs.

Finally, in examining staffing ratios within school districts, this research only focuses on Professional Support Personnel employed directly by LEAs; and, it does not include data on community providers or partnerships with area agencies. Community-based support staff who are *placed* in schools (but are not *employed* by schools) were not included in our dataset. In other words, some of the districts that we have identified as high needs may be well resourced with services coordinated with community partners.

It is also important to note that there is inconsistent application of the skills and competencies of Professional Support Personnel to support PreK-12 students' social, emotional and behavioral health across schools and districts. This can be due to many factors, including district structures, staffing capacity issues, and insufficient training. Further study of current roles and practices throughout the Commonwealth and a resource map of community providers is needed.

Conclusions

Based on these findings, the Department of Elementary and Secondary Education continues to offer a variety of resources for schools and districts to enhance behavioral health efforts. And yet, results from this research suggest that DESE's lack of a cohesive plan across districts results in the perpetuation of an inequitable, fragmented system. DESE has put forth disjointed efforts to address behavioral health

by providing funding and training through various initiatives. Further, these resources often do not reach those districts with the highest need and fewest behavioral health providers. Our data further indicated that regionally-accessed services available through educational collaboratives are inconsistent and limited in the communities that access these networks of support. Ultimately, our state is left with 406 LEA administrators leading school districts without the guidance of a universal and integrated framework to support the behavioral health needs of students. This has resulted in uncertainty in deploying staff, variance in community partnerships, and differences in access to resources and funding. Our highest needs districts continue to disproportionately face barriers to high quality behavioral health service delivery as they often are not a part of collaboratives and are not accessing DESE resources.

Students who are economically disadvantaged are at greater risk for negative school outcomes. For the public schools in Massachusetts to serve students and emphasize prevention and promote positive outcomes, access to coordinated professional development, strategic and collaborative partnerships, and adequate staffing of Professional Support Personnel is required.

Recommendations

Informed by findings and interview feedback, we offer the following policy strategies for more equitable allocation of school-based behavioral health resources.

Consistent and Coordinated Professional Development

DESE can organize professional development structures that support school districts to conceptualize and align multi-tiered systems of social-emotional, and behavioral support, develop and document a clearly articulated school mental health plan, and to strategically develop community partnerships to meet the needs of the most vulnerable students and prioritize resources for high need districts.

Support Workforce Development Opportunities

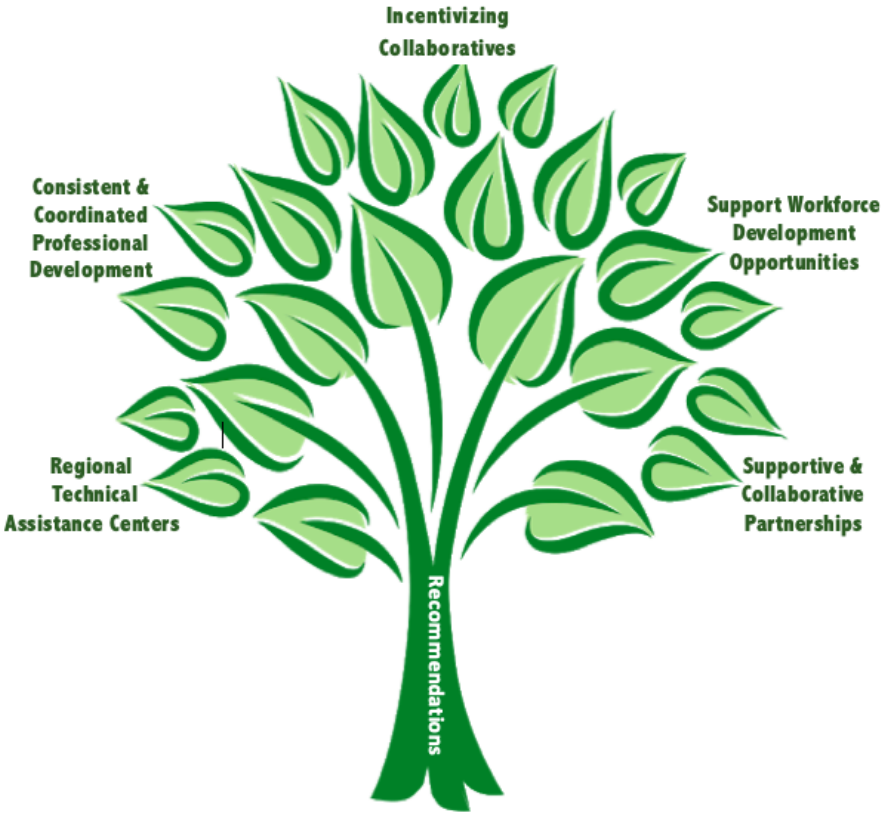
The hiring of key personnel requires a pool of highly qualified school-based behavioral health professionals – national reports suggest that there are labor shortages in these fields. State resources can support pre-service training to build a cadre of licensed professionals, who are trained in coordinated care delivery models, with targeted efforts to diversify personnel.

Supportive and Collaborative Partnerships

Coordinating school-based services with community behavioral health partners, and providing guidance on blending funding from various public systems, can assist in the support of students, families, and staff as schools cannot meet students' needs alone.

Incentivizing Collaboratives

There are currently 25 Collaboratives across the Commonwealth, each with varying resources and services. Most Collaboratives combine resources to address the needs of low incidence populations, and could be further developed to provide consistent offerings across the Commonwealth. These services can help reduce the strain on individual districts and provide high-quality professional development and technical assistance.



Regional Technical Assistance Centers

Similar to an expanded vision for Collaboratives, creating regional resources for districts to contact for best practices, workforce development, and promotion of cultural and linguistic diversity can help promote uniformity and equity across the 406 public school districts.

Next Steps

Informed by these findings, next phases of the BIRCh Project mapping initiative include *deepening* our understanding of resource utilization from school districts' perspectives, as well as *broadening* our resource maps to include services provided by other state agencies and community organizations. Both objectives are described below.

Social Network Analysis: Mapping of Behavioral Health Training Networks

In the next phase of the project, school capacity will be further examined by mapping the professional development efforts that Massachusetts school districts utilize to address the behavioral health needs of students. Social network analysis, a methodology used to mathematically study the size, composition, and structure of relationships, will be used to better understand the extent to which school districts are currently working to coordinate behavioral health efforts that effectively and efficiently meet the needs of youth. This research will describe which organizations districts are partnering with to receive high-quality professional development, how often they are connecting with such organizations, and for what purpose . Additionally, school districts will be asked to provide qualitative information regarding their organizational framework used to support student behavioral health (i.e. SEL curricula, MTSS implementation, etc.). Data for these maps will be specifically drawn from districts across various counties throughout the state with both high and low economic need and varying staffing ratios. As of Summer 2020, 48 school districts have been contacted for this mapping project. To date, data have been collected from 11 school districts across 8 counties in the Commonwealth of Massachusetts. These maps will be analyzed alongside previous ArcGIS resource maps to better understand how school districts are building capacity to support the behavioral health needs of students.

Mapping of Community Services Agencies (Children's Behavioral Health Initiative - MassHealth)

In Massachusetts, there are 32 Community Service Agencies (CSA) that provide intensive behavioral health support to Medicaid eligible children and families with significant behavioral health needs. According to a Children's Behavioral Health Initiative (CBHI, 2018) report, 406 unique youth had an average wait time of 17.9 days for an initial appointment. These children, who represent 5.48% of MassHealth eligible cases, were primarily referred by the Department of Children and Families, the child's family, or an outpatient clinic. While the CBHI Commission continues to address issues of workforce development, the BIRCh Project aims to identify strategies for complementary service delivery with behavioral health professionals working within the school setting (e.g., school psychologist, school counselors).To this end, in the next phase of resource mapping, all CSA catchment areas will be mapped. This map will be layered on top of the current maps, to better understand how CSAs and schools collaborate, gaps in services, and areas for continued partnership development.

The BIRCh Project

The BIRCh Project is housed at both **UMass Boston** and **UMass Amherst**, two of the state-sponsored, public research universities, to address the varying needs across the Commonwealth. This resource initiative at the UMass campuses draws on the expertise of the state universities and enhances the capacity of public schools to efficiently integrate behavioral health supports. This partnership improves access to community resources, promotes greater efficiency in utilization of services, and enhances the integration of non-academic supports across the school and community settings. Likewise, advancing the training for education and behavioral health professionals through the state's public higher education system creates the opportunity for long-term and sustainable practices, particularly for schools that support some of the state's most under-resourced communities (e.g., gateway cities). Moreover, UMass Boston's ongoing partnership with **Boston Public Schools** and **Boston Children's Hospital Neighborhood Partnership Program**, focused on the work of the Comprehensive Behavioral Health Model, and UMass Amherst's partnerships with school districts in Western MA, serve as a resources in the design of coordinated supports for students, schools, and families. The overarching goals are to enhance the capacity of public schools to efficiently integrate behavioral health supports and develop systemic structures (e.g., policies and protocols) that allow for efficient integration of community services.

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