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Strategies to Reduce Wait Times and Enhance Access to Behavioral Health Services

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MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH

Executive Summary

The Massachusetts Department of Mental Health (DMH) serves adults and youth whose mental health treatment needs exceed that which is available in other public and private services in the Commonwealth's behavioral health care system, are more clinically complex than those served by the private behavioral health care system, and/or require intensive mental health treatment for extended periods of time.

In recent years, wait times have increased for adults and youth seeking to access DMH's inpatient levels of care. These longer wait times are driven by challenges that affect DMH's ability to rapidly admit individuals and by obstacles preventing timely transition of individuals to community settings. This report will enumerate the obstacles DMH faces regarding timely admission, i.e., its "entry point" challenges, as well as obstacles it faces regarding timely discharge, i.e., "exit point" challenges. In order to reduce wait times for care, DMH has developed strategies to address both categories of issues. This report will summarize DMH's plans to address these challenges in order to reduce wait times and meet the mental health needs of the populations it serves.

Adult System of Care

- **Key Entry Point Challenge:** DMH's state operated inpatient continuing care and community-based capacity is inadequate, as demand for beds has steadily increased while bed capacity has not changed. Capacity constraints at DMH facilities exacerbate "upstream" Emergency Department boarding and acute hospital capacity issues outside of the DMH system, as patients requiring DMH adult services largely wait for care in acute hospital settings.
- **Key Exit Point Challenge:** Constraints in DMH's community residential services continuum contribute to longer wait times. When adults in DMH hospitals have been determined to meet discharge readiness criteria, they need to move into a placement in a community-based program. However, community capacity is limited, and few placements are available.
- **Plan to Reduce Wait Times:** In order to address today's challenges, DMH will increase inpatient capacity by 65 beds, supported by a parallel increase of 500 group living community-based placements – as well as 270 rental assistance and clinical outreach placements– to promote timely discharge and allow DMH clients to safely reside in their communities. In order to address demand from those transitioning from skilled nursing facilities, DMH will also launch a community-based care model that offers intensive medical support in addition to mental health treatment. It will also expand its existing community care options to serve demand from this population.
    - **Key Risk:** Due to the ongoing housing shortage across Massachusetts, increasing the number of community-based placements for adult DMH clients will require a capital investment in housing development. While the exact dollar amount will depend on final siting of the new beds to be added, DMH estimates a range of $40 to 90 million. While investments supporting expanded community treatment have been made, investments to support capital development necessary to secure housing options remain outstanding.

Youth System of Care

- **Key Entry Point Challenge:** The acuity and clinical complexity of youth clients has increased over time, leading DMH to face two key staffing-related challenges. First, DMH struggles with

insufficient levels of direct care staff for its youth client demand. Like other youth-focused behavioral care programs across the state, DMH faces a limited youth-focused provider workforce and resulting staffing shortages. Second, the increasing acuity and clinical complexity of youth clients requires specialized staffing models to manage clients effectively and safely. An already strained workforce has struggled to meet rising client acuity with existing staffing patterns, resulting in further staffing shortages and a need to update DMH's clinical complement.

- **Key Exit Point Challenge:** Children who receive treatment at the Adolescent Continuing Care Unit and IRTP/CIRT have the most complex and severe behavioral health issues in the Commonwealth. Many of these youth are involved with multiple youth-serving systems including the Department of Youth Services (DYS) and the Department of Children and Families (DCF). As a result, most of these youth also require therapeutic educational settings post-discharge which requires coordinating with local educational authorities. This means discharge planning is an incredibly complex and labor-intensive process that can lead to longer lengths of stay. Locating community prescribers who are willing to treat youth with complex medication regimes is also challenging. Finally, community providers and residential and day schools are facing workforce shortages that have limited their capacity to accept step-downs from DMH settings.
- **Plan to Reduce Wait Times:** DMH will strengthen staffing patterns and clinical treatment across its youth programs to adapt to, and better serve, youths' increasingly severe mental health needs. DMH is also executing a multi-pronged workforce development effort to attract new providers while retaining existing providers in youth behavioral health. DMH will also alleviate demand for its inpatient levels of care by continuing to expand the scope and diversity of community-based placements.

Creating a behavioral health system in which individuals and families can achieve and maintain recovery requires investment and coordination across the care continuum. In serving the Commonwealth's most vulnerable residents, DMH is committed to ensuring a safe and highly supportive care environment for our clients so that they may live and thrive in their communities. The strategies described in this report support that commitment, reinforcing the infrastructure that underpins each step of our clients' care pathway.

Background

Chapter 177 of the Acts of 2022, An Act Addressing Barriers to Care for Mental Health, included a provision requiring the Department of Mental Health (DMH) to provide a report outlining strategies to reduce wait times for DMH services. Specifically, the strategies discussed herein aim to reduce the wait time for patients awaiting discharge from acute psychiatric hospitals and units to 30 days following DMH authorization and approval. Such services include inpatient continuing care at a DMH facility or DMH-contracted facility for adults and adolescents, intensive residential treatment programs (IRTP) for adolescents and clinically intensive residential treatment (CIRT) for children, and other community-based placements, such as Adult Community Clinical Services (ACCS) and child/adolescent intensive community services (ICS).

Overview of the DMH System

DMH serves adults experiencing the most serious and persistent mental illness (SMI), as well as youth experiencing serious emotional disturbance, whose treatment needs exceed that which is available in other public and private services and/or are more clinically complex and require more intensive treatment for extended periods of time. Prospective DMH clients must apply to receive DMH services. In addition to confirming the applicant's clinical diagnosis, the authorization process requires validation that other levels of care and community resources are insufficient to meet the individual's needs.

Once authorized to receive services, DMH's clients are engaged in a specialty service delivery system that includes a continuum of levels of care. For adults, this system is designed to promote increasing levels of independence, support for achieving treatment goals, and maintaining recovery within the community. Depending on the adult client's needs, services for adults may include residential placements, community supports, rental assistance, and/or case management, which are adjusted in frequency and intensity, based on need. DMH's services for child and adolescent clients impacted by wait times include inpatient and intensive residential treatment programs. Children receiving these services transition to appropriate step-down services provided by multiple organizations and agencies, which commonly include residential schools, home (or foster home) with intensive community-based treatment services, or group homes funded by DMH, the Department of Child and Family Services (DCF), private payors, and local education authorities.

DMH clients represent a uniquely complex and high-risk population. Because DMH clients require long-term engagement, the turnover rate for DMH's community-based services is low. Therefore, capacity for these services must far exceed capacity for inpatient levels of care to ensure timely discharge and maintain access for new clients.

As described in later sections of this report, DMH capacity can significantly impact access in the broader behavioral health system. Many individuals enter the DMH system through private acute hospitals where they are then referred for application and authorization. Once authorized, new clients often wait for a DMH placement while staying in a private acute hospital. Longer wait times for DMH placements directly translate into longer wait times for the private acute beds resulting in longer ED boarding experiences. Additional impacts specific to the adult and children, youth and families (CYF) systems of care are discussed further below, along with strategies to reduce such impacts.

Adult System of Care

Accessing Care: Entry and Exit Challenges

For adults accessing DMH services for the first time, there are two common entry points to enter the DMH system. As depicted in Figure 1, acute private hospitals and the courts are the most common referral points for the DMH system, often referring adults with SMI to DMH for long-term inpatient care. Once placed into an inpatient setting, DMH inpatient facilities then rely on DMH residential capacity to discharge clients from inpatient care. Most adult DMH clients require placement in a DMH community service to be safely discharged and reside in community settings. In addition, DMH clients access acute and long-term (DMH) inpatient care through the same pathway.

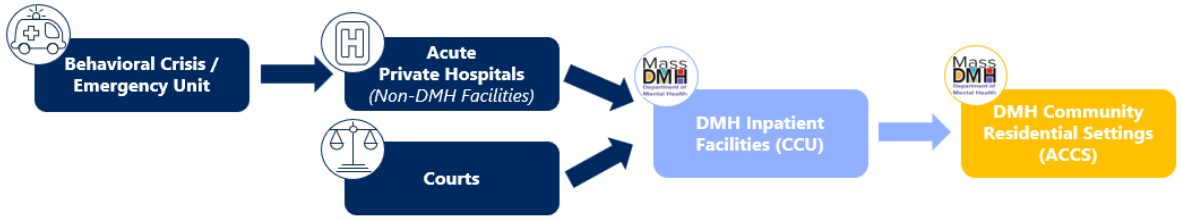

Figure 1. Example of DMH Adult Client Pathway

DMH's ability to admit new patients to its inpatient facilities is impacted by upstream demand. As a result of criminal justice reform, Fiscal Year (FY) 22 saw the volume of court referrals for evaluation to DMH facilities exceed any prior year.[1] DMH is mandated to admit all court-ordered clients, which then constrains the number of referrals DMH inpatient facilities can accept from acute and emergency settings. Criminal justice reform is resulting in the positive impact of diverting people with serious mental illness into treatment. Simultaneously, the clinical acuity and complexity of DMH clients has increased. The average length of treatment required in a DMH long-term inpatient facility increased from 300 days in 2015 to 424 days in 2021.[2] The community and inpatient mental health system are both impacted by this increased volume and acuity and adjustments are needed to meet the demand and provide safe and effective treatment.

To date, this considerable growth in inpatient demand has not been matched by changes in capacity, drastically reducing the ability to accept DMH referrals from acute care. From 2015 to 2021, annual DMH admissions from acute settings declined by 72 percent.[3] As a result, wait time for DMH inpatient care increased from 35 days to 293 days.[4]

DMH's ability to admit new patients to its inpatient facilities is also impacted by "downstream" system capacity. As noted above, increased demand for inpatient care also creates high demand for residential and community placements. Because clients are engaged in residential and community care for much longer periods of time than inpatient care, every new inpatient bed must be matched by a several fold increase in community placements to ensure timely discharge. Without this parallel investment, wait times to access care will continue to climb.

[1] Department of Mental Health. CCU Admissions Data. 2015-2021. Date Accessed: July 2022
[2] Department of Mental Health. CCU Admissions Data. 2015-2021. Date Accessed: July 2022
[3] Department of Mental Health. CCU Waitlist Data. 2015-2021. Date Accessed: July 2022
[4] Department of Mental Health. CCU Waitlist Data. 2015-2021. Date Accessed: July 2022

Importantly, as described in the previous section of this report, maintaining DMH service capacity is also critical to the functioning of the broader behavioral health system. Insufficient capacity within DMH community or inpatient settings creates upstream bottlenecks within the broader system described in Figure 1. Therefore, limited access to DMH services can (1) significantly increase wait times for admission of non-DMH clients in need of acute care, and (2) exacerbate issues with emergency department boarding of individuals waiting for hospital admission. As a result of high demand and inadequate capacity, ED boarding for behavioral health clients has increased substantially. The Massachusetts Health and Hospital Association reported 600-700 individuals boarding in Massachusetts hospital emergency departments each week.[5]

Plan to Reduce Wait Times

For the adult system of care, DMH has planned to execute two critical strategies to reduce wait times for behavioral health care: (1) DMH will expand inpatient capacity to address the demand for new referrals, as well as the clinical acuity and complexity of existing clients, and (2) DMH will expand community capacity to promote timely discharge from inpatient facilities and allow DMH clients to continue to receive care toward their recovery goals within the community. Specifically, three critical types of community placements will be expanded in parallel with inpatient care expansion:

- **Group Living Environment (GLE)**: Provides a range of housing options that serve as treatment settings. GLE programs provide individuals with serious mental illness the support and resources to live successfully in the community.
- **Integrated Team (IT):** Provides outreach clinical interventions, peer support, and family support to individuals residing in community-based settings, including but not limited to independent apartments, family homes, GLEs, shelters, and other settings.
- **Rental Assistance (RA)**: Provides financial subsidies to support client movement toward independence through affordable housing and IT or Program for Assertive Community Treatment (PACT) support.

Table 1 identifies the estimated reduction in wait time under various inpatient and residential capacity expansion scenarios, including the approved investment scenario. Projections include a three-year lead time to achieve operational capacity for all services.

Scenario	Incremental Inpatient Beds Added in Year 3	Incremental Community Placements Added in Year 3	Resulting Estimated % Admission of Civil Clients Authorized for DMH CCU in Year 3	Resulting Estimated Civil Wait Time in Year 3: Authorization to admission
High admission rate	204	GLE: 550 IT & RA: 296	95%	0 days
Mid/High admission rate	93	GLE: 516 IT & RA: 278	75%	8 days
Planned DMH Investment	65	GLE: 509 IT & RA: 273	70%	26 days
Mid/Low admission rate	43	GLE: 501 IT & RA: 270	66%	40 days

[5] Massachusetts Health and Hospital Association. Capturing a Crisis: Massachusetts Behavioral Health Boarding Metrics. October 2021. https://mhalink.informz.net/mhalink/data/images/21-10-08BHreportNEW.pdf

CY15-19 average admission rate	0	N/A	59% (actual)	72 days (actual)
CY21 admission rate	0	N/A	21% (actual)	109 days (actual)

Table 1. Impact of Planned Capacity Expansion on Inpatient Wait Time

The planned level of investment described above represents a 10 percent increase in inpatient capacity from the current state. This increase is expected to reduce average wait times for DMH inpatient care by over 100 days and increase admissions to DMH inpatient facilities from private acute hospitals by over 200 percent compared to Calendar Year (CY) 21. Larger investments in bed capacity beyond the level planned are frustrated by the constrained availability of myriad resources, including providers, hospital capacity, and crucially, housing availability.

In addition to the planned investments in DMH bed capacity and community placements, the Commonwealth of Massachusetts has made significant investment in measures to improve access into the behavioral health delivery system, specifically: a statewide single point of entry call center, the Behavioral Health Helpline (BHHL), with live triage and assessment capacity on a 24/7 basis, a network of Community Behavioral Health Centers with 24/7 capacity for community-based crisis intervention and performance specifications requiring police drop off. With these system improvements, DMH has the opportunity to collaborate and offer services to people with serious mental illnesses who may not have felt comfortable or supported in seeking help in the past. Earlier intervention with those who may otherwise become involved in the criminal justice system promotes better outcomes for individuals and supports safer communities.

Finally, DMH also anticipates increased demand from individuals with serious mental illness who seek to transition from nursing home care to community-based treatment. In order to address demand from those transitioning from skilled nursing facilities, DMH will launch a community-based care model that offers intensive medical support in addition to mental health treatment. It will also expand its existing community care options to serve demand from this population. These strategies will help avoid additional capacity constraints in the community system caused by growing community demand, which in turn helps address discharge-related bottlenecks in the inpatient system.

Housing

Housing Needed to Reduce Wait Times

As noted above, most DMH adult clients require placement in a residential, community-based setting to transition from inpatient care. Research supports that housing with appropriate clinical supports, such as that provided in a group living setting and/or affordable housing (DMH rental assistance) with IT/PACT, can significantly improve both engagement with health care and outcomes for individuals with SMI. [6]

Increasing capacity for such group living in Massachusetts is challenged by the well-documented housing shortage impacting communities across the Commonwealth. A 2022 report estimated total housing underproduction in Massachusetts of 108,000 homes.[7] With competition for existing properties at an

[6] Bausch, Julia C., Alison Cook-Davis and Benedikt Springer. "Housing is Health Care": The Impact of Supportive Housing on the Costs of Chronic Mental Illness. Phoenix, AZ: The Arizona Board of Regents for and on behalf of Arizona State University and its Morrison Institute for Public Policy at the Watts College of Public Service and Community Solutions, 2021.

[7] Up for Growth. Housing Underproduction in the US 2022. https://upforgrowth.org/

all-time high, state-level support for development of new residential settings will be critical to the success of the overall wait time reduction strategy.

To provide a timely and supportive discharge placement for clients discharged from inpatient care, the group living placements must grow by approximately 500 beds, as described earlier in this report. This program is currently operating at full capacity and will require an investment in housing development to meet the identified need. While actual costs will vary by site location, development costs below were estimated using a regional distribution of 6-, 9-, 12-, and 25-bed residential buildings with varying combinations of single and double bed occupancy units. Table 2 summarizes three investment scenarios and their associated assumptions. Cost estimates were calculated using the construction estimate database, RS Means by Gordian.

Scenario Variables	Low Cost	Mid-Range	High Cost
Building Mix	9- and 12-bed GLE	Current Distribution[8]	6-bed GLE and 25-bed SIE
Single Occupancy	25%	50%	75%
Double Occupancy	75%	50%	25%
Americans with Disabilities Act (ADA) Compliant 6-bed GLE			ADA Compliant
Total Cost[9]	**$39,649,511**	**$55,940,918**	**$90,000,053**

Table 2. **Estimated Housing Development Investment Range**

Youth System of Care

Accessing Care: Entry and Exit Challenges

Youth who need long-term intensive treatment via DMH's Continuing Care Unit (CCU) for adolescents, Intensive Residential Treatment Program (IRTP), or Clinically Intensive Residential Treatment (CIRT) program enter the DMH system following a similar pathway as adults. DMH's CCU, CIRT, and IRTP programs discharge youth clients to appropriate step-down services, which commonly include residential schools, home (or foster home) with intensive community-based treatment services, or to a group home funded by DMH or DCF.

[8] Department of Mental Health. Mental Health Services data. FY23. Date Accessed: November 28, 2022. Distribution based on the relative number of beds currently operating in five cities geographically dispersed across Massachusetts (Boston, Lowell, New Bedford, Springfield, Worcester).

[9] Gordian. RS Means Data. December 16, 2022. RS Means construction database is updated quarterly for major metropolitan areas. Includes city cost indices, average crew compositions, and average contractor overhead allocations.

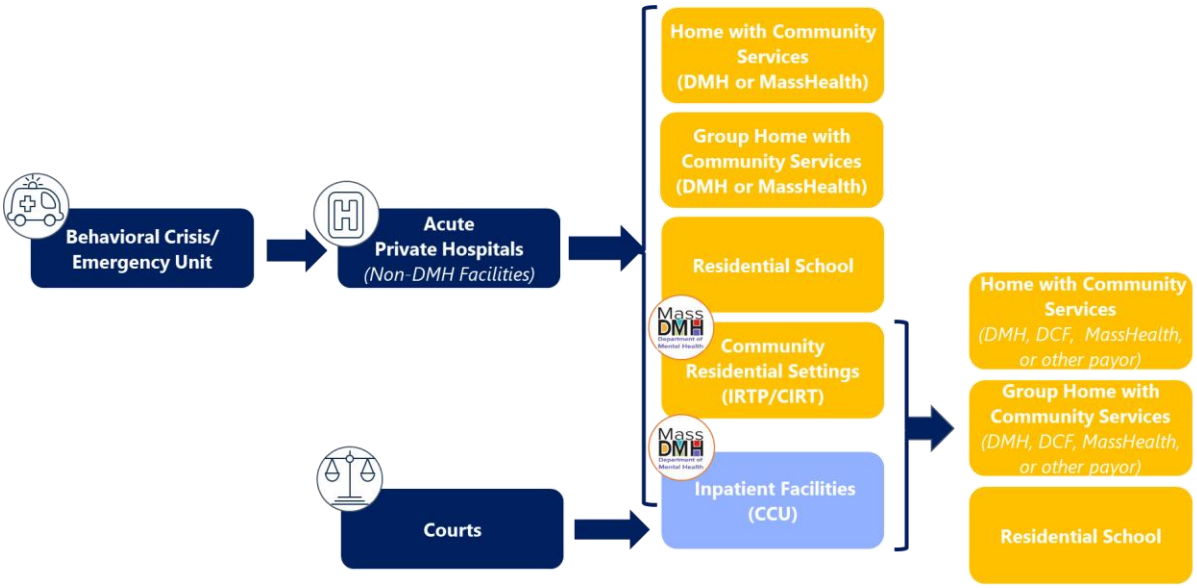

Figure 2. Youth Client Pathway[10]

Similar to DMH's adult system, DMH's youth system of care faces drivers of wait times pertaining to both "entry point", i.e., timely admissions, and "exit point", i.e., timely discharges. Regarding entry-related issues, in recent years, DMH inpatient and intensive residential facilities have experienced an increase in the clinical complexity, clinical acuity, and behavioral dysregulation of admitted clients, including specific increases in the rate of neurodevelopmental co-morbidities and behavioral issues. For the IRTP program, this increased complexity is resulting in need for varied staffing enhancements to achieve more engagement and stabilization, and reduce risk of harm. The enhanced staffing includes care coordination, after hours psychiatry, occupational therapy, and direct care staff.

Not only do DMH's youth programs face needs to adapt their staffing models, but they also face staffing shortages overall. Even if acuity had not increased over time, DMH's inpatient and intensive residential programs would struggle with shortages in behavioral health care staff, as DMH struggles with workforce issues common to all youth-focused behavioral health programs. Coupled with a need to change staffing models to be responsive to the increasing acuity of patients, workforce constraints drive increased wait times. For IRTP, for instance, a 20 percent decline in staffing corresponded to a wait time that has more than doubled over the same period.[11] For both youth and adult populations, the impact of clinical complexity, acuity and behavioral dysregulation on mental health provider burnout is well-documented.[12,13] Rising acuity of the youth client population combined with national workforce shortages in youth behavioral health have created an urgent need to invest in our youth behavioral health workforce.[14]

[10] DMH also has a Memorandum of Understanding with the Department of Youth Services to allow a small number of individuals to be directly admitted to an IRTP.
[11] Ibid. Note: CCU saw a precipitous drop in both wait time and clients during FY21 as a result of COVID-19. Trend analysis excludes this data point.
[12] Hensel JM, Lunsky Y, Dewa CS. The mediating effect of severity of client aggression on burnout between hospital inpatient and community residential staff who support adults with intellectual disabilities. J Clin Nurs. 2014 May;23(9-10):1332-41. doi: 10.1111/jocn.12387. Epub 2013 Oct 15. PMID: 24128052.
[13] Practice Research and Policy Staff. (2018, January 25). Research roundup: Burnout in mental health providers. *PracticeUpdate*. https://www.apaservices.org/practice/update/2018/01-25/mental-health-providers.
[14] National Council for Mental Wellbeing (January 2022). Behavioral health workforce is a national crisis: Immediate Policy Actions for States. https://www.thenationalcouncil.org/wp-content/uploads/2022/01/Behavioral-Health-Workforce-is-a-National-Crisis.pdf.

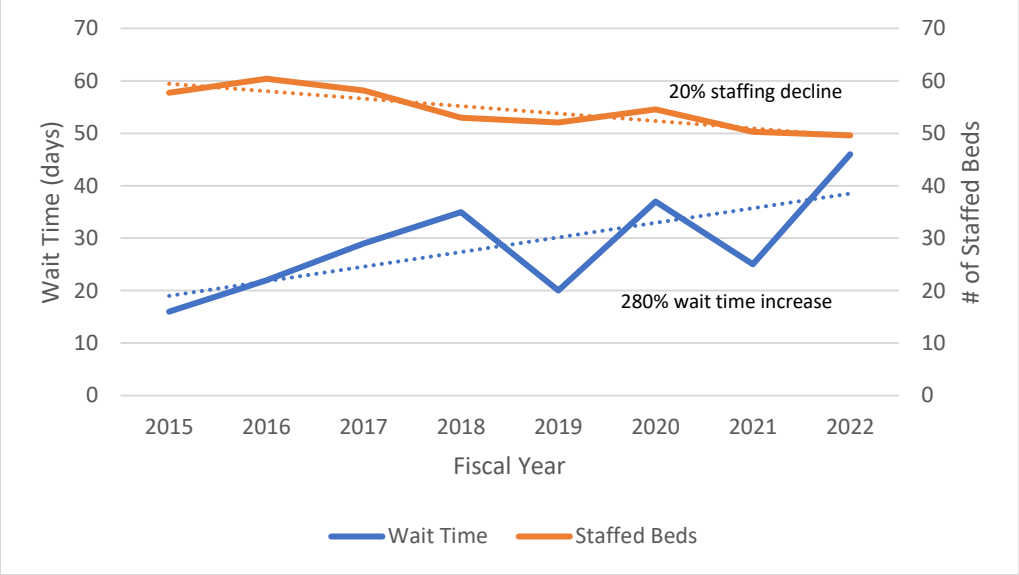

Figure 3. IRTP Wait Time versus Staffed Beds

In addition to obstacles to timely admission, DMH inpatient and intensive programs face challenges to timely discharge. Children who receive treatment at the Adolescent Continuing Care Unit and IRTP/CIRT have the most complex and severe behavioral health issues in the Commonwealth. Many of these youth are involved with multiple youth-serving systems including DYS and DCF. As a result, most of these youth also require therapeutic educational settings post-discharge which requires coordinating with local educational authorities. This means discharge planning is an incredibly complex and labor-intensive process that can lead to longer lengths of stay. Locating community prescribers who are willing to treat youth with complex medication regimes is also challenging. Finally, community providers and residential and day schools are facing workforce shortages that have limited their capacity to accept step-downs from DMH settings. In addition to staff augmentation for inpatient and intensive residential settings, community program placements are key to ensuring that clients have timely access to the least restrictive setting that best meets their needs. Several current community placements – including therapeutic group homes, staffed young adult apartments, and intensive home-based therapeutic care – are executing strategies to meet this need. It is important to note that community based residential programs are experiencing similar shifts in clinical complexity and behavioral dysregulation with newly referred clients and are also experiencing staffing constraints.

Plan to Reduce Wait Times

As described above, youth wait times to access care have not been driven so much by limitations regarding the total number of licensed beds as much as limitations in staffing levels and models to treat an increasingly complex population of children and adolescents. While the current capital infrastructure (i.e., total licensed bed capacity) can accommodate future surges in demand, workforce size as well as appropriately designed staffing models are both rate-limiting factors and therefore key targets for investment across inpatient, residential, and intensive community-based levels of care. As a result, DMH has planned changes to its staffing model for its IRTP program and is actively adapting its approaches to staffing its other inpatient and residential programs to meet clinical acuity.

In addition to program-specific staffing model enhancements, addressing workforce shortages for youth services requires a multi-faceted plan that includes tactics aimed at both recruitment of new providers

and retention of existing providers. Key elements of this plan are currently underway in the Commonwealth as described below:

- **Enhancing Rates for IRTP/CIRT services**: To support the more complex scope of practice now required of these facilities, DMH will move forward with reimbursement rate enhancements for IRTP/CIRT providers beginning in FY24. The new rate will allow IRTP/CIRT programs to augment their teams with additional staff. The planned staffing enhancements are designed to better respond to clinical complexity and behavioral dysregulation, to achieve stabilization more effectively, and to reduce risks. The projected workforce impact is associated with making treatment settings more effective and safer.
- **American Rescue Plan Act (ARPA) Funded Workforce Investments**: The Commonwealth has allocated $110 million in funding to establish a loan repayment assistance program for mental health professionals as well as $11.6 million for a mental health nurse practitioner fellowship program. For health care providers, loan repayment programs have been shown to foster higher retention rates, job satisfaction, and propensity to practice in needier areas serving largely Medicaid and uninsured populations.[15]
- **Substance Abuse and Mental Health Services Administration (SAMHSA) Grant Funding:** DMH is leveraging $2 million in federal SAMHSA grant funding to provide behavioral health internship stipends to those interested in entering the field.
- **Expanding Post-Doctoral Fellowships:** To support and expand access to doctoral level providers for our community, DMH has also expanded the number of slots available in its psychology and psychiatry post-doctoral fellowship programs.
- **Medicaid 1115 waiver**: MassHealth's recently approved 1115 waiver will also infuse the system with federal matching funds to support a broad spectrum of behavioral health provider student loan repayment programs.

Beyond the core workforce strategies described above, DMH is further addressing wait times for services by (1) expanding the diversity and footprint of community services, and (2) implementing process improvements to reduce the administrative impact of authorization approvals.

In December 2022, contracts began for 100 slots of PACT teams for youth providing an opportunity to expand the availability of intensive home and community-based services for youth with the most complex behavioral health challenges.[16] DMH also plans to re-bid its therapeutic group care (TGC) contracts in the Northeastern region of the Commonwealth in 2023, after receiving no successful bids in 2022. If contracts are awarded, this will improve regional access to TGC. With respect to process improvements, DMH is seeking to reduce the time between transfer screening requests and decisions on transfer screening applications as well as provide updated and more accessible training for acute hospitals on the DMH section 3 transfer screening process.

Summary and Recommendations

The adult and youth systems of care are experiencing longer wait times for services, driven by trends that complicate timely admission and discharge for both systems. DMH has planned or enacted

[15] Pathman, Donald E. MD, MPH[*†]; Konrad, Thomas R. PhD[*]; King, Tonya S. PhD[‡]; Taylor, Donald H. Jr. PhD[§]; Koch, Gary G. PhD[‖]. Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians. Medical Care: June 2004 - Volume 42 - Issue 6 - p 560-568 doi: 10.1097/01.mlr.0000128003.81622.ef

[16] The ultimate goal for youth PACT placements is 120. DMH did not receive a successful bidder for the Worcester service area and plans to repost the opportunity in CY 2023.

strategies to address these key drivers such as wait times but looks for further opportunities to work with partners to address housing shortages constraining growth of community-based programs. This essential gap will need to be addressed in the near term so that the system can expand capacity.

Adult System of Care

- **Key Challenges:** DMH's inpatient and community-based capacity is inadequate, as demand for beds has steadily increased while bed capacity has not changed. Community capacity is inadequate to facilitate timely discharge.
- **Plan to Reduce Wait Times:** DMH will increase inpatient capacity by 65 beds, supported by a parallel increase of 500 group living community-based placements – as well as 270 rental assistance and Integrated Team (IT) placements – to promote timely discharge and allow DMH clients to safely reside in their communities.
    - **Key Risk:** Due to the ongoing housing shortage across Massachusetts, increasing the number of community-based placements for adult DMH clients will require a capital investment in housing development. While the exact dollar amount will depend on final siting of the new beds to be added, DMH estimates a range of $40 to 90 million.

      Housing also poses a risk to implementing DMH's proposed investments in community programs, as location development is often a process. Not only does securing the financial support required for housing development take time, but time is needed to identify and develop new residential settings. The time needed to both secure funding and execute new housing developments is a key risk to the community-based care expansion that will need to be managed.

    - **Other Risks:** Other potential risks to DMH's plans include demand for beds from the criminal justice system outpacing DMH's capacity to add beds. Courts can refer individuals for court-ordered treatment or evaluation more quickly than DMH can add staff, beds, and other resources necessary to keep pace with the demand. Demand from the newly launched Community Behavioral Health Centers statewide, will increase demand and may outpace its ability to fully meet the needs of Commonwealth residents.

Youth System of Care

- **Key Challenges:** The acuity and clinical complexity of youth clients have increased over time, requiring additional, specialized staffing to manage effectively. An already strained workforce has struggled to meet this demand, resulting in staffing shortages that leave licensed beds unable to be filled.
- **Plan to Reduce Wait Times:** DMH will enhance staffing models so that DMH can provide care safely to a population with increasing acuity and complexity, invest in a multi-pronged workforce development effort to attract new providers while retaining existing providers in youth behavioral health, alleviate inpatient demand by continuing to expand the scope and diversity of community-based placements, and implement process improvements to reduce administrative approval times.