

**Commonwealth of Massachusetts
Executive Office of Health and Human Services**

**THE CHILDREN'S BEHAVIORAL
HEALTH
ADVISORY COUNCIL**



Annual Report 2016



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health
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Hon. Charles D. Baker, Governor of the Commonwealth
Thomas Weber, Commissioner, Department of Early Education and Care
James Peyser, Commissioner, Department of Elementary and Secondary Education
Hon. Elizabeth A. Malia, House Chair, Joint Committee on Mental Health and Substance Abuse
Hon. Jennifer L. Flanagan, Senate Chair, Joint Committee on Mental Health and Substance Abuse; and Senate Chair, Joint Committee on Children, Families and Persons with Disabilities
Hon. Kay Khan, House Chair, Joint Committee on Children, Families and Persons with Disabilities
Hon. James Welch, Senate Chair, Joint Committee on Health Care Financing
Hon. Jeffrey Sanchez, House Chair, Joint Committee on Health Care Financing
Hon. Karen E. Spilka, Chair, Senate Committee on Ways and Means
Hon. Brian S. Dempsey, Chair, House Committee on Ways and Means

On behalf of the Children's Behavioral Health Advisory Council (Council), established under the provisions of Chapter 321 of the Acts of 2008, I am pleased to transmit its 2016 Annual Report.

Council membership is diverse and multi-disciplinary. It is comprised of representatives of leading professional guilds, trade organizations, state agencies, family and young adult leaders, and other stakeholders. A listing of the Council's membership is attached as **Appendix A**. Throughout its years, the Council has worked to ensure that children's behavioral health receives the attention that it deserves in the larger policy conversations about healthcare reform.

The Council's work is driven by the knowledge that:

- Half of all lifetime mental illnesses begin by age 14; three quarters by age 24.
- Between 13-20% of children living in the United States are affected by mental illness in a given year.
- 50% to 75% of youth with a substance use disorder also experience a co-occurring mental illness.
- Suicide is now the second leading cause of death for youth between the ages of 10 to 24.
- 50% of students age 14 or older with a mental disorder drop out of high school, the highest drop-out rate of any "disability" group.
- The CDC estimates that the economic impact of mental health challenges among youth under age 24 is \$247 billion annually.

Without intervention, child and adolescent psychiatric disorders frequently continue into adulthood and are increasingly associated with disability and increased medical costs. For example, research shows that when children with coexisting depression and conduct disorders become adults, they tend to use more health care services and have higher healthcare costs than other adults. Thus, while children are not "cost drivers" our failure to intervene or engage in preventative measures result in bringing them to adulthood, where their medical needs and costs become significantly higher.

The Council believes that the best and most cost effective treatment for behavioral disorders is through the development of integrated delivery of health care systems, with attention to preventative care. The Council has prioritized providing guidance to MassHealth on its system reform work. This complex, multi-year system evolution holds the potential for improving outcomes, lowering long-term costs, and doing better by our children and adolescents with behavioral disorders and their families.

Sincerely,



Joan Mikula
Commissioner
On behalf of the Children's Behavioral Health Advisory Council

cc: Marylou Sudders, Secretary, Executive Office of Health and Human Services

I. INTRODUCTION AND PRELIMINARY STATEMENT

Section 1 of Chapter 321 of the Acts of 2008 amended Chapter 6A of the Massachusetts General Laws, by inserting Section 16Q and established the Children’s Behavioral Health Advisory Council (Council) and placed the Council, “within but not subject to control of, the executive office of health and human services.” Additionally, the language of section 16Q (a) states the Council is to, “advise the governor, the general court and the secretary of health and human services.” The scope and breadth of the Council’s advisory role is best evidenced in subparagraph (d) of Section 16Q, which authorizes the Council to make recommendations in the following areas:

- (i) best and promising practices for behavioral health care of children and their families, including practices that promote wellness and the prevention of behavioral health problems and that support the development of evidence-based interventions with children and their parents;
- (ii) implementation of interagency children’s behavioral health initiatives with the goal of promoting a comprehensive, coordinated, high-quality, safe, effective, timely, efficient, equitable, family-centered, culturally-competent and a linguistically and clinically appropriate continuum of behavioral health services for children;
- (iii) the extent to which children with behavioral health needs are involved with the juvenile justice and child welfare systems;
- (iv) licensing standards relevant to the provision of behavioral health services for programs serving children, including those licensed by entities outside of the executive office of health and human services;
- (v) continuity of care for children and families across payers, including private insurance; and
- (vi) racial and ethnic disparities in the provision of behavioral health care to children.

The Council believes it is vital to its mission, and ultimately to the families and children of the Commonwealth, that it was established as an independent advisor to both the Executive and Legislative branches. Our credibility as an advisory body depends upon our independence and ongoing commitment to advocate for legislation, policies, practices and procedures that best serve the families and children of the Commonwealth with emotional disorders and behavioral health needs. Our recommendations are guided by our expertise, experience, and our commitment to the families and children of the Commonwealth. We hope our work is useful to both the Executive and Legislative branches as we collectively work toward an integrated health care system that addresses the behavioral health needs of our children and adolescents.

II. COUNCIL’S ACTIVITIES

Generally, the Council meets on the first Monday of each month. During the period covered by this Report (October 2015 through September 2016), the Council met eight

times, including attending the Children’s Behavioral Health Knowledge Center’s 2nd Annual Symposium and Gailanne Reeh Lecture.

During the course of the year, our presentations and discussions focused on key issues of concern not only to Council members but throughout the children’s behavioral health system. Through our deliberations, we have developed and conveyed recommendations as well as informed the work of the organizations represented by our members.

➤ **Restructuring MassHealth**

The Council has received, and is greatly appreciative of, several briefings from MassHealth leaders regarding the emerging plans for Accountable Care Organizations (ACOs), Behavioral Health Community Partners (BHCPs) and the use of Delivery System Reform Incentive Payments (DSRIP). We particularly acknowledge the attention that MassHealth leaders are giving to the needs of children, youth, and their families in their decisions regarding the roles and relationships among organizations in the service delivery system as well as the definition and measurement of quality.

In addition to the robust discussion at our meetings, the Council has provided written comments to MassHealth. We highlight here three important recommendations submitted to MassHealth regarding the ACO procurement:

1. Improve the process of referring youth to behavioral health services, to shorten the often lengthy “trial and error” process of matching the youth’s needs to appropriate services. Access to the right service in a timely manner is complicated by a fragmented service system that is hard for parents and primary care providers to fully understand. One solution to this is to allow BHCPs to use DSRIP funds for education of referral sources, such as Primary Care Clinicians (PCCs), inpatient units, Schools and State agencies about available services.
2. Improve the “clinical acumen” of community-based children’s services through more effective supervision and the use of clinical consultants. The frontline staff in community-based services are largely recent graduates, with high rates of turnover. This less experienced workforce needs robust clinical supervision and sometimes clinical consultation to perform well. Massachusetts Child Psychiatry Access Project (MCPAP) provides a consultation model worthy of consideration.
3. Encourage ACO attention to the parenting role of adult members with behavioral health needs in order to prevent childhood trauma. In light of what research and experience tells us about the impact of a parent’s mental illness on their child’s health and well-being, there is high value and impact on prevention in bringing a family focus to the adult healthcare system. Council members emphasized the role of family partners in easing a parent’s willingness to engage in behavioral health services “for the sake of their child.”

➤ **Substance Abuse and Co-Occurring Disorders**

For our December meeting, the Council and the Children’s Behavioral Health Knowledge Center convened a daylong forum on improving access to high quality treatment of co-occurring disorders for youth. Estimates indicate that between 50% to 75% of youth with a substance use disorder also experience a co-occurring mental illness; yet, the workforce does not reflect this reality. Practitioners are usually trained in separate fields, operate under distinct licenses, and know relatively little about each other's organizational culture and operations.

The forum brought together young adults, families, providers, and policy makers to learn about effective strategies used in other states and to begin formulating specific actions for cross-agency collaboration in Massachusetts. The CBH Knowledge Center sponsored a keynote by national expert Dr. Rick Shepler, Ph.D., PCC-S, the Director of the Center for Innovative Practices (CIP) at the Begun Center for Violence Prevention Research and Education at Case Western Reserve University. Dr. Shepler is also the co-developer of the Integrated Co-Occurring Treatment (ICT) model, one of the first treatment models designed specifically for youth with the co-occurring disorders of substance abuse and mental illness.

➤ **Emergency Department (ED) Boarding**

Council members from the Children’s Mental Health Campaign (CMHC) presented their three-year project to develop a better understanding of the factors that contribute to pediatric psychiatric "boarding" and, ultimately, to successfully advocate for solutions.

Over the years, the Council has discussed the inappropriate use of EDs to board children awaiting care that they need. Despite many changes for the better in the children’s behavioral health system, children in psychiatric crisis too often sit in EDs across the Commonwealth awaiting care. While children sit in the ED or medical units awaiting placements, they are not receiving the treatment they were assessed to require. Boarding creates a multitude of stressors for children, families, health care providers, and hospitals across the Commonwealth.

We are grateful to our CMHC colleagues for leading an effort to fully examine and address the dysfunction that persists at this high end of the service continuum. Council members look forward to attending the Campaign’s stakeholder summit in December 2016.

➤ **Reinforcing Outpatient Services**

Council member Carla Saccone, CEO of Children’s Friend, led a presentation and discussion regarding the need to shore up the deteriorating outpatient system. Outpatient services are a critical component of the service delivery system. A February 2016 survey

by the Association of Behavioral Healthcare (ABH) of its member organizations with outpatient services found that:

- 76% reported operating losses for their outpatient services
- 32% reported closing clinic sites in the previous three years
- 20% have reduced clinic staff
- 20% have reduced services to specialty populations
- 24% have medication management services

These trends do not bode well for the success of healthcare reform in meeting goals related to access, quality and cost.

The Massachusetts Association for Mental Health (MAMH) (also a Council member) is leading a study of the structural weaknesses and the investments needed in order to ensure that outpatient services can fulfill the promise of community based services.

III. THE CHILDREN'S BEHAVIORAL HEALTH KNOWLEDGE CENTER

In May 2015, Council members attended the Children's Behavioral Health Knowledge Center's Second Annual Symposium and Gailanne Reeh Lecture. The Knowledge Center was mandated in the same enabling legislation that created the Council (Chapter 321, Acts of 2008) and its stated mission is to ensure that:

- the workforce of clinicians and direct care staff providing children's behavioral health services are highly skilled and well trained,
- the services provided to children in the Commonwealth are cost-effective and evidence-based, and
- the Commonwealth continues to develop and evaluate new models of service delivery.

Located at the Department of Mental Health, the Knowledge Center fills a gap in the children's behavioral health system by serving as a knowledge broker, collaborator, and an information hub, through its Annual Symposium, website, workshops, and webinars.

The Center works with state agencies, community based service providers, advocates, and other stakeholders who are developing, implementing, and advocating for practices, programs, and service delivery models that are based on the best available evidence about what works to improve outcomes for children and youth. In collaboration with these partners, it has sponsored webinars and workshops on a variety of policy and practice issues, including suicide prevention, parental substance abuse, early psychosis, transition planning for young adults, and implementation science.

The Center also collaborates on developing and managing long-term strategic projects. For example, it is working with MassHealth to improve the quality of in-home therapy services, the most frequently utilized CBHI service. Drawing from implementation

science research, the Center has developed an approach to working with practitioners to establish and support achievement of best practice standards.

The Council believes that funding beyond the initial start-up funds provided by DMH is essential for the Center to continue to be a valuable resource for the children's behavioral health system. MassHealth should consider allocating DSRIP funds and/or encouraging ACOs and BHCPs to use their funds to work with the Center.

V. THE YEAR AHEAD

We anticipate the Council will be very much engaged in the MassHealth's work to integrate behavioral health and primary care.

The Commonwealth has invested in important foundations in the children's behavioral health system. We lead the nation in developmental screenings, including behavioral health screenings for youth. Nearly every (98%) youth in Massachusetts with an emotional or behavioral developmental issue is consistently insured. Because of the *Rosie D* litigation and remedy plan, considerable attention has been paid to the public delivery of care system and to the creation and penetration of the new services created as part of the remediation plan under that litigation. The *Rosie D* (aka Children's Behavioral Health Initiative) service array has provided a strong platform on which to incorporate evidence-based programs and innovative service delivery models funded by sister state agencies. It has also highlighted the gap between the services available to families and children covered under MassHealth and those covered by commercial carriers. The Council looks forward to advising the system's continued evolution beyond the accomplishments of the *Rosie D* remedy.

APPENDIX A

The Children’s Behavioral Health Advisory Council (the Council) was established under the provisions of Chapter 321 of the Acts of 2008. The Council is a unique public-private partnership representing child-serving agencies, parents and professionals with expertise in the issues of children’s mental health. The membership of the Commission is as follows:

Joan Mikula, Chair Commissioner Department of Mental Health	Maria Mossaides The Child Advocate Office of the Child Advocate
Kristen Alexander Department of Children and Families	David Matteodo Massachusetts Association of Behavioral Health Systems Representative
Janet George Department of Developmental Services	Carla Saccone Association for Behavioral Healthcare Representative
Emily Sherwood Office of Medicaid	Erin Bradley Children’s League of Mass Representative
Carol Nolan Department of Early Education and Care	Peter Metz, M.D. New England Council of Child and Adolescent Psychiatry Representative
Division of Insurance	Barry Sarvet, M.D. Massachusetts Psychiatric Society Representative
Teri Valentine Department of Elementary and Secondary Education	Michael Yogman, M.D. Mass Chapter of the American Academy of Pediatrics Representative
Robert Turillo Department of Youth Services	Eugene D’Angelo, Ph.D. Massachusetts Psychological Association Representative
James Hiatt Department of Public Health	Carol Trust, LICSW National Association of Social Workers – Massachusetts Chapter Representative
William R. Beardslee, M.D. Massachusetts Hospital Association Representative	Dalene Basden Parent/Professional Advocacy League Representative
Danna Mauch Massachusetts Association for Mental Health Representative	Lisa Lambert Parent/Professional Advocacy League Representative
Jack Simons Director Executive Office of Health and Human Services Children’s Behavioral Health Interagency Initiative	Mary McGeown Massachusetts Society for the Prevention of Cruelty to Children
Sarah Gordon Chiramida	Ken Duckworth, M.D.

Massachusetts Association of Health Plans Representative	Blue Cross Blue Shields of Massachusetts Representative
Kermit Crawford, Ph.D. Professional in human services workforce development Boston Medical Center	John Straus, M.D. Massachusetts Behavioral Health Partnership Representative
Gustavo Payano Young Adult Policy Team	Samantha Sandland Young Adult Policy Team
Theodore Murray, M.D. Cambridge Health Alliance	Jill Lack Neighborhood Health Plan
Amy Carafoli-Pires Boston Medical Center HealthNet Plan	Elizabeth Bosworth Beacon Health Strategies
John Sargent, M.D.	Gisela Morales-Barreto, Ed.D.
Paul Shaw	Midge Williams
Toni Irsfeld	Mary Ann Gapinski