MEMORANDUM ON FOCUS GROUP FINDINGS

**Parents, Parent Partners, Students, School Liaisons,**

**Advocates, Clinicians, and Professionals**

Massachusetts Advocates for Children

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# 1. INTRODUCTION

This memorandum to the Safe and Supportive Schools Commission distills discussions from six focus groups conducted throughout the winter of 2018 in accordance with the statutory mandate to the Commission to gather information from which to use as a basis to “*propose steps for improving schools' access to clinically, culturally and linguistically appropriate services.”* MGL c. 69 § 1P (g)(iii). The Commission also determined to gather further information relative to its “Proposed Principles of Effective Practice for Integrating Student Supports” sent to the Board of Education in December 2017. As an appointed member of the Commission, Massachusetts Advocates for Children (MAC), a children’s rights organization, through its Harvard Education Law Clinic,[[1]](#footnote-1) agreed to hold the first focus group interviews with parents, parent partners, students, school liaisons, advocates, clinicians, and professionals. The focus groups were held at Community Service Agencies (CSAs),[[2]](#footnote-2) Family Resource Centers (FRCs)[[3]](#footnote-3) and MAC. The findings from six focus groupsare scheduled to be presented at the April 25, 2018 Commission meeting. A seventh focus group was held with students. Information from that focus group is not included in this report, but will form the basis for further discussions with students to be reported at a later time.

We are grateful to the professionals, parents, advocates, and students who took time from their very busy schedules to share with the Commission their experiences with the service system and its relationship to schools. Questions focused on the availability of services in various parts of the Commonwealth, the barriers that families encounter in accessing these services, and the challenges of coordinating and integrating services with schools. Focus group participants’ depth of knowledge and the extraordinary commitment by participants to serving all students in linguistically-, culturally-, and clinically-appropriate ways was inspiring and humbling. The Commonwealth’s structure for referral and service provision is impressive. However, the need is greater than the capacity and we hope these findings will be helpful in moving forward to meet the needs of all families and youth.

# II. KEY FINDINGS

* **Overwhelming Need; Waitlists**. Across the board, focus group participants reported significantly greater demand for critically important services than the current supply can satisfy, resulting in long waitlists and protracted service gaps.
* **Workforce Shortfalls**. The supply side is challenged by significant workforce challenges caused by low salaries, low reimbursement rates, and insufficient supervision to ensure the delivery of effective services for highly complex cases.
* **Clinically-Appropriate Services**. Availability of clinically appropriate services is also limited by the need for high levels of expertise for students with complex problems and multiple disabilities, as well as special treatments such as cognitive behavior therapy for trauma and dialectical behavior therapy for drug abuse.
* **Transition Services**. Graduating students in special education are legally entitled to community-based transition services in order to enable them to be successful post-high school, but these services are few in number.
* **Linguistically- and Culturally-Appropriate Services**. All focus groups emphasized the critical need both for increasing linguistically-appropriate services to meet the needs of non-English-speaking students and families, and for culturally-responsive providers.
* **Geographical Disparities**. Significant geographical disparities in service availability exist, particularly in rural and isolated areas. The few services available in isolated areas are overburdened and under-resourced. Many programs in the western part of the state have been curtailed due to lack of funding. Families in need of services reported facing long travel times, limited travel options, and long waitlists.
* **Stable Housing**. The lack of stable, affordable housing in the Commonwealth is increasing student transience, interrupting their learning, and disrupting access to services.
* **Coordination and Confidentiality**. Coordination of services within schools and between schools and community agencies emerged as a critical issue. Some participants recommended that districts employ school-based coordinators, and one focus group discussed the need for additional school liaisons at FRCs. Participants also emphasized the importance of honoring confidentiality, retaining families’ trust, and allowing families to guide what information is shared in order to facilitate collaboration between educators and providers.
* **Undocumented Immigrant Families**. Undocumented immigrants experience enormous difficulties, including fear of deportation, which prevent them from requesting services and render them ineligible for critical public benefits such as Medicaid, financial assistance for non-U.S. born children, the Supplemental Nutrition Assistance Program (SNAP), as well as housing and childcare subsidies.
* **Transportation**. Transportation issues pose barriers to accessing services in communities across the Commonwealth. Families who live in areas outside of Metropolitan Boston must contend with the scarcity of public transportation, a problem that is amplified if the family is unable to purchase a car or pay for fuel. Transportation costs sometimes prevent families in outlying regions of Greater Boston from accessing services in the city center. Even in Boston, transportation does not always reach service locations directly, thereby causing long commutes to bring a child to an appointment—which, in turn, may affect job security.
* **Insurance Barriers**. One focus group reported that families in need are burdened by quotas on the number of MassHealth clients who can access health services from a particular provider. Additionally, low-income families above the poverty line often cannot afford to pay for secondary MassHealth coverage or navigate the required paperwork in order to access certain resources. Billing rules can discourage integrated support to students because consultations by outside mental health providers with teachers are billable only if there is a crisis and the child is already in the caseload. Military families on TriCare have difficulty finding providers, because few accept TriCare due to its low reimbursement rates.
* **Prevention**. There is an enormous need for “tier 2 level” student supports, to prevent more extreme symptoms down the line. There is limited availability of: (i) enrichment activities for adolescents, (ii) affordable after-school and summer programs that include students with special needs, and (iii) subsidized daycare slots.

# III. POSSIBLE FUTURE DIRECTIONS

We suggest that the Safe and Supportive Schools Commission continue to convene focus groups with diverse organizations/agencies represented on the Commission and, based on accumulated information, consider recommending further investigation by state agencies on the identified issues. Future directions could include workforce development at CBHI and FRCs to increase the supply of culturally-, clinically-, and linguistically-competent providers and supervisors, as well as increased salaries for professionals and specialists. Focus groups indicated the importance of consistent skill building for providers in developing trust with families and sharing information while respecting confidentiality. We suggest additional exploration in order to increase connections to services through additional liaisons and/or coordinators at schools and through improved technology to reach isolated populations.

# IV. DISCUSSION OF FINDINGS

**A. Need Outpaces Availability of Services**

This section summarizes discussion regarding the level of service availability for families.

***1. Waitlists resulting from overwhelming need; MassHealth quotas.***

Each of the six focus groups confirmed that shortages of medically necessary mental health services have resulted in the creation of impermissible waitlists as providers struggle to properly allocate scarce resources. As a result, families often face long waits for mental health and/or psychiatric services or to be assigned a therapeutic mentor. Professionals on the South Shore described how, even in dire situations involving a suicidal child, families may fill out all the paperwork to obtain authorization and arrange transportation, only to discover that a waitlist prevents the student from obtaining services for nine months.

"There are massive waitlists. . . . One place I called told me they got rid of their waitlist because there is no point . . . Because it was so completely pointless, people were never going to get in." *Professionals at a Family Resource Center*

In the western part of the Commonwealth, focus group participants reported that long delays in service delivery—sometimes up to two years—have led families to turn to DCF in order to access services.[[4]](#footnote-4)

Advocates explained that they know families who have experienced an unofficial two-year limit on services and, as a result, having their treatment goals limited. They also described providers who struggled to find a “warm handoff” or referral to continuing services once CBHI services are discontinued.

South Shore participants described medical practices that have unwritten quotas for MassHealth Clinics. They stated, “Not everyone will accept MassHealth, or they have a quota. . . . When they’re trying to find doctors or pediatricians, [offices will] say ‘sorry, we’re not taking any more MassHealth clients.’”

A parent in Boston also emphasized the shortage of in-school services and the difficulty of obtaining testing upon parent request to evaluate students for special education. This parent stated, “The problem is the abundance of need in [my] school and the levels of severity of some of those kids.” Another shared: “There is a sincere shortage of what’s needed in the public school system for things surrounding kids who have been exposed to trauma.”

***2. Workforce Shortfalls***

Low salaries and reimbursement rates were cited as leading to high burnout rates and difficulties in attracting and retaining staff with the necessary skills to address specialized needs.

Some advocates described pervasive workforce shortages and providers not given sufficient supervisory support to handle extraordinarily complicated multi-agency cases involving serious mental health diagnoses and substance abuse. Parents and advocates also reported that families are often frustrated by disruptions in care due to high turnover in professionals and the lack of access to staff with the particular skill sets they required.

“There’s a high level of turnover in CBHI that has really impacted some of my cases where the young person forms a relationship with a therapeutic mentor, and that person leaves, and there’s another one, and a third one, and by that time the kid is just too far gone.”   
*an Advocate*

These workforce problems can lead, in turn, to difficulties in providing clinically-appropriate services, as set forth in more detail below.

***3. Clinically-Appropriate Services***

Specialized services*.* A clinician on the Cape identified critical needs for providers trained and certified in trauma-informed therapy -- particularly Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) -- to address complex cases. DBT is considered particularly important for addressing substance abuse, as direct treatment centers for students are limited and alternative supports have long waitlists. The clinician stated, “they’re typically using substances because of trauma, depression, or anxiety…. [I]t’s a drug problem but it stemmed [from] somewhere.”

Students with multiple needs*.* South Shore participants emphasized the need for expertise in treating students who have intersecting needs in more than one area, such as a student with autism, intellectual disabilities, and trauma. They stated that many mental health providers cannot take a case with a primary diagnosis of autism, even if the secondary diagnosis, for example, is Post-Traumatic Stress Disorder related to bullying. An advocate explained that it is not uncommon for a student with autism and depression to be placed in a siloed room at school for students with behavioral problems, which may not address the depression and may even serve to exacerbate the student’s condition. Moreover, there are simply not enough programs for students with multi-dimensional needs. An advocate described one case:

*“My 18-year-old client had a mental health diagnosis, an intellectual disability, and a substance use disorder . . . There were schools and programs for young people with mental health disorders or intellectual disabilities or substance abuse challenges, but very few, if any, were equipped to meet the intersecting needs . . .”*

Diagnosis*.* Providers in western Massachusetts identified a need for more careful identification of clinical diagnoses. They were concerned about a pattern of screen-outs from services. Although evaluator reports may describe student symptoms as general “behavioral health” issues or the student “acting out,” these professionals see the need for more accurate diagnosis that would enable them to access specialized services.

Schools*.* The western Massachusetts focus group also emphasized the lack of clinically-appropriate services at schools. One participant described that occupational therapy at a local school emphasizes handwriting rather than the sensory processing issues many children have. Advocates stated that students with autism often cannot obtain appropriate specialized support for developing their social pragmatic skills or use of Augmentative Communication, which makes them more susceptible to bullying as a result of their inability to communicate. Additionally, parents reported a need for educators to know how to address significant clinical needs and work with providers to understand the root of a child’s behavior to avoid punitive responses. Parents also described feeling judged by teachers unfamiliar with the effects of medication, trauma, and so forth.

***4. Transition Services***

Advocates reported a critical shortage of services across the Commonwealth that support students with disabilities aged 14 to 22 to successfully transition to employment, higher education, and independent living. In addition, there are few school-based or independent experts who can provide comprehensive transition assessments, design and implement appropriate transition plans, and coordinate individualized community-based services to support development of vocational, social, and independent living skills. Also, students often cannot receive assistance when transitioning from their pediatrician to a primary care provider (e.g. retrieving and filling out documents, transferring records), or from school-based to community-based mental health services. Moreover, there are not enough hospital beds for young people transitioning to adulthood who are struggling with substance abuse.

***5. Preventive Opportunities for Students***

Boston area professionals shared great concern about the scarcity of “tier 2 level” services for students. These students may not beformallydiagnosed with a medical or psychological disorder or be placed on an IEP. Thus, “tier 2 level” supports are not always available for students who need them. And, yet, these students have often experienced traumatic events that cause behavioral, attentional, social or other problems and could benefit from receiving these services. The Boston focus group found that there is a significant gap in available services to help prevent these students from experiencing more extreme symptoms down the line.

“For the tiered approach, what’s available at the second tier is the biggest resource gap right now, which would be kids that aren’t going to have an individual diagnosis, but who could still benefit from individual supports. We’re missing the middle group of kids. That’s where school-driven resources would be necessary.”   
a *Boston Professional*

Although some services exist in western Massachusetts for at-risk teenagers and adolescents with special needs, focus group participants emphasized the lack of enrichment opportunities for teenagers without diagnoses, resulting in increased risk of gang membership and drug use. One participant stated, “Teenagers are getting into drugs and gangs because there is nothing here to do.” The western Massachusetts focus group participants also cited the lack of anger management groups for teens and pre-teens, a service which is frequently requested.

Even students with formal diagnoses cannot always obtain necessary preventive services, such as partial (rather than full) hospitalization, because their insurance may not provide coverage.

After-school and summer programs that are both affordable and can accommodate children with clinical and special needs are likewise in short supply. One parent reported being denied three times by an area program provider due to her child’s medication regimen, which the program stated it was unable to administer.

Participants also reported that the few subsidized daycare slots for young children that exist are plagued by three- to four-year waitlists. Guardians have a difficult time maintaining a work schedule, given the need to care for their children. Boston parents corroborated that child care is prohibitively expensive. One focus group participant described that accessing daycare would require her to spend an entire paycheck on child care alone.

***6. Need for Linguistically- and Culturally-Appropriate Providers***

i. Providers Skilled in Languages of Families

All six of the focus groups emphasized the need for linguistically-appropriate services within the community to meet the needs of non-English-speaking students and families. In the Berkshires, for example, there are few service providers to accommodate the needs of immigrant residents who primarily speak Spanish, Mandarin, or Cantonese. In terms of the availability of Spanish-speaking mental health providers on the South Shore, one provider said, “There’s almost none.” The Boston area was described as having a number of outstanding clinicians who speak Spanish and can deliver services to students who need them. However, the need exceeds the capacity of existing Spanish-speaking clinicians. On the Cape and Martha’s Vineyard, participants identified the need for Portuguese-speaking providers.

Advocates specified the need for bilingual clinicians such as neuropsychologists and speech language therapists, as well as qualified interpreters to help overcome language barriers to obtaining services at school. It is not uncommon for schools to ask bilingual staff members to serve as interpreters in meetings with families. Unfortunately, many of these staff members do not have professional training. Furthermore, schools often assign interpretation responsibilities to staff without determining: (i) their proficiency in English or another language, (ii) whether they understand the complexities of the IEP process, and (iii) whether they understand their responsibilities to safeguard confidentiality and remain impartial.

While providing language access alone does not address the need for culturally-responsive providers, as discussed below, professionals on the South Shore described a need for full-time ESL teachers to facilitate transitions for adults to their new communities. However, in some areas, ESL classes are at capacity, with waitlists extending over a year.

ii. Culturally-Responsive Providers

Advocates stated that many families require services to be explained by someone who shares or understands their cultural background. This person should also explain the limits and benefits of those services and the role that parents are encouraged to play on the student’s support team. Professionals on the Cape poignantly described the benefits of having an FRC team member on the Vineyard who is fluent in Portuguese and able to connect well with Brazilian and Portuguese families because she is a trusted member of their community. In school settings, parents who come from cultures where it is not safe to question authority or assert individual rights might be hesitant to advocate for their child. One Cape professional explained:

*“In a meeting with parents, depending on their cultural background, they come into it with . . . their own thoughts about what they are allowed to say, what they are not allowed to say, how much their opinion matters, what they are allowed to ask for. . . . In many cultures, people think, ‘the schools are the experts, I know nothing,’ so there is a big cultural component when it comes to interpreting in schools and in terms of understanding that dynamic.”*

In Boston, parents described feeling judged or looked down upon for their non-traditional families, their choices concerning child care, or their racial or cultural identities.

***7. Geographical Disparities***

The western Massachusetts focus group reported that families in rural areas face a significant disparity in services compared to urban areas, and that many programs in that part of the state have been curtailed due to lack of funding. The few services available in isolated areas are overburdened and under-resourced. Families in need of services report facing long travel times and longer waitlists. These participants also reported that where there is only one service provider available, lack of competition leads to complacency and reduced quality of service. Referencing the way residents in western Massachusetts often feel about the Boston-centric focus, one participant stated, “The state ends in Springfield.”

The FRC professionals on the Cape reported similar difficulties. The closing of the office of a long-established provider has greatly diminished available services. The long distances to the FRC, located in Hyannis, and to the Community Service Agency for CBHI, located in Yarmouth, are burdensome to many families. The Cape providers believe an additional FRC is needed.

Even in Boston, where resources are more prevalent, gaps were noted in areas such as home ABA services and bilingual and culturally responsive services. As detailed in section C(3) below, both Cape and western Massachusetts participants described geographically unique transportation challenges.

**B. Coordination of Service Delivery to Students**

***1. Student-Specific Coordination***

Providers emphasized the need for improved coordination between schools and community agencies regarding individual students. One professional on the South Shore felt that because the task is overwhelming, schools need staff who are specifically focused on referral and coordination. Professionals in Boston suggested that schools employ resource coordinators in order to keep track of available resources, help families know what community services are available, and assist with access to the FRCs. They stated that teachers and school social workers are not able to help families in this way, as their workload and professional constraints preclude them from doing so. As a result, professionals recommended that there should be one coordinator located at the Boston schools for a specific number of students. On the other hand, a Cape participant noted that many FRCs only have one school liaison to serve all of the schools within their district and suggested that the number of FRC school liaisons be increased.

An advocate stressed the need for providing regular, flexible in-class consultation so students can be better integrated into the mainstream school environment. A parent described the impact of a lack of good coordination, stating that parents too often must take full responsibility for updating their children’s service providers and teachers by, for example, informing them about changes in their child’s IEP or another provider’s care plan, including medications and behavior. This parent emphasized the need for more coordination, but also expressed that coordination can only work where confidentiality rights are respected.

“I can’t expect our clinician here, whom she sees for her meds, to know that I’ve scheduled her neuropsych evaluation somewhere when systems don’t talk to one another. I can’t expect our school nurse—or anybody at the school—to know that some things have changed in our lives and it’s going to impact her, so when you see things I want them to know what it is.”   
*a Massachusetts Parent*

Finally, an advocate stated that there is surprising lack of collaboration between the Department of Mental Health and CBHI, despite the fact that the two agencies are now working in overlapping catchment areas.

***2. Student-Specific Communication within the Bounds of Confidentiality***

A South Shore participant described the natural tension between a family’s desire to keep their need for services private and the need for schools to leverage work being done between families and the FRC. They felt the solution to this tension was to redouble efforts to develop trust between the schools and the FRCs—starting with superintendents meeting with FRC and CSA directors—so that parents and staff can find a trusting way to work together within the bounds of important confidentiality protections.

To this end, one set of Boston professionals described their detailed process for protecting confidentiality when sharing information. They stated that getting authorizations and releases of information has become a regular part of their training. They focus on working closely with families to ensure that the families are in charge of what is acceptable and unacceptable to share. They suggested particular attention be paid to confidentiality when the providers are embedded in the school.

We “[w]ork with families to make sure that enough information is shared with the school for the school to be helpful, but not too much...Boundaries get difficult and challenging sometimes. It’s a regular part of our training both at [the FRC] and then in our [clinical] program. . . . . Every one of our [embedded] clinicians has an individual clinical supervisor plus me, so I feel like we’re pretty good at gatekeeping and checking in on [confidentiality issues].”   
a *Boston professional*

Advocates explained that providers are often appropriately reluctant to share information with school staff as they do not want to break client confidentiality. However, advocates have witnessed that while this may lead to services being provided successfully in isolation, much of the positive effects of the services are not transferred to the school without good communication. They shared a concern that some providers need more training on proper confidentiality practices so they can guide trusting discussion within the bounds of confidentiality in order to effectively provide appropriately integrated services.

A related dilemma confronts LGBTQ students who desire services but are reluctant to seek them out due to their parents being legally entitled to receive certain confidential information. Professionals on the South Shore noted that students can legitimately feel at risk and, therefore, unsafe [e.g., shunned from families] when seeking services. They felt that the need for serving this population of youth within the limits of confidentiality is a critical issue.

Focus groups described numerous instances of breached confidentiality. MAC staff discussed situations where police departments and school personnel shared information about students with each other. As discussed above, unqualified school staff members serving as interpreters can result in breaches of confidentiality. Parents in Boston noted instances in which school providers inappropriately discussed confidential matter in public hallways—in one case between a provider and another parent. In small communities, it was observed that familiarity among families, schools, providers, and agencies—particularly DCF—heightens the likelihood of casual breaches of confidentiality. The participants on the South Shore raised concerns about both school, state agency, and community providers improperly sharing confidential information.

**C. Barriers to Access**

This section reviews the barriers that families can face in accessing services that are available.

***1. Categorical Ineligibility of Undocumented Immigrant Families***

Immigration status can significantly hinder access to services. Undocumented immigrants are ineligible for critical public benefits such as Medicaid, cash assistance for non-U.S. born children, the Supplemental Nutrition Assistance Program (SNAP), as well as housing and childcare subsidies. A professional reflected on a case where a child citizen was unable to obtain the benefit of parent-related CBHI wraparound services because the child’s father was undocumented.

“We can serve anybody regardless of their legal status, but that doesn’t mean we can get them to the things they need. What they might need might be things they’re not eligible for”

*an FRC Professional*

Several participants across focus groups believed that fear of deportation has discouraged families from reaching out to service providers, communicating with their children’s schools, and engaging with resource coordinators. MAC received reports that rumors of ICE raids at a particular school had spread across social media, heightening fears among families in that community. In addition, some parents are refraining from driving children in their cars to service providers or schools for fear of being pulled over by immigration enforcement officials.

***2. Access to Stable Housing***

The lack of stable, affordable housing in the Commonwealth is preventing access to resources and disrupting services that were already in place. A MAC advocate emphasized that the Emergency Assistance family shelter system, including motels, provides a vital safety net for families. The advocate also stated, however, that this system is overburdened and has led to an acute need for more permanent affordable housing.

Homeless children: “I think it’s the relocation process . . . they go three or four places, and by the time they get to be known by the next school department, you . . . missed a lot of ground . . . with their educational goals; they’ve missed school [and] families may not have . . . basic resources.”

*a Boston Professional*

Western Massachusetts participants explained that housing services are hard to reach for clients in rural communities. Even when services are nearby, they tend to lack funding or are understaffed. Participants also noted how homelessness and frequent moves undermine student focus and the ability to achieve in school.

Boston participants reported that the increasing shortage of affordable housing due to rising real estate costs in the Boston area has reached crisis levels and represents one of the greatest unmet needs for low-income families. Rising rents have led to disruptive evictions, which can traumatize students. The relocation process is time-consuming and causes students to miss significant amounts of class. Some relocated students can be transported back to their home district for school, but the process of obtaining this transportation may take weeks (causing the student to miss school while waiting for approval). Once approved, the commute to and from their home district may take several hours depending on their location. The commute can disrupt students’ participation in after-school programs, community services, and extracurricular activities. Relatedly, for those students transferring to a new school district, it takes additional time for their new district to become acquainted with new students’ needs, for caregivers to become familiar with the new area (e.g., the neighborhood, the community, the transit system, etc.), and for students to adjust to the new school setting. Caregivers are especially at risk of losing their jobs due to unstable housing when it conflicts with attending to their children with disabilities.

***3. Transportation***

Four of the focus groups stressed that there is currently no effective service delivery model in place for those who cannot readily travel to service provider locations. Outside of Boston, concerns were voiced about the scarcity of public transportation and the unaffordability of cars. Providers in W\western Massachusetts reported few bus routes in Pittsfield and even less in the Berkshires, where many bus routes stop running at approximately 6:00 p.m. There are few alternatives, as there is only one taxicab company service in Pittsfield, and many rural communities have none. Providers felt that the availability of taxi vouchers does not help as private taxis avoid voucher holders who might not be able to tip.

“You could take a bus from Provincetown to [Hyannis], but you better have four hours to get there.” *One provider describing the difficulty of travelling to available services*

On the Cape it was reported that buses stop running after Columbus day on Nantucket and do not restart until May. A trip from Provincetown to Hyannis where the FRC is located takes four hours. In addition, Cape Cod FRC professionals found that lack of transportation prevents successful referrals to neighboring CBHI providers off the Cape that have more capacity.

Boston professionals explained how transportation costs prevent families in outlying areas of Greater Boston from accessing services, although there was concern that even in the center of Boston, transportation does not always reach service locations directly, causing long commutes to take children to appointments and affecting parents’ employment. One parent stated that MassHealth did not reimburse transportation costs incurred from transporting her children to appointments.

In addition to transportation issues related to unstable housing (see Section H), Boston participants also identified families’ struggles to get students to school. MBTA transportation is only provided to students who live a certain distance from their school and is not free or subsidized for high school students. Some students must walk significant distances in order to attend classes and receive school-based services. This can decrease attendance, especially in the winter. Even when students do have bus access, parents can be discouraged from sending their children to school due to safety concerns related to time of day and location of stops. A provider told of a parent who unsuccessfully attempted to get BPS to change the bus stop location for her child after a shooting occurred near his route to the bus stop.

***4. Insurance Barriers***

Quotas on MassHealth. Practitioners on the South Shore described unofficial quota systems for MassHealth or refusals to take MassHealth clients, making finding a doctor very difficult. As one person stated, “Not everyone will accept MassHealth, or they have a quota . . . . When they’re trying to find doctors or pediatricians, they’ll [hear,] ‘sorry, we’re not taking any more MassHealth clients.’” In addition, it is difficult to find private mental health providers who accept MassHealth.

Families with Secondary MassHealth. Providers on the South Shore observed that some families who carry private health insurance and need CBHI services for their children apply for MassHealth as a secondary form of insurance. However, many of these families are unable to afford the monthly payment for the secondary MassHealth insurance. Consequently, some families do not have adequate access to CBHI or other services available through Secondary MassHealth.

Procedural Barriers. Advocates and providers cited insurance billing rules and lack of knowledge about how to bill as barriers to integrated provision of certain services. According to an advocate, a clinician placed in a school by her community employer explained that educators frequently requested consultations from clinicians. But her outside organization was unable to bill insurance for classroom consultation, unless the child was already on her caseload and in crisis. Even in a crisis circumstance, the billing could only cover one contact per day, so if a crisis happened after a session later in the day, an in-class consultation was not billable. In addition, group counseling could be provided only if every child was in her caseload; integrated small groups were not billable. It was felt that some clinicians are not aware of how to bill beyond one-to-one segregated services.

A Boston professional explained that a CBHI provider can be embedded in a school if there were enough students seeking the billable service, thereby making it economically feasible. This participant stated that to her knowledge this has occurred only once in a very large school. Providers on the South Shore raised concern about an apparent rule that students must complete a certain number of psychotherapy sessions before becoming eligible for a psychiatry appointment with child psychiatry services. Even if their therapist deems the student eligible after just one session, the student must attend the required number of sessions to qualify. This process may deprive students of accessing needed services in a timely way.

Another procedural issue involves delays in providing services to children. One parent described repeated gaps in her daughter’s care whenever they had to wait for their insurance program to match her with a new clinician: “We have a trend here where my daughter will meet with the clinician, that clinician will leave, and then we have to wait until somebody else has contracted with our [insurance] to come on. They’ve been very creative [with the billing] at times to not disrupt [care. But my daughter] will have little breaks of not having therapy when her clinician [leaves].”

Military Families with TriCare. According to participants, many veterans and military families on Cape Cod are insured through TriCare, yet only a limited number of mental health service providers accept TriCare due to low reimbursement rates. A focus group participant also noted that some TriCare families are denied access to specialized service providers, such as a therapist who is knowledgeable on LGBTQ issues or a therapist of a specific gender, due to providers not accepting TriCare.

1. The Harvard Education Law Clinic is part of the Trauma and Learning Policy Initiative, which is a joint program of Massachusetts Advocates for Children and Harvard Law School. [↑](#footnote-ref-1)
2. A CSA is a community-based organization that has received a contract as part of the Children’s Behavioral Health Initiative (CBHI) and whose function is to facilitate access to, and ensure coordination of, care for MassHealth-eligible youth with serious emotional disturbance (SED) who require or are already utilizing multiple services or are involved with multiple child-serving systems (e.g., child welfare, special education, juvenile justice, mental health), as well as their families. (See Center for Public Representation, *www.rosied.org*). CSAs were created as part of the remedy in the *Rosie D.* litigation. [↑](#footnote-ref-2)
3. FRCs are “a statewide network of community-based providers offering multi-cultural parenting programs, support groups, early childhood services, information and referral resources and education for families whose children range in age from birth to 18 years of age. A [FRC] is located in each of the 14 Massachusetts counties to provide easy access to information and assistance related to health care, safety, employment training, education and peer support.” (UMass Medical School 2018, *www.frcma.org*). FRCs were established pursuant to Chapter 240 of the Acts of 2012, the Massachusetts law reforming the former CHINS (Children in Need of Services) system. [↑](#footnote-ref-3)
4. DCF’s involvement can result in access to resources such as after school programs, dance or Taekwondo classes, and other sports and recreation opportunities. Such determinations also provide immediate access to certain benefits including, but not limited to, housing subsidies or reduced rent, $25 gas cards and bus tickets, clothing and birthday presents for the child, and immediate admission into daycare. [↑](#footnote-ref-4)