Commonwealth of Massachusetts
Executive Office of Health and Human Services

THE CHILDREN'S BEHAVIORAL HEALTH ADVISORY COUNCIL

Annual Report 2021

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
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Rep. Michael Finn, House Chair, Joint Committee on Children, Families and Persons with Disabilities

On behalf of the Children's Behavioral Health (BH) Advisory Council (Council), established under the provisions of Chapter 321 of the Acts of 2008, I am pleased to transmit its 2021 Annual Report.

The Council is a diverse and multi-disciplinary group with representatives from professional guilds, trade organizations, state agencies, families and young adult leaders, advocates, and other key stakeholders. A complete list of the Council's membership is included in ***Appendix A*** of this Report. The Council always considered children's behavioral health reform in the context of the Commonwealth's broader health policy reform initiatives. In the past year, the Baker-Polito Administration released its *Roadmap for Behavioral Health Reform*, a multi-year blueprint based on extensive feedback from families, providers, and other key stakeholders. The Council looks forward to continuing to work with the Administration on the implementation of the *Roadmap* and ensuring that children's behavioral health remains a central tenet. You can learn more about the *Roadmap* at mass.gov.BHRoadmap.

The Council's work is driven by the well-documented behavioral health needs of children and adolescents, including:

- Half of all lifetime mental illnesses begin by age 14; three quarters by age 24.[1]
- Between 13-20% of children living in the United States are affected by mental illness in a given year.[2]
- Roughly two-thirds of youth with a substance use disorder also experience a co-occurring mental illness.[3]

The behavioral health needs of children and adolescents have been significantly exacerbated by the COVID-19 pandemic, as illustrated by the following data points:

- In June 2020, approximately 1 in 4 individuals aged 18-24 reported seriously considering suicide in the 30 days before completing the survey.[4]
- 45% of 14- to 18-year-olds are not hopeful about the future, and more than half of Lesbian Gay Bisexual Transgender and Queer (LGBTQ+) teens are not hopeful about the future.[5]

There has never been a more crucial moment to improve access to children's behavioral health care. Acting now can help us to prevent the delayed access to treatment and further worsening of behavioral health symptoms throughout childhood and into adulthood. This all-too-common trend *can* be interrupted. As we implement the *Roadmap for Behavioral Health Reform*, the Commonwealth is poised to create real and lasting change in access to behavioral health care for its youngest residents. As part of its work in 2021, the Council has outlined specific recommendations for improving access to and the quality of children's behavioral health care in Massachusetts. These recommendations are outlined in Appendix B.

Sincerely,

Brooke Doyle, M.Ed, LMHC
Commissioner
On behalf of the Children's Behavioral Health Advisory Council

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

[1] National Alliance on Mental Illness. Mental health facts in America. Retrieved from https://www.nami.org/nami/media/nami-media/infographics/generalmhfacts.pdf.
[2] Centers for Disease Control and Prevention. (2019). Key findings: Children's mental health report. Retrieved from https://www.cdc.gov/childrensmentalhealth/features/kf-childrens-mental-health-report.html#:~:text=Based%20on%20the%20National%20Research,up%20to%201%20out%20of.
[3] Conway, K. P., Swendsen, J., Husky, M. M., He, J. P., & Merikangas, K. R. (2016). Association of lifetime mental disorders and subsequent alcohol and illicit drug use: Results from the national comorbidity survey–adolescent supplement. *Journal of the American Academy of Child & Adolescent Psychiatry, 55*(4), 280-288.
[4] Czeisler MÉ , Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1.
[5] Mental Health America. (2020). Young people's mental health in 2020: Hope, advocacy, and action for the future. Retrieved from https://mhanational.org/sites/default/files/Young%20People's%20Mental%20Health%20Report%202020%20with%20Program%20Appendix%2012.8.20.pdf.

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 to the families and children of the Commonwealth, that it is 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 meet the needs of 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 that our work is informative 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

From October 2020 through September 2021, the Council met six times. A survey of Council members in the summer 2020 informed the agenda for the meeting topics, enumerated below:

- System navigation
- Behavioral Health Redesign
- School mental health
- Pediatric boarding in Emergency Departments (ED)
- Workforce development

This year, the Council served as key advisors on several timely and important issues, which are detailed below.

October 2020 –
The Council's first meeting opened by acknowledging the retirement of Commissioner Joan Mikula and welcoming Acting Commissioner Brooke Doyle.

Kate Ginnis, Senior Director of Child Youth and Family Policy and Programs at MassHealth, presented an overview of the Child and Adolescent Needs and Strengths (CANS) redesign, currently underway at MassHealth as part of the broader *Behavioral Health Redesign* initiative and informed by feedback from the 2019 *BH Redesign* listening sessions. Kate emphasized the need for a functional cross-agency (inclusive of MassHealth, Department of Mental Health (DMH), Department of Youth Services (DYS), and Department of Children and Familied (DCF)) streamlining of the CANS, which the new CANS will be designed to achieve.

Following the presentation, Emily Sherwood, Deputy Commissioner, Child, Youth, & Family Services at DMH and Carol Murphy, Director of Caring Together at DMH presented the plan for the procurement of DMH's Intensive Community Services. The newly designed service features several models—intensive home-based therapeutic care, therapeutic group care, and young adult therapeutic care, —and incorporates family, youth, and provider feedback. The RFP was released in November 2020 and contracts began in July 2021.

The meeting concluded with a preview of the new online tool, HandholdMA.org, an interactive, family-friendly website designed for parents and caretakers of children ages 6-12.

December 2020 –
The Council welcomed Matt Pecoraro, Associate Director, The Evidence-Based Policy Institute at Judge Baker Children's Center, and Dr. Christopher Bellonci, Vice President of Policy & Practice and Chief Medical Officer at Judge Baker Children's Center, who presented findings from their most recent report, *The Impact of COVID-19 On Children, Youth and Families*. The objective of this report was to explore the impact of COVID-19

on children, youth, and families; explore implications and approaches to promote positive outcomes for children, youth, and families during and after COVID-19; and collectively identify strategies and next steps.

Following this discussion, Commissioner Doyle, and Kate Ginnis presented on the surge in ED boarding among children and adolescents. DMH, the Department of Public Health (DPH), and MassHealth are working together to add bed capacity throughout the state; the Commissioner underscored the importance of flexibility throughout the system and noted that beds alone are not the solution to the problem.

February 2021 –
Rayna Charles and Tammy Bernardi of the Children's Trust provided the Council with an overview of the website Safe Kids Thrive (safekidsthrive.org), which offers youth-serving organizations an interactive toolkit and resources dedicating to preventing child sex abuse.

Following this presentation, Courtney Chelo, Assistant Director for Government Relations at the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), Daniela Reyes, Policy Project Coordinator at Boston Children's Hospital (BCH) and Nancy Allen Scannell, Director of External Affairs at MSPCC gave an overview of the school-based mental health work occurring at the Children's Mental Health Campaign (CMHC). Nancy provided a legislative and budget overview of school mental health initiatives, including a bill first filed in the 2019-2020 legislative session to require mental health education in schools and a $50K allocation in the state budget to create a School Behavioral Health Technical Assistance Center.

Melissa Pearrow, Kathryn Kurtz, and Sara Whitcomb of the Behavioral Health Integrated Resources for Children (BIRCh) Center then provided an overview of the capacity of school-based behavioral health throughout the state. Massachusetts does not meet the national recommended ratios between students and behavioral health specialty providers (counselors, social workers, and psychologists), demonstrating inequitable access to school behavioral health with students in high-needs districts and those in the western region of the state less likely to receive support. In response to these trends, the BIRCh team recommended the creation of regional school behavioral health technical assistance centers.

March 2021 – Dr. Kathy Sanders of DMH presented an update on the Expedited Psychiatric Inpatient Admissions (EPIA) process. The purpose of EPIA continues to be decreasing both the numbers of individuals who board and the length of stay of those who do board. Early in the pandemic the numbers of adult and pediatric patients boarding in EDs decreased. However, as the pandemic continued, the mental health impact of COVID-19 became evident, resulting in an increase in patients presenting to EDs. ED boarding trends can be viewed on DMH website at EPIA Dashboards | Mass.gov

Following the EPIA presentation, Courtney Chelo provided an overview of legislative and budget initiatives being led by the Children's Mental Health Campaign, Amara Azubuike of Boston Children's Hospital then discussed *An Act relative to child emergency*

department boarding (SB107), which aims to increase transparency with respect to pediatric ED boarding.

Lastly, Commissioner Brooke Doyle and Kate Ginnis provided an overview of the child-specific components of the newly-released *Roadmap for Behavioral Health Reform,* which is centered on the creation of Community Behavioral Health Centers (CBHCs). More information on the *Roadmap* can be found at mass.gov/BHRoadmap. Across the community system, there will be an infusion of urgent and crisis care. One new component for children will be Community Crisis Stabilization units, which will be designed differently from the adult version of this service.

April 2021 –
Commissioner Brooke Doyle opened the meeting with an overview of the plan for Massachusetts' use of Substance Abuse Mental Health Services Administration federal block grant resources, strategies to address ED diversion and crisis care, continuity of funding for young adult access centers in Worcester and Springfield whose funding was set to expire, and the *Roadmap's* Front Door initiative, a new, centralized service for people or their loved ones to call or text to get connected to mental health and addiction treatment.

Following Commissioner Doyle, Courtney Breen of Riverside presented the MassSupport program, which is providing customized training and support to both school personnel and students using FEMA funding that Massachusetts received early in the pandemic.

The meeting concluded with a presentation on Infant and Early Childhood Mental Health (IECMH) by Andrea Goncalves-Oliveira of DMH and Aditi Subramaniam of MSPCC. Massachusetts is in the early stages of adopting an IECMH endorsement system among its workforce. The endorsement process centers on diversity, equity, and inclusion by prioritizing lived experience as well as education and focusing on endorsement of non-licensed providers. So far in Massachusetts, 45 people are endorsed. In addition to the endorsement process, there is ongoing training and piloting of the DC:0-5 diagnostic criteria, the diagnostic manual for children ages birth through 5 years. So far, 300 people have been trained in the DC:0-5, and the crosswalk for MA billing using the DC:0-5 is still in development.

June 2021 –
Kelly English, Deputy Commissioner, Child, Youth, & Family Services at DMH, opened the meeting by welcoming everyone and explaining the plan to break into four groups to discuss and develop recommendations within each group's assigned topic. Council members had an opportunity to select a preferred topic prior via an online survey and are as follows:

- ED boarding
- School mental health
- COVID-19 impact
- Infant and Early Childhood Mental Health

The Council's recommendations were gathered following the meeting and can be found in ***Appendix B*** of this Report.

III. THE YEAR AHEAD

Working closely with the Administration and its *Roadmap for Behavioral Health Reform*, the Council will continue to advocate for the needs of youth and their families with behavioral health challenges. Specifically, the Council will continue to address the ongoing workforce and access issues faced by the system which have continued to be compounded by the COVID-19 pandemic. The Council looks forward to another productive and impactful year of work ahead in 2021-2022.

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:

Brooke Doyle, Chair Commissioner Department of Mental Health	David Matteodo Massachusetts Association of Behavioral Health Systems Representative
Lauren Almeida Department of Children and Families	Marsha Medalie Association for Behavioral Healthcare Representative
Janet George Department of Developmental Services	Tammy Mello/Joe Leavey Children's League of Mass Representative
Kate Ginnis MassHealth Office of Behavioral Health	Vacant New England Council of Child and Adolescent Psychiatry Representative
Carol Nolan Department of Early Education and Care	Barry Sarvet, M.D. Massachusetts Psychiatric Society Representative
Kevin Beagan Division of Insurance	Michael Yogman, M.D. Mass Chapter of the American Academy of Pediatrics Representative
Jane Ewing Department of Elementary and Secondary Education	Eugene D'Angelo, Ph.D. Massachusetts Psychological Association Representative
Vacant Department of Youth Services	Rebekah L. Gewirtz National Association of Social Workers – Massachusetts Chapter Representative
Brian Jenney/Rebecca Butler Department of Public Health	Dalene Basden Parent/Professional Advocacy League Representative
Maria Mossaides The Child Advocate Office of the Child Advocate	Lisa Lambert Parent/Professional Advocacy League Representative
Danna Mauch Massachusetts Association for Mental Health Representative	Mary McGeown Massachusetts Society for the Prevention of Cruelty to Children Representative
William R. Beardslee, M.D. Massachusetts Hospital Association Representative	Ken Duckworth, M.D. Blue Cross Blue Shield of Massachusetts Representative

Sarah Gordon Chiaramida Massachusetts Association of Health Plans Representative	John Straus, M.D. Massachusetts Behavioral Health Partnership Representative
Theodore Murray, M.D. Cambridge Health Alliance	Elizabeth Bosworth Beacon Health Strategies
Amy Carafoli-Pires Boston Medical Center HealthNet Plan	

APPENDIX B:
Recommendations

ED Boarding

1. Enhance acute behavioral health supports for children while they are actively in crisis
    a. Continue increased flexibility within the children's behavioral health system, specifically continue access to telehealth. In terms of ED boarding, telehealth can improve access to real-time care when children are boarding in the ED and there are few, if any, care options available
        i. The virtual statewide PHP has helped to connect children who are boarding to treatment
        ii. Connecting children and families to care while they are in the ED virtually can help to determine whether a particular service is a good fit for the child/family and jumpstart access/treatment
    b. Expand the role and presence of Family Partners in ED, particularly for BIPOC families, who are more likely to face discrimination while their children board in the ED
        i. Allowing FPs to be employed part time would enable them to keep their benefits, avoiding the cliff effect of becoming FPs that deters many parents from becoming FPs
        ii. Creating a specialized FP role working in EDs could help parents connect to other parents who really have experienced a similar situation.
            1. FPs would be assigned to one or a few local EDs and would help the transition/warm handoff from the ED to an agency/other provider
2. Enhance the behavioral health system such that there are a range of treatment options available to children once they are boarding, recognizing the strain among the behavioral health workforce across the care continuum due to the pandemic as well as the importance of shared racial/ethnic identity that many families do not experience due to the current composition of the workforce.
    a. Attract, recruit, retain a workforce with lived experience, same racial/ethnic background
    b. Expand the role of the Family Partner to perform non-traditional care and *outreach* to engage children and families in their communities and address issues as they arise
    c. To support the children's behavioral health workforce, which is experiencing higher-than-usual levels of turnover and churn, we recommend:
        i. Providing financial assistance to community-based providers to help them retain staff (from psychiatrists to milieu staff)
        ii. Training staff to adequately identify, support, and de-escalate children who have experienced trauma, particularly BIPOC children.
        iii. Training staff in the provision of behavioral health supports that are newly virtual and will continue to be available virtually

d. Ensure that schools are adequately resourced to cope with the expected influx of behavioral health needs among students and staff this fall
e. Create enhanced crisis-focused home and community based services

School Mental Health

1. Create a statewide infrastructure dedicated to school behavioral health. All statewide infrastructure should align with *Roadmap* initiatives and prominently consider the family/youth voice.
    a. Such an infrastructure must prioritize high need, low-income districts due to historical inequities
    b. Create a school Behavioral Health Advisory Council as part of the statewide infrastructure
    c. Create regional technical assistance centers that include consultation to teachers, school personnel (other than teachers: paraprofessionals, specialists, administrators, etc.)
2. Provide additional resources to school through influx of federal funding
    a. Help schools design physical spaces for supporting children experiencing dysregulation, where they can calm down to avoid ED use
    b. Add behavioral health staff to schools to support children's behavioral health
    c. Professional development around trauma and de-escalation, particularly important in the context of diversity, equity, and inclusion
3. Establish links between schools and community-based care, particularly working to ensure schools are aware of newly-created CBHCs for children as part of *Roadmap* initiative. Schools must have clear referral processes to the correct community-based care.

COVID-19 Impact

1. Prioritize caring for the depleted behavioral health workforce
    a. Dedicate resources to behavioral health providers to help care for the behavioral health needs of the workforce itself
    b. Provide rate increases that support salary increases for behavioral health clinicians
    c. Diversify the workforce able to provide behavioral health care, including
2. Provide student loan debt relief that is targeted at both new graduates and existing clinicians
3. Provide training and supports to prepare the workforce for meeting the increased demand by implementing evidence-based practices
    a. Adopt group service models and group supervision to expand capacity to meet increased demand
    b. Provide capital and technical assistance to enable providers to employ/expand tele-behavioral health services

Infant and Early Childhood Mental Health

1. Require IECMH endorsement for workforce providing care to young children in the Community Behavioral Health Centers (CBHC), Early Education and Care providers (especially Mental Health Consultation Teams), and home visiting service teams
    a. Create an online foundations on IECMH course to create a baseline level of knowledge around child development and IECMH, in order to better provide prevention and promotion services
    b. Provide access to reflective supervision and consultation
2. Integrate Family Partners (FP) and Community Health Workers (CHW) who are trained in IECMH principles (and a cohort who are multilingual) into the EEC consultation programs and Family Resource Centers
    a. Support career ladders to enable paraprofessional workforce to train to become clinicians (many LAUNCH Family Partners went onto become social workers)
3. Increase salaries of EEC and IECMH workforce, especially given the impact of COVID on these workforces and the increased behavioral health needs among young children and families, necessitating more specialized knowledge
    a. Tie increased salaries to enhanced training in child development, IECMH, trauma-informed care
4. Integrate principles of IECMH into primary care settings
    a. New primary care tiers as part of the 1115 waiver renewal should specifically name and cover IECMH services
    b. Prevention and Promotion Codes from the DC: 0-5 should be supported for billing for preventative services
    c. Create a standard prevention curriculum in primary care so providers are aware of child development and can support parents in early years
    d. Continue to employ telehealth for parenting support
5. Provide direct assistance to families potentially in the form of a child tax credit