SENATE DOCKET, NO. 1716 FILED ON: 1/16/2025

SENATE . . . . . No. 111

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:	DISTRICT/ADDRESS:
Brendan P. Crighton	*Third Essex*

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SENATE . . . . . No. 111

By Mr. Crighton, a petition (accompanied by bill, Senate, No. 111) 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.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. *72* OF 2023-2024.]

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Fourth General Court
(2025-2026)

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:

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

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

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

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

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

peer support, and available resources and methods of outreach to non-clinical and clinical services related to behavioral and mental health.

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

(e) Following a medical or non-medical leave of absence from a congregate care program under contract to provide foster care to children in the care or custody of the department, there shall be a presumption that the child will return to the congregate care program if it is determined that the program is appropriate to meet the needs of the child. The department shall reimburse, at the prevailing rate of reimbursement, the congregate care program to hold the bed of a child for each day of their hospitalization or other leave of absence from the program.

(f) If a child requires care in another setting, including, but not limited to an emergency department visit or a stay in an inpatient setting, community behavioral health center, intensive community based acute treatment, community based acute treatment, or youth community crisis stabilization, a congregate care program, under contract to provide foster care to children in the care or custody of the department, shall not refuse to readmit a child living in that congregate care program after a medical or non-medical leave of absence, including an emergency or acute behavioral or psychiatric circumstance, provided that the child has been determined medically and psychiatrically stable and provided further, it is appropriate for the child to be discharged to

return to their congregate care program. A congregate care program may deny readmission to a child whose needs have been determined by the program's director or clinical director to exceed the program's capability at the time readmission is sought; provided the program reports the denial of readmission of the child to said program to the department of children and families pursuant to section 33D. The determination shall be recorded in writing and shall include the factors justifying the denial and why mitigating efforts would have been inadequate to address the care needs of the child.

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

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

33D. (a) The department of children and families shall collect data on the instances when a congregate care program, under contract to provide foster care to children in the care or custody of the department, denies to readmit a child who has been determined appropriate for the program after a circumstance requiring care in another setting, including, but not limited to an emergency department visit or a stay in an inpatient setting, community behavioral health center, intensive community based acute treatment, community based acute treatment, or youth community crisis stabilization. A congregate care program shall report to the department when it denies readmission to a child after a medical or non-medical leave of absence, including an emergency or acute behavioral or psychiatric circumstance when the child has been determined appropriate for the program. Such report shall include, but not be limited to, i) instances when a congregate care program denies readmission of a child following a medical or non-medical leave

of absence, (ii) the underlying factors justifying denial of readmission of the child to a congregate care program, and (iii) why mitigating efforts would have been insufficient.

The department shall post to the department's website, on a quarterly basis, a report on the data collected in this section. To the extent feasible, all data shall be disaggregated by race, ethnicity, gender identity, age and other demographic information. The department shall provide a copy of the report to the executive office of health and human services; the joint committee on mental health, substance use and recovery; and the joint committee on children, families and persons with disabilities.

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

SECTION 4. Notwithstanding any general or special law to the contrary, the department of children and families shall prepare a comprehensive plan to address access to behavioral and mental health services for individuals in their custody or care. The plan shall include, but not be limited to: (i) strategies to expand access to post-hospitalization settings, including but not limited to, services for transitional age youth, youth with complex behavioral health needs, youth with autism spectrum disorders, youth with intellectual or developmental disabilities, youth with co-occurring behavioral and substance use disorders, youth with co-occurring behavioral and medical needs, school-based services, and respite services; (ii) strategies to reduce the wait times for patients awaiting discharge so that the patients determined appropriate for congregate care, intensive residential treatment programs, community-based programs or other appropriate settings would be admitted to the appropriate setting within fourteen days of their application; and iii) strategies to facilitate care coordination between the department and local education agencies including, but not limited to, recommendations for streamlined communications between local and out-of-district schools, community partners, and other residential-educational settings. The department of children and families shall submit a copy of the plan, including any budgetary needs, to the executive office of health and human services; the clerks of the senate and house of representatives; the joint committee on mental health, substance use, and recovery, and; the joint committee on children, families, and persons with disabilities within 60 days of the effective date of this act.

SECTION 5. Notwithstanding any general or special law to the contrary, the department of developmental services shall prepare a comprehensive plan to address access to behavioral and mental health services for individuals in their custody or care. The plan shall include, but not be limited to: (i) strategies to expand access to post-hospitalization settings, including but not

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

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

The Commission shall consist of 25 members or their designees: the Secretary of Health and Human Services or a designee, who shall serve as chair; the Commissioner of Public Health or a designee; the Commissioner of the Department of Children and Families or a designee; the Commissioner of the Department of Youth Services or a designee; the Commissioner of the Department of Developmental Service or a designee; the Commissioner of the Department of Early Education and Care or a designee; Chief Justice of the Juvenile Court Department or a designee; the Chairs of the Joint Committee on Mental Health, Substance Use and Recovery or their designees; the Chairs of the Joint Committee on Children, Families and Persons with Disabilities or their designees; a representative from the Office of the Child Advocate; a representative from the Association for Behavioral Healthcare, Inc.; a representative from the Massachusetts Health & Hospital Association; a representative from the Massachusetts Association of Behavioral Health Systems; a representative from the Children's Mental Health Campaign; a representative from the Children's League of Massachusetts; a representative from the Parent/Professional Advocacy League; a representative from the Massachusetts Behavioral Health Partnership; 6 members to be appointed by the chair, 2 of whom shall be a family member of a child or adolescent with behavioral health needs or who has been involved in the juvenile court system; 3 of whom shall be a behavioral health provider specializing in serving children and adolescents with intensive behavioral health needs; and 1 of whom shall be a clinician or researcher with expertise related to children and adolescents with intensive behavioral health needs. In making appointments, the Secretary shall, to the maximum extent feasible, ensure that the Commission represents a broad distribution of diverse perspectives and geographic regions.

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

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

The Commission shall submit its findings and recommendations to the clerks of the senate and the house of representatives, the joint committee on mental health, substance use and recovery, the joint committee on children, families and persons with disabilities and the senate and house committees on ways and means not later than January 1, 2026. The secretary of health and human services shall make the report publicly available on the website of the executive office of health and human services.