

# **Massachusetts Special Commission on Access to Behavioral Health Services for Children and Families**

**Established with the enactment of the FY2026 Budget**

**Submitted June 30, 2026**



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## **1. Executive Summary**

The Special Commission on Access to Behavioral Health Services for Children and Families was convened with a two-fold goal to: 1) examine the barriers that prevent children, youth, and families in Massachusetts from obtaining timely, appropriate, culturally-responsive behavioral health care, and 2) recommend policy, operational, and investment strategies to strengthen the Commonwealth's child and family behavioral health continuum.

The Commission's work occurred in the context of budgetary constraints; high and persistent demand for child and adolescent behavioral health services; workforce shortages across outpatient, community-based, crisis, residential, school-based, and intensive levels of care; uneven access to services by geography, insurance type, language, disability status, race and ethnicity, and family circumstance; and ongoing pressure on families, schools, emergency departments, state agencies, and community providers. Massachusetts recently made significant investments in behavioral health access, including the Behavioral Health Help Line, Community Behavioral Health Centers, Behavioral Health Urgent Care, and related reforms. The Commission's recommendations are intended to build on these investments, addressing remaining gaps in access, coordination, prevention, capacity, and accountability. Recommendations are prioritized based on their feasibility and potential impact, while acknowledging the current budgetary climate the Commonwealth faces, as it receives significantly less in anticipated federal support.

The Commission held full Commission meetings and smaller workgroup discussions, reviewed prior reports thoroughly, and sought stakeholder input. From this work, several themes emerged:

1. Families need a simpler, more navigable system with a clear "front door" and warm handoffs across services.
2. Children and youth need access to the right intensity of care at the right time, not only after crisis escalation.
3. Workforce capacity and reimbursement are central constraints across the continuum.
4. Schools, pediatric primary care, community-based organizations, and state agencies are essential access points and must be connected to the behavioral health system.
5. Services must be designed around equity, cultural responsiveness, language access, disability access, and family voice.
6. The Commonwealth needs better data, transparency, and accountability to understand wait times, unmet needs, service availability, outcomes, and cross-agency performance.

In an effort to be mindful of the current environment, the Commission's recommendations are presented in two categories. The first is a set of recommendations that can be acted on in the shorter term even with the current fiscal challenges facing the Commonwealth and federal political environment. The second set of recommendations include priorities that the Commission believes are critical for addressing the broad behavioral health care needs for children and families but

requires substantial state investments. Commission members felt strongly that these longer-term recommendations be presented to the Legislature so that as resources become available investments can be made.

## **2. Commission Overview**

### **Charge and Scope**

The Special Commission on Access to Behavioral Health Services for Children and Families was established through the FY2026 Budget to examine barriers that prevent children, youth, and families in Massachusetts from obtaining timely, appropriate, culturally-responsive behavioral health care, and to recommend policy, operational, and investment strategies to strengthen the Commonwealth’s child and family behavioral health continuum.

Specifically, the Commission was responsible for examining:

1. the behavioral health services, including services and treatment for substance use disorder and for autism spectrum disorder, available to children and adolescents under 22 years of age;
2. common challenges that children, adolescents and families face in seeking behavioral health services including challenges associated with program eligibility criteria, affordability and cost-sharing, insurance or state program denials, application processes and service authorization processes, staffing, wait times and geography;
3. recommended policies to address challenges and for streamlining access to behavioral health services for children, adolescents and families including adolescent continuing care inpatient and residential treatment services<sup>1</sup>;
4. state funding dedicated to behavioral health services for children across state agencies and MassHealth and an examination of the impact of how such funding is used to maximize the delivery of services and available federal resources;
5. the feasibility and effects of creating a single integrated children’s behavioral health agency;
6. a 3-year strategic plan for the delivery of behavioral health services for children and families that considers all providers and payers.

(The full text of the Commission’s charge appears in Appendix A.)

The Commission was tasked with summarizing its findings and recommendations for improving access to behavioral health services for children and families in a report submitted to the Clerks of the House of Representatives and Senate, the Joint Committee on Mental Health, Substance Use and Recovery, the Joint Committee on Children, Families and Persons with Disabilities, the Joint Committee on Health Care Financing, and the Senate and House Committees on Ways and Means not later than June 30, 2026.

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<sup>1</sup> For this report, “residential treatment services” as well as similar terms such as “residential treatment settings” and “group/congregate care” indicate out-of-home placement environments inclusive of congregate group home care and residential educational settings.

## **Leadership and Structure**

The Commission was chaired by Executive Office of Health and Human Services (EOHHS) Undersecretary for Health, Amy Rosenthal, acting as the designee of the EOHHS Secretary, and was comprised of a diverse panel of policy experts (see full list in Appendix B).

The Commission convened eight virtual, public meetings from November 2025 through June 2026. All meetings were subject to the Open Meeting Law and minutes were taken and approved for each meeting. All materials considered by the Commission, as well as minutes of the Commission's meetings, were posted on a publicly available Mass.gov webpage:

<https://www.mass.gov/special-commission-on-access-to-behavioral-health-services-for-children-and-families>

### **3. Process and Organization of Work**

#### **Review of Prior Reports and Formation of Workgroups**

The Commission initiated its assessment with a detailed review of prior reports, stakeholder recommendations relevant to child and family behavioral health, and state initiatives developed by a variety of state agencies, including the Department of Mental Health (DMH), the Department of Developmental Services (DDS), the Department of Children and Families (DCF), the Department of Youth Services (DYS), the Department of Public Health (DPH), the Division of Insurance (DOI), MassHealth, the Department of Early Education and Care (EEC), and the Department of Elementary and Secondary Education (DESE). This review of prior findings included those on emergency department boarding, gaps in community-based services, youth mental health needs, family navigation barriers, insurance and reimbursement challenges, workforce shortages, and disparities in access. See Appendix C for a full list of reports and resources reviewed by the Commission.

The Commission also considered how recent behavioral health initiatives, including the Behavioral Health Help Line, Community Behavioral Health Centers, and Behavioral Health Urgent Care, intersect with the child and family service continuum. These initiatives create a stronger statewide infrastructure for access, assessment, urgent care, crisis response, and referral. However, the Commission identified a need to ensure that children and families experience these reforms as a coordinated, developmentally appropriate, family-centered system rather than as separate programs.

Additionally, to work as efficiently as possible, the Commission organized itself into three workgroups, based on the specific areas of interest outlined in the Commission's charge:

- Workgroup #1: Landscape & Funding Analysis
- Workgroup #2: Challenges & Policy Recommendations
- Workgroup #3: Feasibility and Effects of Creating a Single Integrated Children's Behavioral Health Agency

Commission members self-selected into one of the workgroups, meeting in between the Commission's broader meetings and reporting back both status updates and full report-outs to the full Commission.

(Work products for each of the workgroups appear in Appendices D, E, & F)

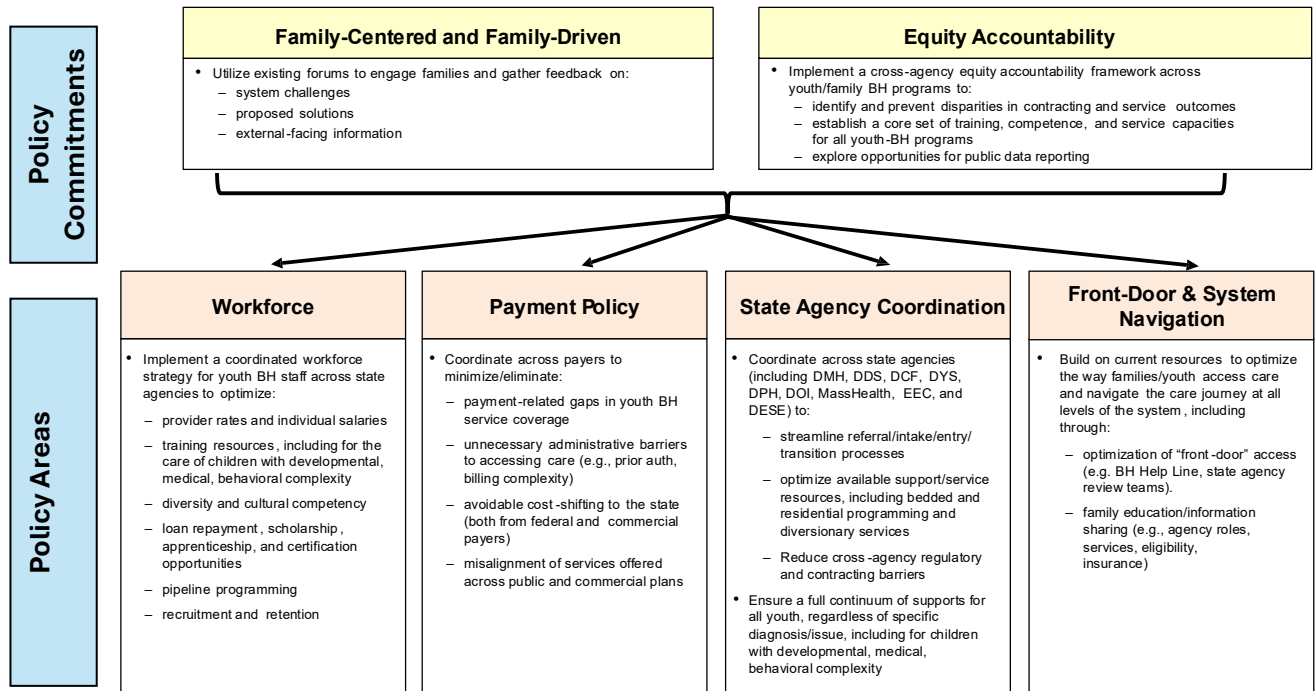
#### 4. Policy Framework

Based on the work of the Challenges & Recommendations workgroup, the Commission developed a framework for organizing its recommendations, consisting of two overarching policy commitments (i.e., the commitment that all initiatives are family-centered and family-driven and that there is equity accountability for all future initiatives) that permeate four targeted policy areas (i.e. Workforce, Payment Policy, State Agency Coordination, and Front-Door & System Navigation).

Within each of the policy commitments and policy areas, the Commission included recommendations that were considered both highly impactful and feasible, given the current budgetary climate, which is anticipated to get worse in the coming years as the Commonwealth receives significantly less federal support.

- **Impactful:** Will the investment materially improve timely access, reduce crisis escalation, reduce emergency department boarding, support family stability, improve equity, or strengthen outcomes?
  - system challenges
  - proposed solutions
  - external-facing information
- **Feasible:** Can the Commonwealth implement the investment within existing administrative structures, workforce capacity, provider networks, and federal funding?

The graphic below illustrates the overarching policy commitments and policy areas, as well as the specific recommendations that the Commission considers both impactful and feasible in the current climate. While these short-term recommendations outlined below may still require investments from the state, they were deemed to be the most feasible in the current budgetary climate.



## **5. Short-term Recommendations & Implementation Timeline**

### **Recommendation 1: Ensure the youth and family behavioral health system is designed in collaboration with families.**

Despite a relative wealth of behavioral health services and supports in Massachusetts, many youth and families struggle to understand and navigate an inherently complex and fragmented behavioral health system. As a result, many youth and families are unfortunately unable to access appropriate and impactful care to address their unique needs.

As the Commonwealth pursues policy reform to improve the behavioral health system, all efforts should be taken to utilize existing forums to engage families and gather feedback on system challenges, proposed solutions, and external-facing information. This will ensure that all initiatives are targeted to address the needs of highest importance to youth and families, and that all improvement efforts are structured to optimize the family care experience.

### **Recommendation 2: Ensure there is an appropriate equity accountability structured throughout the youth and family behavioral health system.**

Access barriers are not evenly distributed. Families with limited English proficiency, families of color, immigrant families, children with disabilities, LGBTQIA+ youth, families in rural areas, low-income families, and families involved with multiple state systems often face additional barriers, including lack of culturally-responsive providers, transportation challenges, stigma, digital access gaps, eligibility complexity, and mistrust of systems.

To address these barriers, the Commonwealth should implement a cross-agency equity accountability framework across youth and family behavioral health programs to identify and prevent disparities in contracting and service outcomes, establish a core set of training, competence, and service capacities for all youth behavioral health programs, and explore opportunities for public data reporting to share insights into system performance.

### **Recommendation 3: Implement a coordinated strategy to stabilize and grow the youth behavioral health workforce**

Workforce shortages limit access across the continuum. Providers report difficulty recruiting and retaining high-quality, culturally-responsive staff across the continuum of services, citing concerns with payment rates, administrative barriers, burnout, training and career development, and competition from other sectors.

The Commonwealth should implement a coordinated workforce strategy for youth-focused behavioral health staff across state agencies to optimize provider rates and individual salaries; training resources, including for the care of children with developmental, medical, and behavioral

complexity; diversity and cultural competency, loan repayment, scholarship, apprenticeship, and certification opportunities; pipeline programming; and recruitment and retention.

**Recommendation 4: Coordinate across payers to maximize available resources and improve the experience for families seeking behavioral health care**

Providers and families alike report payment-related barriers to behavioral health care, including health insurance coverage gaps or payment denials, cost-sharing obligations, administrative complexity, and inconsistent expectations and practices across different payers.

To address these issues, the Commonwealth should coordinate across payers to minimize/eliminate payment-related gaps in youth behavioral health service coverage, unnecessary administrative barriers to accessing care (e.g., prior auth, billing complexity), avoidable cost-shifting to the state (both from federal and commercial payers), and misalignment of services offered across public and commercial plans.

**Recommendation 5: Coordinate across state agencies to maximize available resources and streamline the experience for youth and families accessing behavioral health supports**

Children with behavioral health needs often interact with multiple systems, including many of our state agencies, such as Medicaid, child welfare, public health, juvenile justice, disability services, and education. Despite the robust services our state agencies offer, families often report fragmented experiences accessing support across our state agencies, with different eligibility criteria, intake processes, and service offerings.

Additionally, the Commission identified a need to clarify how major access, urgent response, and intensive service initiatives fit together for children and families. Families do not experience programs as separate policy initiatives. The Behavioral Health Help Line (BHHL), Massachusetts Youth Care: Closer to Home (MY Care), formerly known as the RISE initiative, and the Interagency Response Team (IRT) should, therefore, be described as parts of a connected continuum.

To improve the experience for families and maximize finite resources, the Commonwealth should improve coordination across state agencies (including DMH, DDS, DCF, DYS, DPH, DOI, MassHealth, EEC, and DESE) to: streamline referral, intake, entry, and transition processes and optimize available support/service resources, including bedded and residential programming and diversionary services.<sup>2</sup> Additionally, efforts should be made to minimize cross-agency regulatory and contracting barriers, which can prevent children from being served in some settings. Finally,

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<sup>2</sup> Note: DCF is a statutorily mandated child welfare agency whose involvement with families is determined by legal authority and responsibilities established under child abuse and neglect statutes. In contrast, agencies such as DMH and DDS are eligibility-based service systems that engage individuals who meet established clinical and functional criteria.

state agencies in the Commonwealth should work together to ensure a full continuum of supports for all youth, regardless of specific diagnosis/issue, including for children with developmental, medical, and behavioral complexity.

### **Recommendation 6: Optimize the way families and youth access care and navigate the care journey**

Families seeking behavioral health care for their children routinely experience difficulty in identifying the appropriate entry point through which to access care that addresses their clinical needs, is accepted by their insurance, and is concordant with their linguistic and cultural preferences. This difficulty in navigating the system often results in care delays and further worsening of behavioral health symptoms, sometimes reaching a crisis state.

The Commonwealth should build on current resources to optimize the way families and youth access care and navigate the care journey at all levels of the system, including through optimization of “front-door” access points (e.g. Behavioral Health Help Line, state agency review teams), as well as family education and information sharing (e.g., agency roles, services, eligibility, insurance).

### **Implementation Timeline**

#### **Year 1:**

- Confirm Commission recommendations and assign lead agencies.
- Re-engage members of the Commission to assist in sizing, scoping, triaging, and operationalizing the recommendations.

#### **Years 2 & 3:**

- Update recommendations based on continued work of Commission members and experiences of families accessing the system.
- Begin implementation of the most feasible of the initiatives, given budget environment.

## **6. Longer-term Policy Recommendations Requiring State Investment**

The Commission recognized that some recommendations require significant new state investments, while others can be advanced through administrative coordination, procurement, contract management, data alignment, or regulatory change. Considering current budget constraints, the Commission recommends a phased approach that prioritizes high-impact investments, leverages public and commercial payer opportunities where available, and sequences implementation based on feasibility and urgency.

The list below summarizes the proposed recommendations that the Commonwealth could potentially implement in a less restrictive budgetary climate.

1. Further Study: Commission studies/analyses to inform future policy development, including in topic areas such as:
  - a. Service capacity within children's systems in every public school district, grounded in the Multi-Tiered Systems of Support framework, integrating universal education and prevention, and including targeted supports for emerging and moderate mental health challenges and intensive supports for highest-need students
  - b. Bridge programs that support youth returning to school from behavioral health treatment (e.g. BRYT & BIRCh)
  - c. Early childhood behavioral health prevention and consultation programs
  - d. Family navigation supports
  - e. Residential and group home settings' capacity to serve youth with complex co-occurring needs, including behavioral health challenges, intellectual and developmental disabilities, autism, and significant medical needs. This assessment should identify barriers to service provision and the resources, supports, and system changes necessary to strengthen capacity within the existing continuum of care.
2. Infrastructure investment: Invest in infrastructure improvements that improve coordination and efficiency of care, such as:
  - a. A centralized, real-time bed and service availability tracking system for in-patient, diversionary, residential, and step-down programs
  - b. A shared cross-agency data system to track service access, waitlists, and outcomes in real time, identify disparities by race, language, geography, and program type, and support real-time reporting of critical incidents

The above investment opportunities should be prioritized based on both available funding and an assessment of feasibility to implement and impact on youth and family behavioral health access. All efforts should be taken by the Commonwealth to capitalize on previous and existing workstreams that overlap with any of the above initiatives, and the Commonwealth should engage youth and families, providers, and health care advocates when planning the strategic order for implementation.

## Appendices

### **Appendix A – Full Text of the Commission’s Charge**

#### **FY26 Budget 4000-0300 ([link](#))**

There shall be a special commission which shall consist of: the secretary of health and human services, or a designee from the office of the secretary, who shall serve as chair; the assistant secretary of MassHealth or a designee; the commissioner of mental health or a designee; the commissioner of children and families or a designee; the commissioner of insurance or a designee; the commissioner of early education and care or a designee; the commissioner of elementary and secondary education or a designee; the house and senate chairs of the joint committee on mental health, substance use and recovery or their designees; a representative of Association for Behavioral Healthcare, Inc.; a representative of Children’s League of Massachusetts, Inc.; a representative of Massachusetts Association for Mental Health, Inc.’s Children’s Mental Health Campaign; a representative of Massachusetts Association of Behavioral Health Systems, Inc.; a representative of Massachusetts Health and Hospital Association, Inc.; a representative of Massachusetts Association for Mental Health, Inc.; and a representative of the Parent/Professional Advocacy League, Inc.;

Provided further, that not later than June 30, 2026, the commission shall submit a special report to the joint committee on mental health, substance use and recovery, the joint committee on children, families and persons with disabilities, the joint committee on health care financing and the senate and house committees on ways and means detailing recommendations for improving access to behavioral health services for children and families;

Provided further, that the special report shall include, but not be limited to: (aa) a list of the behavioral health services, including services and treatment for substance use disorder and for autism spectrum disorder, available to children and adolescents under 22 years of age; (bb) a list of common challenges that children, adolescents and families face in seeking behavioral health services including, but not limited to, challenges associated with program eligibility criteria, affordability and cost-sharing, insurance or state program denials, application processes and service authorization processes, staffing, wait times and geography; (cc) recommended policies to address challenges identified under clause (bb) and for streamlining access to behavioral health services for children, adolescents and families including, but not limited to, adolescent continuing care inpatient and residential treatment services; (dd) a review of state funding dedicated to behavioral health services for children across state agencies and MassHealth and an examination of the impact of how such funding is used to maximize the delivery of services and available federal resources; (ee) analysis of the feasibility and effects of creating a single integrated children’s behavioral health agency; (ff) a 3-year strategic plan for the delivery of behavioral health services for children and families that considers all providers and payers; and (gg) any matters deemed relevant by the commission; provided further, that 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.

## **Appendix B – List of Commission Members**

<b>Name</b>	<b>Seat</b>
Amy Rosenthal	Chair and designee of the Secretary of the Executive Office of Health and Human Services (EOHHS)
Lauren Almeida	Designee of the Commissioner of the Department of Children and Families (DCF) Commissioner
Kevin Beagan	Designee of the Commission of the Division of Insurance (DOI)
Carmel Craig	Representative from Association for Behavioral Healthcare (ABH)
Rachel Gwaltney	Representative from Children’s League of Massachusetts
Paul Hyry-Dermith	Designee of the House Chair of the Joint Committee on Mental Health, Substance Use, and Recovery (MHSUR)
Robyn Kennedy	Senate Chair of the Joint Committee on Mental Health, Substance Use, and Recovery (MHSUR)
Jessica Larochelle	Representative from the Massachusetts Association for Mental Health (MAMH)
David Matteodo	Representative from the Massachusetts Association of Behavioral Health Systems (MABHS)
Kristen McKinnon	Designee of the Commissioner of the Department of Elementary and Secondary Education (DESE)
Lisa Morrow	Representative from Health Law Advocates
Lee Robinson	Designee of the MassHealth Assistant Secretary
Pamela Sager	Representative from the Parent/Professional Advocacy League (PPAL)
Leigh Simons	Representative from the Massachusetts Health and Hospital Association (MHA)
Aimee Smith-Zeoli	Designee of the Commissioner of Early Education and Care (EEC)
Charlene Zuffante	Designee of the Commissioner of the Department of Mental Health (DMH)

## **Appendix C – Reports and Resources Reviewed by the Commission**

- **Children's Behavioral Health Initiative**
  - [Data and Reports](#)
- **Children's Behavioral Health Advisory Council Reports:**
  - [2022](#)
  - [2023](#)
  - [2024](#)
- **Autism Commission Reports:**
  - [2022-2024](#)
- **Unaccompanied Homeless Youth Commission Reports**
  - [Youth Count Reports, 2022-2024](#)
- **Children's Mental Health Campaign**
  - [School Based Behavioral Advisory Group 2023 reportp](#)
  - [Infant and Early Childhood Mental Health \(IECMH\) Workgroup](#)
  - E4 Project: [Recommendations](#) & [Services Landscape & Family Journey Maps](#)
- **Massachusetts Taxpayers Foundation**
  - [Overview of Pediatric Behavioral Health Crisis \(2024\)](#)
- **MA Child Psychiatry Access Project (MCAP) Report**
  - [FY 2023, FY2024](#)
- **Office of the Child Advocate**
  - [Office of the Child Advocate FY 2025 Strategic Plan](#)
- **Children's Trust**
  - [2025 Annual Report](#)
- **DCF HealthCare Oversight and Coordination Plans**
  - [FYY2025 - FYY2029](#)
  - [2020-2024](#)

- **Health Policy Commission**
  - [Children with Medical Complexity in the Commonwealth, February 2022](#)
  - [Consolidation and Closures in the Massachusetts Pediatric Health Care Market, September 2023](#)
  - [Report on Behavioral Health Managers, November 2024](#)
  - [Behavioral Health Emergency Department Boarding in MA, February 2025](#)
- **Association for Behavioral Healthcare**
  - [Kids are Waiting: Children's Behavioral Health Crisis and Collapse, December 2023](#)
  - [Roadmap for Behavioral Health Reform](#)
- **MA Health & Hospital Association (MHA)**
  - [Behavioral Health Reports](#)
- **MA Department of Public Health**
  - [DPH Community Health Equity Initiative](#)
- [New Jersey Children's System of Care \(CSOC\)](#)
- [Delaware Division of Prevention and Behavioral Health Services](#)
- [Illinois Blueprint for Transformation: A vision for improved behavioral healthcare for Illinois children](#)
- [Philadelphia: Department of Behavioral Health Services and Intellectual Disability Services](#)
- [National Academy for State Policy: Children and Youth Behavioral Health](#)

## Appendix D – Workgroup #1 – Landscape & Funding Analysis

**Workgroup Members:** Kevin Beagan, Rachel Gwaltney, Jessica Laroche, David Matteodo

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/provide the service/program	Entity that provides oversight and/or licensing oversight to service/program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
Emergency/Crisis	DMH Youth Emergency Department (ED) Diversion Program - Part of the DMH Flexible Support Program	All	DMH Youth Emergency Department (ED) diversion teams are included in DMH Flexible Support services.	DMH		DMH	No	No	No	ED	
Emergency/Crisis	988 Suicide & Crisis Lifeline (MA)	All	988 provides support to people who are experiencing emotional distress or suicidal thoughts — or are worried about a loved one who is. You do not need to be suicidal to contact 988.	DPH		Free to caller	No	No	No	Free 24/7/365	
Emergency/Crisis	911 / Emergency response	All	Emergency safety response for immediate, life-threatening situations	EOPPS (911) and DPH (Office of Emergency Medical Services)		N/A for call; User free on cell phones and land lines (911); Commercial coverage varies for EMS and ambulance	Yes - EMS	No	Reponds in SU crisis	Call 911	
Emergency/Crisis	Emergency Services Program / Mobile Crisis Intervention (MCI)	All	MCI is a mobile (and site-based), face-to-face, therapeutic response to a youth experiencing a behavioral health crisis to reduce the risk of danger to the youth or others. The service is provided 24 hours a day, seven days a week.	MassHealth delivered by CBHCs		Crisis access designed to be universal; DOI regulated commercial insurers required to cover; Behavioral Health Access and Crisis Intervention Trust Fund	Yes	No	Provide SUD emergency response	Free - Any one can call for self, family, friend, or client	
Emergency/Crisis	Youth Community Crisis Stabilization (YCCS)	0-18 (sometimes 19-20)	Provided to children/adolescents up to and including the age of 18 (youth ages 18-20 may be eligible for admission based on a program's licensing requirements and a member's clinical needs) with behavioral health symptoms that require a 24/7, staff-secure (unlocked) treatment setting. The primary function of YCCS is to provide short-term (one to five days) crisis stabilization,	MassHealth delivered by CBHCs (or CBHCs subcontract with other organizations)		Bill pending to require DOI regulated commercial insurers to cover YCCS; Behavioral Health Access and Crisis Intervention Trust Fund	Yes	No	No	Typically from MCI or ED	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
			therapeutic intervention, and specialized programming in a staff-secure environment with a high degree of supervision and structure.								
Emergency/Crisis	Emergency Department (ED)	All	ED stabilization; may lead to inpatient/residential/PHP discharge plans; may lead to ED or med-surg unit boarding	Private hospitals (not a state program) - Licensed by DPH		Payer + safety-net rules	Yes	No	Treats people in SU crisis	Walk-in; EMS; transfer from CBHC/MCI; Police drop-off	
Acute IP	DMH Continuing Care Inpatient	13-18	Provides locked psychiatric hospital level of care for adolescents ages 13-18 who require the most clinically intensive treatment available in the state. The service also includes on-site educational programming provided by DESE. Most adolescents are referred by acute inpatient providers when extended, specialized psychiatric treatment is indicated. Some adolescents may be referred by the Court for a short-term forensic evaluation or psychiatric treatment.	DMH		Commercial insurance pay also be billed	Yes	No	No	DMH, usually referral from private psychiatric hospitals	
Acute IP	Youth inpatient psychiatric hospitalization	All	24/7 locked psychiatric units that provide a high degree of structure and clinical services for youth in acute psychiatric distress.	Private hospitals; DMH licensed		MassHealth/commercial ; other payment routes if uninsured	Yes	No	No	Usually via ED/clinical referral	
Urgent	Community Behavioral Health Centers (CBHCs) - Urgent Access	All	Provide wide range of mental health and substance use services and treatment, Urgent access includes same or next-day evaluations, extended evening and weekend hours, and access to psychopharmacology within 72 hours of an initial evaluation.	MassHealth delivered by provider orgs		Crisis access and three outpatient visits - including urgent visits (per year) designed to be universal; Behavioral Health Access and Crisis Intervention Trust Fund	Yes	No	Provide SUD treatment and care for people with co-occurring conditions.	Self or referral	
Urgent	Behavioral Health Urgent Care Providers (BHUC)	All	Same/next-day BH visits (varies by site model) and extended evening and some weekend hours; Providers have met MassHealth attestation requirements	MassHealth delivered by provider orgs		Lots of variation in commercial coverage; some sites have self-pay policies	Yes	No	Provides care for SUD urgent needs	Self or referral	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
Urgent	Pediatric Behavioral Health Urgent Care in Schools Pilot	Middle and High School Students	CBHC clinician based in middle or high school to address students' urgent behavioral health needs and connect to longer-term supports if indicated.	Private - MAMH managed project, foundation funding		Private foundations - grants	No	No	Helps students with SU needs.	School referral typically	
Intermediate	DCF Family Support & Stabilization Services ("Support & Stabilization" / S&S)	Families (Youth, caregivers, family system) with an open DCF case	Broad array of services that builds caregiver and/or youth skills; strengthens family relationships; builds community supports to prevent escalation/out-of-home placement	DCF	DCF	DCF Funding - From DCFs operational budget	No	No	Some services are substance use specific for youth	Having an open/ongoing DCF case	
Intermediate	Young Parent Living Program	Youth who are young parents, Up to age 22y.o.	Group Home specifically for young parents (male/female); parenting skills and support to achieve permanent housing	DTA and DCF	EEC Licensing	Funding is shared between DTA and DCF	No	No	No	Young adults are eligible by being an open DCF child consumer or meeting DTA eligibility guidelines.	
Intermediate	DCF Contracted Emergency Residence and Intensive Emergency Residences	Youth that are open DCF child consumer and are in DCF Custody	Congregate care placement on an emergency basis for youth with moderate to severe behavioral health needs, requires intake on same day as referral. Not long term placement or long term therapeutic treatment and intended for utilization of emergency placement needs for youth.	DCF	EEC Licensing	DCF	Partial CPE funding	No	No	Must be an open DCF child consumer and DCF must have custody of the youth.	DCF relies on a network of community-based providers/entities to provide congregated care placement services to youth. These entities have the decision-making authority on accepting the youth into their program. They can decline youth based on factors such as clinical needs of youth being a match to the program, and several other factors. The programs can also discharge youth if they determine they can no longer meet the youth's needs. Youth living in this environment attend a community based educational setting as determined by their LEA.
Intermediate	DCF Contracted Group Homes	Youth that are open DCF child consumer and are in DCF Custody	A variety of congregated care placements for youth with moderate to severe behavioral health needs. This includes placements for youth transitioning to adulthood, and with medically complex/behavioral health needs.	DCF	EEC Licensing	DCF	No	Some group homes are ASD specific	No	Must be an open DCF child consumer and DCF must have custody of the youth.	The medically complex/behavioral health group home will be starting in late Feb/March 2026. DCF relies on a network of community-based providers/entities to provide congregated care placement services to youth. These entities have the decision-making authority on accepting the youth into their program. They can decline youth based on factors such as clinical needs of youth being a match to the program, and several other factors. The programs can also discharge youth if they determine they can no longer meet the youth's needs. Youth living in this environment attend a community based educational setting as determined by their LEA.

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
Intermediate	Residential Schools	Youth (under 22y.o) who's school district (LEA) indicates the youth is unable to be educated in a lower level, educational setting.	Facilities that provide 24-hour, specialized and intensive educational services to students with disabilities whose needs cannot be met in a less restrictive, day setting. A placement environment that provides specialized educational supports, therapeutic and living environment supports youth.	School Districts/LEA, DCF (For youth in DCF custody only)	EEC Licensing - DESE Approves	School Districts/LEA, DCF . School districts can fund res-ed placement for students they determine require that level of care and would for youth that are no in DCF custody. For youth in DCF custody, DCF and school districts will often enter into a cost sharing agreement.	No	Some are ASD specific	? would need to ask EEC/DESE - DCF is not aware of any that we have access to that are Substance use specific	A youth's School District/LEA must determine the youth requires a res-ed and authorize it. For youth in DCF custody, that are an open child consumer, DCF and the school district can determine if a res-ed is needed jointly. DCF cannot independently authorize res-ed for youth in DCF custody. The school district must agree the youth requires a res-ed level of education.	Residential schools are provided by a variety of private entities throughout the state and are authorized by DESE to be a residential school. These entities have the decision-making authority on accepting the youth into their program. They can decline youth based on factors such as clinical needs of youth being a match to the program, and several other factors. The programs can also discharge youth if they determine they can no longer meet the youth's needs. DCF and MA school districts share the res-ed resources in MA. Some res-ed schools will not service youth in DCF custody, while others have contracts with DCF to be willing to serve youth that DCF and school district are seeking a res-ed level of care for a youth. Youth at res-ed are living and attending school at the same location.
Intermediate	TCU — Transitional Care Unit	Youth in DCF custody - Licenced to accept 5-17y.o. but program decides acceptance	A short-term, structured 24/7 setting for youth (in DCF custody) moving from acute inpatient care to a home or lower-level placements, offering intensive therapy, case management, and planning for a stable return, focusing on behavioral health needs for up to 30 days.	St. Anne's Home, Inc. (Only entity in state contracted to provide TCU Service)	EEC	Medicaid	Yes	No	No	Step down from inpatient psychiatric facility or transfer from a CBAT level of care	There are only 3 contracted spots for TCU statewide.
Intermediate	DDS Intensive Family Flexible Supports	Children eligible for DDS services	Provides case management services for families and flexible funding to help families purchase other items or services that the child may need with the goal of easing the level of stress families are experiencing and to helping them keep their child/youth in the home.	DDS		?	No	No	No	DDS	
Intermediate	DESE/DDS Residential Prevention Program	6-21	A program of wraparound services for students helps prevent a more restrictive educational or out-of-home residential placement by creating an individualized plan of supports for the participant that promotes skill building, independence, and social integration across multiple settings including the	DDS		ISA from DESE	No	No	No	DDS	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
			participant's home, school, and community.								
Intermediate	DDS Children's Autism Waiver Program	0-9	Children receive Expanded Habilitation, Education which are in-home services and supports such as Applied Behavioral Analysis (ABA), Floor Time, and Relationship Development Intervention (RDI), for a total of up to 3 years. At the conclusion of the 3 years of the intensive in-home services, a child may access ongoing Supplemental Services (for example: respite and goods and services, etc.) that meet the child's needs and help with the transition out of the intensive portion of the Autism Waiver Program—until the child's 10th birthday.	DDS Autism Division		Medicaid waiver structure (administered by DDS)	Yes	Yes	No	DDS	
Intermediate	ICBAT — Intensive Community-Based Acute Treatment	0-18 (sometimes 19-20)	Same as CBAT but higher intensity	DEEC licensed; defined in MA materials; delivered by providers		DOI regulated commercial insurers also required to cover	Yes	No	No	Typically from ED or hospital	
Intermediate	CBAT — Community-Based Acute Treatment	0-18 (sometimes 19-20)	Provided to children/adolescents up to the age of 18 (youth ages 19-20 may be eligible for admission based on a program's licensing requirements and an enrollee's clinical needs) with serious behavioral health disorders who require a 24-hour-a-day, seven-day-a-week, staff-secure (unlocked) treatment setting. The primary function of CBAT is to provide short-term crisis stabilization, therapeutic intervention, and specialized programming in a staff-secure environment with a high degree of supervision and structure, with the goal of supporting the rapid and successful transition of the	DEEC licensed; service model appears in MA coverage definitions; delivered by provider network		DOI regulated commercial insurers also required to cover	Yes	No but one ASD specific program exists.	No	Typically from ED or hospital	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
			child/adolescent back to the community.								
Intermediate	Flexible Support	Children eligible for DMH services	Flexible Support Services include Clinical Services, Therapeutic Support, Young Adult Peer Mentoring, and Parent/Caregiver Peer Support designed to prevent out-of-home placement, maintain the youth with his/her family, help the youth function successfully in the community, and assist families in supporting the growth and recovery of their child. These services are provided through three modalities: Flexible Support Teams, Flexible Support Groups, and Individual Practitioners.	DMH		DMH	No	No	No	DMH	
Intermediate	DMH School and Community Therapeutic Support	Children eligible for DMH services	<b>Parent and Family Support Services</b> - Provides information and support to families of children with mental health challenges. Includes information and referral; individual community advocacy; parent support groups; targeted supports; and expedited access to services for parents with mental illness. <b>Community and School Therapeutic Supports</b> - Provides consultation and assistance to schools and the community that support youth with significant mental health needs and their families.	DMH		DMH	No	No	No	DMH	
Intermediate	Program for Assertive Community Treatment for Youth (PACT-Y)	Children eligible for DMH services	PACT-Y is a comprehensive service for individuals under the age of 22 with serious emotional disturbance who have not responded well to traditional office- and/or community-based services and interventions, and may benefit from intensive, coordinated, and comprehensive services that	DMH		DMH	No	No	No	DMH	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
			are provided by one integrated, multi-disciplinary, community-based team - the PACT-Y Team.								
Intermediate	Day Services (Therapeutic After School)	Children eligible for DMH services	Therapeutic After School Programs provide youth with recreational and skill building activities and clinical services in a structured environment.	DMH		Mental Health Block Grant	No	No	No	DMH	
Intermediate	Intensive Community Services (ICS)	Children eligible for DMH services	A range of in home and out of home services for youth, young adults, and their families who are involved with DMH. ICS provides clinically intensive treatment and outreach support to help build, strengthen, and maintain youths' connections to family, home, and community. ICS Services include Intensive Home-Based Therapeutic Care, Therapeutic Group Care, and Young Adult Therapeutic Care.	DMH		?	?	No	No	DMH	
Intermediate	Clinically Intensive Residential Treatment (CIRT)	6-12	The CIRT is for children whose needs exceed community-based services and require specialized, comprehensive, onsite individual/family clinical support in a staff-secure setting. This service also includes on-site educational programming provided by DESE.	DMH		For youth who do not have Medicaid, this is state only funded.	Yes	No	No	DMH, usually referral from hospitals	
Intermediate	Intensive Residential Treatment Programs (IRTPs)	13-18	Clinically intensive residential treatment intervention for adolescents ages 13-18 in a locked environment. The IRTPs are for adolescents whose needs exceed community-based services and require specialized, comprehensive, onsite individual/family clinical support. These services also include on-site educational programming provided by DESE.	DMH		For youth who do not have Medicaid, this is state only funded.	Yes	No	Program serves youth with co-occurring needs.	DMH, usually referral from hospitals	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
Intermediate	Transition Aged Youth and Young Adult Residential	16-25	Residential programs provide a structured environment for young people ages 16-25 in an alcohol and drug-free residential treatment setting. Services include assessment, comprehensive substance use treatment, mental health counseling referrals, case management and coordination, psycho-education on a variety of topics relating to health and wellbeing, life skills enhancement, vocational/educational support, recovery support, parent/caregiver support, and aftercare planning. Average length of stay depends on individual treatment and recovery goals.	DPH/BSAS		DPH/BSAS	Yes	No	Yes	BSAS	
Intermediate	Youth Residential Programs	13-17	The length of stay varies based on treatment needs and can be up to 90 days.	DPH/BSAS		DPH/BSAS	Yes	No	Yes	BSAS	
Intermediate	DYS Clinical Services	Justice-involved youth	Comprehensive assessment after commitment; clinical services inside DYS system	DYS		DYS	No	No	No	DYS	
Intermediate	DYS Substance Abuse Services for Juvenile Offenders	Justice-involved youth	SUD screening and services for DYS-involved youth; Justice-involved youth clinical care	DYS		DYS	No	No	Yes	DYS	
Intermediate	Family-based Intensive Treatment (FIT)	MassHealth	FIT is a specialized service offering a combination of medically necessary, intensive family therapy with robust care coordination and family partner engagement for MassHealth youth with serious emotional disturbance. The FIT team is made up of a master's level clinician, a qualified paraprofessional staff, and a family partner. Each family is assigned a full team.	MassHealth (CBHI)		MassHealth	Yes	No	No	Child can be referred by parent/guardian, PCP, or other mental health provider	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
Intermediate	ICC — Intensive Care Coordination	MassHealth, commercial coverage varies	High-intensity care coordination + team planning for complex youth. (ICC is a care coordination service for children and youths with serious emotional disturbances. In Wraparound Care Planning, families and youth work together with professionals, talk about their strengths and needs, and actively guide their own care. A care coordinator works with the youth, family/caregiver, and others involved in a youth's life to create an Individualized Care Plan to meet the youth's needs and help meet the goals identified by the family/caregiver. The service is designed for youth who need or receive services from multiple providers, schools, or state agencies.)	MassHealth (CBHI) + DOI (BHCA)		MassHealth + Commercial insurers regulated by DOI are required to cover	Yes	No	No	Child can be referred by parent/guardian, PCP, or other mental health provider	
Intermediate	IHT — In-Home Therapy	MassHealth, commercial coverage varies	Family therapy delivered in home/community. (The provider works closely with the child and family to create a specific behavior plan to improve the child's functioning. The provider may also work as a team with a skilled paraprofessional called a "behavior management monitor." The monitor works with the child and family to implement the child's behavior plan.)	MassHealth (CBHI) + DOI (BHCA)		MassHealth + Commercial insurers regulated by DOI are required to cover	Yes	No	No	Child can be referred by parent/guardian, PCP, or other mental health provider	
Intermediate	IHBS — In-Home Behavioral Services	MassHealth, commercial coverage varies	Behavioral interventions/supports in home/community. (In-Home Behavioral Services offer support to a child or youth who has a challenging behavior that interferes with everyday life. Services are provided by a behavioral health provider, such as a therapist, who is skilled in understanding and treating difficult behaviors in children and youth.)	MassHealth (CBHI) + DOI (BHCA)		MassHealth + Commercial insurers regulated by DOI are required to cover	Yes	No but has the capacity to serve this population	No	Child can be referred by parent/guardian, PCP, or other mental health provider	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
Intermediate	Family Support & Training (Family Partner)	MassHealth, commercial coverage varies	Caregiver peer support/navigation tied to youth's plan (Family Partners help parents and caregivers to help their children reach their treatment goals. They are parents or caregivers of children with special needs themselves—they've "been there," understand what families go through, and can share their experiences. Family Partners are not behavioral health professionals, but work closely with parents to make sure that children and youth receive services that are needed.)	MassHealth (CBHI) + DOI (BHCA)		MassHealth + Commercial insurers regulated by DOI are required to cover	Yes	No	No	Child can be referred by parent/guardian, PCP, or other mental health provider	
Intermediate	Therapeutic Mentoring (TM)	MassHealth, commercial coverage varies	Skill-building support for youth in community settings (A therapeutic mentor works one-on-one with a youth to support and coach him or her to learn social skills, including better ways to communicate with other youth and adults, how to deal with different opinions, and how to get along with others. The therapeutic mentor works with the child to achieve goals in the plan written by an outpatient therapist, In-Home Therapy provider, or an Intensive Care Coordination (ICC) team. Therapeutic Mentoring Services can be delivered in the home, school, or community, including social and recreational settings.)	MassHealth (CBHI) + DOI (BHCA)		MassHealth + Commercial insurers regulated by DOI are required to cover	Yes	No	No	Child can be referred by parent/guardian, PCP, or other mental health provider	
Intermediate	BRYT	Middle and High School Students	The Brookline Center's bryt Team works with schools to implement intensive interventions based in the signature bryt Model for intensive and comprehensive support for youth who have fallen behind academically in association with a mental health disruption.	Private - The Brookline Center for Community Mental Health		Funding from DMH and school districts	No	No	Helps students with SU needs.	Post hospitalization.	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
Intermediate	PHP — Partial Hospitalization Program	All, coverage varies	Short-term, high-intensity day treatment; diversion from inpatient / step-down	Private providers - Licensed by DPH		MassHealth/commercial ; sometimes grant-funded	Yes	No	No	Referral from inpatient/ED/outpatient	
Intermediate	IOP — Intensive Outpatient Program	All, coverage varies	High-intensity outpatient treatment; typically fewer hours than PHP	Private providers - Licensed by DPH		MassHealth/commercial ; sometimes grant-funded	Yes	No	No	Referral from outpatient/ED/PHP	
Community-Based Tx/Support	Coordinated Community & Family Engagement Program	Children in early education and childcare programs	Provides services to address and support the social-emotional development and behavioral health of children in early education and care programs.	DEEC		?	No	No	No	?	
Community-Based Tx/Support	School Psychologists, Counselors, Adjustment Counselors	Pre-K-12 students	Therapeutic services (1:1 counseling, groups, accommodations) provided to students by school staff.	DESE		State funding that contributes to the district's "foundation budget" (behavioral health is approx. 3% of this budget).	Eligible for school-based Medicaid program (SBMP).	No	Helps students with SU needs.	Varies - School or caregiver referral typically.	
Community-Based Tx/Support	Supporting Students' Social Emotional Learning, Behavioral & Mental Health, and Wellness Grant	PreK-12 students	This grant program supports Massachusetts public school districts and communities to adapt, expand, or strengthen multi-tiered systems of support to respond to the social-emotional and behavioral health needs of students, families, and educators and to build strong partnerships with community-based mental health agencies and/or providers. This includes universal screening and professional development to help staff implement tier 2/3 (supplemental, small group, and more intensive) interventions.	DESE		DESE (state funding)	No	No	Can help with SU needs.	DESE	
Community-Based Tx/Support	School-Based Special Education Services	3-22	Special education services are available to eligible students ages 3 up to 22 in Massachusetts who 1) have a disability and 2) as a result of their disability require specially designed instruction or one or more related services (i.e., speech therapy) to access and make progress in the general curriculum.	DESE		Federal, state, local resources	Eligible for school-based Medicaid program (SBMP).	Helps students with ASD/IDD.	Helps students with SU needs.	Referred by EI, parent, school	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
Community-Based Tx/Support	MCPAP (and variants like ASD-ID, Early Childhood)	Provider consultation	MCPAP provides pediatricians and primary care physicians quick access to psychiatric consultation and facilitates referrals for accessing ongoing behavioral health care. MCPAP offers training and support to PCPs treating youth with behavioral health challenges and supports practices to integrate behavioral health resources and work with behavioral health providers.	DMH		General Funds through MBHP; Also contributions from commercial insurers	No	There is an ASD-ID specific MCPAP service	No	Pediatricians and PCPs	
Community-Based Tx/Support	DMH Young Adult Access Centers	All	Access Centers focus outreach and engagement efforts on those who may be facing challenges such as: mental illness and substance misuse, economic insecurity, homelessness, pregnant/parenting, commercial/sexual exploitation, and those facing other challenges that have posed barriers to engagement in services.	DMH		DMH	No	No	No	Open to all	
Community-Based Tx/Support	School-Based Tele-Behavioral Health	K-12 students	Virtual (phone or video) behavioral health services with the referral typically coming from the school. The student may receive services in the home or school setting.	DPH - Contracts with the Brookline Center; also Heywood Hospital and Outer Cape Health Services		Varies - MassHealth, some commercial, contracts with school districts	Yes	No	No	Varies - School or caregiver referral typically.	
Community-Based Tx/Support	MassSTART School-Based Intervention Programs	8-13	MassSTART is a school-centered intervention program, which has proven positive outcomes for youth, their families, and the community. MassSTART serves youth 8 to 13 years old at high risk for or experiencing criminal justice involvement, substance use, family violence, and school, social, and/or behavioral problems. Case workers use a positive youth development framework to coordinate and provide support and services at school and in the home.	DPH/BSAS		?	No	No	Yes		

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
Community-Based Tx/Support	iDECIDE	12-17	Provided by BA level staff or paraprofessionals in the school and/or community. Education-based intervention for students caught violating school substance use policy.	DPH/BSAS		?	No	No	Yes	This is a collaboration between BSAS, Massachusetts General Hospital, the Institute for Health and Recovery. Not in all schools.	
Community-Based Tx/Support	Project AMP	13-17	Provided by BH level staff, paraprofessionals, or people with lived experience in the school or community. Enhanced brief intervention delivered by trained near-peers. 4-6 sessions in school-based settings.	DPH/BSAS		?	No	No	Yes	Not in all schools.	
Community-Based Tx/Support	Adolescent Community Reinforcement Approach (ACRA)	13-25	Adolescent Community Reinforcement Approach (A-CRA) is a developmentally-appropriate behavioral treatment for youth and young adults 13 to 25 years old with substance use disorders. The model is delivered in the community and typically involves weekly session which can include parent/caregivers.	DPH/BSAS - Certifies clinicians		BSAS pays for training.	Yes	No	Yes	BSAS	
Community-Based Tx/Support	Recovery High Schools	High school	Recovery high schools are four-year high schools for youth who are experiencing a problem with substance use. Recovery high schools were created to provide educational environments suited to support youth recovering from substance use disorders.	DPH/BSAS and DESE		Jointly funded by DPH/BSAS, local school districts, and educational collaboratives/consortiums	No	No	Yes		
Community-Based Tx/Support	ABA (Applied Behavior Analysis)	0-21	ABA therapy aims to increase skills (communication, social, daily living) and decrease challenging behaviors, delivered through home-based, center-based, and school consultation models, often for those with Autism Spectrum Disorder (ASD).	MassHealth + DOI		DOI regulated commercial insurers also required to cover	Yes	Yes	No	Self, PCP, mental health provider referral	
Community-Based Tx/Support	Community Behavioral Health Centers (CBHCs) - Outpatient	All, Limited commercial coverage	Provide wide range of mental health and substance use services and treatment, Outpatient routine care includes assessment, shorter-term goal-driven therapy, medication evaluation and management, peer supports,	MassHealth delivered by provider orgs		Crisis access and three outpatient visits (per year) designed to be universal; ongoing care covered by MassHealth; Commercial coverage for ongoing care depends on payer/site and can be limited.	Yes	No	Provide SUD treatment and care for people with co-occurring conditions.	Self or referral	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
			nursing, case management, groups, etc.								
Community-Based Tx/Support	Tele-Substance Use Treatment	Adolescents	The Primary Care Plus and Adolescent Substance Use & Addiction Program (ASAP) at Boston Children's Hospital offer virtual substance use care (the child does not have to be a patient of BCH).	Private - Boston Children's		MassHealth and most commercial insurers	Yes	No	Yes	Self, PCP, behavioral health provider referral	
Community-Based Tx/Support	Outpatient routine mental health (state-defined categories used in coverage definitions)	All, coverage varies	Therapy (individual, group, and family/couples)/med management in ambulatory settings	Private - Clinics licensed by DPH; Practitioners have own licensing bodies		MassHealth/commercial/self-pay; Lots of variation across payors	Varies	No	No	Self, PCP referral	
Community-Based Tx/Support	Outpatient routine substance use (state-defined categories used in coverage definitions)	All, coverage varies	Therapy (individual, group, and family/couples)/med management in ambulatory settings	Private - Clinics licensed by DPH; Practitioners have own licensing bodies		MassHealth/commercial/self-pay; Lots of variation across payors	Varies	No	Yes	Self, PCP referral	
Community-Based Tx/Support	Medication for Opioid Use Disorders (MOUD) for Youth	Youth with OUD	SAMHSA defines Medication-Assisted Treatment (MAT) as the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.	Private - Clinics licensed by DPH; Practitioners have own licensing bodies		MassHealth/commercial/self-pay; Lots of variation across payors	Yes	No	Yes	Self, PCP, behavioral health provider referral	
Care Mgmt and Coord	DDS Family Support Navigation	Children eligible for DDS services	[Need to get description from DDS]	DDS		?	No	No	No	DDS	
Care Mgmt and Coord	DDS Children's Services Coordinators	Children eligible for DDS services	[Need to get description from DDS]	DDS		?	No	No	No	DDS	
Care Mgmt and Coord	Case Management	Children eligible for DMH services	Comprehensive mental health and family assessment as well as individual service planning, coordination of DMH funded services, and linkage to other community supports.	DMH		DMH and MassHealth	Yes	No	No	DMH	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
Care Mgmt and Coor	Care Coordination for Children & Youth with Special Health Care Needs	Families with youth with special needs	Care coordinators help families obtain services, providing links to community-based resources and providing consultation to parents, educators, and medical and social service providers. Care coordinators partner with families and providers and promote continuity of care.	DPH		?	No	No	No	?	
Care Mgmt and Coor	Intensive Case Management	Parents of youth ages 8-17	School-based 6-24 month intervention. Students are identified and referred by school staff for poor school attachment or academic performance, conduct problems, and family history of substance use.	DPH/BSAS		?	No	No	Yes	Not in all schools.	
Early Identification/Intervention	Early Intervention	0-3	A program for infants and toddlers (birth to 3 years old) who have developmental delays or are at risk of a developmental delay.	DPH		Also may be billed to commercial insurance.	Yes	There are EI specialty services for children with ASD.	No	Anyone can make a referral to EI	
Early Identification/Intervention	ECMHC — Early Childhood Mental Health Consultation (EEC network)	Early education /childcare consultation	Consultation to early education/childcare settings to support social-emotional development & behavioral health; Early childhood prevention/consultation	EECS/EEC administered grant network		Grant-funded	No	No	No	Early education/childcare providers	
Early Identification/Intervention	EEC Behavioral Health Team	Early Education Licensed Programs	Direct Support to Programs providing Behavioral and Mental Health Tech Assistance and Resources	EEC		EEC	No	No	No	Early Education Child Care Providers	
Early Identification/Intervention	Integrated Behavioral Health in Pediatric Primary Care	All	Integrated behavioral health clinicians as part of primary care teams support early identification of behavioral health needs and access to treatment.	Private - Examples include Team Up, PPOC at BCH, the Collaborative Care Model (CoCM) among others		MassHealth, commercial coverage varies	Yes	No	Can help with SU needs.	Primary care.	
Front Door/Navigation	Family Resource Centers (FRC) network	All	Community-based hubs connecting families to supports (including information and referral, parent education programs, youth/parent support groups, early childhood services, Child Requiring Assistance (CRA)	Serves any family in the state, no referrals needed	DCF oversees network	State-administered network w/ partners	No	No	No	Engage locally at one of 33 sites. Serves any family in the state, no referrals needed	

Continuum level	Specific program/service name (MA)	Who it Serves	What it provides	Entities that have contracts to offer/ provide the service/ program	Entity that provides oversight and/or licensing oversight to service/ program	Who typically pays	Medicaid funded?	ASD specific?	Substance use specific?	Access pathways	Additional Information
			intervention, basic needs support).								
Front Door/Navigation	DDS Regional Autism Support Centers	Children with ASD/IDD	Information/referral, resources and supports, navigation for ASD (regional network); Autism/IDD family navigation & supports	DDS		DDS-funded/support model	No	Yes	No	?	
Front Door/Navigation	DDS Family Support Centers	Children eligible for DDS services	Provide information and referral services, support groups, trainings for families, parent networking and mentoring opportunities, social services, and family support services for children with IDD/ASD.	DDS		DDS	No	Yes	No	?	
Front Door/Navigation	Massachusetts Behavioral Health Help Line (BHHL)	All	24/7 call, text, chat helpline to connect people with qualified professionals for referral and connection to routine, urgent, and crisis mental health and substance use services.	DMH delivered by Carelon		Free to user; BH Access and Crisis Intervention Trust Fund	Partial	No	Helps people with SU needs	Free - Can call for self, friend, family member, or client	
Front Door/Navigation	Children & Youth with Special Needs Community Support Line	Families with youth with special needs	The Division for Children & Youth with Special Health Needs toll free statewide Community Support Line provides information, technical assistance and resources for families with children and youth with special health needs and the providers serving these families.	DPH		?	No	No	No	Available to everyone	
Front Door/Navigation	MA Substance Use Helpline	All	24/7 free/confidential navigation to SUD harm reduction, treatment, recovery, and problem gambling.	DPH/BSAS		Free to user	No	No	No	Free - Can call for self, friend, family member, or client	

## **Appendix E – Workgroup #2 – Summary of Challenges and Recommendations**

**Workgroup Members:** Carmel Craig, Kristen McKinnon, Pam Sager, Leigh Simons, Aimee Smith-Zeoli, Charlene Zuffante

### **1. Access, Entry & Navigation - Challenges and Recommendations**

- No clear starting place; inconsistent entry, referral, and intake pathways
- Families lack clear information on services, roles, and eligibility
- Caregiver burden + barriers from requirements, hours, transportation, transitions

#### **Policy Recommendation:**

Reduce unnecessary burdens and service delivery delay by ensuring access, entry, and navigation system design is family centered and family driven.

#### **Key Elements:**

1. Utilize existing behavioral health groups, such as the Children’s Behavioral Health Advisory Council, the various Family Advisory Councils, and family-serving community agencies to elicit significant input from families on potential improvements to the child-serving systems.
2. Gather information from stakeholders (i.e., providers, schools, pediatricians, behavioral health professionals, MassHealth, community health centers, family advisory councils, first responders, etc.) regarding potential improvements to the child-serving systems.
3. Utilize the Children’s Behavioral Health Advisory Council or an extension of this Special Commission to develop and make recommendations gathered from stakeholder input for a framework to access, enter, and navigate children’s services that will reduce the burden on caregivers and ensure timely services.
  - a. The recommendations should include proposed funding mechanisms for the framework.
  - b. Provide sufficient time for the Council or Commission to gather the data and develop the framework in a meaningful and thorough manner.

#### **Policy Recommendation:**

Provide clear information to families, providers, professionals, and the community about state agency (or community-based program/service, such as CBHC or CBHI) roles and services.

#### **Key Elements:**

1. Engage users of the services (families and children), service providers, professionals, and community agencies at the outset to help design materials and programs to educate stakeholders and the public about state agency, CBHC, BHUC, and CBHI roles and services.
  - a. Ensure that such materials and programs are widely disseminated using service providers, professionals, and community agencies on an ongoing basis.
  - b. Keep the materials updated.

### Policy Recommendation:

Create a clear starting place for obtaining children's services. Too many helpline numbers and siloed agencies confuse not only families, but also providers, professionals, and the community when making referrals.

### Key Elements:

1. **Create a single point of entry ("single entry door") with cross-agency trained staff who can help families navigate across child-serving systems.**
2. Create a single pool of funds for this purpose regardless of utilization of the service by a particular agency (DMH, DDS, DYS, DCF, DPH, DESE).
3. After input from single-entry staff, create an interagency centralized data dashboard of information helpful to them so that they can efficiently and successfully perform their job.
4. Utilize all agency, providers, professionals, community partners, first responders, and the OBHPP to market this single-entry door in a family centered manner.

### Policy Recommendation:

Standardize application processes and eligibility criteria across agencies, child-serving system, and/or programs to eliminate undue burden and confusion for families and those making referrals. **(Overlap with Coverage & Affordability, Equity, and System Design)**

### Key Elements:

1. Create a standardized, streamlined, digitized **referral process** across all referring partners (agencies, providers, professionals, families, first responders, community.) **(Overlap with System Design)**
2. Create a standardized, streamlined, digitized **application process** across all agencies with succinct addendums for needed agency specific information. **(Overlap with System Design)**
3. Align eligibility criteria across all agencies as much as possible. **(Overlap with Coverage & Affordability, Equity, and System Design)**
4. Ensure single-entry staff are well trained and receive ongoing *effective* training and updates across all agencies.

### Policy Recommendation:

Ensure access for those children whose multi-complex needs do not fit squarely within a single agency through agency collaboration and clarifying service accessibility.

### Key Elements:

1. **Improve meaningful cross-agency and cross-sector communication** among child-serving agencies with targeted goals and collaborative problem-solving. **(Overlap with Equity and System Design)**
2. Utilize the single-entry point system to bring agencies together to best serve the needs of the children and families.
3. Utilize the pooling of funds concept to reduce the concern of individual agency budget expenditures.

### Policy Recommendation:

Clarify what services are covered by MassHealth, by commercial insurers, and which providers take which insurances to reduce confusion, misinformation, and inaccessibility of covered services. **(Overlap with Coverage & Affordability and Service Design)**

### Key Elements:

1. Work with MassHealth and commercial insurers to align language around services as much as possible. **(Overlap with Service Design)**
2. Encourage community providers, particularly CBHCs, to align commercial insurance payors they accept. **(Overlap with Coverage & Affordability)**
3. Utilize all avenues available to educate families, providers, professionals, and the community about the availability of insurance reimbursable services in a family-driven, understandable manner.

## 2. Workforce Capacity, Stability & Training

- Shortages and closures reduce availability and continuity
- Turnover (wages, burnout, competition) undermines stability and responsiveness
- Training gaps + lack of diverse/bilingual workforce limits appropriate care (ASD/IECMH)

### Policy Recommendation:

Address workforce shortages across settings to ensure availability and continuity of care, as well as reducing waitlists, limited capacity, and service gaps.

### Key Elements:

1. Address the root cause of workforce declines
  - a. Make salaries and benefits competitive and comparable to market rate, including by ensuring sufficient reimbursement
  - b. Offer flexible scheduling to meet both staff and family needs (e.g., matching families with staff employed on weeknights and weekends).
  - c. Ensure manageable caseloads with awareness of needs and intensity
    - i. Establish foundational behavioral health staffing benchmarks/ratios for BHI services as well as school- and community-based children's services.
2. Create a Mental Health Talent/Workforce pipeline **(Overlap with Equity)**
  - a. Provide a clear path to careers in behavioral health from entry-level positions to individuals seeking bachelor's- and master's-level degrees, paying for part of MA's degree in return for a 2- or 3-year commitment to work in children's behavioral health community services.
  - b. Provide incentives to higher education institutions to grow school and community behavioral health programs.
3. Develop a program/cohort of providers and students that meet regularly (e.g., throughout a semester) to better understand school and community behavioral health programs.
4. Incentivize providers to finance MA-level program for staff

### Policy Recommendation:

Reduce high turnover and instability that disrupt relationships, responsiveness, and care continuity.

### Key Elements:

1. Identify, improve, and develop new investment in retention initiatives through the Health Policy Commission Behavioral Health Workforce Center or other appropriate agency/entity.  
**(Overlap with Equity)**
  - a. Reinvestment in MA Repay program
  - b. Develop a scholarship program that prioritizes diverse applicants and placements in areas of highest need, including recruiting efforts in underrepresented communities (e.g., Franciscan Children’s Community Health Initiative, William James College, etc.) **(Overlap with Equity)**
2. Simplify licensing processes and reciprocity from other states/US territories/etc.

### Policy Recommendation:

Enable the children’s behavioral health delivery system to serve children and families by eliminating training and specialization gaps.

### Key Elements:

1. Provide adequate and ongoing training for staff delivering child behavioral health services **(Overlap with Equity recommendations)**
2. Expand the trainings offered through the [Behavioral Health Workforce Training Clearinghouse](#) to all state agencies, schools, etc.
3. Maximize existing workforce
  - a. Remove the Hub requirement from CBHI services so that families can appropriately access just a Family Partner or Therapeutic Mentor
  - b. Build workforce using paraprofessionals and other support roles with incentives and creative approaches to credentialing **(Overlap with Equity recommendations)**
  - c. Provide compensation for clinical supervision and reflective supervision
4. Improve access to linguistically and culturally competent care (including ASL) through a rate differential for services offered in a language other than English **(Overlap with Equity recommendations)**
5. Expand fellowship slots and residency training grants for child psychiatrists/psychologists focusing on co-occurring ASD and behavioral health
6. ASD Expansion
  - a. Expand training to focus on ASD, complex medical, and aggressive behaviors.
  - b. Legislative changes to allow a broader array of licensed professionals to diagnose ASD, reducing diagnostic bottlenecks.

## 3. Coverage, Affordability, Administrative Barriers & Financing/Sustainability

- Coverage gaps/denials, cost-sharing, reimbursement issues block access
- Administrative complexity (eligibility, authorizations, billing) delays care
- Financing/payment rules (rates, grants) affect sustainability and provider participation

### Policy Recommendation:

Reduce and/or eliminate insurance coverage gaps and denials so that children promptly receive appropriate and timely services

### Key Elements:

1. Solicit BHCA utilization and reimbursement feedback from stakeholders through on-going DOI information sessions and other various channels
  - a. Gather data, analyze it to ensure a clear understanding among stakeholders of commercial insurance challenges encountered by families and CBHI providers (e.g., limited services, incomplete reimbursement, etc.)
  - b. In conjunction with various stakeholders, including families, develop a comprehensive market conduct survey to better understand BHCA utilization, including what works and what doesn't
    - i. Survey children/families to determine whether they have had timely and effective access to mandated benefits.
  - c. Compile, analyze, and publish stakeholder feedback information and data accompanied by specific proposals to address gaps and denials
2. Eliminate cost-sharing, including co-pays, for home-based behavioral health services for children
3. Expand Medicaid coverage for early screening and promotion services.
4. Add information to insurance cards indicating whether the plan is subject to MA insurance laws.

### Policy Recommendation:

Reduce administrative complexity (e.g., eligibility, authorizations, billing, etc.) within child-serving systems for families, providers, agencies, and payors.

### Key Elements:

1. Identify administrative burdens across the child-serving systems that limit or delay access to services (e.g., eligibility criteria, prior authorization, billing complexity, credentialing delays). **(Overlap with Access recommendations)**
  - a. Gather data, input, and recommendations from all stakeholders including families, providers, agencies, and payors.
2. Streamline and reduce administrative hurdles to improve timely access to services **(Overlap with Access recommendations)**

### Policy Recommendation:

Maximize the impact and sustainability of funding across child-serving agencies and programs

### Key Elements:

1. Incentivize primary care providers (PCPs) to deliver behavioral health services.

2. Use data from various sources, including BHHL, to guide investment or reinvestment of funds across state agencies, ensuring that adequate and representative data is gathered as to both adult BH services and children’s BH services.
3. Use a fiscal cost analysis to guide sustainability of current services and the potential scale-up of children’s behavioral health services.
  - a. Fiscal analysis considerations should include short-term vs. long-term cost implications, budget neutrality requirements, prevention cost offsets, and workforce availability and sustainability.
4. Align and coordinate federal and state funding streams.
  - a. Coordinate Medicaid, CBHI, and other funding streams for prevention and family support.
  - b. Standardize rates for similar services across state agencies.
  - c. Coordinate funding to strengthen workforce capacity and culturally responsive community care.
  - d. Ensure alignment and coordination activities consider legal and regulatory impacts (i.e., state insurance mandates vs Medicaid rules, federal waivers, parity compliance, and coverage that exceeds federal requirements services)
5. Sustain IECMH funding beyond short-term grants by identifying revenue sources and workforce investment.

#### 4. System Design, Fragmentation & Coordination

- Multiple agencies/payors with limited coordination and accountability
- Inconsistent care coordination processes create gaps and duplication
- Limited cross-system integration; unclear roles/leadership (incl. ASD coordination)

#### Policy Recommendation:

Create and empower a leadership hub to facilitate consistency and alignment across children’s behavioral health systems **(Overlap with Equity)**

#### Key Elements:

1. Develop, incentivize, and coordinate/streamline both interagency and cross-sector collaborations among health care providers (physical and behavioral), child welfare, schools, juvenile justice, and payors (Medicaid, private insurers), families, etc. **(Overlap with Access and Equity)**
2. Align definitions and language across systems (e.g., “crisis”)
3. Align referral, intake and eligibility requirements (need to account for insurance approval/payor challenges/differences) **(Overlap with Access and Service Capacity)**
4. Ensure care coordination across systems by integrating health records across care settings **(Overlap with Access)**
5. Align service areas, to the extent possible **(Overlap with Access and Service Capacity)**
6. Add MCO contract deliverables to coordinate and standardize children’s mental health services and operational processes. (CBAT, ICBAT, CBHI)

### Policy Recommendation:

Create a “front door” system through which children access the care they need, regardless of the point of entry. **(Overlap with Access)**

### Key Elements:

1. Identify appropriate entity and/or individuals to provide “front door” services **(Overlap with Access)**
  - a. Family Partners
  - b. Systems Navigator
  - c. Family Resource Centers?
  - d. New Jersey has developed a model
2. Improve transparency/accountability for BH managers (apply DOI provider directory requirements; identify key contact).
3. Participate in MassHealth ACO / integrated care payment model

## 5. Equity & Population-Specific Gaps

- Persistent inequities by race, language, geography, income, disability, identity
- Insufficient language access and culturally responsive care
- Systems don’t fit high-need groups (ASD/DD, medical complexity, DCF/homelessness; ACEs)

### Policy Recommendation:

Require an Equity Impact Framework across all publicly funded children’s behavioral health services.

### Key Elements:

1. Implement a unified equity accountability framework across MassHealth, DMH, DCF, DPH, DYS, DDS, and EEC-funded behavioral health services.
  - a. Framework could consist of data collection through required quarterly reporting of access, utilization, wait times, level-of-care decisions, length of stay, discharge outcomes, and readmissions, disaggregated by race, ethnicity, primary language, disability (including ASD/DD), ZIP code, insurance type, DCF involvement, and housing instability.
  - b. Establish measurable disparity thresholds and require corrective action plans for providers or managed care entities exceeding them.
  - c. Incorporate equity metrics into MassHealth managed care contracts and state agency procurement standards.
  - d. Produce an annual public equity report and/or dashboard.
2. Embed equity in contracting and rate-setting to ensure accountability across agencies
  - a. Mandate routine **equity impact reviews** internally:
    - i. Service access

- ii. Referral pathways
- iii. Waitlists
- iv. Placement decisions (including inpatient and residential)
- b. Disaggregate all utilization and outcome data by:
  - i. Race, ethnicity
  - ii. Primary language
  - iii. Geography (urban/rural, region)
  - iv. Disability status
  - v. Child welfare involvement
  - vi. Housing instability/homelessness

**Policy Recommendation:**

**Establish enforceable language access standards across the behavioral health continuum.**

**Key Elements:**

1. Direct the Office for Refugees and Immigrants (ORI) and relevant agencies to establish enforceable language access standards applicable to MassHealth providers, DMH and DCF-contracted services, EEC-funded early childhood mental health programs, and inpatient and residential settings.
  - a. Timely access to **trained medical/behavioral health interpreters**
  - b. Translate materials at **all points of entry** (referrals, intake, consent, discharge)
  - c. Prohibit reliance on children, family members or untrained staff as interpreters
  - d. Fund and credential **bilingual/bicultural clinicians** and community-based language brokers
  - e. Monitor compliance through licensing and contract oversight.

**Policy Recommendation:**

Prioritize culturally responsive care as a reimbursable, measurable standard of quality.

**Key Elements:**

1. Require providers to demonstrate culturally responsive practices and documented partnerships with community-based organizations serving historically marginalized populations (e.g., faith groups, cultural organizations, mutual aid networks, etc.) **(Expansion of Access recommendations)**
2. Fund community-based, identity-affirming models (i.e., BIPOC-led, immigrant-serving, LGBTQIA+ affirming) and community-rooted providers.
3. Embed **family and youth voice**, particularly from historically marginalized communities, in program design, evaluation and oversight. **(Expansion of Access recommendations)**
4. Ensure ongoing training in culturally responsive and anti-racist practices. **(Expansion of Work Capacity recommendations)**

### Policy Recommendation:

Create specialized pathways for children and youth whose needs do not fit traditional service models. **(Expansion of Access Recommendations)**

### Key Elements:

1. Establish a formal interagency pathway for children with complex behavioral health profiles, including those with ASD/DD, medical complexity, aggressive behavior, DCF involvement, or homelessness. **(Expansion of Access Recommendations)**
2. Require inpatient and residential providers licensed by DPH and/or contracted by DMH, DCF, DYS, DDS, or MassHealth to demonstrate competency serving youth with developmental disabilities, aggressive behavior, and complex medical needs.
3. Prohibit denial of admission or exclusion of care to multi-complex children or children with cross-system involvement
4. Create regional multidisciplinary care coordination teams with representation from DMH, DCF, DYS, DDS, MassHealth, DESE, and housing agencies to expedite placement and align funding.
5. Establish enhanced reimbursement tiers for high-acuity youth to incentivize appropriate placement.
6. Require inpatient and residential programs to demonstrate disability competence, trauma-responsive practices, and medical-behavioral integration
7. Expand step-down and continuing care options to prevent unnecessary re-hospitalization

### Policy Recommendation:

**Establish a unified, child- and family-centered access system for behavioral health services. (Expansion of Access Recommendations)**

### Key Elements:

1. Develop a centralized, real-time bed and service availability tracking system for inpatient, CBAT, residential, and step-down programs. **(Overlap with Access and Service Capacity Recommendations)**
  - a. Create a single point of entry for behavioral health referrals across agencies **(Expansion of Access Recommendations)**
2. Standardize level-of-care criteria across MassHealth managed care plans and state agencies (e.g., Outpatient, Inpatient, Residential and continuing care) **(Expansion of Access Recommendations)**
3. Require warm handoffs and documented transition planning between levels of care.
  - a. Prohibit discharge to “no services available.”
4. Fund regional family navigation services through MassHealth or braided EOHHS resources.
5. Develop and monitor maximum wait-time standards with escalation protocols for urgent referrals.

### Policy Recommendation:

Modernize child and adolescent inpatient and residential systems to emphasize continuity, equity, and recovery for the child or adolescent and family.

### Key Elements:

1. Encourage individualized transition planning early in an inpatient admission that is patient and family centered and confirm step-down appointments prior to discharge to ensure next steps in the continuum of care.
  - a. Family engagement should be culturally and linguistically inclusive and consider geography.
  - b. Transition planning should occur regardless of custody status.
2. Expand intensive outpatient, partial hospitalization, in-home therapy, and community-based step-down services.
3. Monitor disparities in admissions, length of stay, restraints, and readmissions.
4. Align payment models to incentivize successful community reintegration rather than prolonged institutional stays.
  - a. Support step-down care
  - b. Incentivize successful transitions, not just occupancy

### Policy Recommendation:

Implement a coordinated workforce strategy to address provider shortages and improve culturally responsive care. **(Overlap with Workforce Capacity)**

### Key Elements:

1. Invest in and expand loan repayment and scholarship programs for bilingual and culturally responsive workforce and clinicians. **(Overlap with Workforce Capacity)**
2. Create workforce pipeline partnerships with public higher education institutions. **(Overlap with Workforce Capacity)**
3. Expand adequate reimbursement for peer specialists and family partners through MassHealth. **(Overlap with Workforce Capacity)**
4. Require annual training in trauma-informed care, disability inclusion, and culturally responsive practices for state-contracted providers. **(Expansion of Work Capacity Recommendations)**

### Policy Recommendation:

Mandate cross-agency coordination with shared outcomes and data systems.

### Key Elements:

1. Formalize an interagency Children's Behavioral Health Council within EOHHS with representation from state agencies (i.e., MassHealth, DMH, DCF, DPH, DYS, EEC, DESE, housing and homelessness agencies, and family representatives)

- a. Require shared accountability for wait times, placement stability, and family experience
2. Issue annual public reports on system performance and equity outcomes
3. Oversee data-sharing agreements across agencies
4. Coordinate braided funding strategies for high-need youth
5. Include youth and family representatives in governance structures

## 6. Service Capacity, Wait Times & Crisis Dependence

- Demand exceeds capacity across community and inpatient settings
- Long waits and evaluation backlogs delay diagnosis and treatment
- Limited community options drive ED use and boarding (beds/workforce/step-down limits; acuity)

### Policy Recommendation:

Enhance/expand the existing Behavioral Health Treatment and Referral Platform (BH TRP)

### Key Elements:

1. Publicly report boarding data, including data on those who tend to board the longest
2. Data elements should include age, diagnosis, demographics, geography, and payer

### Policy Recommendation:

Strengthen transition services and communication channels for children/families

### Key Elements:

1. Smooth transition back to school by expanding bridge program for kids who have not been in school (i.e., BRYT & BIRCh or BRYT- and BIRCh-like services) to other state agencies serving kids with similar profiles. Bridge programs should be available for all schools and ages
2. Use upcoming BH TRP expansion to CBHCs to allow communication and feedback loop between EDs and community services
3. Enhance interagency communication and collaboration by setting shared treatment goals and reducing conflicting regulations, requirements, funding, and eligibility requirements with the goal of getting a child appropriate services, with an emphasis on inclusion of the youth and family voice in the shared agency planning (**Overlap with Access, Equity, and System Design**)

### Policy Recommendation:

Divert children from EDs to community-based services when appropriate

### Key Elements:

1. Develop/enhance intensive home- and community-based services (crisis/stabilization supports, intensive in-home, intensive care coordination).
  - a. Ensure access to CBHI Family-based Intensive Treatment (FIT) services
2. Refer children who have engaged with MCI to other appropriate settings (e.g., CBHI, YCCS, etc.)

### Policy Recommendation:

Expand residential and inpatient care capacity (including psychiatric residential treatment facilities) and increase psychiatric services/supports/competencies in other state agency residential treatment settings (DCF, DMH, DDS, DYS)

### Key Elements:

1. Conduct a study, developed with stakeholders including families and youth, to determine system needs, including alternative models for children with complex and/or chronic medical and psychiatric needs (e.g., ASD, aggressive behavior, etc.), particularly for children involved with state agencies (**Expansion of Access Recommendations**)
2. Increase capacity by expanding eligibility for current programs across agencies and developing new service types to achieve a full continuum of care.
3. Reimburse congregate care programs to hold a bed while a child from said program receives treatment in another setting (e.g., hospital, PHP, YCCS, CBAT, etc.)
4. Eliminate/reduce regulatory, reimbursement, and inter-agency barriers to support community-based settings for children with co-occurring behavioral health and medical needs (e.g., co-occurring medical diagnosis with or without complexity including barriers on insulin and g-tube or ng-tube administration in group homes through the Medication Administration Program) (**Overlap with Access, Equity, and Service Design**)
5. Fund and/or develop care models and settings for children that are not adequately addressed through inpatient psychiatric hospitalizations, Community Based Acute Treatment (CBAT) services, or existing residential or community treatment models (e.g., enhanced payments for residential settings that have enhanced BH capabilities)

## **Appendix F – Workgroup #3 – Single Agency Evaluation Report**

**Workgroup Members:** Lauren Almeida, Paul Hyry-Dermith, Lisa Morrow, Lee Robinson

Charge (ee) analysis of the feasibility and effects of creating a single integrated children’s behavioral health agency

Building from lessons learned from other state agency integration efforts, we analyzed the feasibility and effects of creating a single integrated children’s behavioral health (BH) agency in Massachusetts according to several criteria. See below for this analysis:

### **Feasibility**

- **Time:** Other state examples of BH agency integration has required years of strategic planning and years of implementation.
  - **Massachusetts assessment:** The Commonwealth recently finished a long and comprehensive BH strategic planning process with the Roadmap for Behavioral Health Reform, first started in 2019, which culminated in the revamping of the state’s BH crisis system, including the 2023 launch of a statewide network of 31 Community Behavioral Health Centers (CBHCs), offering the full continuum of BH crisis services, and the Behavioral Health Help Line which provides 24/7/365, payer agnostic live support for triaging BH needs and connecting to indicated care. As these large scale initiatives are still relatively early in their implementation, and in the context of difficult budget years ahead, it is unlikely that the state is able to commit to the time requirements needed for another large, statewide BH strategic initiative at this time.
- **Starting Place:** Other state examples of BH agency integration started at a time of tremendous unmet need, and relatively little integrated BH initiatives.
  - **Massachusetts assessment:** The Commonwealth already has a number of state-of-the-art BH integration efforts, including the BH crisis continuum described above, a statewide network of youth and family wraparound, home- and community-based BH supports (the Children’s Behavioral Health Initiative), and a growing number of innovative statewide BH consultation programs (Massachusetts Child Psychiatry Access Program- MCPAP services). In this context, the “burning platform” that existed in other states prior to their large integration efforts is more attenuated in Massachusetts given our strong recent history.
- **Leadership/Governance:** In other states, BH agency integration efforts have been prioritized and driven throughout all levels of government leadership.
  - **Massachusetts assessment:** Given the multitude of issues facing Massachusetts health care budgeting in the years ahead, state leadership is laser-focused on health care affordability. For any large scale projects in the health care space that do not have a primarily budgetary focus, it will be difficult to muster adequate political support.

- Resources: While difficult to quantify, other state integration examples have expended considerable resources, often through contracted consultants and technical vendors, and staff time support.
  - Massachusetts assessment: As mentioned previously, in the current budgetary climate, it will be very difficult to garner support for the resources required to pursue a large scale agency integration effort similar to other states.
- Scope: All of the above feasibility criteria have a relatively direct relationship with the scope of integration being pursued.
  - Massachusetts assessment: For the reasons already presented, a large scale, comprehensive single integrated children’s BH agency would not likely be feasible in the coming years in Massachusetts. That said, perhaps more targeted opportunities for integration and/or coordination could be worth exploring.

## **Effects**

- Youth/Family experience: Some integrated agency states have reported some early benefits to member experience, including the ability to better incorporate family/youth voice throughout the youth BH system
- Youth/Family outcomes: BHAC members should commit to engaging with family advocacy groups in CT, NJ and CO to ensure that family and youth voice regarding outcomes is heard and considered.
- State operations: additional research required to assess
- State resources: Some integrated states have reported successful reductions to residential placements for youth, which have generated cost savings.
  - Massachusetts assessment: While the goals of any integration efforts in the Commonwealth would be focused on improving youth/family experience, youth/family outcomes, state operations, and utilization of state resources, it is difficult to say how those goals would be better achieved through a single integrated state agency versus other efforts to coordinate and/or integrate state agency processes and resources.

## **Conclusion**

Several other states have pursued ambitious efforts to consolidate state agencies into a single integrated agency for BH, including some who have created a single, integrated state agency for youth BH. The goals of these integration efforts have largely been aligned with the goals identified by this Commission, including improving youth and family experience in accessing BH care that effectively improves outcomes and uses less state resources. That said, many of these examples in other states are relatively early in their progress of achieving these goals. Additionally, Massachusetts is in a very different point in our work for youth/family BH and in a very different budgetary and political environment than these other states when they undertook their integration efforts. These factors lead to the conclusion that it not feasible at this time for Massachusetts to pursue a single, integrated child BH agency, though the state can and should learn lessons from other states who have pursued this path to inform Massachusetts effort at improved coordination, integration, and efficiency in supporting youth and family BH.

## Colorado

### Source of Information:

Online materials and interview with member of state leadership

### History:

In April 2019, Governor Jared Polis directed the Colorado Department of Human Services to lead a Behavioral Health Task Force to establish a roadmap to improve the behavioral health (BH) system in Colorado. The task force unanimously recommended the establishment of a Behavioral Health Administration (BHA) to serve as the state's single state entity responsible for "leading, coordinating, and strengthening the statewide behavioral health system." The BHA was officially established in July 2022.

### Structure:

The BHA sits within the Department of Human Services and is led by a Cabinet-level Commissioner appointed by the Governor. The BHA took over roles/responsibilities previously held by other state agencies, including BH rulemaking and safety net contracting from the Department of Human Services; most programs and functions from the previous Office of Behavioral Health; BH facility licensing and clinical treatment oversight from the Department of Public Health and Environment; federal BH grants and public grievance management from other agencies. Of note, the BHA does not include the state Medicaid program, which sits within the Department of Health Care Policy and Financing, and does not include oversight and operation of the state's mental health hospitals and forensic mental health system, which sit in the Office of Civil and Forensic Mental Health.

### Impact/Experience:

While still relatively early in its existence, the BHA has demonstrated several notable achievements and concerns, including:

#### Achievements:

- Starting 1/2024, the BHA began transitioning legacy licensing structures for substance use disorder (SUD) treatment licenses, Community Mental Health Center (CMHC) and Community Mental Health clinic (CMHc) designations, Controlled Substance Licenses (CSLs), and Recovery Support Service Organization (RSSO) licenses into one unified Behavioral Health Entity (BHE) licensing process.
- In 7/2025, the BHA formally launched Colorado LIFTS (Linking Individuals and Families To Services), which is a streamlined program to connect people to a statewide network of regional BH administrative service organizations offering mental health, substance use, and crisis support and care navigation.

#### Concerns:

- The BHA has now had five Commissioners or Interim-Commissioners since its launch in 2022, owing to the difficulty in finding effective leadership to oversee an integration effort of the size and scope of the BHA
- In light of this leadership turnover, there has been concerns about the BHA being able to achieve its ambitious strategic plan, with some questioning whether a smaller scope would have led to more stability and targeted impact.

- There have been some concerns about the BHA being able to optimize federal revenue without being more closely connected to Medicaid funding, and there have also been some concerns that carving out the civil and forensic mental health programs is a missed opportunity at integration.

## **Connecticut**

### Source of Information

Online source materials, presentation materials and communications/meetings with DCF CT leadership

### History

The CT DCF was established in 1974 via the legislature. In 1975 legislation added children's mental health services into the CT DCF. Over time, Connecticut DCF reorganized and expanded services through legislation and policy reforms. One of the largest reforms occurred in 2013 via the legislation passing Public Act 13-178 of 2013, which directed DCF to create a statewide children's behavioral health plan, in response to the Sandy Hook tragedy.

### Structure

CT DCF considers itself a consolidated children's agency with co-equal mandates and statutes. Statutes, regulations and laws relative to youth and families and youth with mental health needs do not contradict each other to drive un-equal access to care and create a system of care for all citizens of CT. The scope of the 2013 reform was for DCF to create statewide access to children and families with behavioral and mental health needs. Connecticut's behavioral health system provides a service continuum from outpatient clinics and evidence-based interventions to intensive in-home services, and crisis stabilization pathways intended to reduce unnecessary out-of-home placements. In addition, it manages out of home/congregate care placements. DCF's statutory authority is for implementing, operating and maintaining a statewide behavioral health service system for all children and relies on contracted, community-embedded nonprofit providers. CT utilizes a central portal for families and providers to find services and trainings.

DCF has one Commissioner. Within DCF there are 8 separate divisions, including the Behavioral Health & Wellbeing and Child Protection & Permanency division. The DCF Behavioral Health and Wellbeing division manages providing support and services to children and families in CT relative to mental and behavioral health challenges. The child protection division manages child welfare, foster care, and reports of abuse and neglect.

CT DCF has a voluntary services division that is under the behavioral health and wellbeing umbrella. Under the behavioral health and wellbeing division, they manage clinical supports and services, Medicaid funded services, a community-based system of care, the CT psychiatric residential treatment facility (PFRTs) and congregate group care. All services are provided through contractors and non-profits. CT DCF contracts out to a provider (Carelton) to manage approval for youth who require any out-of-home care.

CT does not have CRA system like MA. In addition, their child welfare division does not manage voluntary case matters. The behavioral health division and/or the entity contracted to provide that service provides oversight, management and support for voluntary case items. CT DCF funds the services.

### Impact/Experience

- Achievements
  - Service continuum includes early intervention, traditional outpatient and inpatient treatment, including the crisis stabilization continuum all with the intention to limit out-of-home placements. Specific treatment modalities and intensities, include outpatient psychiatric clinics, evidence-based therapies, intensive outpatient models, ICAPS and in-home services. Connecticut has implemented multiple evidence-based and intensive home-based models, including FFT, IICAPS, MST, MDFT, and Child's First.
  - DCF CT has an active data dashboard with numerous data reports, summary and active data reporting that could be utilized further to reflect evidence of impact.
- Concerns
  - CT DCF indicates with many stakeholder agencies involved in the system can, at times, create complexity and siloing risks. The "one" DCF agency does not include; Department of Education, Department of Developmental Services, Juvenile Justice or the Judicial Branch which can create fragmentation.
  - Community based Services for families and children are primarily established on a regional basis which can at times then create inconsistencies across the state.
  - There is some fragmentation within CT agencies. CT operates a separate Department of Developmental Services (DDS). This provides support for services and resources for individuals with intellectual disability. They also operate a division for those with no ID and only Autisim. There are gaps in services and supports for children with Autisim and/or Intellectual Disabilities within the DCF Systems of Care/Behavioral health care network.
  - Since the 2013 legislation, CT DCF and its provider network have experienced ongoing organizational, policy, and operational changes that have influenced both leadership stability and workforce morale to varying degrees. These changes have included shifts in service delivery models, funding structures, accountability measures, interagency collaboration expectations, and evolving clinical and administrative requirements.
  - From a leadership perspective, periods of transition have at times created uncertainty regarding strategic direction, implementation priorities, and resource allocation.
  - In terms of workforce morale, the impact has been mixed and has varied across programs and service systems. Many providers and stakeholders have expressed commitment to the broader goals of improving outcomes for children and families; however, ongoing system transformation, workforce shortages, administrative demands, funding complexities, and increasing service needs have also contributed to stress, turnover, and concerns regarding sustainability. There are ongoing and at times competing demands between child welfare division and the behavioral health division relative to accessing of resources, staff morale and workforce shortages.
  - Plan4Children is CT's behavioral health roadmap and has extensive information available as well as progress reports:

- <https://plan4children.org/2024-progress-report-childrens-behavioral-health-plan/>

## New Jersey

### Source of Information

Online materials, presentation slides, and interviews with a systems leader.

### History

- NJ's child welfare system was reformed as a result of settlement agreements from the *Charlie and Nadine H. v. Governor Murphy* case, a federal class action case filed in 1999 on behalf of foster children who experienced abuse and neglect while in state custody, and whose families were not provided with required social services. The Division of Youth and Family Services (DFYS) became the Department of Children and Families (DCF); it is now a cabinet-level agency that reports to the governor. The settlement agreements required modifications to intake, caseloads, training of social workers, and a focus on appropriate services and placements to ensure children in state custody are safe and are not experiencing multiple placements. The federal court monitored progress towards reforms required by the settlement agreements and in 2023, federal court oversight was ended.

### Structure

- DCF includes the division of the Children's System of Care (CSOC). A contracted system administrator (CSA) provides the single point of access to care. Services are organized and provided at the local level by county-based Care Management Organizations, Mobile Response and Stabilization Services, and Family Support Organizations.
- In addition to the Children's System of Care, DCF has a range of other divisions/offices including: Division of Child Protection; Division of Family/ Community Partnerships; Office of Education (runs and contracts for residential programs and schools); Office of Family Voice; Division on Women; Office of Adolescent Services (transition to adulthood); Office of Advocacy.

### Impact/Experience

- Achievements
  - The New Jersey CSOC engages a Contracted System Administrator (currently PerformCare New Jersey) that serves as the front door and care navigator for families. The CSA's work does not just involve finding services, but also (critically) involves engaging with kids and families to assess readiness and sequence care. Major investment up front has led to major savings down the line, especially on residential programming.
  - Robust utilization of services and decreased reliance on residential facilities.
    - In 2018, 2,796 NJ youth were served in out of home treatment settings, and in 2025, 1649 youth were served in out of home treatment settings. (<https://njchilddata.rutgers.edu/csoc>)
  - No eject, no reject (there are no youth that wouldn't be served via CSOC if referred).
- Concerns

- NJ Health Care Quality Institute released a report on 6/4/26 that highlighted challenges families face navigating the mental health system, and that families may receive “multiple handoffs before their child begins receiving treatment.”
  - <https://www.njhcqi.org/wp-content/uploads/2026/05/NHC0300-Childrens-Mental-Health-Report-FINAL-Web-1.pdf>