

1. How do you anticipate health resource planning for Behavioral Health to **help you in your work**? How do you expect to **use the information resulting from the effort**?

I will use the inventory as a directory for two separate purposes: 1) to approach behavioral provider organizations to engage them on relevant initiatives, and 2) to provide the directory to behavioral organizations and to tobacco treatment organizations that might have a need to refer to patients to either organization type.

Once the capacity and gap analysis planning data come out, if there is actionable information about either lack of capacity in geographic areas or changes in demand, then I will certainly consider how to reorganize relevant service providers in those areas.

2. Are there specific services within **Mental Health & Substance Abuse** that you would like to see **studied**, and were not already included in the list of services on page 6? Please describe with as much specificity as possible. Please indicate how they can be addressed through health resource planning.

The single area that I would suggest for inclusion in planning is tobacco cessation treatment. Tobacco use is very well known to co-occur with and interact with both mental illnesses and substance abuse disorders, and yet is not represented in the survey. Comprehensive treatment for both mental illness and substance abuse includes tobacco screening and intervention.

Concerning resource planning for tobacco treatment, while there is an inventory of providers at present, there are no data collected re: capacity, demand, forecasting, or gap analysis. These data could be obtained from the EHR's of mental health and substance use providing organizations as well as through interviews with administrators and staff at those organizations, though each of these efforts might require a small amount of funds. Additionally, gap analysis could be performed through a population-based geographic survey of smokers and the resources available, using either existing data (e.g. BRFSS) or developing a new instrument.

Interestingly, tobacco treatment is mandated to be offered by service providers through the substance abuse service contracts with the Department of Public Health, however this requirement is not monitored closely via data collection so that consistent follow-up can be done. This may be due to a lack of resources but is nonetheless important because of its system-wide impact.

3. Given the importance of **prevention and also “post-acute” services** for mental health & substance abuse, what critical evidence-based services & programs are available, should be expanded, or need to be developed? Are there specific models you suggest we study?

There are five evidence-based services and programs for tobacco cessation treatment available and they are, at times, underutilized for lack of public and/or healthcare provider awareness. These programs include: 1) QuitWorks, a state-supported phone-based counseling support line that also dispenses medications with a provider's referral; 2) the Massachusetts Smokers' Helpline, a phone-based support line that provides counseling and education about quitting tobacco; 3) in-person counseling groups that are run at various healthcare facilities; 4) individual counseling accessed via the healthcare system; 5) educational websites for residents seeking treatment for tobacco (both state and federal). All of the above could be recommended to both patients and providers who want to work on tobacco cessation treatment.

In addition, systems assessment and systems redesign assistance for tobacco cessation are available to enable healthcare providers to better implement the 5A's treatment model (Ask, Advise, Assess, Assist, Arrange).

Finally, there is strong emerging research indicating that people living with mental illness not only want to quit tobacco at similar rates to the general population, but they can be equally successful as the general population at quitting if given the evidence-based interventions listed above.

4. Obtaining capacity, workload/volume, and demand data for outpatient & community mental health & substance abuse services is a challenge. **Do you have ideas for data sources or suggestions for collecting data now or in the future?** Are there specific **"data gaps"** that you feel are important for future data collection.

There are four suggestions for data related planning that may be useful.

1. EHR systems should be in use at all DMH and BSAS facilities in order to more quickly track trends or needs.
2. Massachusetts needs a population-level surveillance tool for mental health that is equivalent to BRFSS. Or several more questions on mental health need to be added to BRFSS.
3. A shared or centralized data system to track patients back and forth between the DMH and BSAS systems would help with having a clear record of patients' needs.
4. Perhaps a pro-active flag for follow-up or monitoring could be put into a patient's record if that person might be expected to need help in the coming weeks or month. These could be used for any topic area but would need certain criteria associated.