BARNSTABLE COUNTY
DEPARTMENT OF HUMAN SERVICES

Barnstable County Department of Human Services Children's Behavioral Health Needs Assessment

Report of Findings

October 2024

Prepared by Health Resources in Action

HEALTH RESOURCES IN ACTION

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Summary of Key Themes and Recommendations

The following section summarizes the key themes and recommendations that were provided throughout the assessment conducted in Barnstable County over 14 months (June 2023-August 2024). The overarching goals of this assessment were to:

- Document and better understand the behavioral health issues and needs of children, youth, and young adults in each of the four sub-regions of Barnstable County.
- Document and better understand the availability and accessibility of behavioral health services for children, youth, and young adults in each of the four sub-regions of Barnstable County.
- Inform future efforts towards advocacy, including secure funding and services specifically for and within Barnstable County.
- Inform future efforts towards collaboration and service sharing across Barnstable County.

Throughout the assessment, behavioral health was defined broadly as individual and family experience of life stressors – beginning in early childhood – and stress-related symptoms; mental, emotional, and social well-being; health-related behaviors; and mental health and substance use disorders. Qualitative and quantitative data were collected through community forums, focus groups, surveys, and secondary data reviews.

This summary aims to highlight the main takeaways of the assessment; the in-depth and detailed information on the data collected (beginning on page 14) delves more deeply into each key theme and recommendation.

Behavioral health issues are growing among youth in Barnstable County, driven by a variety of factors that also simultaneously hinder access to care.

This assessment gathered information on the behavioral health needs most affecting young people in Barnstable County; both universally identified needs and those named by specific groups.

- **Anxiety** – providers identified as the top need for all age groups (0-24 years); caregivers identified as the top need; young people identified as the top need; one of the most frequently discussed needs during community forum and focus group discussions, particularly highlighting how it is becoming more common, affecting everyone, and happening at younger ages.

- **Depression** – providers identified as a top need for young people 10-24 years old; caregivers identified as a top need; young people identified as a top need; often discussed alongside anxiety related needs, depression also has begun to impact younger age groups.
- **Autism** – providers identified as a top need for young people 0-9 years old; named as a critical need in focus groups with caregivers (particularly grandparents raising grandchildren), health providers and school staff, and young people with emphasis put on the challenges in getting a diagnosis for both younger and older youth; the limited availability of providers who work with young people on the autism spectrum posed a significant challenge even after diagnosis.
- **ADHD** – providers identified as a top need for young people 0-14 years old; caregivers identified as a top need; young people identified as a top need; focus groups discussed ADHD as a need on its own as well as how it can co-occur with other behavioral health needs such as anxiety.
- **School refusal/absenteeism** – providers identified as a top need for young people 10-19 years old; caregivers identified as a top need; young people identified as a top need; focus group participants, particularly health providers and school staff, saw this need increasing among young people.
- **Eating disorders** – young people identified as a top need while this did not come up for caregivers or providers; young people discussed how this is a taboo topic not talked about in their communities but emphasized it is an issue impacting many young people, most of whom cannot access information or resources if they take the step to seek out help.
- **Substance use** – providers identified as a top need for young people 15-24 years old; this was discussed as a need that has a bidirectional relationship with other behavioral health needs – substances are being used as a coping mechanism for anxiety and depression, which in turn worsens these mental health conditions; young people specifically highlighted the pervasiveness of vaping among young people.
- **Suicidality & self-harm** – providers identified suicidality as a top need for young people 15-24 years old; caregivers identified self-harm as a top need; young people identified self-harm as a top need; providers noted seeing an increase in these behavioral health needs among young people; young people themselves discussed that these issues are experienced by their peers and often need to get to this level of severity before action is taken by adults in their community; this was discussed primarily in the context of schools needing to be better able to recognize and address needs before these more severe issues arise.

Underlying and Contributing Factors

The data collected related to the underlying factors contributing to these behavioral health needs will help guide future action to address and prevent more severe needs. These factors are part of a cycle in that they contribute to the development and severity of behavioral health needs among young people in the county as well as impact the ability to access

appropriate care to address these needs. There were stark differences in some of the contributing factors identified by caregivers when stratifying by family structure (i.e., relationship to children) and economic status (i.e., insurance status).

- **Trauma & adverse childhood experiences** – providers identified as a top contributing factor for all age groups (0-24 years); caregivers with public or no health insurance and those with relationships to their children other than biological or adoptive parent identified as one of the top contributing factors; young people identified as a top contributing factor; community forum and focus group discussions frequently brought up the high experience of loss and trauma among young people in the county, particularly in connection with the opioid epidemic.
- **Parenting & family dynamics** – providers identified as the top contributing factor for young people 0-19 years and also a top factor for those 20-24 years old; caregivers with relationships other than biological or adoptive parent identified as a top contributing factor; young people identified as a top contributing factor; focus group and forum participants discussed the impact of different family dynamics for those being raised by someone other than their biological or adoptive parent, e.g., other family members, foster care, and how those young people have more severe and unique behavioral health needs; was often directly connected to the experience of trauma and the opioid epidemic, especially for grandparents raising their grandchildren.
- **Social media & technology** – providers identified as a top contributing factor for all age groups (0-24 years); caregivers identified as a top contributing factor; community forum and focus groups with providers and caregivers discussed that social media and technology lead to less interaction/more social isolation for young people, less coping mechanisms, and that younger and younger kids are gaining access; young people, while they did not identify this as a top contributing factor, discussed the negative impact social media can have on young people's behavioral health, but they recognized the fact that social media and technology are not going anywhere and called for adults in the community to understand this when addressing its impact.
- **Bullying** – providers identified as a top contributing factor for young people 10-19 years; caregivers overall, with any insurance status or relationship to their children, identified as a top contributing factor; caregivers with public or no health insurance and those with relationships to their children other than biological or adoptive parent identified as the top contributing factor; young people identified as a top contributing factor; forum and focus group participants talked about in-person bullying, and drawing the connection to young people feeling unsafe in schools, as well as cyberbullying and its connection to the challenges of social media; others discussed severe bullying and discrimination based on identities including race and ethnicity, immigration status, and those who identify as LGBTQ+.

- **Peer relationships & peer pressure** – providers identified as a top contributing factor for young people 10-19 years old; caregivers overall, with any insurance status or relationship to their children, identified as a top contributing factor.
- **Body image** – caregivers, except for those with relationships to their children other than biological or adoptive parent, identified as a top contributing factor; young people identified as a top contributing factor; while eating disorders were only identified as a need by young people, caregivers identifying body image as a top contributing factor indicates some level of understanding of related concerns that should be built on when raising awareness and addressing the needs of young people with eating disorders; both young people and caregivers most frequently selected body size as the characteristic they felt led them/their children to be treated negatively when seeking behavioral health services.
- **Academic pressure** – caregivers, except for those with public or no insurance, identified as a top contributing factor; young people identified as the top contributing factor; discussions were around how academic pressure leads to stress and can result in behavioral health needs like anxiety and depression as well as unhealthy coping mechanisms; this factor was selected more often by those who had private insurance and those who were the biological or adoptive parent of their children, indicating that while this is an important factor among young people, there are some groups that have more impactful, severe, and pressing contributing factors rising above academic pressure.
- **School environment** – young people identified as a top contributing factor; this being selected by young people can be seen as connected to the peer relationships/peer pressure noted by caregivers and providers; however, it is clear young people see it as more of an issue within the school context than overall interactions with their peers.
- **Social isolation** - young people identified as a top contributing factor; another contributing factor uniquely identified by young people that can also be connected to the peer relationships/peer pressure identified by caregivers and providers, but again adding important nuance from those who have the direct lived experience that there is a major factor of disconnection and isolation impacting their behavioral health.
- **Economic factors** – providers identified as a top contributing factor for all age groups (0-24 years); given the cost associated with accessing behavioral health services, it is understandable why providers and others that work with young people would note economic factors as something that impacts both the behavioral health needs of young people and the ability to get care while caregivers and young people focused more on the experiences of their day-to-day interactions.
- **Stigma** - a factor, noted by young people but less so by caregivers and providers, impacting both the behavioral health needs of young people directly and their willingness and ability to access care; young people reported experiencing discrimination in accessing behavioral health services more often than adults reporting on if they felt their child had been discriminated against; a greater proportion of young people disagreed

that they felt comfortable talking about behavioral health with family or friends, and some of the top barriers young people noted when thinking about accessing care were about fear of information not being kept confidential and fear that others would find out; these differences highlight complexity in getting young people, particularly older kids and teens, to seek help in the first place and get connected to services; for them, it not only about systemic barriers but also stigma and interpersonal concerns.

Youth and Young Adult Engagement

It is critical to recognize there were needs, contributing factors, and barriers identified by young people, and not by providers and caregivers, emphasizing the importance of continuing to center and engage youth in these conversations around understanding needs and implementing future programming efforts. Moreover, it would be beneficial to engage different subpopulations within the young community in the county to further understand their specific needs. This could include younger students (i.e., middle school aged), young adults transitioning into adulthood, young people engaged with the foster care system, those being raised by someone other than a biological parent, homeless or housing unstable youth, as well as other groups that were not able to be robustly engaged in the assessment process.

The limited number of behavioral health providers and services available in Barnstable County poses a foundational barrier to addressing the growing behavioral health needs of young people.

Across data collection methodologies, participants and respondents consistently identified the need for greater capacity across the behavioral health system of care to meet the current need for services among children and youth in Barnstable County. The most common challenges and barriers that were identified by participants included long waitlists, difficulty finding specific types of services or providers, and difficulty scheduling appointments. All of this points to a system with low capacity to meet the needs of the population. As detailed throughout the findings, the types of behavioral health services and/or providers most needed in Barnstable County included:

- **Counseling services (school or community based)** – identified by providers as one of the top services that was limited for all age groups in the county; identified by providers as the top service most critically needed in the county; identified by providers as the top services that would most improve prevention or early intervention in the county; this was the most frequent type of service parents/caregivers attempted to access for their child(ren); consistently mentioned among focus group participants as a type of provider/service that is lacking in the county.

- **Psychiatric services (medication management, psych evaluations)** – identified by providers as the top service that was limited across age groups; identified by providers as one of the top services most critically needed in the county; this was the second most frequent type of service parents/caregivers attempted to access for their child(ren); consistently mentioned among focus group participants as a type of provider/service that is lacking in the county; focus group participants particularly noted the lack of psychiatrists working with younger children.
- **Day treatment or intensive outpatient programs** - identified by providers as one of the top services that was limited for all age groups in the county; identified by providers as one of the top services most critically needed in the county.
- **Therapeutic interventions (individual, group, family therapy)** - identified by providers as one of the top services that was limited for all age groups in the county; identified by providers as one of the top services most critically needed in the county; this was the third most frequent type of service parents/caregivers attempted to access for their child(ren); focus group participants specifically discussed the lack of longer-term interventions, which are needed to support higher-need situations.
- **Inpatient psychiatric hospitalization** – identified by providers as a service that was limited for most age groups in the county; identified by one quarter of providers as a service most critically needed in the county; focus group participants also highlighted the absence of inpatient services in the county specifically for substance use disorders and eating disorders among youth.
- **Crisis response services** – Children and youth increasingly reaching crisis level in the county were attributed to the lack of sufficient prevention and early intervention providers/services; participants consistently expressed the need to develop and expand a specialized behavioral health emergency system to do outreach and respond to mental health emergencies, including in the home; about one quarter of providers identified crisis intervention services as limited for the 10- to 19-year-old age groups in the county; about one quarter of providers identified crisis intervention services as most critically needed in the county; about 15% of parents/caregivers attempted to access crisis intervention services their child(ren); participants recounted their personal stories of taking their children to the ER in response to a mental health crisis, where treatment was not sufficient or appropriate; pediatricians noted that the lack of emergency mental health services impaired their ability to meet the needs of patients currently in crisis.
- **Early intervention services** – providers identified ADHD, autism spectrum disorders, and disruptive behavior disorders among the top five behavioral needs of children in the 0-4 and 5-9 year old age groups; over half of parents/caregivers identified ADHD as a behavioral health need for their child(ren); about 15% of parents/caregivers identified autism spectrum disorder as a behavioral health need for their child(ren); nearly half of youth identified ADHD as one of their own behavioral health needs; focus group participants advocated for more neuropsychiatric specialists to increase access to timely

testing as it frequently blocked access to subsequent services needed to support their child(ren) with neurological and developmental disorders.

Stronger and expanded school-based services and programming are needed to positively impact young people across Barnstable County.

Given the amount of time children and youth spend in school, it is not surprising that a common theme was the need for more school-based mental health support. As one grandparent commented, ***"the people who have our children the longest everyday are the schools. They need to be supported."*** There was a consistent perception that school staff are overworked, under-resourced, and ultimately unable to meet the needs of growing kids (developmental screening, response to bullying, education/awareness to recognize behavioral, social-emotional health needs, etc.) Specific recommendations from participants included:

- **Enhance school-based social emotional programs** – Focus group and community forum participants emphasized the importance of prevention programming and suggested expanding school-based programs focused on mindfulness, education on healthy relationships, interpersonal skill building, anti-bullying, suicide prevention. They noted that schools were ideal settings to ensure all age groups develop the pro-social skills they need to build kinder and more supportive communities. Such efforts could help to make the school community more supportive of different subgroups of young people, e.g., those who are neurodivergent and LGBTQ+ students. Aligning with other findings and recommendations, it is critical to ensure young people are actively engaged and participate in designing and delivering such programs is critical, as one participant observed, ***"any programming [that] is peer to peer is more successful than adults trying to send messaging to kids."*** Some of this programming has already started—participants mentioned Hope Squads and Sharing Kindness as two current initiatives—and should be built upon.
- **Strengthen teacher and staff knowledge and skills around behavioral health** – Youth focus group members shared that they would like to see teachers and other school staff better skilled at recognizing and responding to students who appear to be struggling, i.e., asking the right questions, listening without judgement, and seeking to better understand the reasons for some behaviors. Participants suggested consistent and ongoing professional development to improve their ability to respond and support students, particularly their knowledge and skills in managing students with specific behavioral health diagnoses.
- **Increase the number of school-based counselors** – As part of the discussions around the lack of counselors and therapists to meet the needs of youth in Barnstable County,

many focus group participants advocated for more school-centered delivery of care to help fill in this gap through in-school counselors and therapeutic services, provided by either school staff or community-based agencies located in schools. These staff would enhance the ability of schools to assess students for special services, identify and support students who are struggling, and connect families with additional resources. These providers, several suggested, could also lead group sessions and student support groups. School-based services were also viewed as a direct way to reduce transportation barriers and potentially out-of-pocket costs if external funding sources could be secured.

- **Promote and expand school-based wellness spaces** - A few caregivers and youth focus group members shared positive experiences with school-based wellness spaces that provide students an opportunity to briefly take some time away from the day to relax and recenter if they are struggling mentally. They suggested that these should be continued or expanded. Youth emphasized that these spaces should limit the number of students there at any one time and be staffed with people able to provide support if needed.

Community-based social and recreational opportunities for children and youth in Barnstable County create safe spaces for connection, which support the well-being of young people.

A central theme that emerged through data collection was the importance of and need for more community-based social and recreational opportunities for children and youth in Barnstable County. These opportunities create safe spaces for connection, which are essential for supporting the well-being of young people. Social and recreational programs were identified by participants as vital for fostering a sense of belonging, building social skills, and counteracting the social isolation and dependence on technology that were seen as contributing to the behavioral health issues of youth in the county. As one caregiver noted, *"We need more programs for kids and youth to socialize and do group activities together."*

Youth participants expressed frustration with the lack of age-appropriate spaces and activities, noting that many programs are designed for seniors or young children, leaving teenagers and young adults without suitable options. This gap in services contributes to feelings of being *"in limbo"* for older youth. Provider survey results reinforced this sentiment, with 42% of respondents identifying youth centers, after-school programs, and recreational activities as critically needed in the county; 50% of providers also identified such programing as among those that would be most impactful for improving prevention and early intervention—ranking second just behind counseling services.

Barriers to accessing current programs were also highlighted by participants. These included transportation limitations, high cost/low affordability, language accessibility, and program

capacity. Over half (53%) of providers working in after-school programs reported current waitlists, underscoring the insufficiency of current programming.

> *"I like the idea of having places for kids to go, [for] so many it's the sports. Many kids can't afford the sports. Good old intramurals, safe spaces to play."*

Participants suggested increasing lower-cost activities for youth, such as after-school programs, summer camps, and sports, which would reduce isolation and build protective factors. Focus group participants also suggested the expansion and support of existing community spaces such as arts centers, Boys and Girls Clubs, libraries, parks, and other regional hubs to increase and broaden recreational opportunities. Collaboration across town lines and between community-based organizations, schools, and behavioral health providers to provide these opportunities was identified as essential for sustainability and success of these efforts.

Navigation support and other resources for Barnstable County families, and those who work with young people, are critically needed to facilitate referrals and enable connection to behavioral health services for young people.

The assessment process successfully engaged many community members who had direct experience seeking behavioral health services for their child(ren) in Barnstable County. Among parent/caregiver survey respondents, nearly all who felt their child(ren) needed some type of behavioral healthcare (90%) did try to receive services. However, one quarter of these respondents (24.7%) reported that they were not successful in any of their attempts and half (50.5%) reported that they were only successful with some services, but not all of them. Furthermore, when asked about the situations that had made it harder to access behavioral healthcare for their child(ren), 60% of parent/caregiver survey respondents reported that they could not find a program or professional to go to and 25% reported they did not know how or where to go to get treatment. These data highlight the frustrations many families are experiencing due to their low awareness of the landscape of behavioral services in the region or lack of skill in navigating the various systems of care.

Several recommendations arose during qualitative discussions that would help to better support connections to services for families:

- **Expand navigation services -** there is a pressing need to expand navigation services, particularly for populations with language barriers where awareness of available resources varies significantly. As one Spanish-speaking caregiver observed, ***"we do not know where the resources are or what resources are available."*** Increasing communication efforts and hiring more culturally competent social services navigators could help bridge these gaps and ensure families are better connected to essential

programs and resources. Additionally, **provider-based navigators** should be placed within healthcare settings to assist families in accessing mental health services and overcoming common barriers such as insurance coverage and transportation. As one provider noted, reimbursement mechanisms will be crucial to the success of this approach. Strengthening connections between schools, communities, and healthcare providers is also vital for improving referrals. A member of the grandparent focus group suggested placing **school-based caregiver advocates** in every school to further aid in navigating available resources. There is also widespread recognition of a lack of centralized information.

- **Create and maintain a comprehensive online registry of resources, programs and services available for children with behavioral health issues –** a central registry should include listings of therapists, psychiatrists, outpatient and inpatient hospital programs, residential services, and community-based programs, complete with names and contact information. This type of resource would be invaluable for parents, caregivers, schools, social service providers, pediatricians, and other healthcare professionals, making it easier to access and share critical information. One participant highlighted the difficulty of tracking down providers, particularly those accepting private insurance, and emphasized how beneficial a central registry would be for families seeking to identify and connect with the right services. They noted, *"Often a family finds a therapist but only has half of a name or partial information. If we had a place to find out who's in town and accepting certain ages, it would be very helpful."*
- **Support pediatricians and advocate for co-location of behavioral health services** – To better support pediatricians and advocate for the co-location of behavioral health services, it is important to recognize the critical role pediatricians in Barnstable County play in supporting children, youth, and their families, particularly when dealing with mental health, neurological, and developmental disorders. Focus group participants recommended improving the accuracy of information available to pediatricians and other healthcare providers regarding mental health resources. Specifically, they called for ensuring that providers have up-to-date information on which mental health professionals are accepting new patients and which insurances they accept. Additionally, participants emphasized the importance of continuing to expand existing practices that co-locate pediatric, social, and behavioral health services, as this integration has been shown to improve both service delivery and the local health infrastructure.

Individuals who support young people with behavioral health needs in Barnstable County want, and would benefit from, more programming focused on their unique needs as caregivers and loved ones of those with behavioral health needs.

To better support parents, guardians, and families of children with behavioral health issues, a variety of resources and services are needed, including caregiver support groups, grief groups, and educational opportunities that build parenting skills. Among parent/caregiver survey respondents, only about one-third (39%) reported that they were very or extremely confident in their ability to support the behavioral health of their child(ren), leaving a lot of room for improved support, education, and skill-building.

Focus group participants shared their personal journeys and struggles in understanding mental health and neurological disorders, navigating complex systems, and advocating for their children's needs. One caregiver expressed a desire for shared experiences, stating, ***"I want to hear from a mom that's gone through the same struggle as me."*** Caregivers emphasized the importance of education on topics such as typical childhood and adolescent behavior, neurological differences, and available services and supports. These educational opportunities would help address caregivers' questions and empower them to better advocate for their children. Participants also stressed the need for caregiver support groups to foster community and provide a strong, supportive network. As one caregiver noted, ***"when parents are feeling supported because they've got a support group, it builds their resilience to help their children build resilience."*** It was suggested that these groups be offered in multiple languages to ensure inclusivity.

Additionally, several caregivers highlighted the need for mental health support for themselves, acknowledging the emotional strain of parenting children with neurological differences and mental health challenges. One focus group member pointed out, ***"they do it with the children, but they don't always do it with the caregivers,"*** emphasizing the importance of providing caregivers with the same level of mental health support that is available to their children.

Introduction and Background

The Barnstable County Children's Behavioral Health Work Group (CBHWG) was formed in February 2019 in response to the prevalent behavioral health challenges facing youth in the county. Since that time, the initiative has actively sought to understand, plan for, and address the gaps in the behavioral health system of care for children and youth. In September 2019, the CBHWG conducted a System Scan of available and needed behavioral health services. Upon completion of this scan, they produced a **Recommendations and Action Plan** to address gaps in care. One central recommendation included a comprehensive baseline needs assessment, which would help identify the depth and breadth of behavioral health needs among children and youth and help the working group prioritize future efforts and drive decision making.

In 2023, ARPA funds were awarded to the Barnstable County Department of Human Services (BCDHS), which allowed the **Children's Behavioral Health Baseline Needs Assessment** process to be launched. Health Resources in Action (HRiA) was hired to conduct the assessment in collaboration with BCDHS and a Core Planning Group that included representatives of the CBHWG. The assessment process took place over approximately 14-months (June 2023 through August 2024).

The overarching goals of this assessment were to:

- Document and better understand the behavioral health issues and needs of children, youth, and young adults in each of the four sub-regions of Barnstable County.
- Document and better understand the availability and accessibility of behavioral health services for children, youth, and young adults in each of the four sub-regions of Barnstable County.
- Inform future efforts towards advocacy, including secure funding and services specifically for and within Barnstable County.
- Inform future efforts towards collaboration and service sharing across Barnstable County.

Throughout the assessment, behavioral health was defined broadly as individual and family experience of life stressors – beginning in early childhood – and stress-related symptoms; mental, emotional, and social well-being; health-related behaviors and mental health and substance use disorders.

Methodology

Secondary Data Review

To understand the context and characteristics of the population in Barnstable County, a number of existing data sources were reviewed. These were used to help to identify the service needs of youth and young adult residents and to inform subsequent data collection

methodologies used in the assessment. Data sources included the American Community Survey (ACS) from the U.S. Census Bureau, MA Department of Elementary and Secondary Education (DESE), and the National Survey on Drug Use and Health (NSDUH) from SAMHSA, among others. Data included in the 2022 Cape Cod Health Care Community Needs Assessment were also reviewed. Key indicators from the secondary data review have been integrated into this report to provide important context and fill specific information gaps.

Community Forums

A series of four regional Community Forums were hosted through the Fall of 2023 to hear directly from a broad cross-section of community members. Community members were invited to attend through a series of direct outreach by core planning group members, flyers, emails, newsletters, social media, and other media outreach efforts, beginning approximately 3-4 weeks prior to each forum. Dinner and refreshments were provided to encourage attendance. One Community Forum was held in each of the four geographic sub-regions of Cape Cod and three of the four forums included a Zoom feed, which allowed for both virtual and in-person attendance.

- Outer Cape - Truro Community Center in Truro (w/virtual option)
- Lower Cape - Cape Cod Technical High School in Harwich (w/virtual option)
- Mid Cape - The Family Table Collaborative in Yarmouth (in-person only)
- Upper Cape - The Mashpee Wampanoag Government Center in Mashpee (w/virtual option)

One additional virtual-only forum was hosted after the regional forums to engage community members who could not attend the regional forums. Approximately 100 community members attended at least one of the Community Forums. Discussions at each forum varied, but generally centered on the behavioral health needs of youth and young adults in Barnstable County, the experience of seeking/obtaining services for behavioral health, and suggestions for the future services/programming. Detailed notes taken during each Community Forum were compiled and summarized to identify key themes that arose across discussions. These themes have been integrated throughout the report as they align with findings from the other data sources.

Qualitative Data Collection

To capture the perspectives and experiences of community members, individuals with lived experience, providers, and other stakeholders with connection and insight to the behavioral health needs of children, youth, and young adults in Barnstable County, a total of 75 individuals were engaged through a series of eight focus group discussions, three of which were conducted with providers and five with community members. These types of conversations not only collect critical information on the “why” and “how” behind the issues, but also identify the current level of interest, readiness, or political will for future strategies for action. **Figure 1** details the populations reached through each of the focus groups.

Figure 1. Focus Group Populations Reached

Population/Group	Participants
PROVIDER FOCUS GROUPS	
School Counselors & Nurses *(Virtual via Zoom)*	7
Behavioral Health Providers *(Virtual via Zoom)*	5
Pediatricians *(Virtual via Zoom)*	11
COMMUNITY FOCUS GROUPS	
Grandparents Raising Grandchildren *- Hosted in-person by Family Resource Center*	11
Young People, aged 18-24 *- Hosted in-person by Cape Cod Community College*	13
Spanish-speaking Parents, Guardians, Caregivers *- Hosted & facilitated in-person by LatinX in Action*	4
Portuguese-speaking Parents, Guardians, Caregivers *- Hosted & facilitated in-person by Health Ministry*	18
English-speaking Parents, Guardians, Caregivers *- Via Zoom (multiple organizations/locations)*	6

Logistics and Data Analyses

A semi-structured discussion guide was used across groups to ensure consistency in the topics covered, with prompts and some questions tailored to the specific audience and/or sector being engaged. Discussion guides were also translated into Spanish and Portuguese to support groups conducted in those languages. Discussions generally touched upon the behavioral health needs of children, youth, and young adults in the community; perceptions of the driving factors behind the behavioral health concerns; identification and description of barriers and challenges to addressing the behavioral health concerns; perceptions of the landscape of services available for children, youth, and young adults in Barnstable County; perceptions and experiences of seeking/receiving/providing behavioral health care services in Barnstable County; and the identification of service needs, gaps, and recommendations for future action.

Focus groups generally lasted 90 minutes. All English-language groups were led by experienced HRiA facilitators and detailed notes were taken. For groups conducted in Spanish and Portuguese, HRiA supported staff from the host agency who led the facilitation of the group and took notes. Food and refreshments were provided during each of the in-person community focus groups, and all community focus group participants were offered a $75 electronic gift card for their participation.

All notes taken during qualitative data collection were reviewed for completeness and accuracy by both the facilitator and notetaker before being coded for thematic analysis by the qualitative data analyst. The analyst identified key themes that emerged across all groups and interviews, as well as unique issues pertinent to specific populations. Selected illustrative

quotes—stripped of any personal identifying information—are presented throughout the narrative of this report to further clarify and emphasize key points.

Data Limitations

Although focus groups offer rich, detailed insights, the results are not statistically representative of the broader population due to non-random recruitment techniques and the small sample size. And while recruitment priorities were informed by project stakeholders and feedback received during the Community Forums, some important populations may not be fully represented in the data. Recruitment was also led by community/host organizations, which means that participants were often those who are more well informed and engaged with programs or services. As a result, the responses gathered might reflect perspectives and overlook other viewpoints within the community.

Community Survey

To identify and document the behavioral concerns and experiences of children, youth, and young adults across Barnstable County, surveys were administered to providers (defined broadly as those working with children and youth in educational, healthcare, or social services settings), parents/caregivers, and youth/young adults living/working in Barnstable County. Survey instruments were tailored to each group and made available on-line (via Qualtrics). All surveys were developed based on a review of the literature and input from core planning group members and other stakeholders to ensure relevance and cultural appropriateness. Each instrument consisted of both closed- and open-ended questions:

- **Provider survey**: included questions related to specific behavioral health concerns by age group, contributing factors by age group, perceptions of service delivery in the county, service gaps in the county by age group, challenges observed around access, and recommendations for the future.
- **Parent/caregiver survey:** included questions related to the behavioral health concerns of their child(ren), contributing factors, perceptions of discrimination when seeking services, awareness and experience seeking behavioral health services for their child(ren), barriers or challenges faced, and recommendations for the future.
- **Youth/young adult survey**: included questions related to behavioral health concerns they are/have experienced, contributing factors, experience of discrimination when seeking services, awareness and experience seeking behavioral health services for themselves, barriers to seeking help for themselves, perceptions of trusted or preferred sources of support, and recommendations for the future.

The parent/caregiver and youth/young adults surveys were translated and made available in English, Spanish, and Portuguese. A range of communication methods were used to disseminate the survey links to the populations of focus, including electronic and hard copy flyers, emails, social media, email lists, and networking or individual outreach led by core planning group members and other community-based organizations and stakeholders. The surveys were conducted between mid-April and late June 2024. Survey responses were

included for those who lived or provided services in Barnstable County. Partial responses were included and therefore the sample sizes may vary by question.

The overall number of responses included in analyses of each survey and the percentages received by geographic region are detailed in Table 1. A total of 271 provider responses, 518 parent/caregiver responses, and 51 youth responses were received and included in analyses. Survey findings are presented throughout the report for each survey. When sample size allowed, select stratified analyses (i.e., by relationship to child and insurance status) were conducted to examine sub-group differences within parent/caregiver responses.

Table 1. Percent of Survey Responses Received, by Geographic Region

	Providers	Parents/Caregivers	Youth/Young Adults
Count Survey Responses	271	518	51
Mid Cape	81.9%	36.7%	52.9%
Upper Cape	69.7%	31.9%	23.5%
Lower Cape	69.7%	22.0%	21.6%
Outer Cape	59.8%	9.5%	2.0%

Data Source: CBH Provider Survey 2024, CBH Parent/Caregiver Survey 2024, and CBH Youth/Young Adult Survey 2024; NOTE: regions are not mutually exclusive for providers who may work and serve youth in multiple regions

To understand the sectors and perspectives represented among the provider survey respondents, the survey asked them to identify their primary work setting(s). As shown in Table 2, the largest percentages of provider respondents indicated that they worked with a school (43.7%) or a community-based agency or organization (28.5%).

Table 2. Primary Work Setting Reported by Providers

Work Setting (N=270)	%
School	43.7%
Community-based agency/organization	28.5%
Private Practice/Group Practice	9.6%
After-school program (e.g., Boys and Girls Club, YMCA, sports)	7.0%
Other setting	6.7%
State/Government agency (including justice/corrections)	6.3%
Non-profit/public hospital	6.3%
Daycare or early learning setting	5.2%
Online/telehealth	4.1%
Home-based services	4.1%
Hospital based clinic	2.2%
Urgent care clinic / emergency department	2.2%
Healthcare Business/Corporation (e.g., insurance providers, pharmacy clinics, etc.)	1.9%
Community Health Center/Federally Qualified Health Center	1.5%

Data Source: CBH Provider Survey 2024; NOTE: question was check-all that apply, and percentages may sum to over 100%

The provider survey also asked respondents to identify the age groups and sub-populations of youth they work with regularly (Table 3). Percentages were highest for the elementary and secondary school age groups (ages 5 through 19); however, over a third of providers also reported working with either 0- to 4-year-olds or 20- to 24-year-olds. Most providers also indicated that they worked with most of the vulnerable sub-populations asked about in the survey (e.g., low-income families, immigrant families, BIPOC and LGBTQ+ youth, and non-English speaking populations).

Table 3. Populations Served Reported by Providers

Group/Sub-Population	%
Age Groups Served (N=264)	
0-4 years	38.6%
5-9 years	67.4%
10-14 years	74.2%
15-19 years	64.0%
20-24 years	39.4%
Sub-Populations Served (N=256)	
Low-income families	90.2%
Immigrant families	73.8%
BIPOC youth/young adults	87.1%
LGBTQ+ youth/young adults	77.7%
Spanish-speaking youth/young adults	64.8%
Portuguese-speaking youth/young adults	60.9%
Haitian-speaking youth/young adults	36.7%

Data Source: CBH Provider Survey 2024; NOTE: question was check-all that apply, and percentages may sum to over 100%

Among the provider survey respondents, more than one-third (44%) reported that they had been working with youth or young adults for 20 or more years, with another quarter of respondents (27%) reporting 10-19 years of experience working with youth or young adults. Furthermore, the majority (78%) had spent some time receiving professional training or credentials related to the behavioral health of youth. Taken together, these data demonstrate that the provider survey successfully reached professionals with the experience and knowledge most needed to inform the goals of the assessment.

Parent and caregiver survey respondents were asked to report their relationship to their child(ren) to provide insight into the family structure (Table 4). The majority (81.8%) were biological parents. In stratified analyses, responses were examined separately based on their responses; categorized as those reported themselves to be biological or adoptive parents (n=398) and those who have any other relationships with their children (n=117).

Table 4. Relationship to Child(ren) Reported by Parents/Caregivers

Relationship (N=515)	%
Biological parent	81.8%
Adoptive parent	5.6%
Biological grandparent	9.3%
Foster parent	2.1%
Legal guardian	6.2%
Caregiver	5.2%
Other – please specify	3.3%

Data Source: CBH Parent/Caregiver Survey 2024; NOTE: question was check-all that apply, and percentages may sum to over 100%

Parent and caregiver survey respondents were also asked to report the type of insurance coverage they have for their child(ren) (**Table 5**). The majority reported private insurance through work (65.4%). In stratified analyses, responses were examined separately based on their responses; categorized as those with health insurance purchased or through work (aka private insurance) (n=400) and those with Medicare, Medicaid, Tricare, other, or no health insurance (aka public or no insurance) (n=112).

Table 5. Type of Insurance Coverage for Child(ren) Reported by Parents/Caregivers

Insurance Status (N=517)	%
Insurance through work (yours or another family member's)	65.4%
Medicaid, Medical Assistance (MA), the Children's Health Insurance Program (CHIP) or any kind of state or government-sponsored assistance plan. You may know this type of coverage as 'MassHealth'	26.5%
Insurance purchased directly from an insurance company or through the MA Health Connector (by you or another family member)	14.1%
Any other type of health insurance coverage or health coverage plan	2.1%
Tricare or other military health care, including Veteran's Administration health care	1.4%
Medicare, for people aged 65 and older, or people with certain disabilities	0.8%
No insurance, uninsured	0.4%

Data Source: CBH Parent/Caregiver Survey 2024; NOTE: question was check-all that apply, and percentages may sum to over 100%

Youth survey respondents represented a range of ages. Based on their current/most recent year of school (**Table 6**), most youth respondents reported that they were in high school (55%), and another quarter reported that they were at some level of higher education (27%).

Table 6. Current/Most Recent Year in School Reported by Youth/Young Adults

Year of School (N=51)	%
High School	55%
Higher education (e.g., college/university, technical school, vocational school, etc.)	27%
Less than 9th grade	12%
I am not currently in school	6%

Data Source: CBH Youth/Young Adult Survey 2024

Data Limitations

The surveys used convenience sampling, meaning they were conducted with individuals who were readily available, and therefore the results may not fully represent the entire Barnstable County community. In addition, the individuals who chose to participate in the survey (parents/caregivers, providers, and youth/young adults) were likely to have more interest in and/or direct lived experience with behavioral health concerns and services, so the survey sample may overrepresent these experiences compared to the average community member. Despite limited generalizability, the data do provide essential insight into the experience of the populations most impacted.

Stratifications of data by sub-population were explored within the caregiver survey results; however, the sample size was too small to explore differences within the youth survey sample. And while differences by region were of interest, sample sizes by region were small when stratified across response categories; any differences were limited and difficult to interpret.

Scan of Services

The Recommendations and Action Plan set forth by the Children's Behavioral Health Work Group was informed by an initial "system scan" of services in Barnstable County, which sought to identify and document the types of behavioral health services available to children and youth in the county. Through this process, the scan served to identify key gaps in the system of care available to residents. Conclusions from this initial scan identified a need for a Partial Hospitalization Program and an adequate number of professional providers.

One aim of this assessment was to revisit the initial scan and update, revise, and/or expand the information captured as there was an ongoing need for documentation of available and existing services (a need that was further validated through discussions at the regional community forums). As a first step, the assessment team reviewed and reorganized the existing scan data. The file was then shared with CPG members in January 2024 who were asked to review the current list of services, programs, and other resources for accuracy and completeness of information. The shared document allowed reviewers to update service listings with correct and/or new information based on their knowledge of the community service landscape.

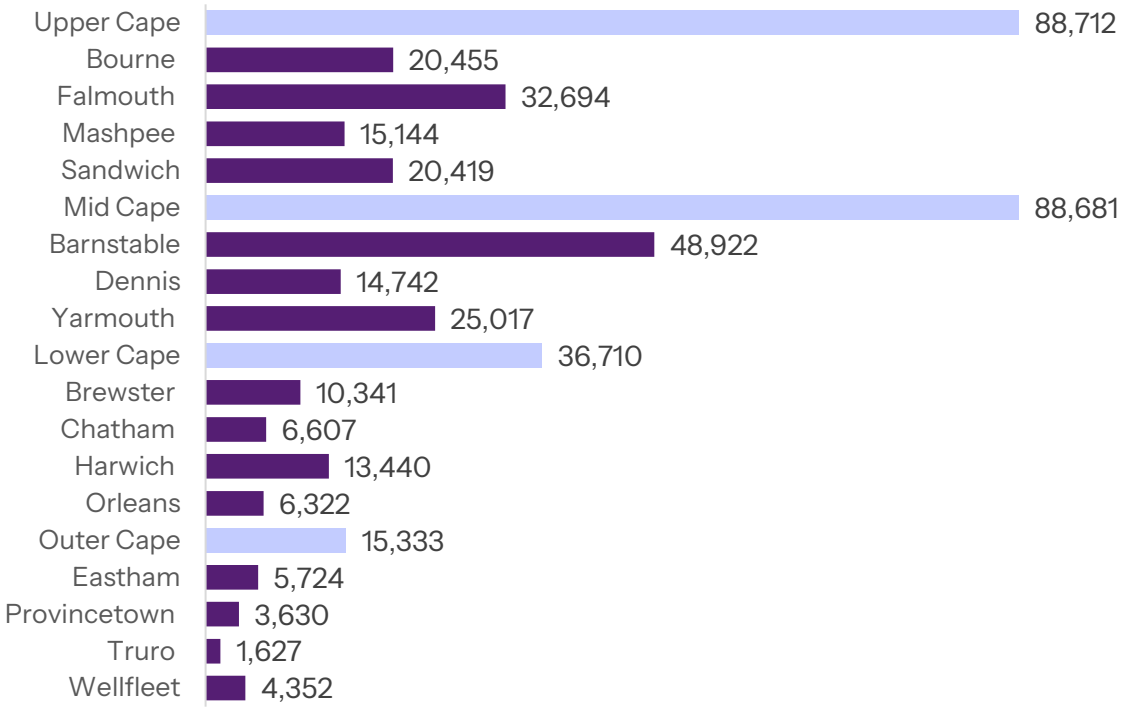
CPG members ultimately faced challenges, which hindered their ability to contribute to an updated scan of existing services, primarily related to the lack of time and capacity to contribute. As a result, an updated scan of existing services was not included as part of this assessment due to incompleteness. Future efforts aim for an approach that is more feasible and able to generate accurate data. This will be a critical next step in action planning and is a necessary community resource.

Assessment Findings

Community Context

Barnstable County, made up of 15 municipalities among four regions, has a total population of 229,436 residents with almost 77% of the population living in the Upper and Mid Cape regions (**Figure 2**). Additionally, data from the Mashpee Wampanoag Tribe indicate there are currently approximately 3,200 citizens enrolled in the Tribe and living in Barnstable County within their ancestral home.

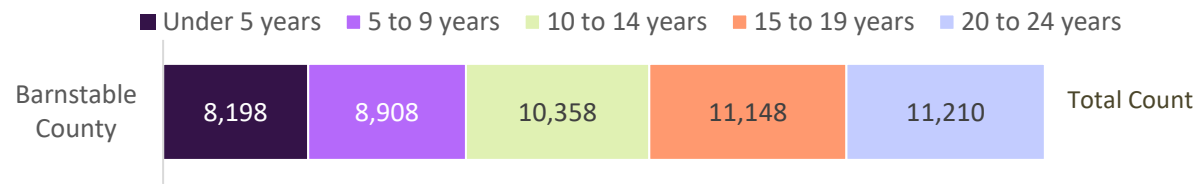
Figure 2. Total Population, by Region and Town (2022)



DATA SOURCE: U.S. Census, American Community Survey, 5-Year Estimates, 2018-2022

In Barnstable County, approximately 50,000 residents are under the age of 25, representing one-fifth of the total population in the county (**Figure 3**). The distribution across specific age groups is similar, with approximately 8,000-11,000 falling within each 5-year age category.

Figure 3. Age Distribution, County of Residents by County (2021)



DATA SOURCE: U.S. Census, American Community Survey, 5-Year Estimates, 2017-2021

Regionally, the Upper Cape and Mid Cape regions each have about 40% of the total under 25 population in Barnstable County. In contrast, smaller percentages of the under 25 population reside in the Lower Cape (approximately 13%) and Outer Cape (approximately 7%) regions.

The size of the public-school populations across the county provides additional insight into the youth population. There are fourteen public school districts in Barnstable County with about 19,850 students enrolled among these districts (**Table 7**). Barnstable Public Schools has the most enrolled students (4,817), followed by the Dennis-Yarmouth district (2,941).

Table 7. Student Population, Count by School District, 2022-2023

School District	Number of Schools	Grades Served	Number of Students
Bourne Public Schools	4	PK-12	1,563
Falmouth	7	PK-12	2,892
Sandwich	3	PK-12	2,129
Mashpee	3	PK-12	1,430
Barnstable Public Schools	9	PK-12	4,817
Dennis-Yarmouth School District	6	PK-12	2,941
Monomoy Regional School District	4	PK-12	1,746
Nauset Public Schools	2	6-12	1,236
Brewster	2	PK-5	431
Orleans	1	K-5	145
Eastham	1	PK-5	186
Wellfleet	1	K-5	98
Truro	1	PK-6	99
Provincetown	1	PK-8	142

DATA SOURCE: MA Department of Secondary Education, School and District Profiles, 2022-2023
NOTE: Monomoy Regional School District serves students from the towns of Chatham and Harwich. Nauset Public Schools serves students from the communities of Brewster, Orleans, Eastham, Wellfleet, Truro, and Provincetown.

Youth focus group participants described the community as small and tightly knit, a place where everyone knows everyone else. They noted that some residents distrust and dislike those who are not longstanding residents or who do not live on the Cape; a couple of youth reported that they have felt like outsiders in the community. Similarly, youth observed a resistance to change; as one young person stated, ***"everyone wants Cape Cod to stay this little town and doesn't want it to change."***

During Community Forum discussions, participants underscored how the social determinants of health underlie the behavioral health issues experienced by children on the Cape. Issues of housing, transportation, and economic stability factor into both drivers of mental health and substance use disorders, as well as barriers to finding and using services.

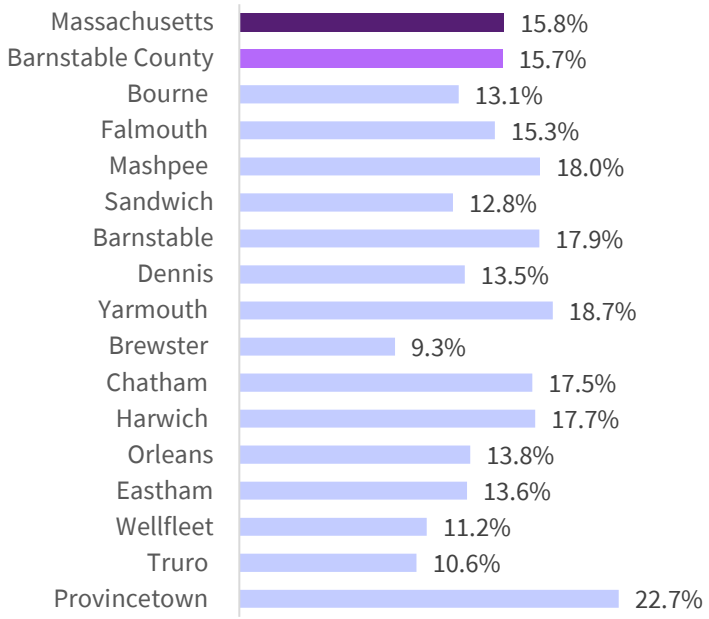
High housing costs, low salaries, and limited year-round employment opportunities can fragment families. Parents commute long hours to work, spending many hours away from home, or live outside of the Cape, leaving their children with others for care.

"Families and kids are fractured, because families are so spread out, folks have to work so many jobs to provide and stay here. Kids can go to school, doesn't mean sense of belonging." – Community Forum Participant

Caregiver and provider focus group participants consistently described living on the Cape as expensive, and how this prevents many, including young adults, educators, and mental health providers, from settling in the area. Frequently, participants suggested that the scarcity of mental health providers in Barnstable County was due in part to the high cost of living.

One indicator of housing/economic instability is the percentage of households that are severely cost burdened, that is paying 50% or more of household income towards housing costs (Figure 4). The overall percentage in Barnstable County (15.7%) is similar to the state overall (15.8%), however several towns have percentages that exceed the county average: Mashpee (18%), Barnstable (17.9%), Yarmouth (18.7%), Chatham (17.5%), Harwich (17.7%), and Provincetown (22.7%). Importantly, these percentages are based on all households, those that are owner occupied and those that are renter occupied. Housing cost burden is known to be higher among renters in Barnstable County.

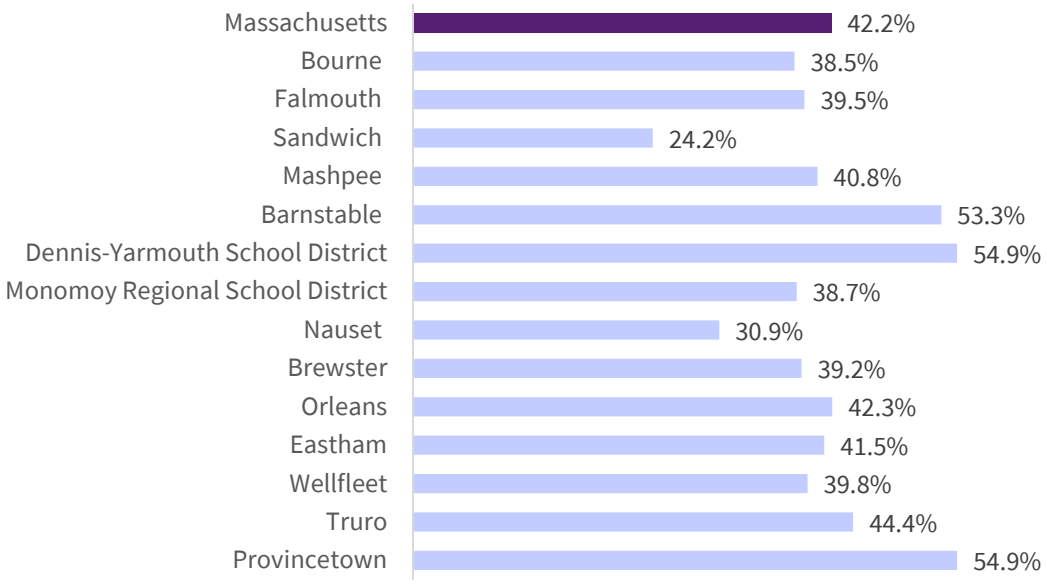
Figure 4. Percent Households Severely Cost Burdened (Housing Costs are 50% or more of Household Income), by State, County and Town, 2018-2022



DATA SOURCE: U.S. Census, American Community Survey, 5-Year Estimates, 2018-2022

Data based on school districts provides additional insight into the percentage of students who may be experiencing economic instability. As illustrated in Figure 5, approximately 40% of public-school students in MA are identified as being low income (42.2%). Most districts in Barnstable County are similar to the state; however, Sandwich and Nauset public schools have lower percentages of low-income students (24.2% and 30.9%, respectively) and Barnstable, Dennis-Yarmouth, and Provincetown each have a percentage that exceeds 50%.

Figure 5. Students with Low Income, by State and School District, 2022-2023



DATA SOURCE: MA Department of Secondary Education, School and District Profiles, 2022-2023;
NOTE: Calculated based on a student's participation in one or more of the following state-administered programs: the Supplemental Nutrition Assistance Program (SNAP); the Transitional Assistance for Families with Dependent Children (TAFDC); the Department of Children and Families' (DCF) foster care program; expanded MassHealth (Medicaid) up to 185% of the federal poverty level, as well as students identified by districts as homeless and students the district confirmed had met the low-income criteria through the supplemental process and collected the required supporting documentation; Monomoy Regional School District serves students from the towns of Chatham and Harwich. Nauset Public Schools serves students from the communities of Brewster, Orleans, Eastham, Wellfleet, Truro, and Provincetown.

Behavioral Health Needs of Children and Youth in Barnstable County

The issue of behavioral health among young people is well known for those living and working in Barnstable County. In the Cape Cod Community Health Survey conducted in 2022, respondents were asked to identify their level of concern for several mental health related issues; respondents answered separately for their concern for themself/family and for their community. About 2 of every 5 respondents (40.5%) reported 'mental health of youth and young adults' as a 'high concern' for their community and 1 in every 5 respondents (20.2%) as a 'high concern' for themself/family (Cape Cod Healthcare Community Health Survey, 2022).

This assessment delved deeper into this concern to name the specific behavioral health needs of young people. Focus group participants emphasized that mental health concerns among children and youth were the primary health issue in the community; two areas of need that were identified universally were anxiety and depression and developmental disorders.

All focus group discussions brought up high rates of depression and anxiety among young people. It was emphasized that these needs are becoming more common among all young people and not exclusively impacting those with adverse or challenging experiences.

> *"Anxiety. A generalized change in kids' tolerance for unpleasant stimuli and it results in anxiety that they need to learn better coping skills for – this is for general population not necessarily speaking about those with trauma. Just generally how much they can tolerate."* – Provider Focus Group Participant

Developmental disorders such as autism spectrum disorder (ASD) and attention-deficit/hyperactivity disorder (ADHD) were named throughout all phases of this assessment as a high need among young people. The experience of these behavioral health conditions was complicated by multiple issues, including an inability to get a diagnosis – early or later in life – and how one of these diagnoses can impact what is available to young people and their families.

> *"My grandson had a therapy mentor that was really helpful. It was through JRI. But when he was diagnosed with autism, but then all my services were pulled away because they said it wasn't mental health."* – Caregiver Focus Group Participant

> *"We have kids that come in clearly autistic and can't get a diagnosis and there's not a lot you can do other than support the parents."* – Provider Focus Group Participant

Often, there were connections made identifying how these common behavioral health concerns co-occur.

> *"The influence of neurodevelopmental disorders on mental health – I was diagnosed with ADHD and autism – something not commonly diagnosed in women. And that can really affect behavioral health because you feel weird, different, probably something wrong with me. And this is seen as something children have – there isn't a focus on undiagnosed, late diagnosed."* – Young Person Focus Group Participant

> *"ADHD and anxiety are mainly what I get. Parents want ADHD fixed, and I've also found that sometimes the anxiety they see is really ADHD."* – Provider Focus Group Participant

While not universally named throughout the assessment, additional critical needs were identified by specific groups including eating disorders, self-harm and suicide ideation, and substance use, which are described further in the sections below.

Trends in Behavioral Health Needs among Young People

An increasing prevalence of behavioral health concerns among younger youth populations, as well as the importance of recognizing age-specific needs, were common themes throughout the assessment. Pediatric providers reported that, not only are anxiety and depression the most common mental health issues they see among their patients, but they are seeing these concerns among a growing number of children in younger age groups. Community forum discussions also touched on this, sharing how behavioral health needs were often different based on age. When speaking about those 8 to 10 years old, forum

participants saw rising incidence of depressive and anxiety symptoms, and the importance of recognizing and proactively responding to this trend as early as possible.

> *"[We need] Intervention for families with really young children, regarding social media and supporting families with not giving out unfettered access to the internet at 8 years old. How do we make that a priority? Kids cannot get away from it. They can't get away from images…. I would love to have a way to access families from pregnancy, supporting a young adult or adult raising children, and not handing a cell phone over and doing that early."* – Community Forum Participant

Another age specific need mentioned was substance use. This need was brought up by community forum participants as a concern for high school aged youth. Individuals share that substance use is often undiagnosed for those with a disorder, is commonly connected to other behavioral health concerns such as anxiety and depression as a coping mechanism, and there are no programs to prevent substance use from escalating into a full-blown health problem. While substance use was not a prominent theme in focus group conversations, some participants noted that mental health concerns, i.e., anxiety and depression, contribute to substance use and misuse among youth, particularly marijuana and alcohol, with one mental health provider stating, *"there's a lot of self-medication that's happening right now."* A focus group of young people shared that vaping is the number one problem among young people sharing, *"[the schools] literally had to install vape detectors in the bathrooms,"* and that use of marijuana and alcohol and peer pressure to use these substances is starting as early as 6th or 7th grade.

While there was heavy emphasis put on the increasingly early onset of behavioral health needs, one specific need brought up only in community forums was focused on young adults and challenges related to the transition into adulthood in general and for specific populations. Issues of economic insecurity were mentioned as more and more young people cannot find employment and/or afford to go to college following high school graduation; participants also connected challenges with this transition with the impact of anxiety and depression. It was noted that this transition time can be uniquely challenging for those young people connected to the Department of Family and Child Services (DCF) due to services and support provided by DCF ending at 22. This leaves a critical gap that, in some cases, leads to homelessness after transitioning out of foster care.

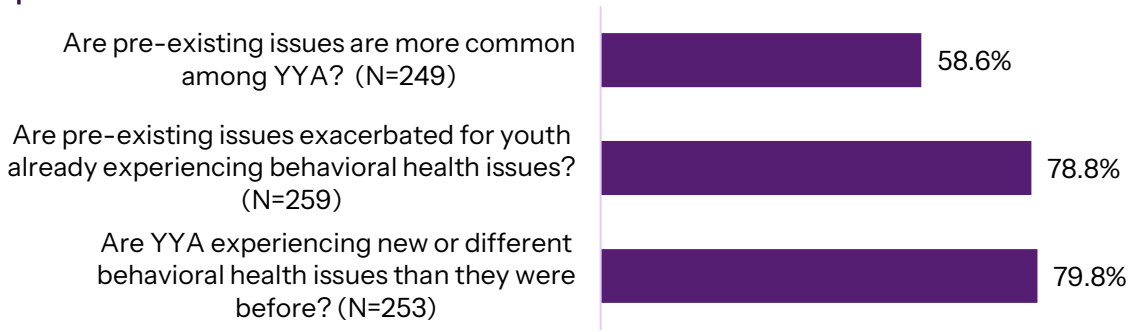
> *"… what I was seeing with kids in 18-22, either going to college and finding that after a year they weren't going to be able to afford it long term and had to take a break, or freshman year, weren't emotionally ready for it and came back and just needed support on decreasing symptoms of anxiety and judgement about 'why am I not ready for this'."* – Community Forum Participant

Another prevailing trend throughout the assessment was that behavioral health concerns for young people were largely becoming more intense and growing in prevalence. Provider survey respondents estimated that more than two thirds (66.9%) of the young people they work with are experiencing some sort of behavioral health issue or concern; a similar

proportion of parents and caregivers (66.7%) indicated their children were experiencing a behavioral health issue. Youth survey respondents added another layer to the story; 3 of every 4 youth respondents indicated they live with either a parent, guardian, or caregiver (43.1%) or another young person (29.5%) currently experiencing behavioral health concerns.

Providers were asked for their perspectives on this trend over the last five years (**Figure 6**). These survey respondents shared they have seen pre-existing issues commonly in over half the young people they work with (58.6%), that most pre-existing issues have been exacerbated for youth already experiencing behavioral health issues (78.8%), and that the young people they work with have been experiencing new or different behavioral health issues (79.8%).

Figure 6. Perception of Providers regarding Trends in Behavioral Health among Young People in Past 5 Years



DATA SOURCE: CBH Provider Survey 2024

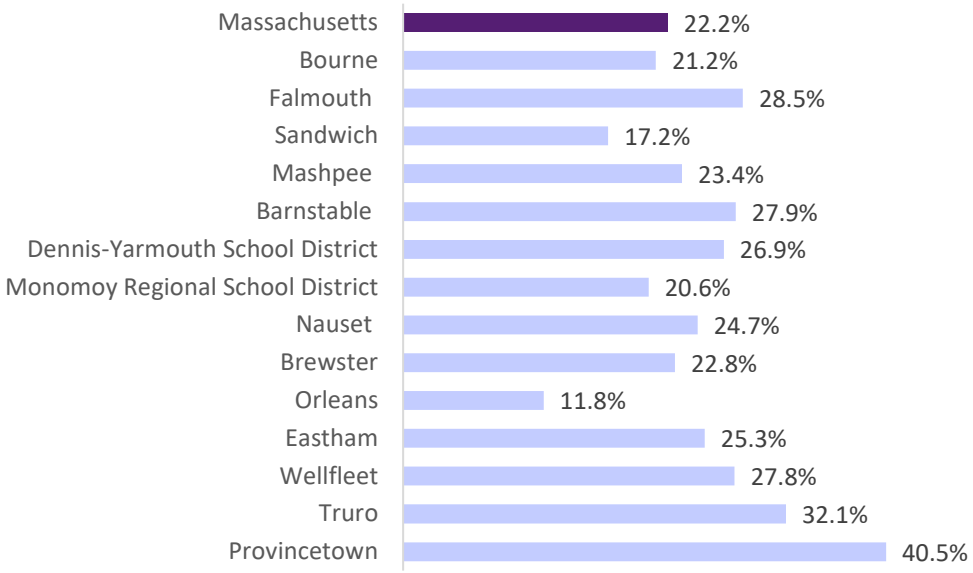
Focus group discussions and survey results brought up the increasing amount of school refusal/avoidance and absenteeism in connection with the increasing and worsening behavioral health concerns among youth. As detailed in later sections, this was noted as a top concern by providers, parent/caregivers, and youth alike.

> ***"We write more notes for school absenteeism than I ever have done."***
> *– Provider Focus Group Participant*

More than a third of provider survey respondents reported school refusal/social phobia as a top concern for young people aged 10-14 years (35.8%) and 15-19 years (33.5%) (see **Table 8**); and just about a quarter of parents/caregivers (25.0%) (see **Figure 8**) and youth (22.5%) (see **Figure 9**) survey respondents indicated school avoidance/refusal was a top issue for young people in Barnstable County.

School district data provide additional insight and context to this finding. For the 2022 to 2023 school year, 10 of 14 school districts in Barnstable County reported higher percentages of chronically absent students compared to the average in Massachusetts (**Figure 7**).

Figure 7. Chronically Absent Students, Percent by School District, 2022-2023



DATA SOURCE: MA Department of Secondary Education, School and District Profiles, 2022-2023
NOTE: The percentage of students who were absent 10% or more of their total number of student days of membership in a school. For example: If a student enrolled in a school for 50 days and missed five days, the student is counted as absent 10% or more that school year. This includes students in grades PK – 12 who have at least 20 days in membership.

Behavioral Health Needs Identified by 'Providers'

Provider survey respondents were asked to identify the top five behavioral health needs for each age group (Table 8). Across all age groups, anxiety was selected as either the number one or two concern. More than a quarter of respondents identified Post-Traumatic Stress Disorder as a top need, reaching the top 5 needs for four of the five age groups.

The top needs for younger age groups (0-9 years) tended to be more behaviorally and developmentally focused (i.e., ADHD, Autism Spectrum Disorder, disruptive behavior disorders, adjustment disorders). In contrast, for older age groups, the top needs were more about depression (10-24 years), social phobia/school refusal (10-19 years), substance use disorders (15-24 years), and suicidality (15-24 years).

Focus group discussions with providers and school staff also reported that they see young patients with more serious mental health issues such as cutting and suicide ideation; while not in the top five needs, almost a quarter of provider respondents (22.2%) selected suicidality for the 10-14 years age group.

Table 8. Percent of Provider Survey Respondents Identifying Top Behavioral Health Needs for Young People, by Age Group

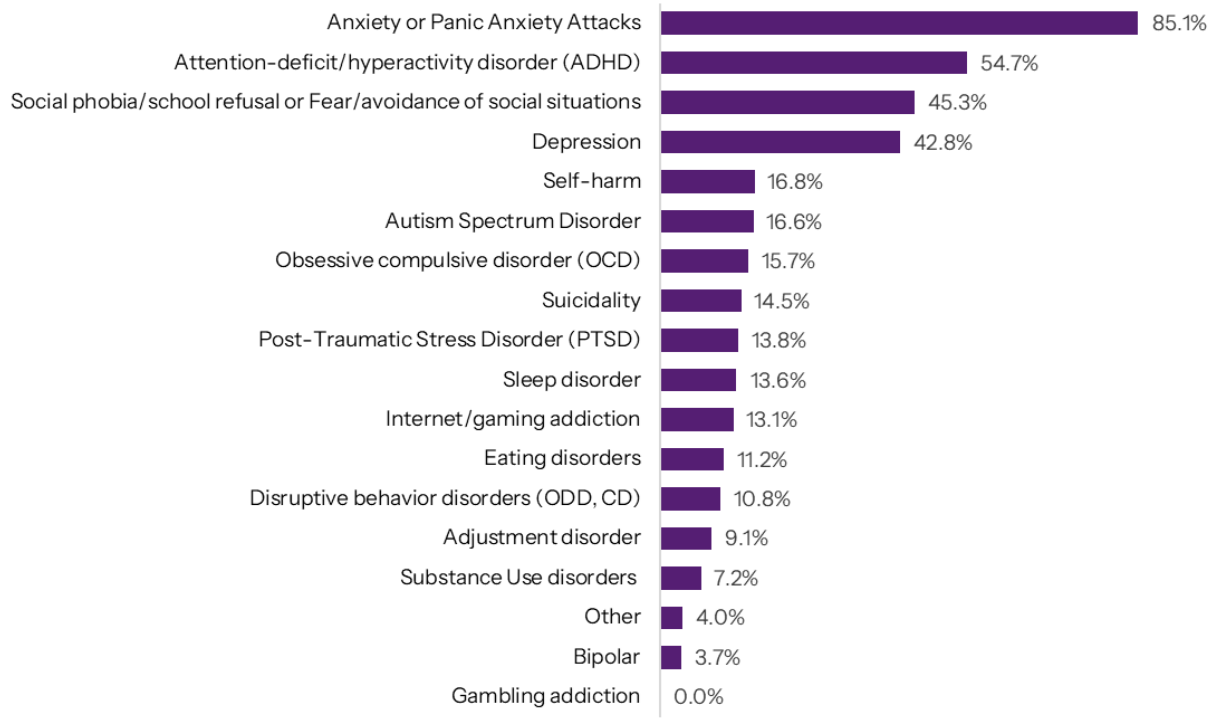
	0-4 years	5-9 years	10-14 years	15-19 years	20-24 years	Average
	N=86	N=149	N=176	N=158	N=110	
	%	%	%	%	%	%
Anxiety	**45.3%**	**65.1%**	**79.0%**	**81.0%**	**71.8%**	**68.5%**
Depression	4.7%	24.8%	**56.3%**	**69.6%**	**62.7%**	**43.6%**
Attention-deficit/hyperactivity disorder (ADHD)	**45.3%**	**70.5%**	**53.4%**	28.5%	19.1%	**43.4%**
Post-Traumatic Stress Disorder (PTSD)	**26.7%**	**31.5%**	**28.4%**	28.5%	**30.9%**	**29.2%**
Autism Spectrum Disorder	**52.3%**	**33.6%**	21.0%	12.0%	12.7%	**26.3%**
Social phobia/school refusal	9.3%	22.1%	**35.8%**	**33.5%**	6.4%	**21.4%**
Disruptive behavior disorders (ODD, CD)	**30.2%**	**38.3%**	21.6%	9.5%	1.8%	20.3%
Substance Use disorders	1.2%	0.7%	11.4%	**35.4%**	**50.0%**	19.7%
Suicidality	0.0%	4.0%	22.2%	**32.9%**	**29.1%**	17.6%
Internet/gaming addiction	9.3%	13.4%	27.3%	25.3%	9.1%	16.9%
Adjustment disorder	**20.9%**	20.8%	15.9%	9.5%	8.2%	15.1%
Self-harm	1.2%	4.0%	23.3%	30.4%	12.7%	14.3%
Sleep disorder	9.3%	5.4%	7.4%	6.3%	9.1%	7.5%
Other	9.3%	7.4%	5.7%	3.8%	6.4%	6.5%
Eating disorders	1.2%	2.0%	5.7%	17.1%	5.5%	6.3%
Bipolar	1.2%	2.7%	2.3%	6.3%	13.6%	5.2%
Obsessive compulsive disorder (OCD)	3.5%	6.0%	5.7%	5.7%	4.5%	5.1%
Gambling addiction	0.0%	0.0%	0.0%	0.0%	4.5%	0.9%

DATA SOURCE: CBH Provider Survey, 2024

Behavioral Health Needs Identified by Parents, Guardians, and Caregivers

Caregiver survey respondents identified what they thought were the top five behavioral health needs overall rather than by age group (**Figure 8**), many of which align with those identified by provider survey respondents. The top need, selected by more than 8 of every 10 caregiver respondents (85.1%), was anxiety and panic/anxiety attacks. More than half of caregiver respondents (54.7%) identified ADHD as a top need; just under half indicated social phobia/school refusal and fear/avoidance of social situations (45.3%) and depression (42.8%) were also top needs. A need identified by caregiver respondents that did not rise to the top five for provider respondents was self-harm (16.8%).

Figure 8. Percent of Parent, Guardian, and Caregiver Survey Respondents Identifying Top Behavioral Health Needs for Young People (N=428)



DATA SOURCE: CBH Parent/Caregiver Survey, 2024

Behavioral Health Needs Identified by Youth/Young Adults

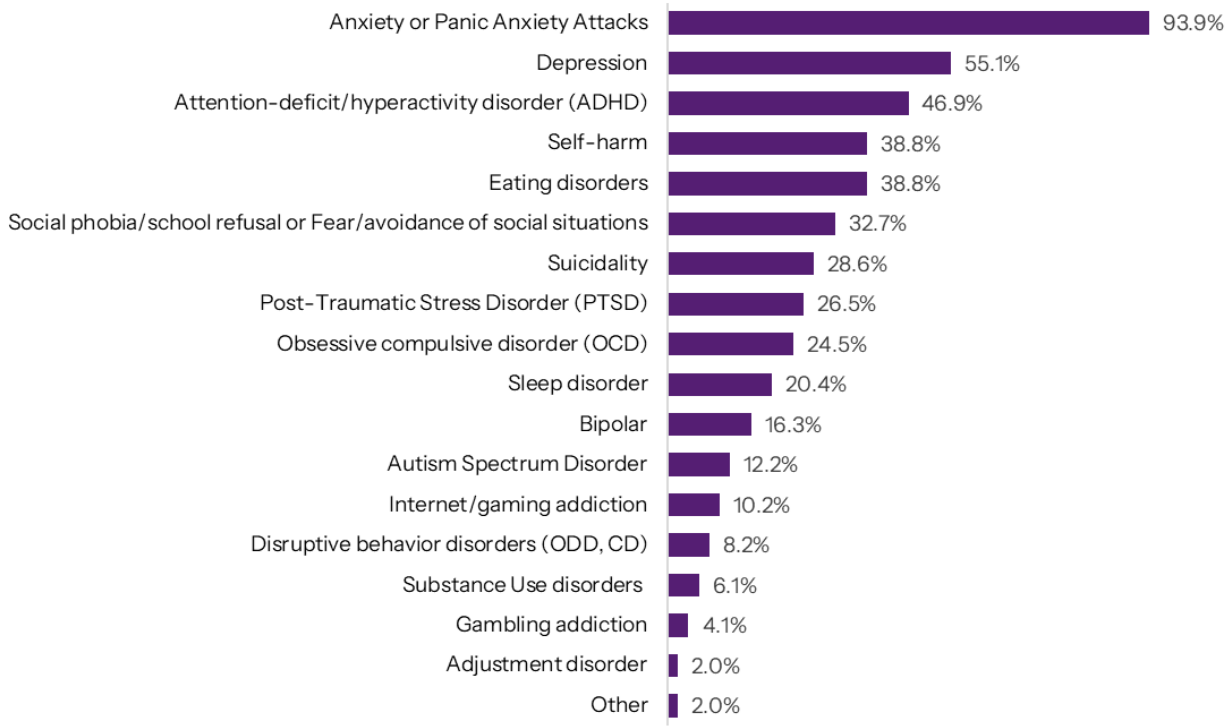
Youth survey respondents identified some similar needs in the top five as provider and caregiver respondents (**Figure 9**). Almost all youth respondents (93.9%) noted anxiety as a top need for young people in their community and more than half (55.1%) selected depression as one of the top behavioral health needs. Like provider and caregiver respondents, youth respondents also identified ADHD (46.9%) and social phobia/school refusal or fear/avoidance of social situations (32.7%) as a top behavioral health need. More than twice as many youth respondents saw self-harm as a top need for young people (38.8%) compared to caregiver respondents.

Eating disorders was a need that was emphasized by youth respondents (38.8%) but not noted as a top concern by provider (17.1%, for those 15-19 years old) or caregiver (11.2%) respondentsParticipants in the young people focus group also raised this as a major, and often unaddressed, concern in Barnstable County. The discussion highlighted that eating disorders are generally not talked about in spaces with young people, e.g., schools, pediatrician offices, and even when someone seeks information it is extremely difficult to find.

> *"There is nothing [out there] about eating disorders, which is a really big problem. I had to do an online search because in MA there is nothing. And in school or pediatricians don't talk about it. But it's really big at school, a lot of*

households deal with it. Not enough dieticians or people educated about it or talking about it. In my experience, I think it is taboo big picture. You don't really learn about it in schools – I think it's a widespread problem. And because it is so sheltered here, it's harder." –Young people focus group participant

Figure 9. Percent of Youth Survey Respondents Identifying Top Behavioral Health Needs for Young People (N=49)



DATA SOURCE: CBH Youth/Young Adult Survey, 2024

Contributing Factors to Poor Behavioral Health of Children and Youth in Barnstable County

Underlying the clear need among young people are the more upstream factors contributing to the development and experience of behavioral health needs. The predominant contributing factors included the influence of social media and technology on young people, ongoing effects from the pandemic, i.e., social isolation, lack of social and/or coping skills; experiences of bullying and discrimination; academic pressures and stressors; and trauma, adverse childhood experiences, and the impact of different types of family structure often resulting from these experiences.

Focus group participants most frequently mentioned the harmful influence of social media when discussing what influences behavioral health needs. Youth, pediatricians, and school staff all spoke about the social pressures, feelings of exclusion, and bullying associated with

social media; one youth described it as *"people mak[ing] it look like it's a picture-perfect life and it really isn't."*

Focus group participants who work with children and youth stated that excessive use of phones and social media has led to incivility among students and lack of resilience in the face of criticism and conflict. One participant commented that today's young people, *"don't go outside and play and learn how to resolve conflict. They don't have conflict resolution skills."* A young focus group member shared a similar view, saying, *"[we are] in a digital age – kids are relying on the internet rather than the person sitting next to them."* Community forum participants saw social media as a source of further disconnect among children and teens, pushing kids on the Cape to spend many hours by themselves in their rooms, losing their socialization skills. Another issue raised at community forums about social media and mental health in children is that it exposes children to information that they are not developmentally ready for, which can be traumatic.

> *"Loneliness is leading causes of illness, connected to illness. I feel like in addition to that, people, all of us, get more and more disconnected from nature. The less time we spend outside in nature, we're such inside beings, but if there's ways to get kids and families more connected to outdoors and wanting to spend time outdoors. That combats a lot of the challenges we have with technology. And unfortunately, in schools now, my kids spend most of their days on technology at school."* – Community Forum Participant

While youth focus group participants talked about the negative impact they have experienced with social media, they further raised an important point that social media and technology are here to stay. They emphasized the importance of learning how to work the technology rather than trying to avoid or remove it, with one young person stating, *"a big thing that society and teachers need to realize – after COVID especially – is that things like social media and internet are not going away. You can't be like no phones in class – still going to be there. It's more about learning how to integrate it properly rather than keep it at home, not worry about it."*

Social media was also often discussed in the context of bullying and its great impact on the behavioral health of young people. Community forum participants noted that excessive time on digital devices and social media has created toxic environments in schools, where rampant bullying exists, further causing feelings of disconnection and isolation.

> *"Children do not feel safe right now. I'm emotional about this. I will start crying. I ask, people aren't being nice in school. It's part of this, we have to look at the parents, this pandemic, everyone walking around, did we survive so well, I don't know."* – Community Forum Participant

Bullying was also a substantial concern and a contributor to mental distress among children and youth discussed in the focus groups. Young people in particular called out the pervasiveness of cyberbullying saying, *"with the social media – they can't control cyber bullying like they think they can. No one has ever done [anything] about me being bullied*

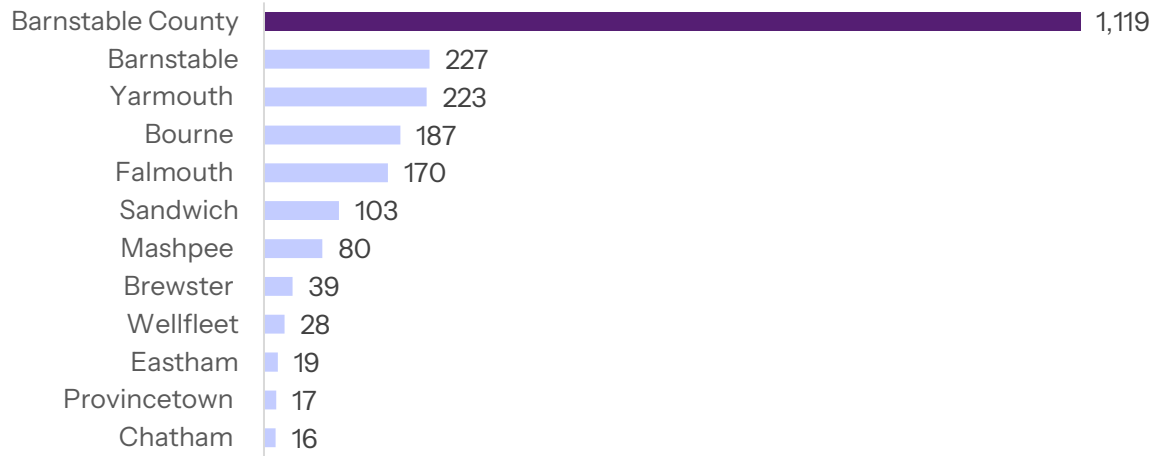
or my friends being bullied – no matter where I've been. But about cyberbullying, they are like 'just turn off your phone, we can't do anything because it's online'." Additionally, participants stated that LGBTQ+ students, students from immigrant and Wampanoag families, and those with learning differences face challenges fitting in and gaining acceptance from their peers and sometimes family members, which can manifest as stress and other mental health conditions. A couple of school focus group members reported that they have observed a growing intolerance among students, including instances of racial slurs and racism.

Another major factor that first came up in the community forum discussion was that many children in the community live in non-traditional families, in single-parent homes, cared for by grandparents and other relatives, or by foster parents who often do not have the skills, time, or resources to care for children with mental health and/or behavioral issues and to manage those issues. Focus groups with health care providers and school staff also shared observations that this group of young people and their families have unique and often more severe challenges related to behavioral health.

> *"Something that keeps happening year after year, the number of students who come from 'typical' supportive homes, two parents, maybe siblings, is dwindling. I just took a quick look on my phone, 20% of my kids come from homes like that, the rest are in foster care, raised by an aunt, grandparents. Lots of trauma involved in 'nontypical'/'expected' homes."* – Community Forum Participant

While only one type of "nontypical" family structure, US Census data provides an estimate into the numbers of grandparents in Barnstable County who are responsible for their grandchildren (**Figure 10**).

Figure 10. Grandparents Living with and Responsible for Grandchildren Under 18, Count by Town, 2018-2022



DATA SOURCE: U.S. Census, American Community Survey, 5-Year Estimates, 2018-2022
NOTE: Towns not listed were suppressed due to low sample size.

In response to the identification of this community with high need and the corresponding secondary data, a focus group was held with grandparents raising grandchildren to directly capture their experiences and perspectives. In this group, caregivers expressed challenges getting support and services for their children (detailed in subsequent sections of this report), that the needs experienced by their children are more severe due to the trauma that led to the grandparent(s) being their caregivers, and their own limitations in providing support at an older age to children.

> *"Once you get into having your own health issues due to age, it gets very difficult."* – Caregiver Focus Group Participant

The trauma that can lead to a need for these "nontypical" family structures was named across all data collection methods. Focus groups discussed a range of adverse childhood experiences, i.e., divorce, parental stress and transience, exposure to domestic violence and neglect, and loss of parents due to substance misuse, which have a negative effect on young people's behavioral health.

> *"Trauma is our number one – I know I only see a certain population but every year it seems to get worse. Also, parental substance abuse or kids not living with biological parents or living with grandparents, aunts or uncles."*
> – Provider Focus Group Participant

Community forum participants discussed more specifically the tremendous impact of the opioid epidemic in Barnstable County and how it is linked to so many children not being cared for by their biological parents. Additionally, forum participants discussed how substance use has affected both parents and children. Many parents have experienced substance use disorders, making them unable to care for their children while many children have substance use disorders themselves; making the important point that substance use is both a behavioral health need and a contributing factor for other behavioral health needs.

Contributing Factors Identified by 'Providers'

Many of the contributing factors providers selected as impacting the behavioral health of young people aligned with these themes; they were also primarily consistent across age groups (**Table 9**). Parenting and family dynamics; trauma and adverse childhood experiences; economic factors or disparities; and technology and media were all selected as the top influences on young people's behavioral health. The different factors noted align with the stages of each age group.

- Biological factors rose to the top for children under 5.
- Providers noted school aged children (5-19 years), and their behavioral health, are impacted by interpersonal factors like bullying and peer relationships/peer pressure.
- For young adults (20-24 years), substance use became one of the factors contributing to behavioral health concerns.

Table 9. Percent of Provider Survey Respondents Identifying Top Contributing Factors for Behavioral Health Needs of Young People, by Age Group

	0-4 years	5-9 years	10-14 years	15-19 years	20-24 years	Average
	N=100	N=143	N=167	N=156	N=94	
	%	%	%	%	%	%
Parenting and family dynamics	**84.0%**	**77.6%**	**68.9%**	**64.7%**	**34.0%**	65.9%
Trauma and adverse childhood experiences	**73.0%**	**69.9%**	**59.9%**	**50.0%**	**52.1%**	61.0%
Economic factors or disparities	**59.0%**	**53.8%**	**42.5%**	**42.9%**	**54.3%**	50.5%
Technology and social media	**20.0%**	**39.9%**	**62.3%**	**60.3%**	**42.6%**	45.0%
Biological factors	**43.0%**	29.4%	22.8%	17.3%	18.1%	26.1%
Substance use/abuse	10.0%	7.7%	13.8%	37.8%	**54.3%**	24.7%
Peer relationships/peer pressure	3.0%	15.4%	**42.5%**	**39.7%**	21.3%	24.4%
Bullying	5.0%	**30.1%**	**44.9%**	23.1%	1.1%	20.8%
Academic pressure	1.0%	10.5%	29.3%	39.1%	10.6%	18.1%
Social isolation	11.0%	13.3%	15.0%	17.9%	26.6%	16.8%
Societal expectations	5.0%	7.7%	10.8%	16.0%	33.0%	14.5%
Discrimination or racism	6.0%	10.5%	13.2%	15.4%	18.1%	12.6%
School environment	8.0%	15.4%	13.2%	12.2%	3.2%	10.4%

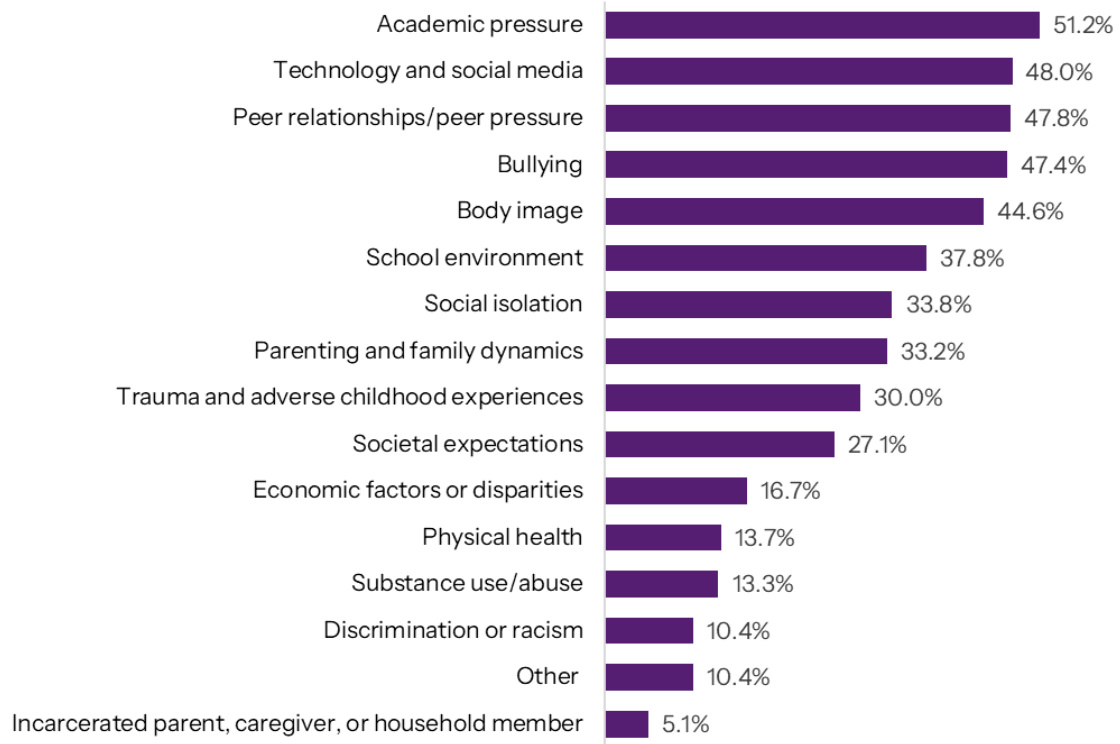
DATA SOURCE: CBH Provider Survey, 2024
NOTE: Percentages highlighted in purple represent the top five services within the age group, some age groups have a top six noted due to ties; Percentages presented under Average calculated based upon percentages across each age group to provide an overall ranking of services.

Contributing Factors Identified by Parents and Caregivers

Caregiver respondents shared what factors they saw as contributing most to their children's behavioral health needs (**Figure 11**). There were similarities between caregiver and provider responses, with technology and social media (48.0%), peer pressure/peer relationships (47.8%), and bullying (47.4%) also seen as top contributions among caregivers; however, there were also differences in what caregivers observed among their children. Caregivers most often selected the impact of academic pressure (51.2%), particularly on issues of stress and anxiety, as the most influential factor.

Another factor caregivers reported that providers did not was body image (44.6%). This emerging as a top factor may indicate that caregivers are aware of these challenges among their children and other young people, even if they did not make the direct connection to eating disorders when thinking about behavioral health needs.

Figure 11. Percent of Parent, Guardian, and Caregiver Survey Respondents Identifying Top Contributing Factors for Behavioral Health Needs of Young People (N=473)



DATA SOURCE: CBH Parent/Caregiver Survey, 2024

Stratified/Differences in Contributing Factors by Insurance Status

When looking at the contributing factors identified by caregivers, based on their type of health insurance, clear differences emerged in the experiences of caregivers and the young people in their lives (**Figure 12**).

For those with private insurance or insurance through their work, the factors identified fully aligned with those of the full group of caregiver respondents. However, when examining the responses of those with public or no insurance, bullying went from the fourth most impactful factor to the most impactful. Additionally, academic pressure did not appear in the top five factors for this group and trauma and adverse childhood experiences, not identified as a top factor overall or by the private insurance group, was identified as a top factor by more than half of caregivers with public insurance (51.4%).

Additional significant differences beyond the top five contributing factors emerged between these two groups of caregivers (see **Appendix Tables**). Nearly twice the percentage of caregivers with public or no health insurance (27.1%) selected economic factors or disparities as influential on young people's behavioral health needs compared to caregivers with private insurance (13.9%). And parenting and family dynamics were selected by a significantly higher percentage of caregivers with public or no health insurance (44.9%) compared to those with private insurance (29.6%).

Figure 12. Percent of Parent, Guardian, and Caregiver Survey Respondents Identifying Top Contributing Factors for Behavioral Health Needs of Young People, by Insurance Status

Ranking	All Caregivers (N=473)	Insurance – Work or Purchased (N=361)	Insurance – Medicare, Medicaid, Tricare, or None (N=107)
1	Academic pressure	Academic pressure*	Bullying
2	Technology and social media	Technology and social media	Trauma and adverse childhood experiences*
3	Peer relationships/peer pressure	Peer relationships/peer pressure	Technology and social media
4	Bullying	Bullying	Peer relationships/peer pressure
5	Body Image	Body Image	Body Image

DATA SOURCE: CBH Parent/Caregiver Survey, 2024
* Differences between stratified groups statistically significant with $p<0.05$

Stratified/Differences in Contributing Factors by Family Structure

To examine differences in contributing factors for other key populations in the county, the caregiver survey responses were looked at separately for those who are biological or adoptive parents and those who have other relationships with their children (**Figure 13**).

Respondents who identified themselves as biological or adoptive parents selected the same top contributing factors as those selected by the overall group of caregivers. Caregivers with other relationships with their children also selected academic pressure and peer relationships/peer pressure; however, for this group of caregivers, these factors ranked lower than among biological or adoptive parents. Both groups of caregivers identified bullying as a top contributing factor but, for those with other relationships with their children, bullying was the most selected while it was the fifth most selected factor among biological and adoptive parents.

Half of caregivers with other relationships identified parenting and family dynamics (50.5%) as well as trauma and adverse childhood experiences (50.5%) as top contributing factors compared to about a quarter of biological or adoptive parents (27.8% and 23.9%, respectively).

Additional significant differences emerged between these two groups of caregivers (see **Appendix Tables**). More than twice the percentage of caregivers with other relationships

(22.5%) selected substance use/abuse as a contributing factor compared to biological or adoptive parents (10.6%). A higher percentage of biological and adoptive parents (30.0%) selected societal expectations as a factor impacting young people's behavioral health compared to those with other relationships with their children (18.0%).

Figure 13. Percent of Parent, Guardian, and Caregiver Survey Respondents Identifying Top Contributing Factors for Behavioral Health Needs of Young People, by Caregiver Relationship to Children

Ranking	All Caregivers (N=473)	Biological or Adoptive Parents (N=360)	Other Relationships (N=111)
1	Academic pressure	Academic pressure	Bullying
2	Technology and social media	Technology and social media*	Parenting and family dynamics*
3	Peer relationships/peer pressure	Peer relationships/peer pressure	Trauma and adverse childhood experiences*
4	Bullying	Body Image	Academic pressure
5	Body Image	Bullying	Peer relationships/peer pressure

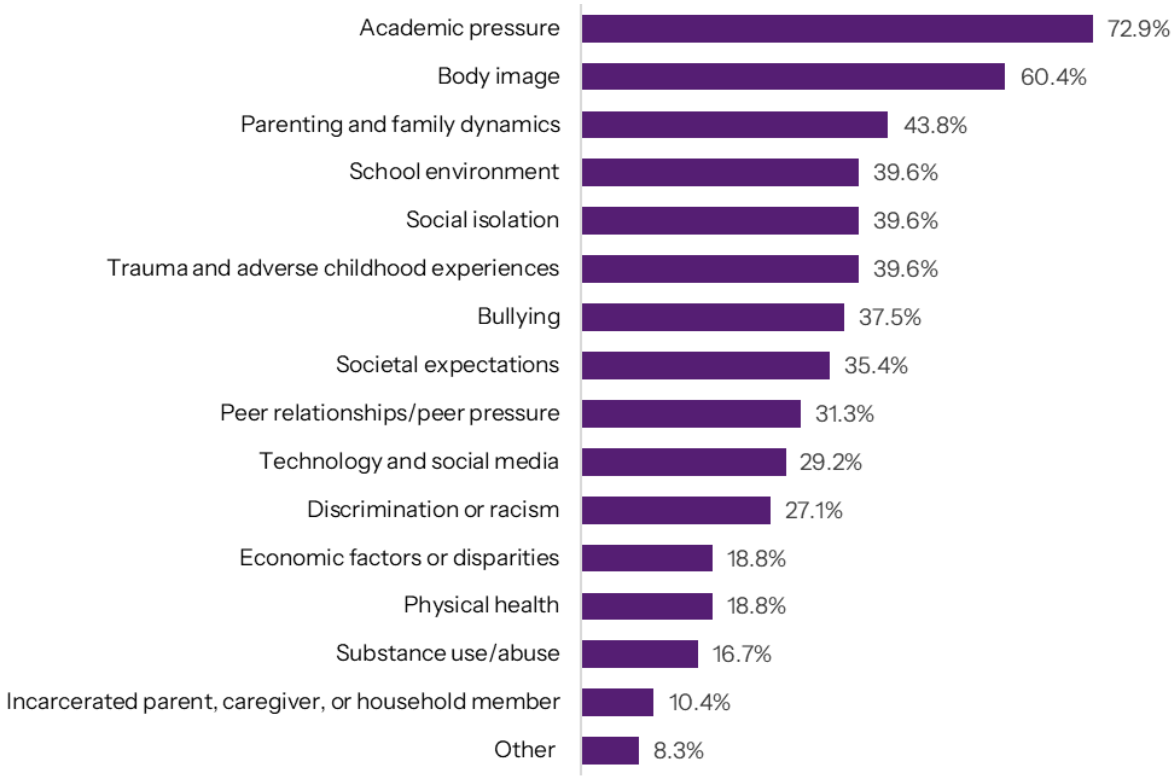
DATA SOURCE: CBH Parent/Caregiver Survey, 2024
* Differences between stratified groups statistically significant with $p<0.05$

Contributing Factors Identified by Youth/Young Adults

Youth survey respondents provided their perspective on the factors that have negatively affected their behavioral health (**Figure 14**).

Academic pressure was selected by almost three quarters of respondents (72.9%). Like with caregivers, young people also identified body image as a top factor; unlike caregivers, among young people this was the second most selected (60.4%). Almost half of youth survey respondents (43.8%) noted the parenting and family dynamics were one of the top factors influencing their behavioral health. Two of every five young people responding to the survey (39.6%) reported that school environment, social isolation, as well as trauma and adverse childhood experiences had a negative impact on their behavioral health. Bullying also rose to the top for youth survey respondents with more than one-third (37.5%) noting its negative effects on their behavioral health.

Figure 14. Percent of Young People Survey Respondents Identifying Top Contributing Factors for Their Behavioral Health Needs (N=48)



DATA SOURCE: CBH Youth/Young Adult Survey, 2024

Availability of Behavioral Health Services for Children and Youth in Barnstable County

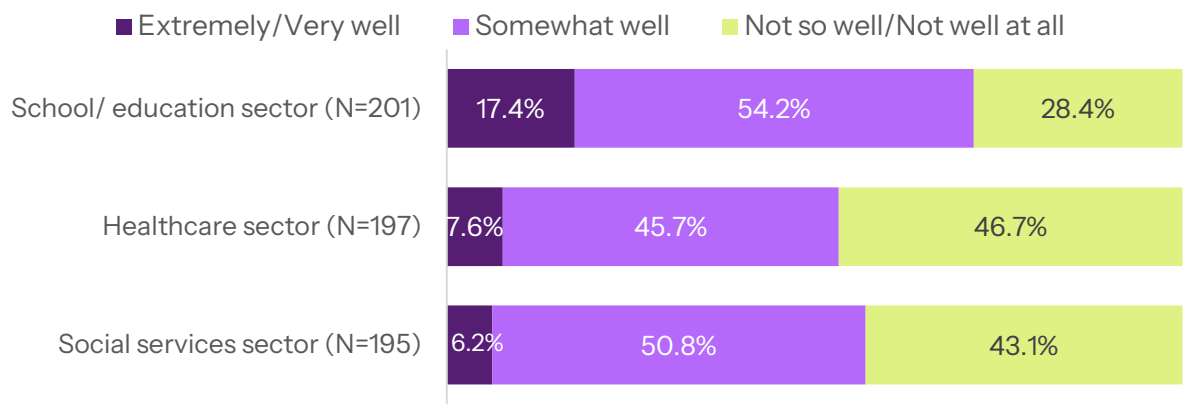
When asked about behavioral health services providers serving Barnstable County, participants most often mentioned Bay Cove (mobile crisis and prevention), Justice Resource Institute (JRI), Gosnold, and Outer Cape Health. Experiences with providers varied. A couple of focus group participants mentioned the value of the community navigator program and Spanish-speaking staff at Outer Cape Health. Other participants appreciated the school-based services Gosnold provides. Several caregiver focus group participants praised JRI's services, which focus on MassHealth patients, although one person mentioned that their child lost services after they were diagnosed with autism. Other caregivers reported that staff turnover and lack of expertise in areas such as trauma affect the quality of mental health services in the community. The community also has several private mental health practitioners; however, participants described these as more expensive and selective in the insurances they will accept.

When asked about other organizations and programs that support children and youth in Barnstable County, focus group participants named afterschool programs and summer

camps. Caregivers mentioned Kind Hearts for Kids, Cape Cod Ambassadors, and the Cape Cod Foster Closet. Some, however, reported that cost and difficulty obtaining vouchers makes it hard to access these programs. Youth mentioned benefitting from a camp for grieving children and on-line autism support groups.

Provider survey respondents were asked to rate how well they thought key sectors were currently meeting the needs of youth and young adults in Barnstable County. These sectors represent the primary systems through which the behavioral health needs of youth and young adults are first identified and/or typically met. Importantly, survey respondents being 'providers' working with or within each of these systems, the information provides an insider's look at how well they are working. As illustrated in **Figure 15**, a notable percentage of providers thought that the healthcare and social service sectors were working 'not so well' or 'not well at all' (46.7% and 43.1% respectively). The percentage reporting the school/education sector was not working well was slightly lower (28.4%), but still over one-quarter of provider respondents.

Figure 15. Perception That Sector is Currently Meeting the Behavioral Needs of Youth and Young Adults in Barnstable County



DATA SOURCE: CBH Provider Survey 2024; NOTE: Responses were on a 5-point scale that has been collapsed for reporting purposes.

Perceptions of the School/Education Sector

There was substantial conversation in focus groups about the role of schools in supporting students with mental health issues and learning differences. Caregiver focus group participants talked about challenges they faced having their children evaluated for additional services in schools. They cited delays in getting their children tested for learning challenges and expressed frustration at the time it took to get IEPs, 504 and individual safety plans, and additional academic supports. One parent stated, ***"the teacher noticed my daughter having difficulties in learning and there was a delay in getting her evaluated. It took two years. She is still struggling in school."*** Several caregivers expressed concern that schools were moving their students along academically, but not addressing underlying issues. For example, one grandparent said ***"the school keeps pushing him along. There's no way he's***

at a 7th grade level." A few caregivers also commented that school districts are reluctant to place students out of district due to expense. As a result, these students remain in school and are labeled as troublemakers or ignored. One focus group participant remarked, *"the schools know the kids are failing, they know they have issues. They need to place them in the right schools where they thrive."* Caregivers talked about the need to be persistent and advocate for their children.

Caregiver and youth focus group participants also shared experiences trying to access mental health supports within schools. Some caregivers were frustrated that they were not listened to when they expressed concern about their children/children in their care and that schools waited until situations escalated before taking action. Several described experiences of school staff discriminating against their children. Some youth focus group members shared their experiences trying to access support in their schools and noted that it is difficult to get in to see busy guidance counselors and social workers; they also saw some teachers and school staff as unsympathetic to students' social emotional concerns.

> *"I was pretty anxious and would have rough days in high school and sometimes I would get in trouble and administration I felt like were out to get me. They weren't trying to see if I was okay."* – Young Person Focus Group Participant

> *"Teachers, guidance counselors, principals don't really put resources or effort unless you are at a severe point. Only if you are hurting yourself, others, suicidal. Even if there is bullying or assault, they still don't do anything. They are like 'oh I'm sorry.'"* – Young Person Focus Group Participant

Caregivers recognized that schools are under-resourced and under-staffed or have strict eligibility requirements, which can get in the way of accessing services. A few shared positive experiences such as supportive teachers, social-emotional programming, and spaces where students can *"take a break."* One parent commented that they had a good experience getting necessary testing and services for their child with the help of a family advocate in a Head Start program. A couple of youth also mentioned that they benefitted from wellness/zen rooms in their schools where they could go if they were feeling anxious or stressed. They also mentioned benefitting from programs such as Best Buddies and art integration programs in their schools.

School mental health staff shared many challenges to meeting the learning and mental health needs of students. They stated that the number of students who need testing and additional supports has grown substantially in recent years, which has made it difficult to conduct them in a timely way. As one person mentioned, *"being able to get IEPs and extra support is fantastic, but I think the numbers are just through the roof with kids eligible for IEPs."*

A few school mental health staff reported that they conduct mental health screenings, including the Devereux Student Strengths Assessment (DESSA) for younger grades and Screening, Brief Intervention, and Referrals to Treatment (SBIRT) for older students;

however, connecting students to follow up supports is difficult due to lack of providers. A couple of school mental health staff reported that they had collaborated with Care Solace, a mental health navigation service, but experienced little success in connecting students to providers who could provide in-person services.

> *"We have so many kids in the schools who should be in a therapeutic program and there's none on the Cape. And they're exploding in the schools and it's affecting everyone."* – Provider Focus Group Participant

School mental health staff reported that they provide counseling to students and also support education about social-emotional health. E.g., Signs of Suicide (SOS). They explained that they work closely with school nurses to identify and build relationships with students who are struggling; one participant shared that the goal is to ensure that students *"know they have a safe adult in the building, whether it's a nurse or whether it's a counselor. And just establishing a baseline relationship. If it's done well, it can be positive."*

Participants of the regional community forums suggested that programming in the schools could be expanded to help prevent the developing or worsening of mental health concerns, such as mindfulness programs (such as Calmer Choice), breathing exercises, yoga, etc., and expand after-school programs (arts, sports, etc.)

> *"We need a little less focus on testing and things like that. Where is the class for the kids in high school who are really in the thick of things to figure out how to regulate their emotions, when things are going south, how do I ground myself without using drugs or alcohol? How do I have a conversation with an adult face to face? How do you put names to my thoughts and emotions?"* – Community Forum Participant

School mental health staff also stated that they are often called on to provide mental health services that are outside their skillsets, including addressing trauma and serious mental illness. As one staff shared, *"I think the hard part is a lot of reliance on school counselors to do full time therapy. Families are thinking that is possible and that is enough, but we don't have enough capacities."* Staff also shared that some families are reluctant to engage with school social workers and counselors because they do not want to share personal information; as one person stated, *"they are worried about DCF involvement. And it's always those kids who need it the most."*

Perceptions of the Healthcare Sector

Because there are fewer mental health providers on the Cape, pediatricians reported that they play a bigger role in addressing mental health needs among children and youth than providers in Boston and other more urban areas. They described their role as *"first-line"* mental health support: conducting screenings, prescribing medications, and connecting patients to other mental health resources. Some offer programs

related to mental health such as coping programs. Providers noted that for some patients, mental health concerns arise during an appointment for other health concerns. One stated, *"people will show up during routine care visits and, especially with teenagers, the kid might not have disclosed to the family that they are struggling."*

Some pediatric offices have internal staff, counselors or social workers, who work with families on a short-term basis or manage referrals to external mental health resources; others do not. Pediatric focus group members stated that they often refer families that need additional mental health supports to psychologytoday.com (on-line database of providers) or share a list of local providers. However, as one pediatrician reported, these lists are often not updated, especially relative to whether providers are taking new patients or which insurances they accept. One participant stated, *"I give this list that has around 50 names of providers from Sandwich to Orleans and families can't get in."*

Pediatricians shared that, given limited mental health resources in the community, they find themselves having to triage children and youth relative to seriousness of their concerns. Those with more serious mental health concerns or coming from a hospital admission are prioritized. As one commented, *"this kid is in crisis so I have to do something about this one and this kid is simmering so they go down the line a little bit."* Pediatric focus group members also explained that because few mental health resources are available, caregivers expect them to be psychologists and counselors, a role they are not trained in. One pediatrician observed, *"the peds out here are willing to take on these patients and become like their surrogate therapist while they are waiting (to see a mental health provider)."*

> **"I get sucked into being counselor – I wasn't trained as a psychologist or counselor."** - Pediatrician Focus Group Participant

Behavioral health providers participating in focus groups shared that in their roles as clinicians in pediatric offices they need to be clear about the services they can provide—short-term therapeutic services rather than deeper and longer engagement to address high-need or crisis situations. In the absence of other providers to refer patients to, however, demand on these providers to meet all mental health needs is high.

> *"[Parents] come in thinking they'll get a therapist, you explain I'm short term, they get upset but stay anyways, and then you run out of time. It's hard not completing the job."* - Behavioral Health Provider Focus Group Participant

Services Identified as Limited in Barnstable County

Provider survey respondents were asked to identify the specific types of behavioral health services that they felt were most limited in Barnstable County by age group. As detailed in **Table 10**, the top five services identified as limited (table cells highlighted in purple) were:

psychiatric services, counseling services, day treatment or intensive outpatient programs, therapeutic interventions, and inpatient psychiatric hospitalization. These were generally consistent across most of the age groups, except for 0–4-year-olds in which early intervention programs were among their top five limited services.

Table 10. Percent of Provider Survey Respondents Identifying Service Availability in Barnstable County as 'Limited', by Age Group

	0-4 years N=94	5-9 years N=128	10-14 years N-149	15-19 years N=135	20-24 years N=101	Average
	%	%	%	%	%	%
Psychiatric services (medication management, psych evaluations)	**27%**	**48%**	**51%**	**52%**	**51%**	**46%**
Counseling services (school or community based)	**38%**	**53%**	**53%**	**46%**	**34%**	**45%**
Day treatment or intensive outpatient programs	**27%**	**37%**	**46%**	**49%**	**38%**	**39%**
Therapeutic interventions (individual, group, family therapy)	**31%**	**42%**	**39%**	**37%**	**35%**	**37%**
Inpatient psychiatric hospitalization	20%	**32%**	**39%**	**44%**	**35%**	**34%**
Youth centers, after school programs, or recreation programs	19%	27%	30%	29%	15%	24%
Support groups (peer or parent)	14%	22%	25%	30%	26%	23%
Crisis intervention services	14%	17%	22%	25%	18%	19%
Peer mentorship programs	7%	16%	26%	22%	19%	18%
Case management services	18%	15%	15%	13%	22%	16%
Prevention programs	13%	18%	19%	16%	14%	16%
School based intervention plans or special ed services	18%	21%	17%	16%	6%	16%
Substance use inpatient treatment/recovery	2%	6%	14%	20%	23%	13%
Early intervention programs	**33%**	10%	5%	6%	2%	11%
Substance use outpatient treatment/recovery	1%	4%	10%	14%	15%	9%
Telehealth programs (counseling or psych)	2%	3%	5%	4%	7%	4%

Data Source: CBH Provider Survey 2024; NOTE: Percentages highlighted in purple represent the top five services within the age group; Percentages presented under Average calculated based upon percentages across each age group to provide an overall ranking of services.

Community forum participants were also asked to identify and discuss the types of services they saw as lacking in Barnstable County. Many of these mirrored the perspectives of the provider survey responses, and included:

Outpatient Therapy: there are insufficient qualified licensed therapists who offer long-term outpatient therapy. Parents seeking a therapist for their child face months- even year-long waits.

> *"As a professional in the human services network, you'd hope I had an easier time navigating the system, but that's not the case. I find myself reaching out for help finding service providers. Waitlists are long. When you do find a provider, it's meant to be short term. In my experience, kids and young adults could use more stable and long-term therapeutic relationships."* – Community Forum Participant

> *"Sometimes they can go to a psychiatrist and get medications and that, but what they really like is to see a therapist on a regular basis and have them touch base with doctors prescribing meds."* – Community Forum Participant

Inpatient Services: for children and youth with severe mental health disorders are insufficient on the Cape, this includes services for teens and young adults facing substance use problems. Participants specifically highlighted the need for Community Based Acute Treatment (CBAT) services on the Cape – so parents and guardians do not have to travel so far - that offers intensive, short-term residential behavioral health services for children and teens in crisis.

> *"On the parent side of things, trying to find in-patient placements is a nightmare. I have spent an accumulation of weeks in emergency rooms waiting for beds. My most positive experience with a facility was over 2.5 hours away. So, for weeks I drove 2.5 hours away for a 1hr visit, and 2.5 hours back. It's difficult. It's exhausting when you're a parent going through this, I have a family, a career, and now I'm trying to support this other young person."* – Community Forum Participant

Management and Care for Specific Disorders: Participants noted a lack of psychiatrists and licensed mental health providers to address the specific needs of children on the autism spectrum and with eating disorders. Participants also mentioned insufficient age-appropriate harm reduction programs and support groups for teens and young adults who have substance use disorders, including alcohol and opioid use disorders.

Acute/Crisis Response: the system capacity for mental health crisis response was identified as needing to improve across the county. When a child is experiencing a crisis and needs immediate intervention, caregivers recounted that there are no appropriate services to address the crisis in a way that is child-friendly. Participants recounted their personal stories of taking their children to the E.R. in response to a mental health crisis, where they were not treated respectfully or kindly. Those without insurance noted being released from the hospital before they were fully stabilized, without the proper referrals in place.

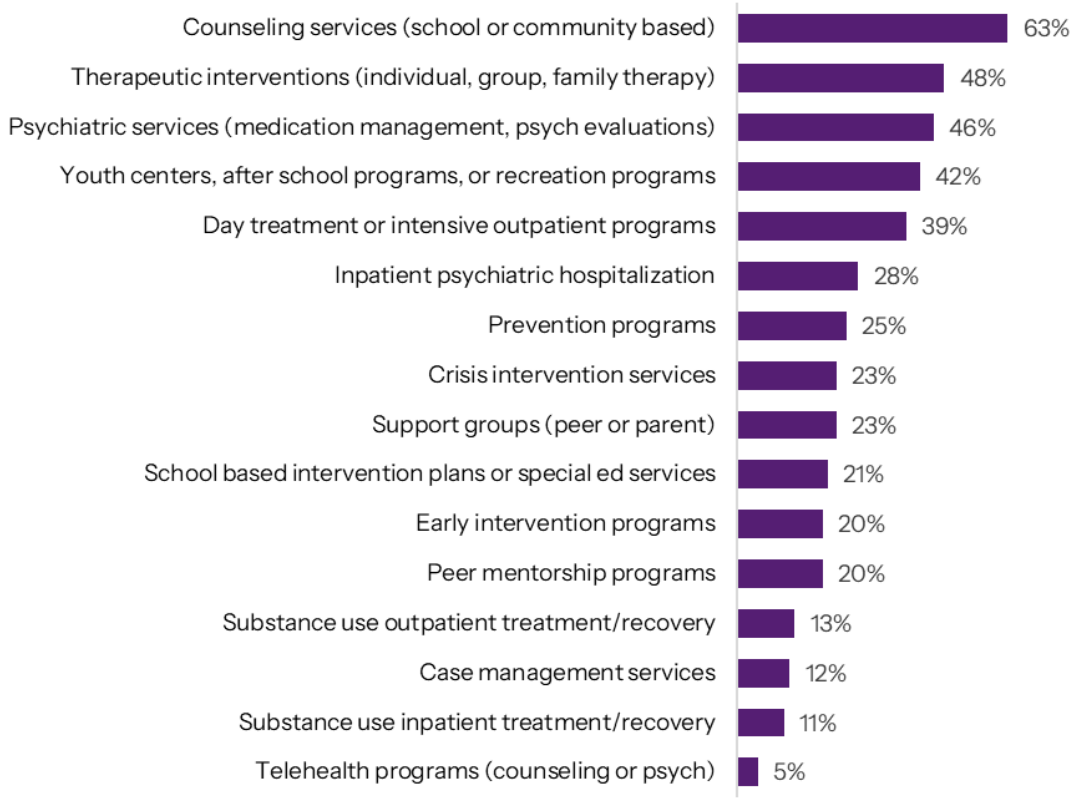
"General process is referral to ER, who sends kids home to follow-up with PCP, who does not have access to services/referrals and just tells people to go to the ER." – Community Forum Participant

"As the crisis team, we are the first line of contact. My staff does their best, but it's dismal out there, the services don't exist. We're not providing therapy, just hand-holding. We have youth coming back again and again because they're still struggling having crises, on waitlists for months and months." – Community Forum Participant

Most Critical and Impactful Services Needed in Barnstable County

The provider survey also asked respondents to identify the behavioral health services that they thought were most critically needed in Barnstable County, regardless of age group. Findings, illustrated in **Figure 16**, showed that counseling services, therapeutic interventions, and psychiatric services were the leading services identified as most critical. Additionally, youth-centered programming (i.e., youth centers, after school programs, or recreation programs) also ranked highly on this list.

Figure 16. Percent of Provider Survey Respondents Identifying Service as 'Most Critically Needed' in Barnstable County (N=182)



Data Source: CBH Provider Survey 2024; NOTE: question was check-all that apply, and percentages may sum to over 100%

The critical need for places and spaces for youth to build and experience community was a common sentiment among focus group and community forum discussions. Youth generally perceived the community to be more oriented to older residents; one young person described the Cape as the ***"Florida of the north,"*** with few activities for youth and young adults. Participants mentioned that existing spaces, such as the community center in Bourne and the Hyannis Recreation Center, have offered programs and spaces more directed toward seniors and younger children, leaving teenagers and young adults ***"in limbo."***

Such programs and opportunities were identified as both a solution to existing behavioral health concerns among youth but also as preventative factors in their development. Participants mentioned that children had no safe places to go to have fun, socialize, and be away from technological devices. Even without therapy, safe prosocial activities were identified as approaches to reduce the incidence of behavioral health conditions, and rebuild the sense of community/belonging, eroded by social media and the COVID-19 pandemic.

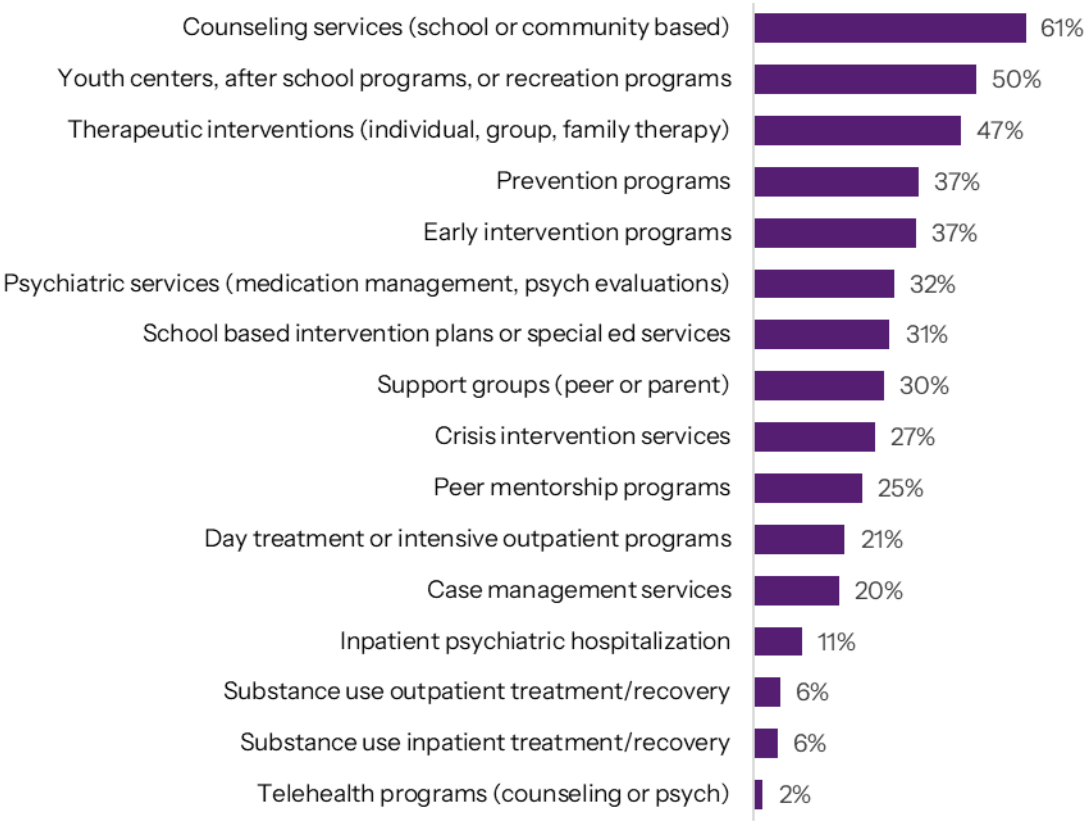
> ***"We need more programs for kids and youth to socialize and do group activities together."*** – Caregiver Focus Group Participant

Opportunities that do exist for youth are often expensive or require transportation. Spanish-speaking caregivers stated that the high cost of summer camps and afterschool enrichment programs prevents some children and youth from accessing these opportunities. One youth participant drew a connection between lack of activities for young people and substance misuse: ***"people like to come here because it's a beautiful place, but when you see it your whole life, you get numb to it. And when you are this closed off and have two 20-foot roads blocking you off from rest of the world, you turn to substances."***

Awareness of community-based programming was also a barrier to participation. Focus group participants recommended that information about programs and recreational opportunities be accessible on-line and in other formats, and in a variety of languages. As one participant stated, ***"if we didn't have to hunt down the services, that would be great."***

Finally, providers survey respondents were asked to identify the behavioral health services they thought would be most impactful or would most improve prevention or early intervention efforts in the county (**Figure 17**). The majority (61%) identified counseling services and about half selected youth centers/after school programs/recreation programs (50%) or therapeutic interventions (47%).

Figure 17. Percent of Provider Survey Respondents Identifying that Service would "Most Improve Prevention or Early Intervention" in Barnstable County (N=172)



Data Source: CBH Provider Survey 2024; NOTE: question was check-all that apply, and percentages may sum to over 100%.

Diving more deeply into the topic of prevention, many focus group participants suggested that there were not enough skilled human resources (in school, community, or healthcare), mechanisms, or programs in the county to address the needs of children who experience adverse childhood experiences (ACEs), need support managing stress, or exhibit early symptoms of anxiety or depression but are functional and not in crisis. Building the capacity to identify the early and emerging behavioral health needs of children and youth could help prevent such problems from reaching crisis level. Thus, participants expressed the importance of prevention and early intervention.

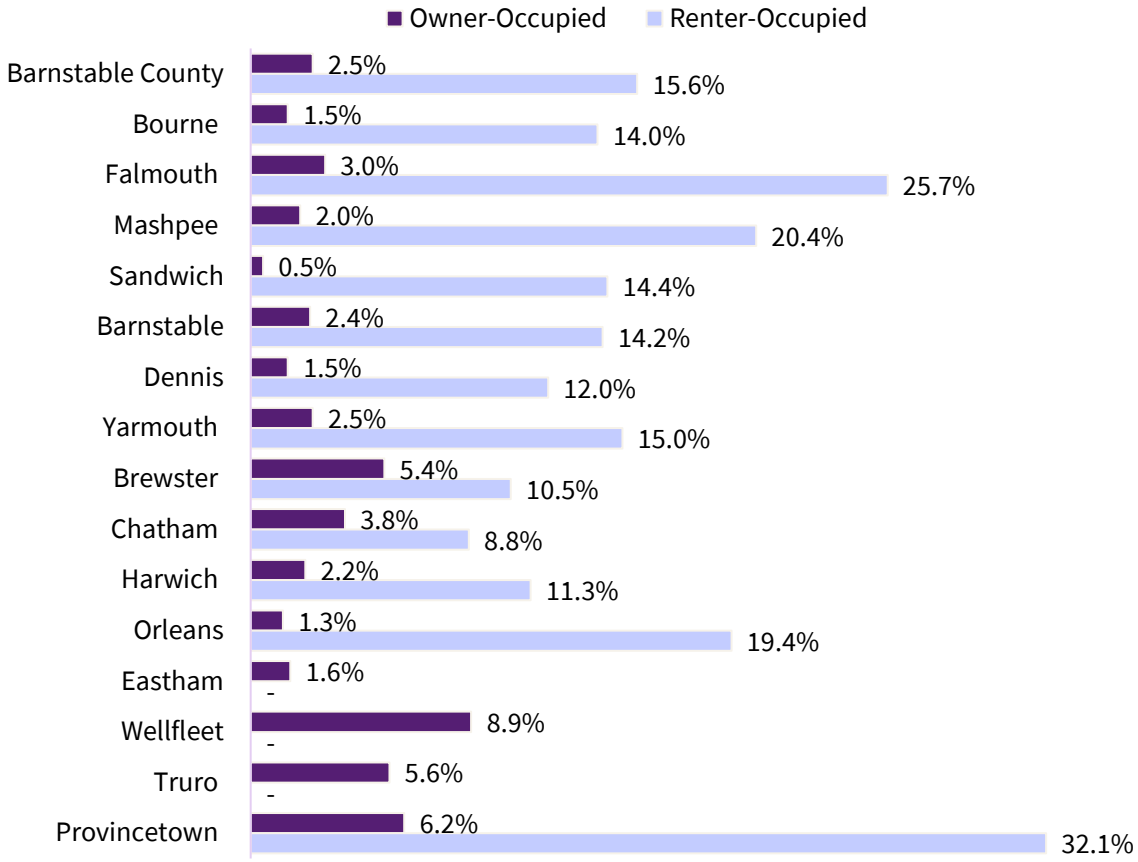
As an example of the current situation, one young participant told their personal story of being ignored by school counselors when they sought help for depression; the participant recounted how they were dismissed and not taken seriously by high school counselors.

> ***"If you were to address these issues at pre-k or even younger level, you wouldn't have these kids in elementary or middle school [with more severe issues]."*** – Provider Focus Group Participant

Accessibility of Behavioral Health Services for Children and Youth in Barnstable County

Barnstable County's distinct geography impacts many of the residents in various ways, including seasonal fluctuations of visitors and short-term residents. Participants of focus groups and community forums voiced that the Cape's geography makes it difficult to ensure easy and nearby access to behavioral health services. Car dependence further limits access to programs and services when parents/caregivers must travel longer distances to reach services. Participants also mentioned that there is limited exchange of information among towns about the resources and programs available in different towns, which would be further exacerbated by transportation challenges. To provide some context, data on the percentage of households that do not have access to a car are shown in **Figure 18**. The percentages of owner-occupied householders without access to a vehicle are consistently lower than among renter-occupied households in all towns. Percentages were particularly high for renters in Falmouth (25.7%), Mashpee (20.4%), Orleans (19.4%), and Provincetown (32.1%).

Figure 18. Households (Renter v. Owner-Occupied) Without Access to a Vehicle Available, Percent by Town, 2018-2022



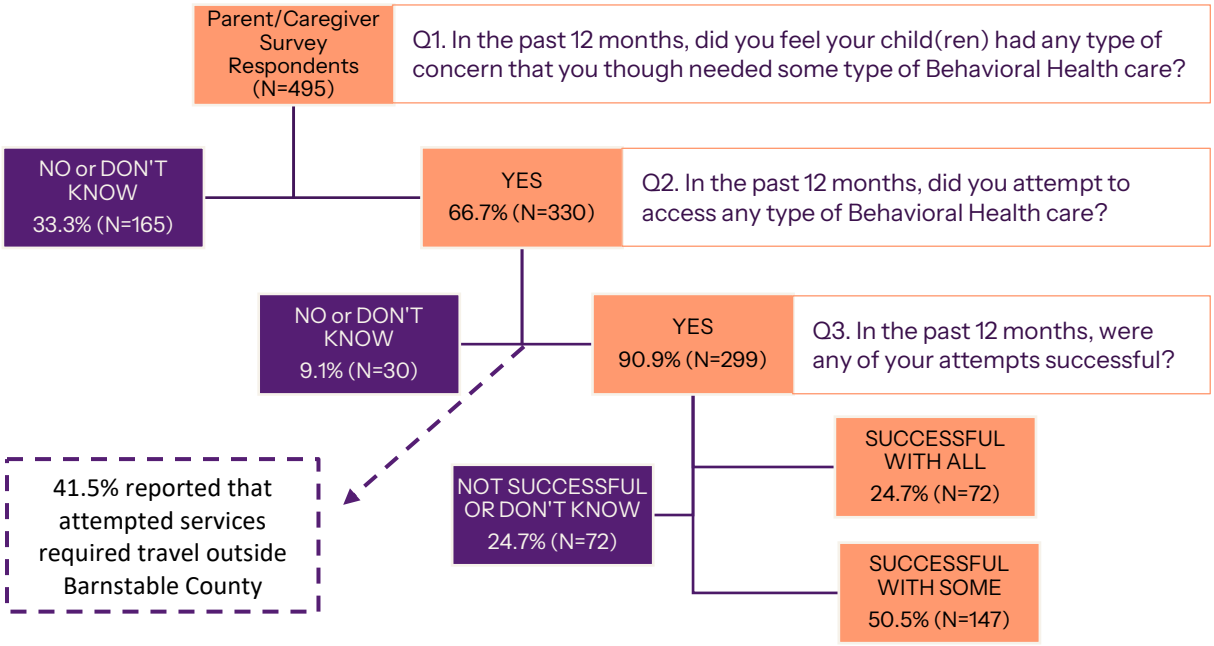
DATA SOURCE: U.S. Census, American Community Survey, 5-Year Estimates, 2018-2022;
Note: - indicates sample size too small to generate an estimate

Experience of Seeking and Receiving Behavioral Health Services

To gain insight into the experience of seeking and/or receiving behavioral health services for their child(ren), caregiver survey respondents were asked a series of questions about needing, seeking, and successfully receiving behavioral healthcare. When reviewed together, these data points allow for a flow diagram, which illustrates the percentage of caregivers who were successfully at each step in the process (**Figure 19**).

The first questions asked if the parent/caregiver had felt that their child(ren) had any type of concern in the prior 12 months that needed some type of behavioral healthcare. Two-thirds of respondents reported 'Yes' (66.7%). Among this group, the second question asked if the parent/caregivers had attempted to access any type of behavioral healthcare in the prior 12 months. Nearly all reported 'Yes' (90.9%). Finally, among this group, the third question asked if the parent/caregiver had been successful in their attempts to access behavioral healthcare in the prior 12 months. One quarter reported they were 'Successful with All' services (24.7%), and half reported they were 'Successful with Some' services (50.5%). The remaining quarter of parent/caregivers were 'Not Successful' in their attempts (24.7%).

Figure 19. Parent/Caregiver Success in Seeking Behavioral Health Services for Child(ren)



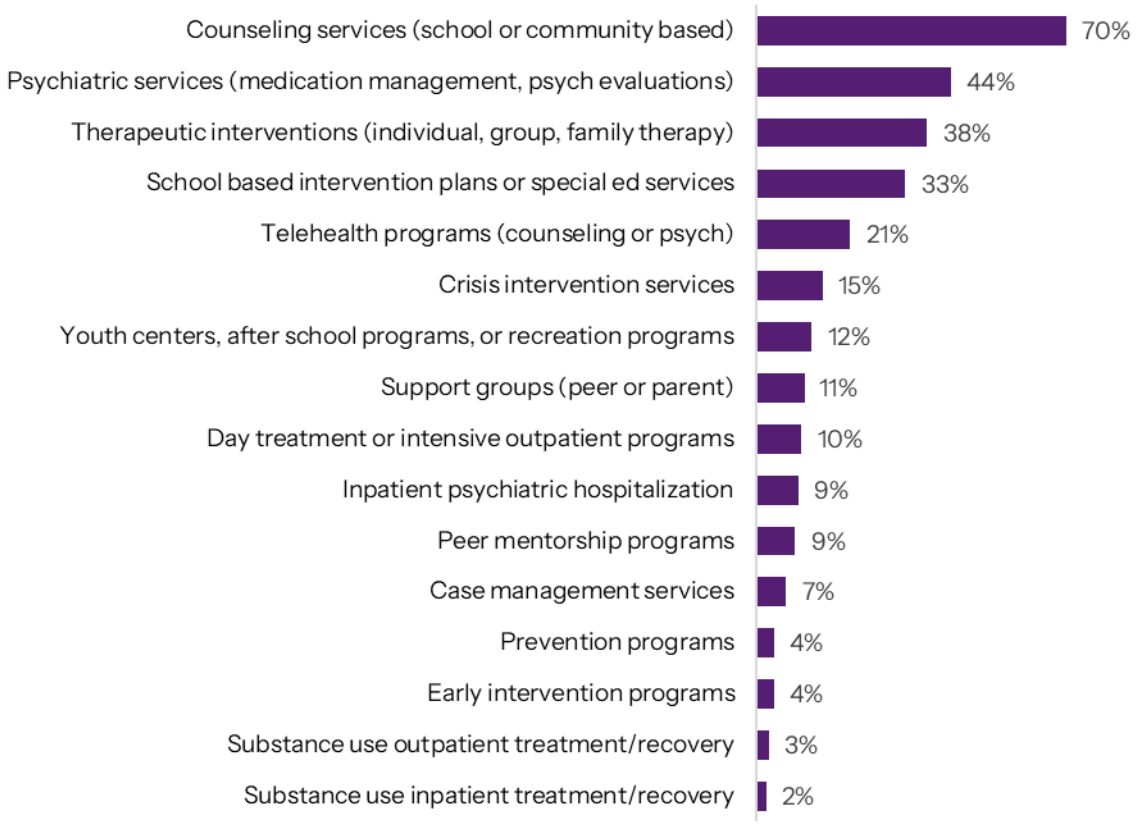
Data Source: CBH Parent/Caregiver Survey 2024

These data suggest that most parents/caregivers who identify a behavioral health need for their child(ren) do attempt to find help or support services or support. However, a large percentage of parent/caregivers appear to encounter challenges, as two-thirds reported they were only partially successful or not successful at all. In further analyses (data not shown), the percentage that reported they were not successful in their attempts to access services was slightly higher among those with public health insurance compared to those

with private insurance (35.1% vs. 20.9%, respectively), suggesting insurance coverage may be one key barrier. The data additionally showed that over one-third of parent/caregivers attempting to access services found that the service required travel outside of Barnstable County, which may be another key barrier to successful access.

The types of behavioral health services that parent/caregiver survey respondents attempted to access are summarized in Figure 20. The most frequently identified service was counseling (including both school- or community-based) (70%), followed by psychiatric services (44%) and therapeutic services (38%). These mirror the services that providers noted as most limited as well as most critical/impactful for youth in Barnstable County.

Figure 20. Percent of Parent Caregiver Survey Respondents Identifying Behavioral Health Services that Were Attempted to Access (N=290)



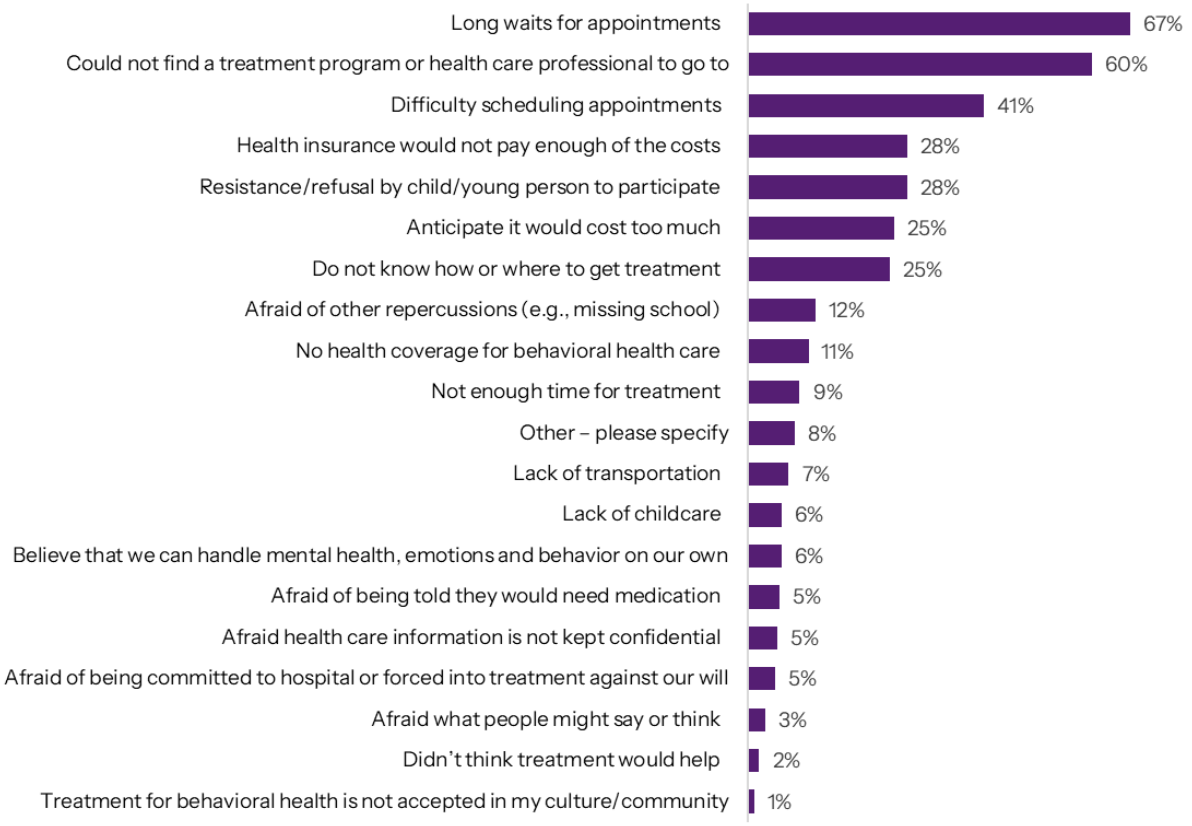
Data Source: CBH Parent/Caregiver Survey 2024
NOTE: question was check-all that apply, and percentages may sum to over 100%

Barriers Experienced when Seeking/Accessing Behavioral Health Services

While survey data were not collected in a way to assess which types of services parents and caregivers were more/less successful in accessing, they were asked to identify the situations that made it harder for them to access behavioral health services more generally. As illustrated in Figure 21, the most common situations were 'long waits for appointments'

(67%) and 'could not find a treatment program or health care professional to go to' (60%). Over one-third also selected 'difficulty scheduling appointments' (41%).

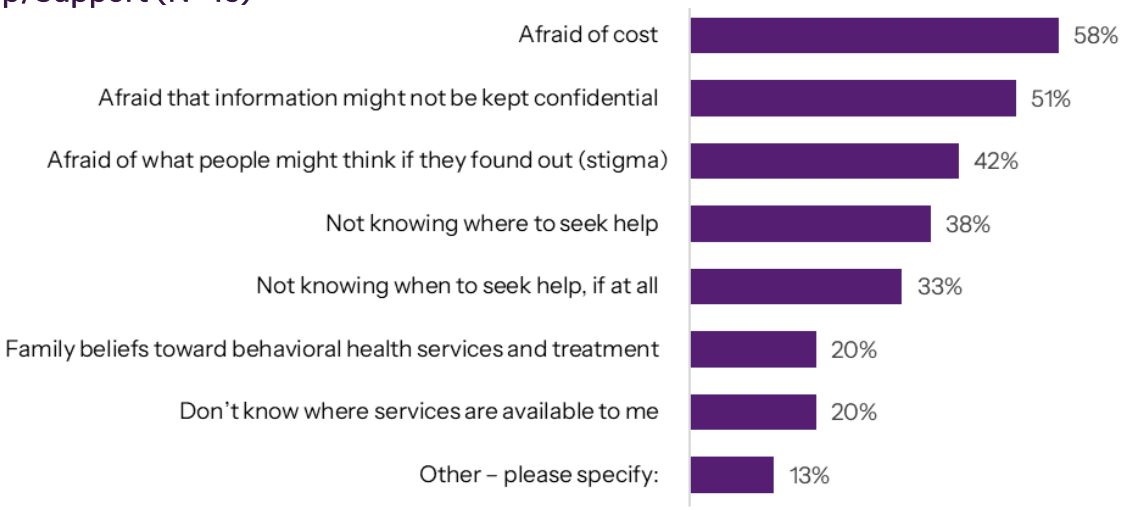
Figure 21. Percent of Parent Caregiver Survey Respondents Identifying Situations Making It Harder to Access Behavioral Health Care (N=255)



Data Source: CBH Parent/Caregiver Survey 2024
NOTE: question was check-all that apply, and percentages may sum to over 100%

Youth survey respondents were also asked to identify situations or barriers; however, the question was framed to be more about their ability or interest in asking for help or support for behavioral health concerns, rather than actual access to services. As illustrated in Figure 22, the most frequent response was 'afraid of cost' (58%), which indicates youth and young adults, like their parents/caregivers, are concerned with more practical aspects of access. However, the data also show that large percentages of youth are concerned about confidentiality and stigma. Half of respondents reported that they were 'afraid that information might not be kept confidential' (51%) and over one-third reported that they were 'afraid of what people might think if they found out (stigma)' (42%). Additionally, about one-third reported not knowing where to seek help (38%) or when to seek help (33%) as barriers.

Figure 22. Percent of Youth Survey Respondents Identifying Barriers to Asking for Help/Support (N=45)



Data Source: CBH Youth/Young Adult Survey 2024
NOTE: question was check-all that apply, and percentages may sum to over 100%

Echoing these barriers and challenges, focus group participants provided more insight and detailed examples of challenges to accessing behavioral health care services in Barnstable County. These most often included lack of providers, variable provider expertise, cost, and language or cultural barriers.

Lack of Providers

> *"The biggest thing I'm seeing is that we don't have enough providers for the need. Access to care is probably my biggest concern, regardless of the diagnosis."* - Provider Focus Group Participant

> *"We have more people in need than we have people responding."* – Caregiver Focus Group Participant

The most frequently mentioned barrier to addressing mental health concerns among Barnstable's children and youth was the lack of providers. Participants said that provider shortages exist across all professions, including counselors, psychologists and psychiatrists, and school-based mental health workers. Caregivers related experiences of long waitlists for services—from many months to over a year. One parent focus group participant shared their experience saying, *"we're looking at 8-12 months before getting any therapy."* A few youth participants stated that it took them one to two years to access therapeutic services. While telehealth has become an approach to increase access to care, a few participants reflected that this has not worked for their children.

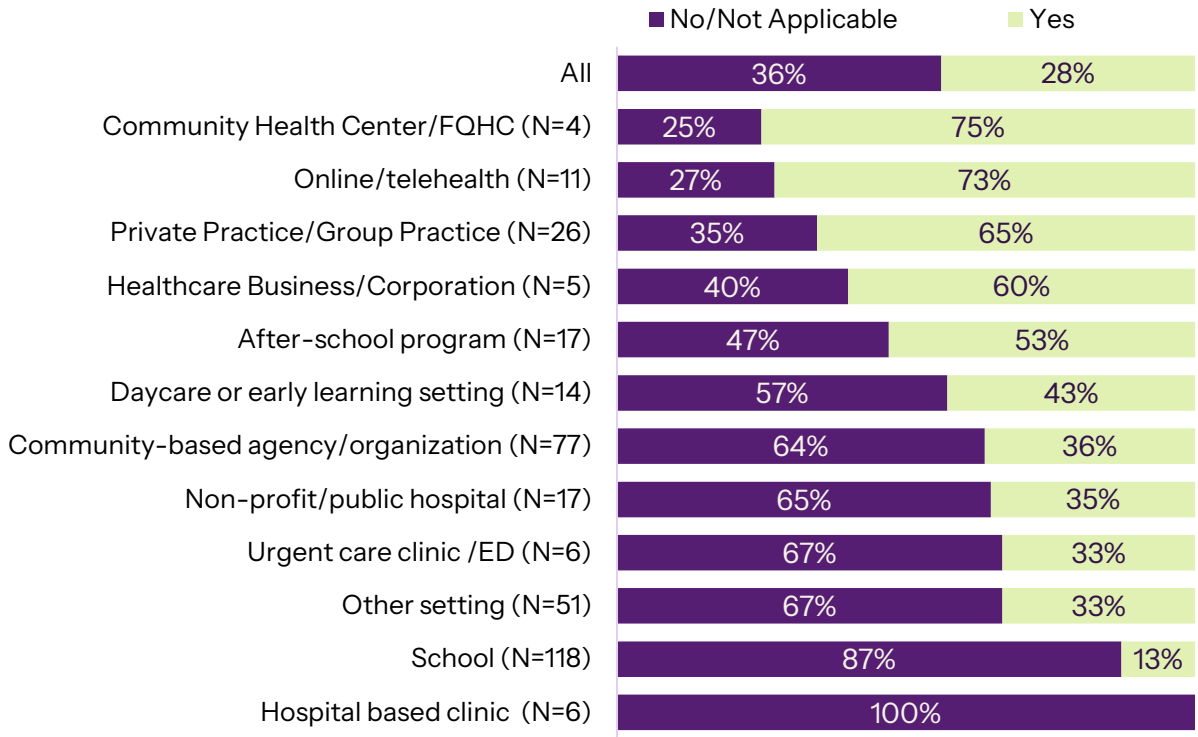
Pediatricians reported that they share lists of mental health providers with caregivers, but when caregivers call, there is no availability. In one office, a provider stated, *"we have a list that our office staff has built up. Four double sided sheets, 60 or more therapists on the*

Cape or close off the Cape. And they are all full". Pediatricians reported the same challenges finding emergency mental health services. As one participant commented, *"we're assessing in the moment, trying to connect people to things quickly, but nothing is available. Nothing. It's very hard to do my job and help my families feel supported when I'm making referrals 6 months out, and this is a family in crisis."* Several participants mentioned that the Cape lacks sufficient in-patient beds for children and youth in crisis.

In addition to the lack of providers for mental health care, providers and caregivers noted that there are long waits to get children and youth tested and diagnosed for autism and neurological services. A couple of caregiver focus group members said they have been more successful in accessing services off the Cape, such as one who stated, *"I just got a call for a neuropsych evaluation, and we are an established patient. They said it's a 2-3 year wait. We now have one in North Reading."* Participants shared, however, that transportation and time to travel off Cape prevents some families from looking outside the community for services.

To determine the extent to which waitlists for services currently exist within the various sectors serving children and youth, provider survey respondents were asked whether their organization/agency/program currently had a waitlist for services. Overall, 28% of providers indicated 'Yes' (**Figure 23**), however, differences emerged when data were stratified by sector, and many sectors had 50% or more of respondents reporting a waitlist.

Figure 23. Percent of Provider Survey Respondents Reporting They Currently Have a Waitlist for Services, by Sector



Data Source: CBH Provider Survey 2024

Several community forum participants highlighted the scenario that many children and youth may go undiagnosed because of the challenges with finding providers who are able to provide an evaluation and proper diagnoses. Further, some services can only be accessed with a diagnosis. For example, participants noted that one of the largest agencies, JRI, only provides wraparound services for youth under 21 who have been diagnosed with a serious emotional disturbance, and they will not intervene in a case without such a diagnosis. In these cases, the lack of services at one point in the system of care is impacting accessibility in other points in the system.

Related to the challenge of finding a provider, a couple of caregiver focus group members commented that it is difficult to find providers available outside of working hours. One participant explained, ***"I had access to a therapist for my son that had autism who was very helpful, but it was a challenge to bring him to the center at an accessible time."***

Participants of focus groups and community forums attributed the lack of providers in Barnstable County to the high cost of living in the community and low pay for mental health providers, especially those who work in community-based agencies. Many providers also have student loan debt. A couple of participants commented that new mental health professionals often begin their careers in community-based agency services and then move onto private practice because the compensation is better. One provider explained: ***"there's this huge turnover--they hit two years and get their licensure and then go into private practice."*** The consequence this participant shared is that patients are unable to get the long-term care needed for stability and improvement. Several caregiver participants shared their frustration with turnover among mental health providers, which disrupts the relationships their children have developed with providers.

> ***"The cost of living is so high, if you go on the bridge in the morning, you see people come onto the Cape and off the Cape. One of the key aspects of all of this is the workforce. It does come down to the money but if we can't get workers here because they can't afford to live here how do we solve this?"*** – Community Forum Participant

Provider Expertise

In addition to an overall shortage of mental health providers, focus group members shared that Barnstable County lacks providers with specialized expertise in addressing issues such as trauma, including reactive attachment disorder, gender and identity issues, and eating disorders. Grandparents in particular shared challenges finding providers with experience in working with children and youth who have both neurological disorders and mental health concerns. Many caregivers reported being shuffled between providers with none successfully meeting their child's needs (e.g., Bay Cove -> DCF -> School -> Bay Cove).

It was also noted that the community lacks pediatric psychiatrists and providers skilled in working with younger children. One focus group member stated that the Cape has only one pediatric psychiatrist. According to caregivers, lack of provider expertise has meant that

children and youth are supported up to a certain point but then are unable to get deeper intervention or are dropped from services.

Many participants also suggested that teachers and others working in the school systems do not have the in-depth knowledge they need to distinguish between mental/behavioral health diagnoses of students, which can lead to insufficient or inappropriate management or response in the classroom. As one participant of the grandparent focus group stated, *"I don't want to blame everything on COVID, but the teachers and staff are not educated. And our kids have attachment disorders, and they think these kids just have behavioral problems, but they [teachers] need more education."*

Cost and Insurance

Several focus group and community forum participants mentioned that high-out-of-pocket cost affect access to mental health providers. They cited high co-pays and additional expenses such as medication. One youth participant shared, *"even with insurance, my copay for my therapist is $50 on my 30-minute session and for 45min-1hr it's $75. So even if you have insurance, it's still a lot of money."* And grandparent focus group participants emphasized that many of them no longer work and do not have any extra income to cover such expenses.

Additionally, participants reported that some providers do not accept some insurance types. Finding providers who accept MassHealth is particularly difficult as one person explained: *"just finding someone is hard, but it's another thing to find someone who takes MassHealth."* A Spanish-speaking focus group member stated that they had difficulty getting their daughter evaluated for autism because she is not a US citizen, and her insurance does not cover it. Another caregiver reported that insurance coverage for services ended.

> *"I'm a therapist … in private practice. One of the biggest barriers I see is what someone alluded to before, the insurance piece. Full disclosure I don't take Mass Health, not because I don't want to, but because they make it almost impossible for someone in private practice to follow their guidelines."* – Community Forum Participant

Language and Cultural Barriers

> *"The Cape is lacking any cultural or ethnic care. In order for my son to see someone who looks like him or even understands what it's like as a Black person, I have to go to Boston."* - Caregiver Focus Group Participant

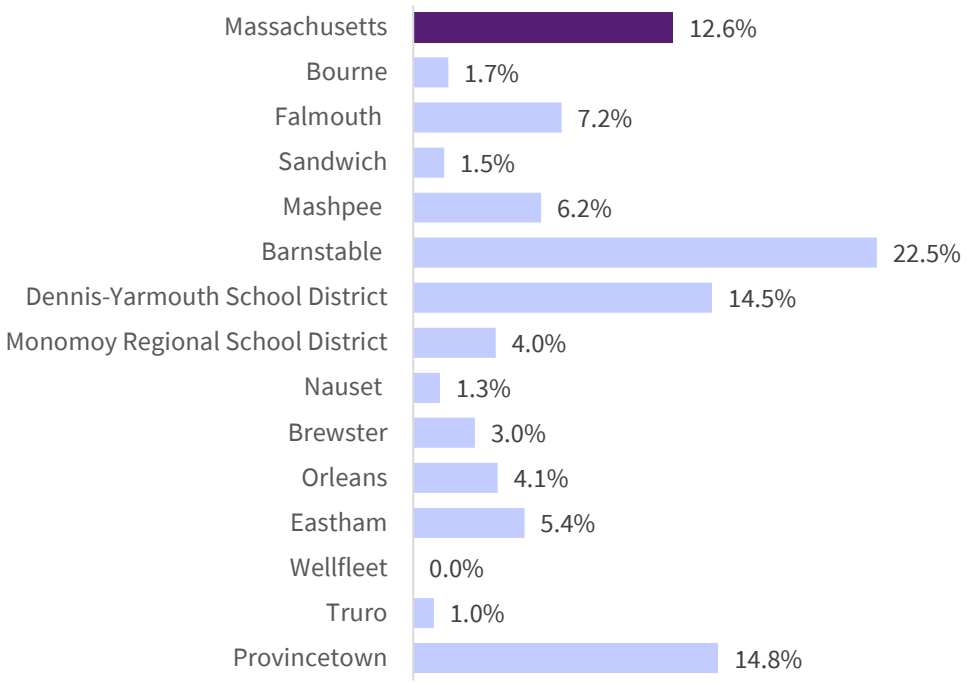
Lack of providers who speak other languages is also a barrier to accessing mental health services according to focus group participants. One youth explained, *"if you have a student whose first language is not English, proximity to resources are just not there."* A Spanish-speaking caregiver echoed this saying, "*there are many times that I go to medical*

appointments and there are no interpreters and there are times that the interpreter does not correctly interpret everything we say at the doctor's office."

Awareness of services is also highly variable among populations with language barriers, highlighting the need for increased communication and navigation in languages other than English. As one Spanish-speaking caregiver observed, *"we do not know where the resources are or what resources are available."*

To provide additional context, school district data on the percentage of students identified as English language learners (ELL) are detailed in **Figure 24**. The percentage ranged from a low of 0% in Wellfleet to 22.5% in Barnstable. Barnstable, Dennis-Yarmouth, and Provincetown all had rates higher than the state average of 12.6%.

Figure 24. English Language Learner Students, Percentage by School District, 2022-2023



DATA SOURCE: MA Department of Secondary Education, School and District Profiles, 2022-2023
NOTE: English language learner is defined as "a student whose first language is a language other than English who is unable to perform ordinary classroom work in English."

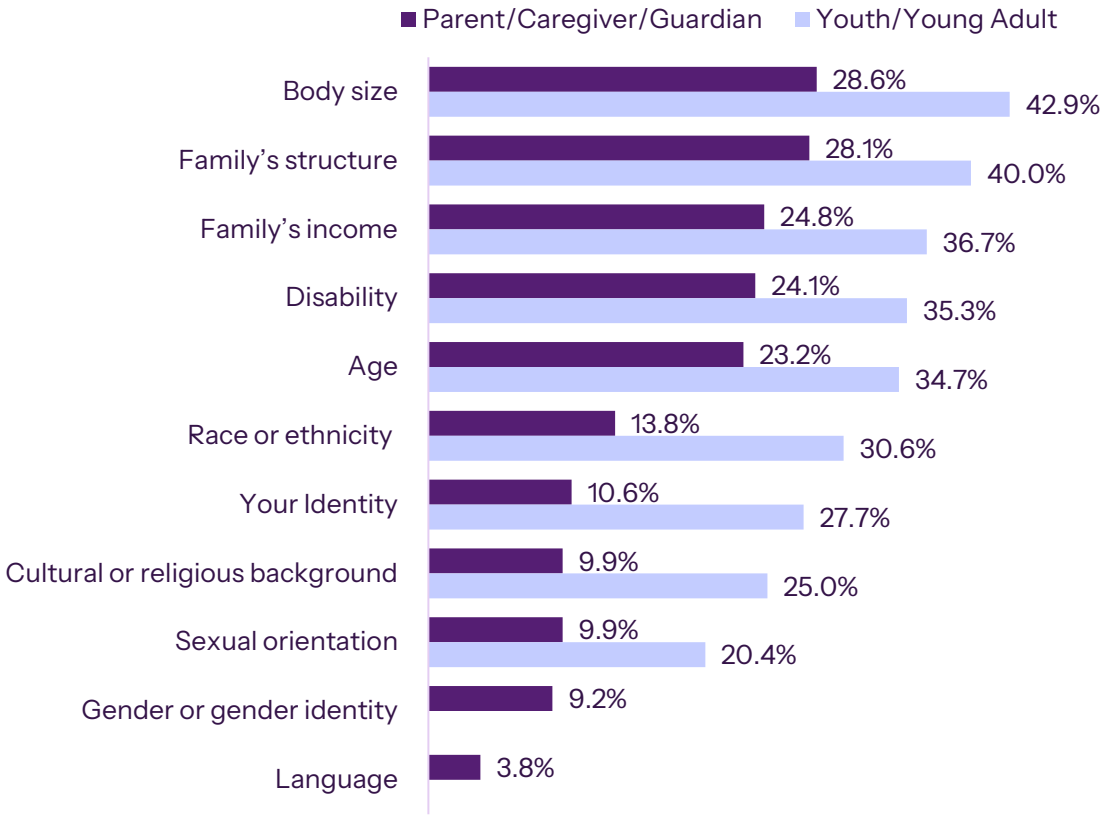
Behavioral Health and the Community in Barnstable County

Experience of Discrimination

To understand how people's multiple identities may have an impact on receiving behavioral health services, youth and caregiver survey respondents were asked how often they were treated in a negative manner based on a list of characteristics when trying to access behavioral health services; caregivers were asked how often they felt their children were

being treated negatively, while youth were asked how often they felt themselves being treated negatively. Overall, higher percentages of youth respondents reported experiencing negative treatment based on these characteristics compared to the perspective of caregiver respondents. The characteristics selected most often, by both youth and caregivers, were body image, family structure, and family income (**Figure 25**). This negative treatment based on body image further adds to the emerging trend around it being a contributing factor to behavioral health needs, specifically those related to eating disorders.

Figure 25. Percent of Parent, Guardian, and Caregiver and Youth Survey Respondents Reporting Negative Treatment While Accessing Behavioral Health Services Sometimes or Frequently

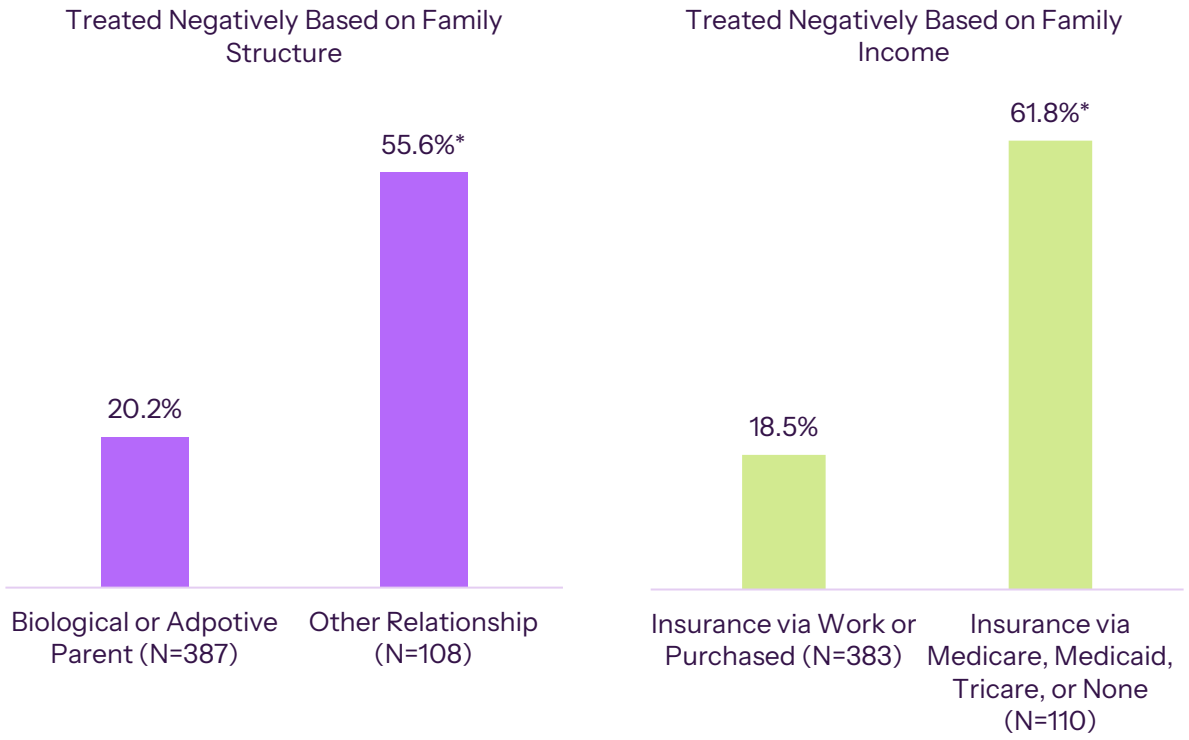


DATA SOURCE: CBH Parent/Caregiver Survey, 2024, CBH Youth/Young Adult Survey, 2024

Given the differences in behavioral needs, and contributing factors identified by those in different family structures and with different types of insurance, the experience of discrimination based on family structure and income were examined separately within these groups among caregiver survey respondents (**Figure 26**). When looking at negative treatment based on family structure, more than two times as many caregivers with other relationships to their children reported this as a part of their and their children's experience (55.6%) compared to biological or adoptive parents (20.2%). The percentage of caregivers with public or no insurance reporting negative treatment based on family income (61.8%) was

more than three times that of those caregivers with private insurance (18.5%), indicating that factors contributing to the behavioral health needs of young people in the county also greatly, and inequitably, impact their comfort with and ability to access behavioral health services.

Figure 26. Percent of Parent, Guardian, and Caregiver Survey Respondents Reporting Negative Treatment of Their Children While Accessing Behavioral Health Services Sometimes or Frequently Based on Family Structure and Income, by Caregiver Relationship and Insurance Status



DATA SOURCE: CBH Parent/Caregiver Survey, 2024
NOTE: Response options included Frequently, Sometimes, and Never. Graph shows cumulative percentage who chose Frequently or Sometimes; * indicates statistically significant difference between groups (p<.001)

Perceptions of Stigma

Throughout the assessment process, the effects of stigma as it relates to behavioral health have been raised as a major challenge to accessing care, as well as allowing people to feel comfortable reaching out and seeking help for any behavioral health concerns. At the community forums, stigma was brought up specifically in the context of school-based services. Participants noted that stigma is a barrier to offering more school-based services in that many children, parents, and administrators appear reluctant to use and or/provide services in schools due to the stigma associated with mental health and the fear of being labeled unfavorably. Some forum participants noted there can be a sense of distrust in

schools among some children and parents that their behavioral health issues will be disclosed to the broader school community, and they fear the social and academic repercussions.

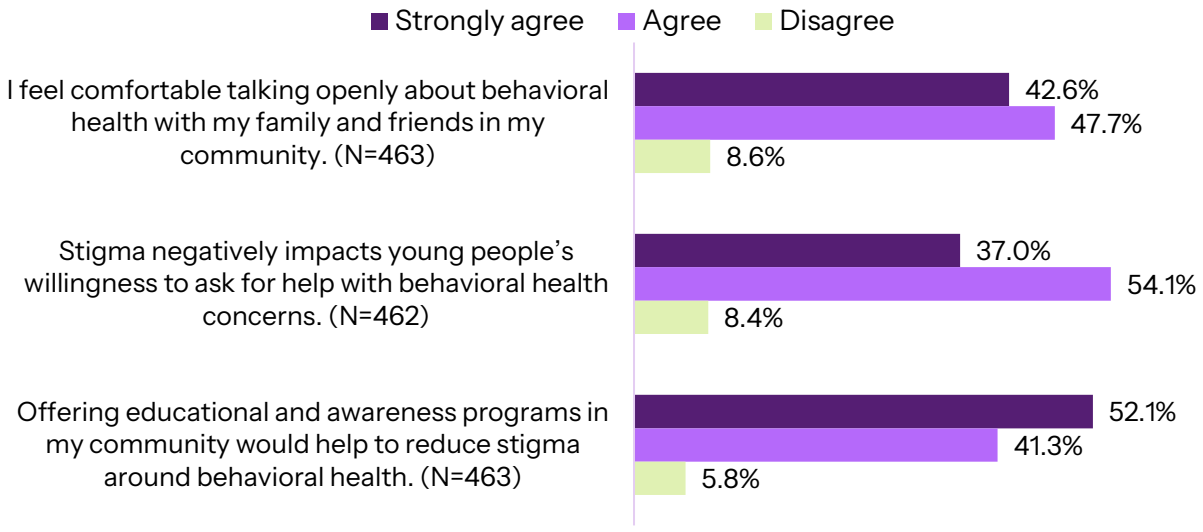
> *"School based services can help, but there is perceived stigma and privacy issues that are barriers."* – Community Forum Participant

> *"To get into the school system was a big deal for us. I've been working on the harm reduction side by bringing the lock boxes to [city], but I can't get them into the schools because of the stigma… We can't bring it up because we can't do anything about it…."* – Behavioral Health Provider Focus Group Participant

Survey respondents also shared their perspectives on the impact of stigma. Both caregiver (**Figure 27**) and youth (**Figure 28**) survey respondents were asked how much they agreed or disagreed with stigma-related statements

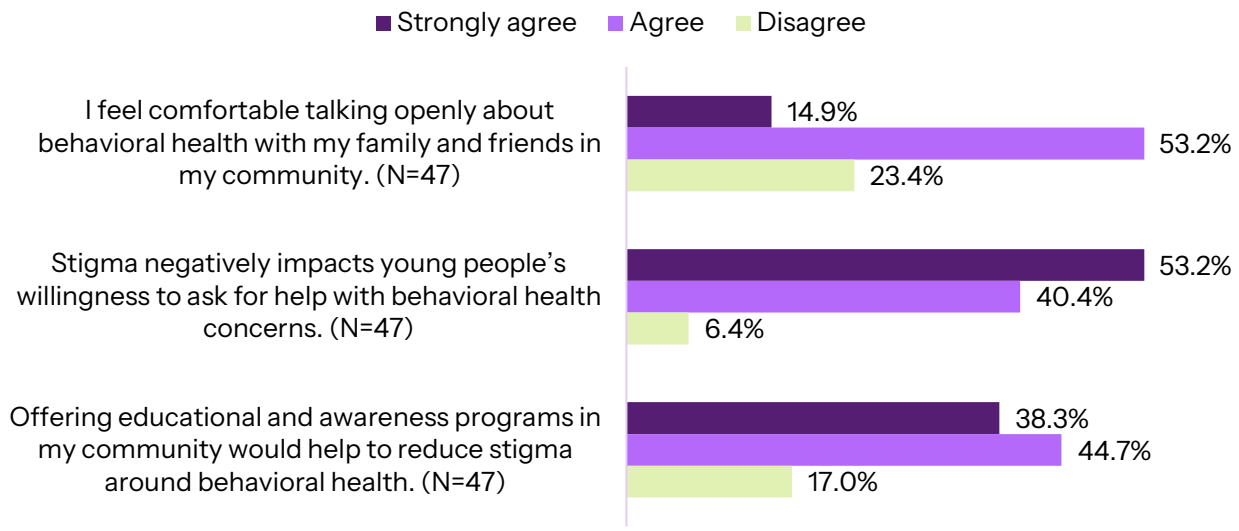
Almost all caregiver respondents (90.3%) agreed or strongly agreed that they feel comfortable talking openly about their behavioral health with their family and friends in the community; fewer youth respondents (68.1%) agreed or strongly agreed with this, indicating higher feelings of stigma related to behavioral health topics. Almost all caregiver (91.1%) and youth (93.6%) respondents agreed or strongly agreed that stigma negatively impacts young people's willingness to ask for help with behavioral health concerns. This echoes the responses shared by youth survey respondents regarding barriers to being open to seeking care for behavioral health issues. Survey respondents were also asked if offering educational and awareness programs in the community would help reduce stigma; almost all caregivers (93.4%) and most youth (83.0%) respondents thought these types of programs would help.

Figure 27. Caregiver Survey Respondent Perspective on Behavioral Health Stigma



DATA SOURCE: CBH Parent/Caregiver Survey, 2024

Figure 28. Youth Survey Respondent Perspective on Behavioral Health Stigma

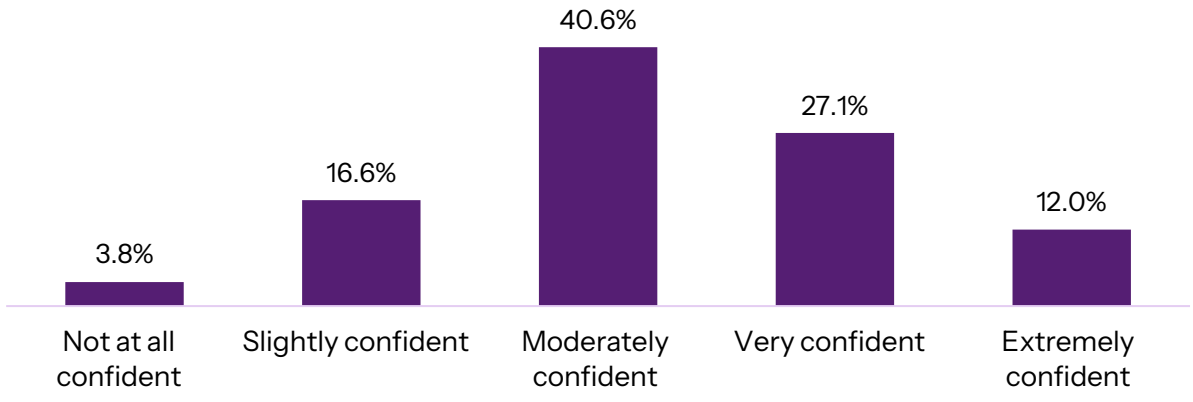


DATA SOURCE: CBH Youth/Young Adult Survey, 2024

Communication and Support

Survey respondents were also asked to provide insight related to communication and support for their behavioral health needs and those of their children. Caregiver respondents shared their level of confidence in their ability to support their children with their behavioral health needs (**Figure 29**). More than a third (39.1%) noted they were very or extremely confident in their ability.

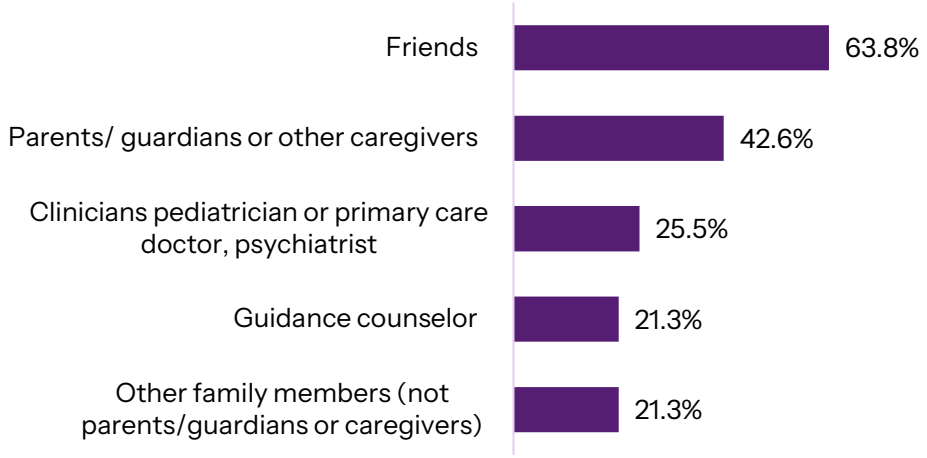
Figure 29. Caregiver Respondent Confidence in Ability to Support Behavioral Health of Their Children (N=476)



DATA SOURCE: CBH Parent/Caregiver Survey, 2024

Young people shared who they feel most comfortable talking to if they had a behavioral health-related concern or experience answering the question “Who do you feel most comfortable talking to if you have a behavioral health-related concern or experience that you want to discuss?” (**Figure 30**). Almost two-thirds of youth survey respondents said they would feel most comfortable talking with friends; the next most selected group was their parent, guardian, or caregiver.

Figure 30. Percent of Youth Respondents Reporting Comfort in Talking About Behavioral Health Concern with Different Individuals (N=47)



DATA SOURCE: CBH Youth/Young Adult Survey, 2024

Appendix Tables

Top Contributing Factors for Young People's Behavioral Health Selected by Caregivers, by Health Insurance Status	All Caregivers N=473	Caregivers with Insurance through *Work or Purchased* N=361	Caregivers with Insurance through *Medicare, Tricare, or Do Not Have Insurance* N=107
	%	%	%
Academic pressure*	**51.2%**	**54.3%**	43.0%
Technology and social media	**48.0%**	**49.3%**	**45.8%**
Peer relationships/peer pressure	**47.8%**	**48.8%**	**45.8%**
Bullying	**47.4%**	**46.3%**	**52.3%**
Body image	**44.6%**	**44.9%**	**45.8%**
School environment	37.8%	37.7%	40.2%
Social isolation	33.8%	33.5%	35.5%
Parenting and family dynamics*	33.2%	29.6%	44.9%
Trauma and adverse childhood experiences*	30.0%	23.8%	**51.4%**
Societal expectations	27.1%	26.6%	29.0%
Economic factors or disparities*	16.7%	13.9%	27.1%
Physical health	13.7%	14.4%	12.2%
Substance use/abuse	13.3%	12.2%	16.8%
Other	10.4%	10.4%	8.3%
Discrimination or racism	10.4%	9.1%	14.0%
Incarcerated parent, caregiver, or household member*	5.1%	3.3%	11.2%

DATA SOURCE: CBH Community Member Survey Parent/Caregiver/Guardian, 2024 * Differences between stratified groups statistically significant with $p<0.05$

Top Contributing Factors for Young People's Behavioral Health Selected by Caregivers, by Relationship with Children	All Caregivers N=473	Caregivers that are *Biological or Adoptive Parents* N=360	Caregivers with *Other Relationships* N=111
	%	%	%
Academic pressure	**51.2%**	**52.8%**	**45.1%**
Technology and social media*	**48.0%**	**50.3%**	39.6%
Peer relationships/peer pressure	**47.8%**	**48.6%**	**44.1%**
Bullying	**47.4%**	**46.1%**	**51.4%**
Body image	**44.6%**	**46.4%**	37.8%
School environment	37.8%	37.5%	39.6%
Social isolation	33.8%	34.2%	31.5%

Parenting and family dynamics*	33.2%	27.8%	**50.5%**
Trauma and adverse childhood experiences*	30.0%	23.9%	**50.5%**
Societal expectations*	27.1%	30.0%	18.0%
Economic factors or disparities	16.7%	16.4%	18.0%
Physical health	13.7%	14.7%	10.8%
Substance use/abuse*	13.3%	10.6%	22.5%
Other	10.4%	10.4%	8.3%
Discrimination or racism	10.4%	8.9%	15.3%
Incarcerated parent, caregiver, or household member*	5.1%	3.3%	10.8%

DATA SOURCE: CBH Community Member Survey Parent/Caregiver/Guardian, 2024 * Differences between stratified groups statistically significant with p<0.05