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Summary of Comments from Public Hearings on:

Crisis Services in the Commonwealth

Prepared for:

Executive Office of Health and Human Services
Executive Office of Public Safety and Security

EOHHS

Prepared by:

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Mar. 27, 2024

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Acronyms Used in this Summary

Acronym	Description
ASL	American Sign Language
BH	Behavioral Health
CART	Communication Access Real-Time Translation
CBHC	Community Based Health Centers
LEP	Limited English Speaker
EOHHS	Executive Office of Health and Human Services
EOPSS	Executive Office of Public Safety and Security

I. Introduction

As part of the Acts of 2020[1], the Massachusetts legislature established the Community Policing and Behavioral Health Advisory Council (Council). The legislature directed the Council to study and make recommendations for the creation of a crisis response and continuity of care system to deliver alternative crisis services outside of the emergency department which should reflect the diverse regional culture and norms. They also requested that the Council prepare and publish a report of the study findings and recommendations and solicit public comment by holding not less than four public hearings, with at least holding one in Berkshire, Franklin, Hampshire, or Hampden counties and one in the Worcester area.

Upon conclusion of the study, the Council published the report on Crisis Services in the Commonwealth[2] containing the findings and recommendations on crisis services in the Commonwealth on the Executive Office of Health and Human Services (EOHHS) website on Nov. 9, 2023.

In accordance with the legislative requirements in December, four (4) public meetings were held, one in Springfield and Worcester on Dec. 5, 2023, one in Roslindale on Dec. 12, 2023, and one virtual meeting held via Zoom on Dec. 13, 2023. The in-person meetings were held at public libraries to ensure that (1) there was easy access to parking and public transportation, (2) the building would meet accessibility standards, and (3) that a meeting space would be available and have the audio/visual equipment necessary to conduct the meeting. The Council advertised the schedule of meetings on the Executive Office of Public Safety and Security (EOPSS) website and through email correspondence to key entities and individuals that participated in the development of the report. They provided accessibility accommodations for each session, including the virtual meeting, that included language translation for Limited English Speaker (LEP) and American Sign Language (ASL) interpreters as well as Communication Access Real-Time Translation (CART) services. See *Appendix C for more information on the public meetings*.

[1] Session Law - Acts of 2020 Chapter 253 (malegislature.gov)

[2] Report of the Community Policing and Behavioral Health Advisory Council in accordance with Section 117 of Chapter 253 of the Acts of 2020 and Section 25 of Chapter 19 (mass.gov)

II. Summary of Public Hearing Testimony

The Council's study identified four major themes based on the information received through key informant interviews and a national landscape analysis, addressing the need to build a robust BH crisis response in Massachusetts. The four major themes that emerged included the need to:

- Design and implement a unified approach to crisis services across sectors to alleviate system confusion, implementation inconsistencies, service delivery gaps, and cross-system communication challenges.
- Expand on the system capacity being developed to meet demand and be managed in the face of a workforce crisis.
- Better use peer support in crisis prevention, response, and post-crisis care.
- Have an organized and detailed implementation strategy to support and inform crisis system operations.

Based on these findings and best practices, key informant contributions, and the reforms currently in development, the Council's report provided three recommendations. The recommendations were:

1. Develop a governance entity that enhances cross-sector collaboration at the state and regional levels.
2. Create a statewide behavioral health workforce strategy, which enhances the capacity and ability of behavioral health (BH) providers to provide alternative emergency services and programs for BH crises across the commonwealth.
3. Develop an organized and detailed implementation strategy in coordination with MassHealth, the Department of Mental Health, the Department of Public Health, EOPSS, and Statewide 911.

The Council's report contained verbal and written testimony with demonstrated support for study findings and recommendations. Two of the written testimonies strongly recommended the creation of a statewide behavioral health workforce strategy and the establishment of single governance entity under the co-direction of the Secretaries of EOHHS and EOPSS to align and integrate the public health and EOHHS responses to behavioral health. Other public input also singled out support for enhanced use of peer support, standardized guidance, and support for local entity local entities to implement 911 diversion for BH crises, and the availability and use of community-based services.

One testimony raised a concern that the recommendations included a consideration to change the current system in which embedded staff in community behavioral health centers (CBHCs) are responsible for dispatching the mobile intervention teams to having the Behavioral Health Helpline (BHHL) be the centralized dispatch for mobile crisis intervention (MCI). Council co-

chairs reached out and sent a written response on March 18, 2024 (see Appendix G). The response clarified every mention of central operations of BH crisis services in the report and reemphasized that there is no recommendation by the Council to centralize MCI dispatch through the BHHL in lieu of CBHC's dispatching their MCI teams. On March 19th ABH acknowledged the response via email thanking the co-chairs for their response, thoughtful review and clarification that there were no recommendations to centralize MCI dispatch through BHHL.

III. Appendices

Appendix A: Section 117 of Chapter 253 of the Acts of 2020

SECTION 117. (a) The community policing and behavioral health advisory council, established in subsection (e) of section 25 of chapter 19 of the General Laws, shall study and make recommendations for creating a crisis response and continuity of care system that delivers alternative emergency services and programs across the commonwealth that reflect specific regional, racial, ethnic, and sexual orientation needs and differences in delivering such services. The study shall include, but not be limited to: (i) a comprehensive review and evaluation of existing crisis intervention, alternative emergency response and jail diversion models, services and programs in the commonwealth at the state, county and municipal level and models used effectively in other jurisdictions; (ii) a method for evaluating the effectiveness of existing crisis intervention, alternative emergency response and jail diversion models, services and programs in diverting individuals from the criminal justice system and emergency departments to appropriate care; (iii) recommendations for expanding effective crisis intervention and jail diversion models, services and programs identified in clause (ii) across the commonwealth; (iv) identification of crisis response training programs and protocols for law enforcement officers and 911 telecommunicators that reflect best practices and a plan for standardizing systems and aligning such programs and protocols across the commonwealth; (v) identification of outcome measurements and data collection procedures to be used to evaluate the effectiveness of the crisis response system and its components; (vi) an analysis of the federal Substance Abuse and Mental Health Services Administration national guidelines for behavioral health crisis care, including regional crisis call centers and mobile crisis teams; and (vii) an estimate of the additional costs or cost savings of implementing the council's recommendations under this section and possible sources of funding for delivering the crisis response and continuity of care system at the state, county and municipal levels. In developing recommendations for a crisis response and jail diversion system, the council, where appropriate, shall prioritize non-police community-based programs.

(b) The council may commission an independent research or academic organization with expertise in clinical social work, criminal justice, behavioral health jail diversion modalities and accessible analysis of quantitative and qualitative data and communication of study results to conduct the study. The council shall facilitate the collection of data needed to complete the study pursuant to a memorandum of understanding with the department of mental health, the executive office of public safety and security, the Executive Office of Health and Human Services and relevant social service agencies.

(c) The study shall be designed in consultation with interested stakeholders, including, but not limited to, the president of the National Association for the Advancement of Colored People New England Area Conference, the American Civil Liberties Union of Massachusetts,

Inc.; the National Association of Social Workers, Inc.; the Massachusetts Association for Mental Health, Inc.; the Association for Behavioral Healthcare, Inc. and members of the general court.

(d) Not later than July 1, 2022, the council shall submit the study's findings to the clerks of the Senate and House of Representatives, the joint committee on mental health, substance use and recovery, the joint committee on public health, the joint committee on health care financing, the joint committee on public safety and homeland security and the center for responsive training in crisis intervention established pursuant to section 25 of chapter 19 of the General Laws. The study's findings shall be published on the department of mental health's website. Not later than 3 months after receiving the study's findings, the council shall solicit public comment and hold not less than 4 public hearings, 1 of which shall be held in Berkshire, Franklin, Hampshire or Hampden County and 1 of which shall be held in the Worcester area.

(e) The council shall report on existing and innovative crisis response models and recommend legislation or regulations to advance and strengthen non-police solutions to crisis response and jail diversion. The report shall incorporate the study's findings and issues raised in public comments and hearings. The report and recommendations shall be submitted to the clerks of the Senate and House of Representatives and the joint committee on mental health, substance use and recovery not later than July 1, 2023.[3]

(f) The center for responsive training in crisis intervention shall consider the council's recommendations for incorporation into regional training opportunities and training curricula.

Appendix B: Section 25 of Chapter 19 – Center for Responsive Training in Crisis Intervention

Section 25. (a) Subject to appropriation, within the Department of Mental Health, there shall be a center for responsive training in crisis intervention, in this section hereinafter referred to as the center. The center shall serve as a source for cost-effective, evidence-based mental health and substance use crisis response training programs for municipal police and other public safety personnel throughout the commonwealth. The center shall conduct activities as the advisory council, pursuant to subsection (e), directs, which shall include: (i) supporting the establishment and availability of community policing and behavioral health training curricula for law enforcement personnel, particularly in interventions that provide alternatives to arrest and incarceration; (ii) serving as a clearinghouse for best practices in police interactions with individuals suffering from mental illness and substance use disorders; (iii) developing and implementing crisis intervention training curricula for all veteran and new recruit officers; (iv) providing technical assistance to cities and towns by establishing collaborative partnerships between law enforcement and human services providers that maximize referrals to treatment

[3] Chapter 77 Section 44 of the Acts of 2023 extended the report submission date to July 1, 2024.

services; and (v) establishing metrics for success and evaluation of outcomes of these programs.

(b) The center shall be funded with revenue from appropriations or other money authorized by the general court and specifically credited to the center, and revenue from private sources including, but not limited to, grants, both state and federal, gifts and donations received by the commonwealth that are specifically credited to the center.

(c)(1) The center shall: (i) establish regional training opportunities for municipal police as needed throughout the commonwealth; (ii) develop and maintain curricula that is updated with the latest research on best practices in community policing and behavioral health; (iii) recruit, reimburse and support trainers with experience in community policing and behavioral health crisis intervention; (iv) ensure the training is targeted to meet specific local needs of participating cities and towns and the commonwealth; (v) support police departments in implementing improved behavioral health responses through responsive policies and procedures and partnerships with community behavioral health providers; (vi) assist municipal police departments to cover backfill costs incurred in sending staff to training; provided, however, that reimbursement shall not exceed the actual cost of the sending department's backfill; (vii) promote the use and adequate resourcing of trained community-based crisis response resources to assist residents when an exclusive police response is not best suited to address the concerns raised or is inappropriate or unnecessary; and (viii) stipulate that each municipal police department receiving reimbursement provide information necessary for the center to evaluate the goals described in paragraph (3), including the percentage of the municipality's police sergeants, lieutenants and other officers who directly oversee patrol officers who have received the center's recommended training and the percentage of the municipality's patrol officers who have received the center's recommended training.

(2) Training shall include, but not be limited to, information on: (i) the signs and symptoms of mental illnesses and substance misuse; (ii) mental health treatment; (iii) co-occurring disorders; (iv) responding to a mental health or substance use crisis; (v) best practices, including efforts to prioritize de-escalation tactics and techniques in crisis response situations; (vi) institutional and structural racism and implicit bias; (vii) best practices for responding to mass gatherings or protests that shall emphasize de-escalation and minimizing the necessity for use of force; and (viii) community policing principles.

(3) The center shall develop and ensure sufficient training resources and opportunities to enable each municipality in the commonwealth to obtain the center's recommended training for not less than 25 per cent of their police sergeants, lieutenants and other officers who directly oversee patrol officers, and not less than 50 per cent of their patrol officers within a time determined by the community policing and behavioral health advisory council as described in subsection (e).

(d) The center shall publish an annual report including: (i) narrative and statistical information about training demand, delivery, cost and identified service gaps during the prior

year; (ii) the effectiveness of the services delivered during the prior year; (iii) the communities that participated in the training; (iv) the number of officers, and their ranks, that participated in the training; (v) the progress each municipality has made in reaching the goals described in subsection (c)(3), including the percentage of each municipality's police sergeants, lieutenants and other officers who directly oversee patrol officers who have received the center's recommended training, and the percentage of each municipality's patrol officers who have received the center's recommended training; and (vi) a review of research analyzed or conducted during the prior year. The center shall submit the annual report not later than February 1 to the governor, the secretary of health and human services, the commissioner of mental health, the secretary of public safety and security, the clerks of the House of Representatives and the Senate, the joint committee on mental health, substance use and recovery, the joint committee on public safety and homeland security and the house and senate committees on ways and means.

(e) There shall be a community policing and behavioral health advisory council, in this section called the council, consisting of 11 members: the secretary of health and human services or the secretary's designee, and the secretary of public safety and security or the secretary's designee who shall serve as co-chairs of the council; the commissioner of the department of mental health or the commissioner's designee; the commissioner of the Department of Public Health or the commissioner's designee; the executive director of the municipal police training committee or the director's designee; a representative of a mental health consumer advocacy group, as appointed by the secretary of Health and Human Services; 2 community members who are consumers of behavioral health services, appointed by the secretary of Health and Human Services; and 3 municipal police chiefs or commanding officers to be selected by the executive director of the Massachusetts Chiefs of Police Association, which shall include 1 police chief or commanding officer employed by a community with fewer than 10,000 residents; 1 police chief or commanding officer employed by a community with 10,000 or more residents and fewer than 60,000 residents; and 1 police chief or commanding officer employed by a community with 60,000 or more residents. Members of the council shall be appointed for a term of 3 years and may be reappointed for consecutive 3–year terms. Each member shall be reimbursed by the commonwealth for all expenses incurred in the performance of their official duties.

The council shall advise the chairs in directing the activities of the center consistent with subsection (c) and shall receive ongoing reports from the center concerning its activities. The council shall solicit public comment in community policing and behavioral health and may convene public hearings throughout the commonwealth. The council shall hold not less than 2 meetings per year and may convene special meetings at the request of the chair or a majority of the council.

Appendix C: Public Meeting Information

Meeting Date and Time	Location	Members of Public in Attendance	Number of attendees that provided comment
Dec. 5, 2023 11 a.m. – noon	Springfield Public Library	1	1
Dec. 5, 2023 2 p.m. – 3 p.m.	Worcester Public Library	1	1
Dec. 12, 2023 1:30 p.m. – 2:30 p.m.	Roslindale Public Library	0	0
Dec.15, 2023 11 a.m. – noon	Remote / Zoom Meeting	4	0

Appendix D: Public Comments

Springfield – Dec. 5, 2023

One individual provided verbal testimony during the Springfield hearing. The individual is a lifelong city resident and is an advisor to an organization that is engaged with connecting and training of law enforcement to address de-escalation matters and enhance response effectiveness in crisis situations that may involve people with behavioral health issues.

They communicated support for the findings, recommendations, and the Commonwealth's reform efforts. The individual stated that the recommendations add and provide a strong defense for improvements in the areas of law enforcement recruitment, training, and supervision to enhance the quality of engagement particularly in the city's minority communities that have experienced negative socioeconomic and educational outcomes. Further, the individual stressed that in the absence of appropriate training and enhancing the understanding of behavioral health problems, engagements between law enforcement and specifically police will continue to be problematic. The stressed relationship and cooperation between the community and law enforcement will deteriorate and result in escalation of issues, and inadequate outcomes that contribute to instability and increased cost to taxpayers.

In closing, the individual extended support of these efforts and communicated they will make a big difference, particularly in urban communities and police departments.

Worcester – Dec. 5, 2023

One individual provided verbal testimony during the Worcester public hearing. The individual is a Peer Specialist at a local Community Behavioral Health provider, Advocates. The speaker was in support of the report's findings, recommendations, and the commonwealth's reform efforts. The individual appreciated that the report included information on peer support. As the commonwealth moves forward with this and other work, the individual suggested that the use of peer support is maximized at every level, and the use of peers will be key in moving the system forward, including in crisis and respite settings. The speaker added that using peers in crisis services can save money while also saving lives and suggested the use of peers as a first point of contact. In support of this recommendation, the individual shared that Community Based Health Centers (CBHCs) have used peers in many aspects of care with success, showing the value of the voice of a person with lived experience in helping those in crisis.

Appendix E: Summary of Written Testimony

Association for Behavioral Health (ABH) – Submitted Jan. 19, 2024

Summary

The Association for Behavioral Health (ABH) wrote a letter supporting the work of the Community Policing and Behavioral Health Advisory Council (the Council). ABH supported the creation of a Statewide Behavioral Health Workforce Strategy and suggested that the

Behavioral Health Workforce Development Center funded in the FY24 budget could be part of that larger strategy.

The testimony included a concern that Massachusetts is considering changing the current system in which embedded staff in community behavioral health centers (CBHCs) are responsible for dispatching the mobile intervention teams to having the Behavioral Health Helpline (BHHL) be the centralized dispatch for mobile crisis intervention (MCI).

ABH supports the report's overarching **themes of coordination** and appreciates the Council's continued work to improve crisis response for people experiencing a behavioral health emergency.

Full Comments found in Appendix F.

Behavioral Health Network (BHN) – Submitted Jan. 2, 2024

Summary

Behavioral Health Network (BHN) wrote a letter expressing support for the recommendations put forward in the report and the work of the Council in researching and defining best practices for the intersection of community policing and behavioral health in the commonwealth. Specifically, BHN especially commends (1) the recommendation to have a **single state oversight body** to align and integrate the public health and EOHHS responses to behavioral health and (2) creating **standardized guidance and support for local entities to implement 911 diversion for behavioral health crises**.

BHN expressed support for the creation of data dashboards but noted that data collection, and centralized reporting will likely require financial resources from provider agencies to support.

Full comments found in Appendix F.

Vinfen – Submitted Jan. 3, 2024

Summary

Vinfen wrote a letter expressing support for many of the report's recommendations and the areas noted where improvements were needed. Specifically, Vinfen strongly supports **establishing a governance entity under the co-direction of the Secretary of Health and Human Services and the Secretary of Public Safety and Security** to allow for clear guidance for communities. Vinfen supports the recommendation to **Move Upstream – Promote Use of Community-Based Services** such as Community Crisis Stabilization (CSS) beds to reduce ED boarding. Vinfen additionally strongly supports the **creation of a statewide behavioral health workforce strategy**.

Vinfen shared several recommendations on how CBHCs could further optimize their services. These include: (1) requiring commercial coverage of all CBHC services beyond just crisis services, (2) requiring health insurers reimburse EMS for individuals who are transported to CBHCs for crisis services, (3) allowing CHBCs to provide medical clearance to allow for direct

admit from CBHCs to psychiatric hospitals, and (4) creating a process to allow for streamlined admissions to psychiatric hospitals from CBHCs, including allowing for admission beyond business hours and paying for EMS transport when indicated.

Appendix F: Written Testimony

Association for Behavioral Health (ABH) Written Testimony Submitted Jan. 19, 2024

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Lydia Conley PRESIDENT / CEO
Kenneth J. Bates CHAIR

ASSOCIATION
FOR BEHAVIORAL
HEALTHCARE

January 19, 2024

Scott Taberner, Co-Chair
Angela F.F. Davis, Co-Chair
Community Policing and Behavioral Health Advisory Council
Via e-mail: CrisisServicesStudy@umassmed.edu
Re: Crisis System Report

Dear Co-Chairs, Taberner and Davis,

Thank you for your work in convening the Community Policing and Behavioral Health Advisory Council (the Council) and for the Council's dedication and focus on providing more effective crisis response to people experiencing behavioral health crisis.

The Association for Behavioral Healthcare (ABH) is a statewide association representing 80 community-based mental health and addiction treatment provider organizations. ABH's members are the primary providers of publicly funded behavioral healthcare services, serving approximately 81,000 Massachusetts residents daily, 1.5 million residents annually, and employing over 46,500 people. As ABH represents 25 of the 26 Community Behavioral Health Centers (CBHCs) in Massachusetts, we deeply appreciate the opportunity to provide comments on the Council's report regarding crisis services in the Commonwealth.

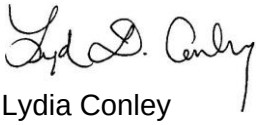
The Crisis System Report indicates that Massachusetts is considering a change from the current system where CBHC's are responsible for dispatching the mobile intervention teams embedded in their practice to a centralized dispatch for mobile crisis intervention (MCI) through the Behavioral Health Helpline (BHHL). While centralization

may suggest benefits through simplification, we would highlight that familiarity with a community/organization can make a significant difference in terms of how resources are used most effectively. CBHCs need to be resourced similarly to first responders that have successfully adopted centralized dispatch before that model can work in this setting. We respectfully request that CBHCs be part of the discussion as this consideration moves forward.

ABH supports efforts to create a Statewide Behavioral Health Workforce Strategy. Currently, no single entity at the state level is charged with addressing behavioral health workforce issues, and as the report indicates, the Commonwealth is in dire need of further planning on this issue. The FY24 budget included $1.8 million for a ***Behavioral Health Workforce Development Center*** to ensure that appropriate resources and time are devoted to the complex issues affecting the behavioral health workforce. An ongoing development center, staffed by experts, could conduct long-term planning, including establishing baseline needs and developing recommendations and strategies to meet these needs. The behavioral health workforce center is the appropriate place to house this work.

The Commonwealth has provided significant investment in bolstering community-based crisis response, and we applaud the Council's continued work to improve the state's ability to respond to individuals experiencing behavioral health crises. ABH supports the report's overarching themes of coordination and recognizes that many of the challenges presented in the findings stem from encounter-driven financing approaches, specifically in strategies that do not promote standing capacity to respond to crises. We look forward to working with you to advance the details of this important work.

Sincerely,



Lydia Conley
President/CEO

Association for Behavioral Healthcare (ABH) Comments on CPBHAC Report (01.24)

Behavioral Health Network (BHN) Written Testimony Submitted Jan. 2, 2024

Executive Office of Health and Human Services (EOHHS) Public Hearings – Community Policing & Behavioral Health Advisory Council Request for Public Input

Report of the Community Policing and Behavioral Health Advisory Council in accordance with Section 117 of Chapter 253 of the Acts of 2020 and Section 25 of Chapter 19 (mass.gov)

Please accept the following written testimony submitted by the Behavioral Health Network (BHN). BHN is the largest behavioral health provider in Western Massachusetts and has many years of

experience operating programs at the intersection of community policing and behavioral health. BHN is the current CBHC and mobile crisis intervention provider for lower Hampden County and operated the mobile crisis teams for all of Hampden County for the previous 20+ years. BHN operates co-response programs with the City of Springfield as well as smaller surrounding cities and towns (Westfield, Agawam) and has been a contracted provider of Crisis Intervention Training for all of Western Massachusetts. As a member of the Association for Behavioral Health, we contributed to their collective written testimony; and our relevant leadership provided subject matter interviews to the Community Policing and Behavioral Health Advisory Council as part of their report preparation. Given the significance of this topic and our role in this work, we feel it is important to submit the following additional testimony.

To begin, we thank EOHHS for dedicating resources and attention to researching and defining best practices for the Commonwealth on the intersection of community policing and behavioral health. This is an area where disparities are deep and where emergency resources could be much more efficiently and effectively applied. We fully support the recommendations as put forth in the Report. In particular, we agree that it would be beneficial to have a single state oversight body which aligns and integrates public safety and EOHHS as it relates to behavioral health crises. In addition, we fully support standardized guidance and support to local entities to implement 911 diversion for behavioral health crises. As stated in the Report, oftentimes the only difference between someone who receives a deployment of behavioral health crises teams and someone who receives a police response is not their presenting need, but simply the phone number that they (or their support team) thought to call.
Creating 911 diversion programs will ensure that people who call that widely known emergency number for behavioral health emergencies will receive the most appropriate response.
Finally, while we support the creation of centralized data dashboards, it is critical to recognize the demand it places on providers to collect and share data centrally. Among the provider network, there is likely a diversity of platforms used to gather and store utilization data, and therefore many if not all will need to translate (or manually re-enter) their data into the platform selected by the Commonwealth. This effort requires financial resources at the provider level for IT and/or program staff to complete.

In summary, we wish to commend the Commonwealth for their leadership in this critically important area and are grateful for the opportunity to share our thoughts and perspective. We are available for any additional provider input as this effort unfolds.

Sincerely,

Steven Winn, CEO
Behavioral Health
Network

Vinfen Written Testimony Submitted Jan. 3, 2024

Vinfen
Transforming lives together

January 3, 2024

Angela Davis, Assistant Secretary
Exec. Office of Public Safety & Security
Co-chair of CPBHAC

Scott Taberner, Special Advisor
Exec. Office of Health & Human Services
Co-chair of CPBHAC

Submitted by email to CrisisServicesStudy@umassmed.edu

Re: Comments on Crisis System Report

Dear Assistant Secretary Davis and Special Advisor Taberner,

Vinfen is writing to share comments on the recently released crisis services study conducted by the Massachusetts Association for Mental Health (MAMH) on behalf of Community Policing Behavioral Health Advisory Council (CPBHAC) and Department of Mental Health (DMH). We commend the General Court for requesting the study and its subsequent recommendations on how to improve the behavioral health crisis system in Massachusetts.

As a non-profit behavioral health and human services organization, we employ over 3,500 employees serving individuals with behavioral health conditions, disabilities, and other life challenges. Our services and advocacy promote the recovery, resiliency, habilitation, and self-determination of the people we serve across 318 programs in Massachusetts and Connecticut.

A component of our comprehensive services are our two behavioral health clinics in Lawrence and Lowell, serving over 2,000 people annually. In Lowell, we are a state-designated Community Behavioral Health Center (CBHC) offering the full spectrum of crisis, urgent, and routine outpatient services. Lastly, we offer a range of community-based mental health programs including Adult Community Clinical Services (ACCS), Clubhouses, Program for Assertive Community Treatment (PACT), and Recovery Connection Centers (RCC).

We appreciate the report's comprehensive review of the Commonwealth's current behavioral health crisis system. While substantial progress has been made in improving access to crisis services, we agree with many of the findings of this report on areas of improvement. Therefore, we submit the following points of consideration, rooted in our deep experience in providing community-based mental health services and our newer experience as a CBHC.

- **Establish a governance entity under the co-direction of the Secretary of Health and Human Services and the Secretary of Public Safety and Security:** We strongly support this recommendation for several reasons. Currently, there is confusion in communities on whether and in which circumstances police are permitted to drop off individuals in crisis at CBHCs. Some police departments believe that they are permitted to drop off at CBHCs when the person in crisis agrees to it (voluntary); other police departments believe that even in voluntary situations, police are obligated to take them to

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an Emergency Department. We believe the ability for police to drop off at CBHCs is important to alleviate Emergency Department boarding and provide individuals in crisis with a range of treatment options. Providing clear guidance to both police departments and CBHCs must come from top behavioral health and public safety leaders in state government. We also welcome the establishment of this governance entity in order to streamline regulatory and reporting requirements across EOHHS entities as well as provide a forum for the development of strategic goals and data for measuring the impact of CBHCs.

- **Move Upstream- Promote Use of Community-Based Services.** Vinfen supports the proposed statewide awareness campaign and/or provider training to help facilitate increased use of Community Crisis Stabilization (CCS) beds, especially for youth which is still widely unknown as a level of care. This would help reduce the number of individuals boarding in the ED for psychiatric services, facilitate step-downs from inpatient psychiatric units, and support the investments CBHC providers have made in community-based service capacity. We understand this work is currently underway with the Office of Behavioral Health and welcome these efforts.

- **Create a Statewide Behavioral Health Workforce Strategy:** Vinfen strongly supports the recommendation to create a 10-year behavioral health workforce strategy that takes into account the workforce of the public sector community mental health system. As an initial step, Vinfen supports legislation to establish a workforce Center of Excellence (S.829/H.1275). Most important though is eliminating the compensation disparities embedded in rates for CBHCs compared to DMH-contracted services. The creation of CBHCs has only exacerbated the critical workforce issues faced by behavioral health and human service providers because CBHC rates assume significantly higher salaries for staff than other DMH-contracted mental health services. It appears that DMH-contracted services set provider rates based on the 53 percentile of Bureau of Labor Statistics (BLS) salary benchmarks for the year prior whereas CBHC rates appear to be based on the 75th percentile of the BLS salary benchmarks. The table below is an example of the salary disparities that result from these two different benchmarks.

Position	CBHC assumed salary	DMH ACCS salary
Approximate	Based on 75th percentile	Based on 53rd percentile
Mental Health clinician (Master's level, licensed)	$80,131	$63,627
Nurse (RN)	$102,875	$90,293
Outreach, care coordinator (Bachelor's level)	$50,834	$45,211
Psychiatrist (MD)	$333,872	$211,870

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The impact of this system on DMH providers like Vinfen is that staff have higher compensation options in organizations that predominantly provide CBHC, or outpatient mental health services compared to organizations that are also human service providers. Vinfen's CBHC staff account for less than 5% of our entire mental health workforce. There are of course even more significant salary differences for staff who work in community health centers or hospital-based organizations compared to human service organizations. The salaries for the CBHC have been enormously helpful in our hiring practice for our own CBHC located in Lowell, we would like to see similar opportunities for other lines of service.

- **Realize the Full Potential of CBHCs by Ensuring Equity for Commercial Beneficiaries:** Though the goal was to be payor-agnostic, commercial payors are only mandated to cover crisis services rather than the entire set of CBHC services. The result is MassHealth is indirectly subsidizing services that are obtained by commercial CBHC clients because the CBHC rates support the more robust set of services included under the CBHC umbrella. Legislation supported by the Association for Behavioral Health (S.613/H.1108) would require commercial coverage of *all* CBHC services, so that the roadmap can be fully realized.

- **Diversify CBHC Entry Points by Clarifying EMS drop off**. The vision of the behavioral health road map has been to have CBHCs be a low threshold, no wrong door entry point for an individual in crisis. We have been working hard to ensure that an individual can access our services whether it is through a walk-in or an appointment. We look forward to implementing the new EMS drop off regulation in partnership with the Greater Lowell EMS provider. One barrier we foresee is the fact that health insurers will not reimburse EMS for individuals transported to the CBHC rather than the ED. We recommend that this reimbursement issue be addressed by state policymakers.

- **Allow Direct Admit from CBHCs to psychiatric inpatient services by creating a mechanism for CBHCs to provide medical clearance:** The psychiatric boarding crisis and evaluations at Emergency Departments has been well-documented for both youth and adults for at least a decade. We value our relationship with Tufts Medicine's Lowell General Hospital and have been working collaboratively to implement the Greater Lowell CBHC while they implement their own ED-based BH crisis services. We understand that despite the significant increase in community-based crisis evaluations that Vinfen has conducted since the CBHC was implemented in January 2023, the hospital continues to experience ED boarding problems. One driver of this ongoing problem is that CBHCs are unable to directly admit persons in crisis to inpatient psychiatric facilities. Rather, individuals who require an inpatient level of care must be sent to the Emergency Department for additional evaluation and medical clearance. Vinfen is prepared to work with Lowell General Hospital's Emergency Department operated Mobile Integrated Health (MIH) program to address this

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barrier by having the MIH program provide evaluation and medical clearance for individuals in crisis at Vinfen's CBHC or at community locations. In fact, we have piloted the MIH medical clearance but, unfortunately, to date, inpatient psychiatric services have been unwilling to accept this medical evaluation. Vinfen recommends developing a mechanism and guidance for CBHCs to work with MIH programs to provide on-site medical clearance and requiring inpatient psychiatric services to allow admissions directly from CBHCs that have this medical clearance capacity.

- **Streamline Psychiatric Hospital Admissions from CBHC:** Furthermore, it is imperative that hospitals improve their admissions process by expanding beyond standard business hours by having a psychiatrist on site to facilitate admissions after hours. Understanding that there has been continued work to address this through the Expedited Inpatient Psychiatric Admissions (EPIA) protocol and workgroup, we still experience cherry picking of patients due to their level of acuity. This can result in individuals needing to board the ED since CBHCs are not meant to do so. Like the issue of EMS transport to the CBHC, we also face an issue of EMS transport from the CBHC to an inpatient facility. EMS transportation to an accepted facility is subject to availability, responsibility and reimbursement from the CBHC or the community to an inpatient facility. We recommend establishing a similar mechanism and guidance for CBHCs, EMS transport and psychiatric facilities to work together to safely transport individuals needing this level of care.

We appreciate the opportunity to share our thoughts and expertise with the Council and for your close attention to an extremely important issue facing the Commonwealth. Please do not hesitate to contact me or our Director of Government Relations and External Affairs, Sophie Hansen, at hansens@vinfen.org.

Sincerely,

Jean Yang, MBA
CEO & President
CC:
Matt Broderick, Department of Mental Health
Charles Smith, Department of Public Health
Robert Ferullo, Municipal Police Training Committee
Tim Burton, NAMI Mass.
Robert Ortiz, Fellowship Health Resources
Ruby Sanders, Behavioral Health Network
Chief Russell Stevens, Hamilton Police Department
Chief Ernest Martineau, Fitchburg Police Department
Chief Robert Pistone, Haverhill Police Department

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Appendix G: Co-Chair's Response to Association of Behavioral Health Written Testimony and ABH E-mail Acknowledgement

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LIEUTENANT GOVERNOR

March 18. 2024

Lydia Conley, President and CEO
Association for Behavioral Health
1661 Worcester Road, Suite 206
Framingham, MA 01701

Dear Lydia,

Thank you for your letter regarding recommendations found in the Crisis System Report, issued by the Community Policing and Behavioral Health Advisory Council. In the letter, you expressed concern with a citation regarding a role for the Behavioral Health Help Line (BHHL) in dispatching mobile crisis intervention (MCI). You stated:

"The Crisis System Report indicates that Massachusetts is considering a change from the current system where CBHC's are responsible for dispatching the mobile intervention teams embedded in their practice to a centralized dispatch for mobile crisis intervention (MCI) through the Behavioral Health Helpline (BHHL)."

You correctly point out that:

"While centralization may suggest benefits through simplification, we would highlight that familiarity with a community/organization can make a significant difference in terms of how resources are used most effectively."

In response to your concerns, we have reviewed the **Report** and all references to Mobile Crisis Intervention (MCI). It is important to understand that the references to central operations of behavioral health crisis services and dispatch of mobile crisis intervention were in reference to reported findings

from a scan of developments across the country in the *National Best Practices Landscape Section* of the Crisis System Report.

- At page 7 in the *Executive Summary* and the *Recommendations Section* of the Report, recommendations are noted and *Recommendation 3.2 Create a Standardized Framework or Process for Screening and Triaging Behavioral Health Calls…* noted the need for cross system integration of Massachusetts' approach to crisis screening and triage, including those functions spread between EOPSS and EOHHS funded entities at both state and local levels**. There is reference in the mix to transfer Public Safety Answering Point (PSAP) calls to the BHHL and the Community Behavioral Health Center's (CBHC) MCI, but this is not a recommendation to centralize those communications or reserve the transfer from PSAPs to the BHHL.**
- At page 20 in the *National Best Practices Landscape Section* of the Report, there is a subsection entitled *Integrated Crisis Components* that references centralized operations, including MCI dispatch, in Georgia and Texas. **There was no intention in reporting on these national developments to recommend that Massachusetts follow suit.** For the record, in that *Section,* there is also reported the most recent guidance issued in May of 2023 by the US Departments of Justice (DOJ) and Health and Human Services (DHHS), calling for creation at local levels of comprehensive community-based crisis services to prevent institutionalization, police encounters, and incarceration among people with behavioral health conditions.
- At page 28 in the *Overview of the Massachusetts Crisis System Section* of the Report, there is a statement that may have contributed to your concern: "Within Massachusetts, mobile crisis teams are currently deployed by their respective CBHC organizations, not from a centralized center, as indicated in best practice and seen in other states such as Arizona, Georgia, Oklahoma, and New Hampshire.[4, 5] Massachusetts is considering centralized dispatching from the BHHL." As cited above, this statement references the national best practices landscape, except for the final sentence regarding consideration of centralized dispatching. **We note that this was reported to the Study authors as something that was complementary to CBHC dispatch, rather than a substitution for CBHC dispatch.**

We underscore that there is not a recommendation to centralize MCI dispatch through the BHHL in lieu of CBHC's dispatching their respective MCI teams. Any reference to having the BHHL direct cases assessed to require MCI or a broader range of crisis evaluation, intervention, and/or stabilization services was intended to be complementary and in coordination with the CBHCs.

As you may recall, key informant interviews were conducted with numerous CBHC and behavioral health provider representatives, including members of the ABH team. We assure you that any discussions about implementation of the Crisis Services Report recommendations that impact CBHCs will be discussed with ABH and its CBHC members.

[4] Gulley, J., Boss, R., Woodsby, A., Arienti, F., & Wachino, V. (2021). *Mobile crisis teams: A state planning guide for Medicaid-financed crisis response services*. Boston, MA: Technical Assistance Collaborative.

[5] Sheamekah Williams personal communication January 6 2023

We are available to meet with you and your members, as are the Study authors at MAMH and TAC, to provide further clarification to these points.

Thank you once again for providing feedback on the Report. Your input is greatly appreciated.

Sincerely,

Community Policing and Behavioral Health Advisory Council Co-chairs

Scott Taberner

Scott Taberner
Executive Office of Health
and Human Services

Angela Davis

Angela Davis
Executive Office of Public
Safety and Security

ABH E-mail Acknowledgement- March 19, 2024

From: Lydia Conley <lconley@abhmass.org>
Sent: Tuesday, March 19, 2024 8:42 AM
To: Taberner, Scott (EHS) <scott.taberner@mass.gov>
Cc: Davis, Angela (EPS) <angela.f.davis@mass.gov>; Danna Mauch <dannamauch@mamh.org>
Subject: RE: Letter concerning ABH's input on Crisis Services Report issued by the Community Policing and Behavioral Health Advisory Council

Scott,

Thank you so much for the thorough review of our comments and even more thorough response. The concerns ABH raised were importing some messaging from the BHHL contractor about centralized dispatch, and it is good to hear, although certainly not surprising, that engagement will continue on adoption of report recommendations.

My thanks to you, Asst. Undersecretary Davis, the Council members, as well as to your thoughtful partner Danna Mauch at MAMH, for the commitment to improving crisis training and response.

Lydia

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