

SENATE No. 72

The Commonwealth of Massachusetts

PRESENTED BY:

Brendan P. Crighton

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act ensuring access to behavioral health services for children involved with state agencies.

PETITION OF:

NAME:

Brendan P. Crighton

DISTRICT/ADDRESS:

Third Essex

SENATE No. 72

By Mr. Crighton, a petition (accompanied by bill, Senate, No. 72) of Brendan P. Crighton for legislation to ensure access to behavioral health services for children involved with state agencies. Children, Families and Persons with Disabilities.

The Commonwealth of Massachusetts

**In the One Hundred and Ninety-Third General Court
(2023-2024)**

An Act ensuring access to behavioral health services for children involved with state agencies.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. Section 21 of chapter 19 of the General Laws, as appearing in the 2020
2 Official Edition, is hereby amended by striking out the fifth sentence and inserting in place
3 thereof the following two sentences:-

4 Pursuant to such agreements the department of mental health shall assume responsibility
5 for individuals requiring specialized mental health services, including, but not limited to,
6 inpatient mental health services, community-based acute treatment, intensive community-based
7 acute treatment, mobile crisis intervention, intensive residential treatment programs, and crisis
8 stabilization services. Pursuant to such agreements the department of mental health may assume
9 responsibility for the provision of other non-mental health services to the department of
10 developmental services.

11 SECTION 2. Section 33C of chapter 119 of the General Laws, as so appearing, is hereby
12 amended by inserting after subsection (b) the following four new subsections: -

13 (c) The department, in consultation with the department of public health and the
14 department of mental health, shall develop a model emergency response plan that includes both
15 medical and behavioral health crisis response in order to promote best practices for congregate
16 care settings, including clear guidelines for the roles and responsibilities of staff in congregate
17 care settings, including but not limited to, protocols to access mobile crisis intervention, and,
18 where applicable, youth crisis stabilization services, and community-based mental health
19 providers; provided, however, that such model plan shall be designed to limit referrals to law
20 enforcement in congregate care settings to cases in which an imminent risk of death or serious
21 physical, emotional, or mental harm to individuals or damage to congregate care property
22 necessitates such referral.

23 The model plan shall be made available to all congregate care settings, provided the
24 department shall support the congregate care setting in adapting said plan for implementation. In
25 developing the model plan, the department shall consult with the department of mental health,
26 the department of public health, the executive office of health and human services, the office of
27 the child advocate, and other relevant organizations that identify the essential components of an
28 emergency response plan. The department shall biennially review and update the model plan,
29 publicly post the model plan on its website, and provide technical assistance to congregate care
30 settings to review and implement changes to model emergency response plan. The model plan
31 shall include, but not be limited to, required access to training in behavioral health for staff in
32 behavioral and mental health competencies, including, but not limited to, de-escalation
33 strategies, trauma-informed, culturally, and linguistically congruent care, suicide prevention,
34 peer support, and available resources and methods of outreach to non-clinical and clinical
35 services related to behavioral and mental health.

36 (d) A congregate care program under contract to provide foster care to children in the
37 care or custody of the department, in consultation with the department, shall ensure the
38 implementation of an emergency response plan for said setting; provided the congregate care
39 program may adapt the department's model emergency response plan to fit the needs of the
40 setting; provided further, the congregate care program shall biennially review the plan. The plan
41 shall be made available to the department upon request.

42 (e) A child in the care or custody of the department has the right to return to their
43 congregate care program under contract to provide foster care to children in the care or custody
44 of the department following a medical or non-medical leave of absence if it is determined
45 appropriate for the child to return to the congregate care setting. The department shall reimburse,
46 at the prevailing rate of reimbursement, the congregate care program to hold the bed of a child
47 for each day of their hospitalization or other leave of absence from the program.

48 (f) If a child requires care in another setting, including, but not limited to an emergency
49 department visit or a stay in an inpatient setting, community behavioral health center, intensive
50 community based acute treatment, community based acute treatment, or community crisis
51 stabilization, a congregate care program, under contract to provide foster care to children in the
52 care or custody of the department, shall not refuse to readmit a child living in that congregate
53 care program after a medical or non-medical leave of absence, including an emergency or acute
54 behavioral or psychiatric circumstance, provided that the child has been determined medically
55 and psychiatrically stable and provided further, it is appropriate for the child to be discharged to
56 return to their congregate care program. A congregate care program may deny readmission to a
57 child whose needs have been determined by the program's director or clinical director to exceed
58 the program's capability at the time readmission is sought; provided the program reports the

59 denial of readmission of the child to said program to the department of children and families
60 pursuant to section 33D. The determination shall be recorded in writing and shall include the
61 factors justifying the denial and why mitigating efforts would have been inadequate to address
62 the care needs of the child.

63 The congregate care program shall participate in the emergency team pursuant to section
64 33D; provided further the department shall assume responsibility to coordinate care for the child.

65 SECTION 3. Chapter 119, as so appearing, is hereby amended by inserting after section
66 33C, the following new section: -

67 33D. (a) The department of children and families shall collect data on the instances when
68 a congregate care program, under contract to provide foster care to children in the care or
69 custody of the department, denies to readmit a child after a circumstance requiring care in
70 another setting, including, but not limited to an emergency department visit or a stay in an
71 inpatient setting, community behavioral health center, intensive community based acute
72 treatment, community based acute treatment, or community crisis stabilization. A congregate
73 care program shall report to the department when it denies readmission to a child after a medical
74 or non-medical leave of absence, including an emergency or acute behavioral or psychiatric
75 circumstance. Such report shall include, but not be limited to, i) instances when a congregate
76 care program denies readmission of a child following a medical or non-medical leave of absence,
77 (ii) the underlying factors justifying denial of readmission of the child to a congregate care
78 program, and (iii) why mitigating efforts would have been insufficient.

79 The department shall post to the department's website, on a quarterly basis, a report on
80 the data collected in this section. To the extent feasible, all data shall be disaggregated by race,

81 ethnicity, gender identity, age and other demographic information. The department shall provide
82 a copy of the report to the executive office of health and human services; the joint committee on
83 mental health, substance use and recovery; and the joint committee on children, families and
84 persons with disabilities.

85 (b) At the request of the congregate care program or the setting where the child is
86 awaiting discharge from, the department shall convene an emergency team within two business
87 days to conduct planning discussions to facilitate child placement in an appropriate setting. The
88 emergency team shall include, but not be limited to, a representative from the child’s clinical
89 care team, including, but not limited to, the team currently caring for the child; the child’s
90 current behavioral health provider and primary care provider, as applicable; a representative of
91 the relevant congregate care program; a representative of the department; and the child’s legal
92 guardian, if applicable. If the team does not determine an appropriate placement within 7 days of
93 convening, or earlier if the department deems additional state-agency involvement is necessary,
94 the department may refer the child to the complex case resolution panel pursuant to section 16R
95 of chapter 6A, as inserted by chapter 177 of the Acts of 2022, provided the department report to
96 the panel a written summary of the team’s determination to refer the case to the complex case
97 resolution panel.

98 SECTION 4. Notwithstanding any general or special law to the contrary, the department
99 of children and families shall prepare a comprehensive plan to address access to behavioral and
100 mental health services for individuals in their custody or care. The plan shall include, but not be
101 limited to: (i) strategies to expand access to post-hospitalization settings, including but not
102 limited to, services for transitional age youth, youth with complex behavioral health needs, youth
103 with autism spectrum disorders, youth with intellectual or developmental disabilities, youth with

104 co-occurring behavioral and substance use disorders, youth with co-occurring behavioral and
105 medical needs, school-based services, and respite services; (ii) strategies to reduce the wait times
106 for patients awaiting discharge so that the patients determined appropriate for congregate care,
107 intensive residential treatment programs, community-based programs or other appropriate
108 settings would be admitted to the appropriate setting within fourteen days of their application;
109 and iii) strategies to facilitate care coordination between the department and local education
110 agencies including, but not limited to, recommendations for streamlined communications
111 between local and out-of-district schools, community partners, and other residential-educational
112 settings. The department of children and families shall submit a copy of the plan, including any
113 budgetary needs, to the executive office of health and human services; the clerks of the senate
114 and house of representatives; the joint committee on mental health, substance use, and recovery,
115 and; the joint committee on children, families, and persons with disabilities within 60 days of the
116 effective date of this act.

117 SECTION 5. Notwithstanding any general or special law to the contrary, the department
118 of developmental services shall prepare a comprehensive plan to address access to behavioral
119 and mental health services for individuals in their custody or care. The plan shall include, but not
120 be limited to: (i) strategies to expand access to post-hospitalization settings, including but not
121 limited to, services for transitional age youth, youth with complex behavioral health needs, youth
122 with autism spectrum disorders, youth with intellectual or developmental disabilities, youth with
123 co-occurring behavioral and substance use disorders, youth with co-occurring behavioral and
124 medical needs, school-based services, and respite services; (ii) strategies to reduce the wait times
125 for patients awaiting discharge so that the patients determined appropriate for congregate care,
126 intensive residential treatment programs, community-based programs or other appropriate

127 settings would be admitted to the appropriate setting within fourteen days of their application;
128 and iii) strategies to facilitate care coordination between the department and local education
129 agencies including, but not limited to, recommendations for streamlined communications
130 between local and out-of-district schools, community partners, and other residential-educational
131 settings. The department of developmental services shall submit a copy of the plan, including
132 any budgetary needs, to the executive office of health and human services; the clerks of the
133 senate and house of representatives; the joint committee on mental health, substance use, and
134 recovery, and; the joint committee on children, families, and persons with disabilities within 60
135 days of the effective date of this act.

136 SECTION 6. There shall be a special commission established for the purposes of making
137 an investigation and study relative to children and adolescents with intensive behavioral health
138 needs whose behavioral health needs, such as acute aggressive, assaultive or otherwise unsafe
139 behaviors, are not adequately addressed through inpatient psychiatric hospitalizations,
140 community based acute treatment (CBAT) services, or existing residential or community
141 treatment models contracted by the Department of Children and Families.

142 The Commission shall consist of 25 members or their designees: the Secretary of Health
143 and Human Services or a designee, who shall serve as chair; the Commissioner of Public Health
144 or a designee; the Commissioner of the Department of Children and Families or a designee; the
145 Commissioner of the Department of Youth Services or a designee; the Commissioner of the
146 Department of Developmental Service or a designee; the Commissioner of the Department of
147 Early Education and Care or a designee; Chief Justice of the Juvenile Court Department or a
148 designee; the Chairs of the Joint Committee on Mental Health, Substance Use and Recovery or
149 their designees; the Chairs of the Joint Committee on Children, Families and Persons with

150 Disabilities or their designees; a representative from the Office of the Child Advocate; a
151 representative from the Association for Behavioral Healthcare, Inc.; a representative from the
152 Massachusetts Health & Hospital Association; a representative from the Massachusetts
153 Association of Behavioral Health Systems; a representative from the Children’s Mental Health
154 Campaign; a representative from the Children’s League of Massachusetts; a representative from
155 the Parent/Professional Advocacy League; a representative from the Massachusetts Behavioral
156 Health Partnership; 6 members to be appointed by the chair, 2 of whom shall be a family
157 member of a child or adolescent with behavioral health needs or who has been involved in the
158 juvenile court system; 3 of whom shall be a behavioral health provider specializing in serving
159 children and adolescents with intensive behavioral health needs; and 1 of whom shall be a
160 clinician or researcher with expertise related to children and adolescents with intensive
161 behavioral health needs. In making appointments, the Secretary shall, to the maximum extent
162 feasible, ensure that the Commission represents a broad distribution of diverse perspectives and
163 geographic regions.

164 The Commission shall: (i) create aggregate demographic and geographic profiles of
165 children and adolescents with intensive behavioral health needs; (ii) examine the current
166 availability of, and barriers to providing, behavioral health services and treatment to children and
167 adolescents with intensive behavioral health needs; (iii) examine existing efforts undertaken by
168 healthcare providers and the existing body of research around best practices for treating children
169 and adolescents with intensive behavioral health needs; including, but not limited to models that
170 promote community involvement and diversion from the juvenile court system; and (iv) examine
171 other matters deemed appropriate by the Commission.

172 All appointments shall be made not later than 30 days after the effective date of this act.

173 The Commission shall submit its findings and recommendations to the Clerks of the
174 Senate and the House of Representatives, the Joint Committee on Mental Health, Substance Use
175 and Recovery, the Joint Committee on Children, Families and Persons with Disabilities and the
176 Senate and House Committees on Ways and Means not later than January 1, 2024. The Secretary
177 of Health and Human Services shall make the report publicly available on the website of the
178 Executive Office of Health and Human Services.