Massachusetts

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 11/19/2015 10.11.14 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year	2016
End Year	2018

State DUNS Number

Number	073130932
Expiration Date	

I. State Agency to be the Grantee for the Block Grant

Agency Name	MA Department of Public Heatlh
Organizational Unit	Bureau of Sustance Abuse Services
Mailing Address	250 Washington Street, 3rd Floor
City	Boston
Zip Code	02108

II. Contact Person for the Grantee of the Block Grant

First Name	Lydie
Last Name	Ultimo
Agency Name	Bureau of Substance Abuse Services, MA Department of Public Heatlh
Mailing Address	250 Washington Street, 3rd Fl
City	Boston
Zip Code	02108
Telephone	617-624-5151
Fax	617-624-5185
Email Address	Lydie.Ultimo@state.ma.us

III. Expenditure Period

State Expenditure Period

From	
To	

IV. Date Submitted

Submission Date	10/1/2015 11:03:26 AM
Revision Date	11/2/2015 1:29:53 PM

V. Contact Person Responsible for Application Submission

First Name	Sarah
Last Name	Ruiz
Telephone	617-624-5136
Fax	617-624-5185
Email Address	Sarah.Ruiz@state.ma.us

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
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Section 1947	Nondiscrimination	42 USC § 300x-57
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Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Monica Bharel, MD, MPH

Signature of CEO or Designee[1]: _____

Title: Commissioner, MA Department of Public Health

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

OFFICE OF THE GOVERNOR
COMMONWEALTH OF MASSACHUSETTS
STATE HOUSE • BOSTON, MA 02133
(617) 725-4000

CHARLES D. BAKER
GOVERNOR

KARYN E. POLITO
LIEUTENANT GOVERNOR

September 25, 2015

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Dear Ms. Simmons:

As the Governor of the Commonwealth of Massachusetts, for the duration of my tenure, according to Section 1921 of title XIX, part B, Subpart II and III of the Public Health Service (PHS) Act, I delegate authority to the current Commissioner of the Massachusetts Department of Public Health, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG).

We greatly appreciate the funding and technical assistance provided to Massachusetts from the Substance Abuse Mental Health and Services Administration.

Sincerely,

Charles D. Baker
Governor

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

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Substance Abuse and Mental Health Services Administrations
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as required by
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2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Monica Bharel, MD, MPH

Signature of CEO or Designee[1]: MBh

Title: Commissioner, MA Department of Public Health

Date Signed: 09/25/2015

mm/dd/yyyy

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name	
Title	
Organization	

Signature: _____ Date: _____

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

Step 1: Overview of the State's Behavioral Health System

The Department of Public Health, Bureau of Substance Abuse Services (BSAS), is the single state authority responsible for the licensing of programs and addiction counselors as well as for purchasing and oversight of drug and alcohol prevention, intervention, treatment, and recovery support services in Massachusetts. BSAS funds and monitors a comprehensive continuum of prevention, intervention, treatment, and recovery support services for alcohol and other drugs. In addition, problem gambling public awareness, counselor education and treatment are funded through a legislative appropriation from the Massachusetts State Lottery and the former State Racing Commission, which is now part of the Massachusetts Gaming Commission.

In Massachusetts, the full continuum of care includes prevention, outreach and engagement, acute treatment, stabilization, long term residential, outpatient, medication assisted treatment (methadone and OBOT), and recovery support services. BSAS also funds case management services to addicted homeless individuals in federally funded HUD programs. These levels of care are available in gender-specific and age-appropriate modalities for adults, adolescents and young adults, and families.

The Bureau promotes the use of evidence-based practices including relapse sensitive care and provides opportunities for staff training and support for adoption of evidence-based practices. The Bureau has developed a series of web based Practice Guidance modules that outline the Bureau's guiding principles drawn from SAMHSA, the National Quality Forum, and Join Together. Individual best practice modules provide succinct guidance to providers on various subject matters including "Integrating Medication Assisted Treatment (MAT) into the Continuum of Care," "Treating Older Adults," and "Working with LGBTQ Consumers,". The goal of these modules is to help providers increase competency in the identified area by outlining what a competent agency would look like in terms of administrative, supervisory and direct service structures and provides ideas for quality improvement projects. The modules synthesize relevant literature and resources, including web based resources with the emphasis on all resources being available at no cost. Additionally, providers from each level of care participate in quality improvement and outcome monitoring initiatives with the Bureau to constantly examine our practices and improve access and outcomes for consumers.

BSAS also collaborates with Medicaid, and particularly the Behavioral Health (BH) staff on MassHealth funded substance abuse services. Treatment services in Massachusetts are reimbursed with a braided funding stream model based on the individual's insurance status and the benefit package. BSAS established an official Memorandum of Understanding (MOU) with Medicaid which formalized the authority of BSAS to oversee the substance abuse services benefit. This authority is parallel to the oversight that the Department of Mental Health exercises over the MassHealth Mental Health benefit. The BSAS Director attends a monthly meeting with the Medicaid Director and the Department of Mental Health to discuss issues related to addiction treatment benefits and rates.

The full continuum of care in Massachusetts includes the following services:

1. Prevention Services:

A. Prevention Technical Assistance
B. Community-Based Prevention Programs
    - Underage Drinking Prevention
    - Substance Abuse Prevention Collaborative (SAPC)
    - Massachusetts Opioid Abuse Prevention Collaborative (MOAPC)
C. Overdose Education and Naloxone Distribution
D. Educational Materials development and distribution
E. Media Campaigns

2. Screening and Early Intervention Services:

A. SBIRT Training and Technical Assistance

3. Acute Treatment Services:

A. Acute Treatment Services (Detoxification)
B. Section 35 Civil Commitment Treatment for Men and Women

4. Short Term Stabilization Services for Adults:

A. Clinical Stabilization Services
B. Transitional Support Services
C. Tewksbury Stabilization Program
D. Section 35 Civil Commitment Treatment for Men and Women

5. Youth Intervention, Treatment and Recovery Support Services:

A. Youth Early Intervention (MassStart)
B. Youth Stabilization
C. Youth and Young Adult Residential
D. Recovery High Schools
E. State Adolescent Treatment Enhancement Grant

6. Adult Residential Treatment:

A. Residential Recovery Services
    - Recovery Homes
    - Therapeutic Communities
    - Social Model Recovery Homes
B. Pregnant and Post-Partum Residential
C. Specialized Residential Services for Women

7. Family Services:

A. Family Residential Treatment Programs
B. Supportive Housing Services For Families
C. Family Centered Home Based Treatment
D. Family Intervention

8. Outpatient Services:

A. Outpatient Counseling, which also can include:
    - Acupuncture Services
    - Day Treatment/Enhanced Day Treatment/Intensive Outpatient
    - Second-Offender Aftercare
    - Youth Outpatient Services
B. Compulsive Gambling Treatment
C. Opioid Treatment Programs
D. Office-Based Opioid Treatment

9. Housing and Homeless Services:

A. Substance Abuse Shelters for Individuals
B. Post Detox Pre-Recovery Programs (PDPR)
C. Supportive Case Management in Housing
D. Outreach to Homeless Youth and Adults
E. Chronically Homeless Case Management in Residential Treatment
F. Community Based Case Management for Homeless Families

10. Recovery Support Services:

A. Recovery Support Centers
B. Consumer Education
C. Access to Recovery

11. Criminal Justice Programs:

A. Services in County Houses of Correction
B. Court Diversion Programs
C. First Offender Driver Alcohol Education
D. Second Offender 14-Day Residential Program for Driving Under the Influence of Liquor
E. Re-Entry Programs
F. Drug Court
G. Jail Diversion

12. Training, Technical Assistance and Support Services:

A. Substance Abuse Information and Referral Helpline

B. Problem Gambling Information and Referral Helpline
C. BSAS Tobacco Training and Technical Assistance
D. Women's Services Capacity Building
E. HIV/HEP C Training and Technical Assistance
F. Office Based Opioid Treatment (OBOT) Technical Assistance
G. Statewide Logistics for Training

A list of brief descriptions of each of these levels of care and service types in the BSAS Continuum of Care is posted in the Attachments for Table 3 "State Agency Planned Expenditures by Services Type" in a document titled "BSAS Program Summaries." The same program categories and definitions are used for the Massachusetts version of Table 3. In Massachusetts there are no regional, county, or local entities that provide behavioral health services or contribute resources that assist in providing the services.

Mental Health and Substance Abuse Services
BSAS collaborates with the Massachusetts Department of Mental Health on statewide Behavioral Health initiatives such as the Children's Behavioral Health Initiative and MassHealth services procurements. BSAS also collaborates with DMH on specific projects related to criminal justice, housing for individuals with co-occurring disorders, and on peer recovery services.

BSAS continues to exercise licensing authority to discrete inpatient and outpatient substance abuse treatment services in hospitals, mental health clinics, and Department of Mental Health facilities. These regulations require specific training on substance abuse topics, including co-occurring mental and physical health conditions, as well as collaboration between state agencies on complaint investigation and resolution in facilities serving persons with mental health and substance abuse disorders.

The Bureau of Substance Abuse Services also ensures that there is training available every year to staff and clinicians working in the substance abuse services field on co-occurring disorders. There is an expectation that BSAS-funded programs are equipped to address a range of co-occurring mental health and substance abuse disorders.

There are a high percentage of clients who have received mental health treatment prior to accessing substance abuse treatment. Out of just over 116,000 disenrollments in FY 2014, 27.9% had received mental health counseling prior to admission, and 15.6% had one or more prior mental health hospitalization(s). Among those disenrollments who responded to social service provider question (over 91,000) in FY 2014, 13% received treatment for an emotional problem during treatment from the same substance abuse services agency, 7.4% received treatment from another agency, and 2.2% received treatment from the same agency and another agency.

Prevention
The state has a technical assistance contract with the Educational Development Center (EDC), which hosts Massachusetts Technical Assistance Partnership for Prevention (MassTAPP), to support the planning, implementation, and evaluation of evidence-based substance abuse prevention programs across the State. MassTAPP, through the use of in-person, group and

distance learning, provides specific assistance and support to programs in the understanding and implementation of all five steps of the Strategic Prevention Framework and environmental substance abuse prevention strategies. BSAS funded and non-funded programs are offered guidance in the development of action plans, logic models, time lines and selection of prevention strategies. Programs have also been offered assistance in the development of social norms campaigns. Through the use of Guidance Documents, which have been developed for each prevention initiative (prevention of underage drinking, prevention of prescription drug misuse/abuse and prevention of opioid overdose), MassTAPP provides a step by step application process for all BSAS funded programs.

The MassTAPP staff also provides consultation and training to municipalities, community-based groups, coalitions, and organizations. These efforts focus on how to maximize the effectiveness of evidence-based substance abuse environmental prevention strategies to impact systemic changes related to ATOD policies, rules/regulations, and community norms at local, regional, and state levels as funds allowed

BSAS currently funds 26 cities and towns to follow a data-informed process focusing primarily on evidence-based environmental strategies that can be sustained through local policy, practice, and systems changes to prevent and reduce underage drinking and other drug use in Massachusetts communities.

BSAS issued a Request for Response (RFR) to procure the above mentioned prevention programs and has awarded contracts using SABG dollars to cities and towns in partnership with neighboring municipalities. Funding was based on need, geography and the bidder's capacity to implement the Strategic Prevention Framework (SPF) and evidence-based strategies to impact a significant population size to reduce underage drinking and other drugs. Community assessments included a description of current capacity and other prevention dollars.

BSAS will continue funding the Massachusetts Opioid Abuse Prevention Collaborative (MOAPC) with SABG prevention set-aside dollars to address the issue of opioid use and abuse, and fatal and non-fatal opioid overdoses in Massachusetts The purpose of the Massachusetts Overdose Prevention Collaborative Grant Program is to implement local policy, practice, systems and environmental change to prevent the use/abuse of opioids, prevent/reduce fatal and non-fatal opioid overdoses, and increase both the number and capacity of municipalities across the Commonwealth addressing these issues.

Strategies and interventions must be consistent with the Substance Abuse and Mental Health Services Administration (SAMHSA), SPF model, consistent with any available evidence-based practices or local best practices such as those developed during the previous SPF State Incentive Grant (SIG) - MassCALL2 Opioid Overdose Prevention initiative, and approved by BSAS. Additionally, this program seeks to provide financial support for groups of municipalities to enter into formal, long term agreements to share resources and coordinate activities in order to increase the scope of this work and capacity of municipalities to address these issues among their combined populations. This program also emphasizes the integration of SAMHSA's SPF model into overall prevention systems, to ensure a consistent data-driven planning process across the Commonwealth, focused on implementing effective and sustainable strategies and interventions.

MOAPC strategies and interventions are consistent with the Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Prevention Framework (SPF) model and consistent with any available evidence-based practices or local best practices. This focus was selected to ensure that successful overdose prevention strategies from our previous SPF-SIG grant were sustained and replicated across the state, and so that the focus could shift to the primary prevention of this issue, which was not previously addressed. In FY16, each MOAPC community will accomplish one policy/practice change. In FY17, an additional policy/practice change will be accomplished per MOAPC.

All 26 BSAS SAPC Programs-and the 18 MOAPC funded communities implement environmental prevention approaches that seek to change the overall context within which substance abuse occurs. Environmental prevention efforts focus on substance availability, norms and regulations.

Additionally, the SAPC and MOAPC programs seek to provide financial support for groups of municipalities to enter into formal, long term agreements to share resources and coordinate activities in order to increase the scope of this work and their capacity to address these issues among their combined populations. In implementing these grants, funded programs must work in partnership with neighboring municipalities to form a "Prevention Cluster." Substance misuse and abuse is a complex problem that requires a comprehensive and coordinated approach.

BSAS also conducts media and social media campaigns directed at youth, seniors, health care providers, parents and other caretakers, and teachers and school staff. Print documents, advertising on public transportation systems, use of the Mass.gov website, blogs and you-tube are some of the other vehicles used to convey the Bureau Prevention message.

Goals related to two of the Prevention initiatives, targeting policy/practice change interventions for the Substance Abuse Prevention Collaborative Programs (SAPC) and the Massachusetts Opioid Abuse Collaborative Programs (MOAPC), are included in the 2016-2017 SAPT Block Grant plan priorities and goals.

Intervention

Screening, Brief Intervention, Referral and Treatment (SBIRT) is one of the Bureau's strategic plan priorities, addressing the continuum of use to identify risk, prevent and reduce harm, and address the potential for addiction as a risk that can and should be caught early as for any other chronic condition. The foundation of this intervention was developed from 2006 – 2012 through a SAMHSA $14 million dollar grant that resulted in the state's expanded capacity to address substance misuse and treat dependence in general healthcare settings.

BSAS has sustained an ongoing effort to increase use of SBIRT across the state by funding an MASBIRT Training and Technical Assistance Project (MASSBIRT TTA), based at Boston Medical Center. In addition to supporting healthcare sites in implementing SBIRT concepts and skills, School Health Services has been piloting the use of SBIRT in school health settings.

BSAS also funded an Emergency Department SBIRT project for several years. BSAS engaged the BNI-ART Institute, affiliated with the Boston University School of Public Health for this

work. The ED SBIRT model, Project ASSERT, engages healthcare providers to prescreen patients who then refer those needing more attention to Health Promotion Advocates (HPAs). This process results in targeted screenings and more HPA time spent making referrals to treatment than with universal screening models.

One BSAS response to the state's extremely high opioid overdose rates has been its Overdose Prevention & Reversal Project. Participants are trained on and can distribute intranasal naloxone (Narcan) which reverses the effects of an opiate overdose when sprayed into the nose of a person who has overdosed. BSAS SBIRT and Narcan project staff collaborated with the BNI-ART Institute to train and incorporate this effort into the ED SBIRT projects at the hospitals where they worked.

The ED SBIRT funding from BSAS also largely ended in 2012. In some cases the Health Promotion Advocates were retained by their hospitals. BNI-ART's training and technical assistance efforts were critical to the SAMHSA funded MASBIRT effort and funding for its work is now a subcontract to the MASBIRT TTA contract. Therefore in Massachusetts there are expert trainers available to work closely with a variety of health care providers to integrate SBIRT into their work. One of the Bureau's 2016-2017 priority areas and goals is to continue the work of integrating SBIRT into general healthcare settings.

Youth and Young Adult Services

The Office of Youth and Young Adults was developed with a SAMHSA adolescent systems development grant in 2005 (SAC Grant). The Office of Youth and Young Adult Services (OYYAS) oversees the substance use services continuum of care for adolescents in the state. The adolescent services include youth intervention, youth-specific outpatient treatment, 2 youth acute stabilization programs, 3 youth residential programs, 3 residential programs tor transitional age youth and young adults, and 5 recovery high schools. Families and youth are supported in their process of accessing treatment by the BSAS-funded Youth Central Intake and Care Coordination Services. The central intakes service is invaluable in helping families to navigate the assessment and treatment placement process.

Following the establishment of a continuum of care for adolescents, OYYAS has continued the development of specialized services for transitional age youth (16-25 years old). With help from a SAMHSA TA Grant, OYYAS staff members have held focus groups with adolescents, young adults, parents, and provider systems to inform the planning related to young adult services. The state established a Transitional Age Youth and Young Adults (TAYYA) Work Group in FY15 to help address the needs of TAYYA in the areas of prevention, intervention, treatment, and ongoing recovery support services. With the support of the SAMHSA SYT-I grant, OYYAS staff will continue to uncover ways to creatively meet the needs of TAYYA using evidence-based practices.

The Office of Youth and Young Adult services is actively planning efforts to ensure that all providers are LGBTQ competent. This effort will extend through the entire treatment and recovery support system for youth and will allow for more individualized and competent care offered to LGBTQ Youth and Young Adults.

Youth Early Intervention
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. BSAS funds and supports the MassSTART intervention model with programs currently running in three sites.

BSAS has partnered with the DYS to adapt and implement a juvenile justice MassSTART model in the Commonwealth. DYS is utilizing the core of MassSTART to address the needs of youth in the juvenile justice system. There are six sites across the state in Holyoke, Springfield, Lawrence, Taunton, Bourne, and Lowell. BSAS is in the early stages of supporting an overdose prevention training-of-the-trainers capacity building initiative with DYS, which is anticipated to launch in the 16/17 grant cycle.

Family Intervention
There are currently two family intervention models being supported by BSAS in MA, the Adolescent Community Reinforcement Approach and Assertive Continuing Care (ACRA/ ACC) and the ARISE model. ACRA/ACC works with the youth/young adults to support their strengths, foster community supports and build coping skills. Clinicians offer case management which can include transportation and support for job and education related searches. Culturally competent clinicians provide home-based services for the young person and their family member/caregiver. These services typically run for three to six months and are available in some areas in Spanish and Portuguese. There are six ACRA-AAC providers currently operating in the state. The ACRA-AAC model was implemented with the support of a three year SAMHSA CSAT collaborative initiative, the State Adolescent Treatment Enhancement Dissemination (SAT-ED) grant, and is being disseminated through the support of the Youth Inter-Agency Working Group (IWG). Sustaining this model via state funding and SAMHSA's SYT-1 grant is a priority for the 2016/2017 grant cycle. As mentioned in section 18, the state has negotiated with the developers of ACRA to allow for an in state ACRA trainer and technical assistance specialist that will bolster the efforts to sustain this evidence-based practice.

BSAS also supports the ARISE model, which meets the need for supporting family members and concerned others to find help for a loved one who may not be willing to enter substance use treatment. Certified ARISE specialists work with family members and provide phone consultation, coaching, and planning to build a support system with the goal of motivating their loved one into treatment and recovery. There are currently three ARISE providers operating in the state.

Pregnant Women and Parents
The Bureau of Substance Abuse Services (BSAS) supports women's services across all modalities including acute treatment services, short term stabilization services, residential, outpatient, prevention, non-traditional services, information and referral, criminal justice programming, youth residential services, and youth intervention services. The continuum of women's services includes specialized residential treatment services for pregnant women and women with dependent children. In addition to providing substance abuse treatment, enhanced

service models offer a range of primary health and support services to mother and child. Pregnant women are prioritized for access in all programs that serve women.

In Massachusetts, specialized residential treatment programs admit pregnant women in all trimesters and keep women approximately 60 days postpartum, with their infants. Specialized programs are located throughout the State. In addition to substance abuse treatment, service elements addressed through required linkages include but are not limited to prenatal, pediatric, and primary health care, early intervention, case management, child care and transportation, job and parenting skills training and aftercare planning. Specialized residential programs are affiliated with prenatal, pediatric, and primary health care providers, hospital-based emergency obstetrical services, appropriate state and local agencies providing services to women and families, narcotics addiction treatment, HIV/AIDS counseling and testing sites, early intervention programs, violence prevention and victims of violence programs.

All Women's residential programs can take pregnant women. There are 14 women's residential programs that can take pregnant women and keep them with their infants for up to six months postpartum that are set up with rooms with cribs. There are eight family residential programs and two family transitional living programs.

Trauma-Informed Services

Massachusetts provides a wide range of training to substance abuse treatment providers on the topic of trauma-specific care. Training is provided on a regular basis through a contract with the Institute for Health and Recovery (IHR). IHR has long served the Bureau as a statewide training source on the topic of trauma. IHR provides on-site trauma training and capacity building to train all staff at programs and to provide planning support and technical assistance and further identify trauma-sensitive and trauma-informed evidence based practices and then implement these practices at the programs. In addition, IHR is now finalizing an online, four-module, four hour training: *A Comprehensive Introduction to Psychological Trauma for Substance Use Disorder Treatment Professionals.* This new training package will serve to further expand, refine, and develop the work that IHR performs for the Bureau.

BSAS has made substantial efforts to promote the use of a variety of evidence-based trauma-specific interventions across the lifespan in Massachusetts. These interventions include trainings and models specific to adult women, adult men, families, and youth and young adults. The Bureau of Substance Abuse Services (BSAS) provides a range of trainings to help treatment providers deliver interventions with trauma-specific excellence. During the 2016/2017 grant cycle, a new round of both in-person and online training will bring providers up-to-date materials and information on trauma-informed care. These trainings span from single-day, level of care focused trainings to multi-year trauma training initiatives. Ensuring that the state's treatment providers are at the forefront of providing trauma-informed services continues to remain a priority for BSAS in 2016/2017.

Recovery Support Services

BSAS has continued increasing its funding for Recovery Support Services across the state. The Department has provided additional funding to increase the number of Recovery Support Centers to 10, and to expand the hours during which these centers are open. Recovery Support Centers

play a key role in providing community-based support to those in recovery from opioid addiction. DPH has also increased funding to Learn to Cope, a support organization which offers education, resources, peer support and hope for parents and family members of people addicted to opioids and other drugs. The additional funding will allow Learn to Cope to establish new support groups across the state. Funding was also awarded for a new Recovery High School, bringing the total of Recovery High Schools across the state to five. These high schools provide supportive environments to assist young people in maintaining their recovery while earning their high school diplomas. Lastly, the Massachusetts Organization for Addiction Recovery (MOAR) was awarded additional funding by DPH to increase its capacity to provide peer services to those in recovery from addiction. The vision for these services is spelled out in the narrative "M. Recovery."

Recovery Support Services in Massachusetts also include the Bureau's work on the Access to Recovery (ATR) grant which is being used in Massachusetts to fund recovery support services. In order to support the goals of ATR, BSAS offers increased opportunities for individuals, such as the week long Recovery Coach Academy. Recovery Coaching is a funded support service in Massachusetts that has been successfully piloted. BSAS is currently implementing a process for certification of Recovery Coaches, a goal for the 2016-2017 SAPT plan.

In addition within the ATR grant, BSAS has provided Employment Preparedness and Support services. Participants in ATR have been able to participate in training programs and employment support services and become employed. ATR has provided BSAS the opportunity to develop partnerships with Employment Services providers in the state. The goal is to sustain these efforts that have had a positive impact on the participants.

NIATx

BSAS has, for many years, strongly urged the Commonwealth's substance abuse treatment agencies to utilize NIATx process improvement principles. BSAS has sought to spread NIATx principles through frequent training opportunities and through inclusion of NIATx language in both site visit and procurement documents. Additionally, the state has offered coaching to agencies in particular need of assistance. BSAS has delivered NIATx Process Improvement training in both FY 2014 and 2015 and will be offering a similar training through AdCare Educational Institute in FY 2016.

These well attended training events are supplemented with nine months of telephone coaching and occasional site visits if needed. Three trained NIATx coaches co-facilitate the training events and then each participant is offered the individualized coaching for the following nine months, after the day-long training. A number of training participants complete NIATx Plan-Do-Study-Act projects during the nine-month coaching period. Average attendance at these events in recent years has been 35 participants and about 75 percent of these individuals accept the coaching that is offered.

BSAS has also used NIATx rapid cycle change principles in supporting a number of treatment programs who are mission driven to serve underserved populations. Through the Health Equity Learning Collaborative (HELC), BSAS has provided NIATx coaching, technical assistance and collaborative learning communities for agencies with large numbers of clients from traditionally

underserved populations. BSAS has helped many agencies to improve both client access and client retention rates through NIATx principles, including rapid cycle and data driven change, process improvement at the agency and program level, and training in nominal group techniques.

Agencies that serve specific underserved racial and ethnic groups

BSAS supports the key principle of providing access to care that is both equitable and responsive to the needs of all populations. To address the issue, in 2011 BSAS convened 11 Massachusetts agencies, each of whom had mission statements focusing on serving minority and other traditionally under-served populations, to participate in a NIATx learning collaborative. The group is called the Health Equity Learning Collaborative (HELC) and has been active since 2011. Participation in the HELC allowed these diverse agencies to collaborate, exploring ways of dealing with common challenges including attracting qualified workers, providing affordable and effective translator services, and enhancing processes assuring quick access to treatment and enhancing length of stay in treatment. Participants welcomed the opportunity to learn from each other but also to learn from national NIATx expert coaches.

BSAS provided the forum, coaches, and opportunity for growth, learning, and collaborative problem-solving. The open and collaborative nature of the NIATx model helped agencies that serve underserved ethnic and racial groups make important process improvements. The group as a whole contributed to creating an environment of openness and mutuality, helping participants both learn from, and share with, others in the group.

HELC participating agencies accomplished notable successes. One provider, CASA Esperanza reduced the wait-time for an initial appointment from three weeks to the next day. They also reduced the "did not keep appointment" rate for initial appointments to null as they ended the process of scheduling appointments for intakes, opting into a walk-in service model for clients seeking treatment. Assessments were completed within 48 hours. Staff became increasingly aware of the importance of customer service, a critical NIATx value. The satisfaction surveys conducted by Casa Esperanza improved to a rate with 98% positive feedback.

The Massachusetts Association of Portuguese Speakers (MAPS) used rapid cycle changes to help increase the number of new members in their "Driving Under the Influence of Alcohol" classes. The Boston Public Health Commission also utilized NIATx process improvement to increase the number of new admissions to their program for pregnant women in early recovery. These successes and many others demonstrate the positive impact that the Health Equity Learning Collaborative has had on the ability of agencies to serve underserved racial and ethnic groups. The strategies and successes of the HELC's work over the past four years will inform BSAS in developing approaches to improve services for underserved racial and ethnic groups in 2016/2017 and beyond.

BSAS also funds and provides guidance to ensure that substance abuse providers are trained in culturally competent modalities. The Latino Behavioral Health Workforce Training Program has trained hundreds of Latinas and Latinos in addiction treatment, while creating access to addiction treatment credentials - licensure and certification. Moreover, by providing technical assistance, capacity building, and support to BSAS funded organizations, the program has increased the publicly funded treatment system's capacity to provide culturally and linguistically competent

services to the Latino population, thereby addressing health disparities and their impact on Latinos and Latinas in the Commonwealth. The in-classroom training component of the program is delivered each year at two sites in Boston and Springfield.

The African American Behavioral Health Workforce Training Program, to start in July, 2016, will provide culturally responsive training to current and aspiring addiction treatment counselors who are African American or of African descent. The program, in the same vein as the Latino program, will increase the system's capacity to provide culturally competent services to African American clients and those of African descent.

Opioid Overdose Prevention and Response

In response to the growing opioid addiction epidemic in Massachusetts, and across the nation, former Governor Deval Patrick declared a public health emergency on March 27, 2014. The Governor directed the Department of Public Health (DPH) to take several actions to combat overdoses, stop the opioid epidemic from getting worse, help those already addicted to recover, and map a long-term solution to ending widespread opioid abuse in the Commonwealth. In 2014, there were 1,256 unintentional/undetermined opioid overdose deaths in Massachusetts. The number of confirmed cases of unintentional opioid overdose deaths for 2014 represents a 57% increase over 2012 (n=668) and a 15% increase over confirmed cases for 2013.

Governor Charlie Baker has continued to prioritize opioid overdose prevention and response. In February 2015, Governor Baker convened an 18-member working group with developing specific, actionable recommendations to curb the opioid crisis. These recommendations are now being carried out by BSAS in the planning and development of opioid overdose prevention strategies.

These strategies include:

- Piloting recovery coaches in the emergency department
- Promoting prescription and pharmacy access to naloxone
- Improving the response of first responders
- Promoting the 911 Good Samaritan Law
- Continuing oversight and expansion of the bystander naloxone program
- Promoting overdose prevention materials
- Supporting the Massachusetts Opioid Abuse Prevention Collaborative

One major Opioid Overdose Prevention initiative that the Department is engaged in is the Overdose Education and Naloxone Distribution (OEND) pilot program. Presently, there are 16 community based agencies participating in this bystander naloxone program. There are 20 Learn to Cope meeting sites across the Commonwealth that provide support for families as well as training on the administration of naloxone and naloxone kits. As of September 15, 2015, there have been a total of 37,359 individual participants trained and given a naloxone kit and 5,591 reported opioid overdose reversals using the bystander pilot program naloxone. In 2014 alone, 10,145 individuals were enrolled in the bystander naloxone program. In 2014, there were 1,567 reported opioid-overdose reversals in the bystander naloxone program.

These strategies and programs continue to bolster innovation and partnerships with harm reduction programs, municipalities, first responders, emergency departments, houses of correction, substance abuse treatment programs, community health centers, outreach workers, and others that work every day to address opioid overdose. Opioid overdose is a top concern of the Commonwealth. Prevention of fatal and non-fatal opioid overdoses remains a top priority for the SAPT plan throughout 2016/2017.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

Step 2: Identify the unmet service needs and critical gaps within the current system

Data Sources:

The data sources for indicators of treatment need that the Bureau currently examines on a regular basis include emergency department and hospital discharges, mortality data, publicly-funded treatment admissions, and population-based surveillance surveys such as the Behavioral Risk Factor Surveillance System and the National Household Survey on Drug Use and Health. The data sources for indicators of need related to prevention include the Youth Health Survey, the Youth Risk Behavior Survey and the Behavioral Risk Factor Surveillance System.

The emergency department and hospital discharge data comes from the Uniform Hospital Discharge Data Set (Emergency Department and Hospital Inpatient Discharge data) complied by the MA Center for Health Information and Analysis. The mortality data comes from Death Certificates on file at the Massachusetts Department of Public Health Registry of Vital Records and Statistics. The publicly funded treatment admissions data comes from the Bureau's own Office of Data Analytics and Decision Support (ODADS).

Needs Assessment Projects:

BSAS partners with the MA Department of Education to develop annual incidence and prevalence estimates by alternating administration of the Youth Risk Behavior Survey with a Massachusetts Youth Health Survey (MYHS). The MYHS contains many CDC Youth Tobacco Survey and Youth Risk Behavior Survey data elements, but also contains information related to students' attempts to gain health services.

The Statewide Massachusetts Epidemiological Working Group (MEW) was first convened in 2007 to identify existing data, enhance data sharing capabilities for tracking emerging drug trends, measure capacity, identify data gaps, and focus and coordinate all substance abuse prevention resources for all 351 communities in the Commonwealth. The MEW is composed of 10-15 representatives identified by the Governor's Interagency Council on Substance Abuse and Prevention, Executive Office of Public Safety, Departments of Education, Children and Family Services, Youth Services, Public Health, Corrections, Mental Health, regional and community level stakeholders, and the Massachusetts Prescription Monitoring Program. The workgroup's goals are to improve the collection, analysis, and reporting of substance use incidence, prevalence, consumption and consequence data in order to plan substance abuse prevention services and to provide communities with access to epidemiological data so that they may use accurate and comprehensive information to design culturally appropriate prevention, intervention, and treatment services.

In September 2013, Massachusetts received a two-year State Epidemiological Outcome Workgroup (SEOW) supplement grant from SAMHSA to expand the MEW's activities and its ability to collect data in middle and high school within BSAS-funded communities. Specifically,

the supplement led to the development and testing of a brief community survey to collect annual data on ATOD use and related issues. The Brief Community Survey was pilot tested in four Massachusetts communities in spring 2014. A total of 2,071 surveys were completed. The state is partnering with the Survey Research Center at the University of Massachusetts to adapt this model for use within all sub-recipient communities.

External Dataset Integration

Integrated Datasets

- The most current ED/Hospital Dataset (MA Center for Health Information and Analysis) year of data integrated into BSAS datamart is for 2012. Including the ED/Hospital dataset allows for incorporation of additional content including, but not limited to, disease states derived from ICD-9 codes and related procedures and treatments from CPT-4 and other standard code sets.
- The Vital Records Dataset (MA Department of Public Health) is also integrated into BSAS datamart up to 2012. We are in the process of acquiring and integrating the 2013 and 2014 datasets. These data include cause of death, co-morbid conditions and other relevant data that may be used in either predicting risk or evaluating program and system level performance.

Planned Dataset Integration

BSAS anticipates access to and integration of additional datasets:

- All Payer Claims Database (MA Center for Health Information and Analysis) – comprised of medical and pharmacy service and cost information. This data is derived from member eligibility, provider, and medical claim files encompassing Commercial, Medicare and Medicaid insured. The APCD will afford a deeper understanding of the MA health care delivery system, including substance abuse, by providing access to timely and accurate data essential to improving quality, reducing costs, and promoting transparency. In addition, it will allow BSAS to have access to outpatient data not previously available. A full description of this project is attached with narrative "U. Technical Assistance Needs."
- Criminal Justice Data – BSAS has met with Massachusetts Office of the Commissioner of the Probation and identified data elements that will be useful in assessing the effectiveness of the drug courts in achieving their goal. The results of this exercise will also inform BSAS about the usefulness of this data in client outcome analysis.

2015 Opioid Work Group Information Gathering/Listening Sessions and Plan

One of the major planning initiatives this year was conducted by Governor Baker's Opioid Working Group. The group held meetings with invited experts and several listening sessions around the state. The details of their process and their findings are outlined in the documents that

are linked to below. BSAS is involved with the implementation of many of the Working Group's recommendations related to treatment access and overdose prevention.

Recommendations of the Governor's Opioid Working Group
http://www.mass.gov/eohhs/images/dph/stop-addiction/recommendations-of-the-governors-opioid-working-group.pdf

Action Plan to Address the Opioid Epidemic in the Commonwealth
http://www.mass.gov/eohhs/images/dph/stop-addiction/opioid-epidemic-action-plan.pdf

SAPT Block Grant Priorities and Goals for 2016-2017

The 10 priorities and 20 goals included in the Massachusetts Block Grant plan for 2016-2017 represent a wide range of activities currently underway at the Bureau of Substance Abuse Services. The Bureau is currently using Opioid overdose numbers and rates, treatment rates and the availability of services along the continuum of care to identify gaps in services in communities. This work is building on the related data and needs assessment goals from the 2014-2015 plan.

The other priority areas were selected for inclusion based on a number of factors including SAPT Block Grant priorities and current BSAS efforts underway in a wide range of areas. Meetings were held within each BSAS unit to compile priority projects and initiatives across all BSAS staff. These units include Program Development and Planning, Youth and Young Adult Services, Housing and Homelessness, Prevention, Adult Field Operations, Quality Assurance and Licensing, and Data Analytics and Decision Support. Each of these units is actively engaged in number of important initiatives so initial planning steps included gathering information on projects related to BSAS and Block Grant priorities and the specific 2016-2017 goals for each initiative. A final planning meetings were held with BSAS management to finalize the 2016-2017 Massachusetts Block Grant priorities and goals. These goals were then posted for public comment on the BSAS website. The final set of goals is reflective of a broad range of BSAS and SAPT Block Grant priorities for 2016-2017.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

I. Quality and Data Collection Readiness

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

Massachusetts's Bureau of Substance Abuse Services (BSAS) requires all BSAS funded substance abuse treatment providers to collect and submit information on each client's socioeconomic and demographic characteristics, current and past substance abuse at enrollment, and a list of information on other client characteristics, (e.g., mental health treatment history, handicaps, state services received, etc.) Additional information is collected at disenrollment including reasons for discharge, referrals and various proxies for estimating treatment outcome. In addition, at some treatment settings, (e.g., residential programs and opioid maintenance programs) a more detailed assessment of clients is done at enrollment, disenrollment, and in the case of opioid maintenance, periodically, every three months. Also, providers must regularly submit information for each enrollment on services provided and bill for services rendered where BSAS is the payer.

Substance abuse service providers collect and enter client enrollment, disenrollment, and assessment information into the BSAS Enterprise Invoice Management/Enterprise Service Management systems (EIM/ESM). Once submitted to EISM/ESM operational data store, data is then extracted into a separate SQL database environment where it is staged (cleansed, mapped and normalized). During the staging process, an algorithm (a.k.a. Client Indexing) utilizes information on enrollees' reported social security number, date of birth and name to link enrollments that appear to involve the same person. As a result, the Client Indexing process assigns a common client identifier to these enrollments and reconciles a variety of reporting issues. After staging, data is loaded into an Enterprise Data Warehouse where it is then available for analysis via SAS, Cognos and other analytical/reporting tools. Thus BSAS can readily report data at the provider level, the enrollment level, and the client level. Processing of linked clients also allows us to construct treatment episodes and entire client histories.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

In Massachusetts, oversight of substance abuse treatment services is the purview of the Bureau of Substance Abuse Services, within the Massachusetts Department of Public Health

(DPH). BSAS reports only on substance abuse treatment clients. Oversight of mental health treatment is the responsibility of the Massachusetts Department of Mental Health (DMH). Both DPH and DMH are agencies under the direct supervision of Massachusetts Executive Office of Health and Human Services (EOHHS).

3. Is the state currently able to collect and report on the draft measures at the individual client level (that is, by client served, but not with client-identifying information)?

As described above, BSAS can link enrollment records to construct client identifiers and can use these client identifiers to link to other data sets. However, BSAS's EIM/ESM system does not currently collect items that relate to medical care provided to the client and which are listed in the measures below:

1. CAHPS_HEDIS – perception of care/family involvement in care
   These questions are currently not asked/collected from clients but could be added to the enrollment assessments.
2. NQF-0104--Major Depressive Disorder/Suicide Risk Assessment
   NQF-1364/1365--Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
   Clinical diagnosis is not a part of data submitted to the Bureau of Substance Abuse Services. Providers that are integrated into community health centers and have electronic medical records (EMR), will have access to the clinical diagnosis and could be asked to submit such information through HL7 like mechanisms. Also, providers serving the dually diagnosed can diagnose mental illness and could submit diagnostic and risk assessment data to the Bureau via similar mechanisms.
3. Percentage of Adults with Serious Thoughts of Suicide in the Past Year. **Questions about suicide ideation are incorporated in opioid maintenance assessments only. They could be added to other assessments.**
4. NQF-0710-Depression Remission at 12 Months
   Same as 2 above.
5. NQF--0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention.
   The current system obtains limited information about tobacco use at enrollment and disenrollment including use of Nicotine Replacement Therapy (NRT) while in treatment at disenrollment but no information is collected on cessation counseling.
6. NQF-2602: Controlling High Blood Pressure for People with SMI.
   Will require access to EMR data by providers.
7. NQF-2603: Diabetes Care for People with SMI: Hemoglobin A1c (HbA1c) Testing.

Will require access to EMR data by providers.

8. NQF--2605: Follow-Up after Discharge from the ED for Mental Health or Alcohol or Other Drug Dependence.
   While we have access to hospital discharge data, we are unaware of any post-discharge data being collected.
9. NQF-2152--Unhealthy Alcohol Use: Screening and Brief Counseling.
   We currently do not have access to Screening and Brief Intervention conducted in medical settings. While SBIRT is conducted in some medical settings, due to lack of uniform payment mechanisms, data on services provided is not captured in any claims or hospital discharge data.
10. Percentage of individuals 12-20 who have used alcohol in the past 30 days
    This information is collected on the current assessment forms for individuals 13-20 served in our funded programs. We do not have information on screening data collected in medical settings.
11. Percentage of patients identified as needing treatment for prescription drug misuse who received treatment and significantly reduced or stopped use at follow up measurement period or discharge.
    This information is collected through the enrollment and disenrollment assessment for patients who received treatment from BSAS funded programs. It is assumed that those reporting prescription drugs as their primary drug are in need of treatment.
12. Percentage of individuals aged 12 and older who reporting initiating illicit prescription drug use in the past month
    This information is not currently collected from clients. We collect information on age of first use and can calculate initiation in the past year based on client's age.
13. Percentage of patients aged 12 and older identified as needing treatment for marijuana use disorder and receive treatment who significantly reduce or stop using marijuana at follow up period or discharge.
    This information is collected through the enrollment and disenrollment assessment for patients who received treatment from BSAS funded programs. It is assumed that those reporting marijuana as their primary drug are in need of treatment.
14. Percentage of individuals 12 and older who report initiating marijuana use in the past year
    We collect information on age of first use and can calculate initiation in the past year based on client's age.
15. Number of adults employed with substance use and/or mental health disorder who are employed (FT/PT/SA)

This information is captured for substance abuse treatment clients served in BSAS funded programs.

16. Average daily school attendance
    Currently not collected.
17. Number of adults 18 and older who incur new criminal charges while in treatment
    We currently collect data on arrests not charges prior to enrollment and during enrollment.
18. Number of DWI and DUI Arrests
    Currently not collected.
19. Living situation past 30 days
    Information about current housing and living arrangements are collected at enrollment and disenrollment.
20. Past 30 days homeless
    Information about homelessness is derived from a number of elements collected at enrollment and disenrollment.

4. If not, what are the perceived or actual barriers to this? What changes or adjustments will the state need to make – or what technical assistance will the state need to receive - to be able to collect and report on these measures?

Our current electronic data reporting system, the EIM/ESM, is a system of collection for a multitude of state agencies and it was primarily designed for fulfilling billing requirements. The assessment information received from the providers is entered manually into the electronic data collection system. This information includes TEDS and Block Grant data elements. In the past three years MDPH has worked with methadone treatment providers and their venders to submit the required information from their EMR through HL7 messaging instead of manual entry into the system. This has been a very resource intensive and inefficient process and has resulted in severe data reporting lags from methadone treatment services. Given that many of the proposed draft measures are collected through EMRs, there would be two approaches to collecting this information from the providers that have an EMR both of which will have significant barriers for implementation. The first approach would be to require providers to submit this information via HL7; as described above this is a significantly time consuming and expensive undertaking. Moreover, some of the smaller providers do not have an EMR system. The second approach would be to incorporate the new measures into our assessment tools. This approach is no less resource consuming as it will not only require changes to the application and the analytic tables, but it will also require providers who have an EMR to enter the information into two independent systems.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Prevention of fatal and non-fatal opioid overdoses

Priority Type: SAP, SAT

Population(s): IVDUs, Other (Opioid Users)

Goal of the priority area:

Goal 1: Implement a Recovery Coach intervention pilot in Emergency Departments for individuals who have come in for an overdose

Goal 2: Promote pharmacy access to naloxone in partnership with pharmacies, communities, and treatment providers

Objective:

Goal 1 objective: Reduce morbidity and mortality related to opioid overdose by implementing a Recovery Coach intervention pilot in Emergency Departments for individuals who have come in for an overdose

Goal 2 objective: Increase the number of pharmacies that have established a naloxone standing order by an additional 10%

Strategies to attain the objective:

Goal 1 strategy: Plan, procure, and begin implementation of Recovery Coaching pilot project in Emergency Departments

Goal 2 strategy: DPH will send communications to pharmacists and prescribers and will partner with pharmacists, pharmacist organizations, the Board of Registration in Pharmacy, treatment programs, and community coalitions to promote pharmacy access to naloxone.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Goal 1: Procurement is posted, vendors are selected and pilot project begins to serve clients

Baseline Measurement: Currently no Recovery Coach in Emergency Department model exists in Massachusetts.

First-year target/outcome measurement: Procurement is posted, vendor is selected and pilot project design is finalized.

Second-year target/outcome measurement: Pilot Recovery Coaches in Emergency Departments program begins to serve ED patients and data is collected.

Data Source:

Procurement and contracting records, site visits and reports from the vendor

Description of Data:

Department administrative records

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: Goal 2: Increase in the number of pharmacies with a standing order for naloxone based on number that have submitted their standing order to the Board of Registration in Pharmacy.

Baseline Measurement: Currently there are 549 pharmacies with standing order, which is 47% of the retail pharmacies in Massachusetts

First-year target/outcome measurement: Increase the number of pharmacies that have established a naloxone standing order by

	10%
Second-year target/outcome measurement:	Increase the number of pharmacies that have established a standing order by an additional 10%

Data Source:

Board of Registration in Pharmacy

Description of Data:

List of pharmacies that have established a standing order and have notified the Board as is required.

Data issues/caveats that affect outcome measures::

List requires regular maintenance since standing orders must be updated annually. Pharmacies need to maintain an active standing order and notify the Board on annual basis by submitting the updated standing order.

Priority #:	2
Priority Area:	Identify high-risk populations using data from multiple sources
Priority Type:	SAP, SAT
Population(s):	PWWDC, PP, IVDUs, Other (Adolescents w/SA and/or MH, LGBTQ, Military Families)

Goal of the priority area:

Goal 1: Identify high risk population groups with unmet treatment needs.

Goal 2: Improve treatment outcomes for clients enrolled in specialty courts.

Objective:

Goal 1 objective: Analyze linked dataset, identify high risk treatment settings and communities, develop intervention strategies.

Goal 2 objective: Analyze linked dataset. Perform outcome analysis to inform the trial court on the development of drug court policies and procedures, propose treatment matching based on risk factors and client characteristics.

Strategies to attain the objective:

Goal 1 strategy: Link Massachusetts state police data on suspected Heroin overdoses to treatment data and identify intervention opportunities in treatment settings and communities. Streamline the process of incorporating state police data into datamart. Analyze linked dataset identify high risk treatment settings and communities and develop intervention strategies

Goal 2 strategy: Link Massachusetts trial court data for clients admitted to drug courts to BSAS and CHIA data; Streamline the process of incorporating trial court data into datamart; Analyze linked dataset; Outcome analysis to inform the trial court on the development of durg court policies and procedures, and propose treatment matching based on risk factors and client characteristics.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Goal 1: Completed process for secure data transmission; Streamlined data linkage process; Preliminary analysis to check the consistency of the linkage; Rigorous analysis to identify areas of intervention; Continuous updating of State police files and linkage with datamart; Convene meetings with stakeholders; develop intervention strategies based on treatment setting, time from disengagement from treatment and client characteristics
Baseline Measurement:	N/A - Process/Deliverables base
First-year target/outcome measurement:	Receive data via Secure transmission; Completed analytic tables that help identify intervention opportunities based on time and treatment type measure
Second-year target/outcome measurement:	Continuous trend analysis; Development and implementation of intervention strategies based on analytic results

Data Source:

BSAS Treatment Data; State Police Suspected Heroin Overdose Death Data

Description of Data:

State Police Suspected Heroin Overdose Death Data are a list of Massachsuetts residents who were identified by the state police as Heroin related deaths based on evidence found at the scene

Data issues/caveats that affect outcome measures::

1) this data only includes Heroin overdoses; 2) it is only a list of overdose deaths that the state police attended and excludes three major cities in Massachusetts (Boston, Springfield and Worcester); and it is not based on medical examiner's report. While these are major shortcomings, it provides us with the most current overdose data that the signle state authority can have access to.

Indicator #:	2
Indicator:	Goal 2: Streamlined data linkage process; Continued analysis on population characteristics and rates of health care utilization; Simplifies data transmission process through receipt of data extracts from the Trial Court; Continued in-depth analysis to identify risk factors and treatment patterns related to best outcomes; and establishement of a data sharing agreement with the trial court for continued outcome analysis
Baseline Measurement:	N/A - Process/Deliverables base
First-year target/outcome measurement:	Develop the code to automatically update the linked tables after each data refresh; Present findings to the Trial Court
Second-year target/outcome measurement:	Validation analysis of data extracts submitted; Presentation of outcome analysis results to the trial court; Data sharing agreement to share data between BSAS and Trial Court

Data Source:

BSAS Treatment Data
CHIA hospital utilization Data
Massachusetts Trial Court enrollment and disposition Data from Drug Courts

Description of Data:

Massachusetts Trial Court collects data on clients admitted to their Drug Courts. This information includes dates of enrollment and disenrollment, reincarceration, charges, phases of drug court, etc.

Data issues/caveats that affect outcome measures::

Currently the data is transmitted by inidvidual courts through a secure fax to BSAS and is being manually entered into a table. The Massachusetts Trial Court has undergone and is still in the process of major IT transitions. The promise to deliver a extract that includes all the necessary variables is a part of an ongoing discussion. If due to various reasons the Trial Court is unable to deliver the data extracts, BSAS will continue to collect the data from the trial courts. This may affect the continuous analysis and reporting of the findings. Given the expansions in prgress, the volume of data submitted is due to increase. Manual data entry is resource intensive and may be done in batches every quarter or six months.

Priority #:	3
Priority Area:	Improved and enhanced substance abuse primary prevention in MA
Priority Type:	SAP
Population(s):	PP

Goal of the priority area:

Goal 1: Develop policy/practice change interventions for Substance Abuse Prevention Collaborative Programs (SAPC)

Goal 2: Develop policy/practice change interventions for Massachusetts Opioid Abuse Collaborative Programs (MOAPC)

Objective:

Goal 1 objective: Each SAPC community accomplish 1 policy/practice change

Goal 2 objective: Each MOAPC community accomplish 1 additional policy/practice change

Strategies to attain the objective:

Substance Abuse Prevention Collaborative Programs (28): review data; assessment and planning to inform future policies/practices; Massachusetts Opioid Abuse Prevention Collaborative Programs (18): promote the use of the Good Samaritan Law, use of the Prescription Monitoring Program (PMP) and access to services through health communications and other means; work with police and communities to decrease stigma

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Goal 1: Each year SAPC programs propose one new policy/practice change; accomplish one policy/practice change
Baseline Measurement:	Substance Abuse Prevention Collaborative Programs (SAPC) – Assessment, capacity-building, and planning to inform policy/practice change for the next year
First-year target/outcome measurement:	SAPC propose one policy/practice change
Second-year target/outcome measurement:	SAPC accomplish one policy/practice change

Data Source:

Quarterly Narrative Report and Contract Management Report

Description of Data:

Each community will submit the: 1) policy/practice change; 2) progress made or implementation challenges; 3) accomplishment of the change; 4) proposed policy/practice change for the next year.

Data issues/caveats that affect outcome measures::

MOAPC and SAPC-- timeliness of data submission; policy/practice change challenges; unexpected barriers to implementation

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Indicator #:	2
Indicator:	Goal 2: Each year MOAPC prgorams propose one new policy/practice change; accomplish one policy/practice change
Baseline Measurement:	Massachusetts Opioid Abuse Prevention Collaborative Programs (MOAPC)--proposed policy/practice change
First-year target/outcome measurement:	MOAPC accomplish one policy/practice change and propose one for FY17
Second-year target/outcome measurement:	MOAPC accomplish one more policy/practice change

Data Source:

Quarterly Narrative Report and Contract Management Report

Description of Data:

Each community will submit the: 1) policy/practice change; 2) progress made or implementation challenges; 3) accomplishment of the change; 4) proposed policy/practice change for the next year.

Data issues/caveats that affect outcome measures::

Timeliness of data submission; policy/practice change challenges; unexpected barriers to implementation

Priority #:	4
Priority Area:	Substance use screening, intervention and treatment integration with health care
Priority Type:	SAP, SAT
Population(s):	PP, Other

Goal of the priority area:

Goal 1: Improved ability to identify of unhealthy alcohol and drug use, including early intervention, and referrals to treatment when appropriate.

Goal 2: Increase and improve access to medication assisted treatment (MAT)

Objective:

Goal 1 objective: Incorporate SBIRT concepts and skills into routine health care practice as part of care integration.

Goal 2 objective: Increase the number of clients in residential treatment in the BSAS system that are on MAT by an additional 5%.

Strategies to attain the objective:

Goal 1 strategy: Continue to work closely with other DPH bureaus and other EHS departments to develop and implement common goals; engage professional health care groups such as the Massachusetts Hospital Association, Massachusetts chapters of medical and nursing organizations, as well as social workers; payers like Massachusetts Behavioral Health Partnership, One Care and senior care organizations; and state policy makers such as the Health Policy Commission in health care integration efforts.

Goal 2 strategy: Enforce the following regulatory requirements for all BSAS licensed substance abuse treatment program: assess for a history of opioid use, education on the benefits and risk of MAT, integration of overdose prevention risk assessment and education into all phases of treatment, ensure that no individual is denied access due to MAT or wanting MAT as part of concurrent treatment, ensure treatment staff are trained on MAT, and ensure treatment programs have Qualified Service Organization Agreements (QSOA) with local MAT programs; Work with Outpatient Treatment Providers (OTP) to expand access to all FDA approved medications for opioid dependence; Provide funding to an increased number of community health centers that will offer Office Based Opioid Treatment (OBOT), with particular focus on areas of high need; Provide technical assistance to all community health centers interested in integrating substance abuse treatment into their behavioral health services, including access to buprenorphine and vivitrol.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Goal 1: Number of sites/providers trained, number of sites/providers coached through to implementation, follow-up, and maintenance training sessions.
Baseline Measurement:	Existing number of sites/providers trained in SBIRT concepts and skills at the locales selected for this intervention.
First-year target/outcome measurement:	10 new sites incorporating SBIRT into routine protocols
Second-year target/outcome measurement:	10 additional sites for SBIRT training and technical assistance.

Data Source:

MASBIRT Training and Technical Assistance vendor communications and reports

Description of Data:

Site and trainer reports

Data issues/caveats that affect outcome measures::

Size of sites will vary

Indicator #:	2
Indicator:	Goal 2: 1) Increase in the number of clients the treatment system services that are on MAT by 5%; 2) Decrease in the number of complaints regarding access to concurrent treatment for clients on MAT; 3) Increase the number of community health centers that provide MAT or apply for a substance abuse treatment license; 4) Increase the number of OTPs that offer buprenorphine and/or vivitrol;5 Increase the number of funded OBOTs at community health centers in high need areas.
Baseline Measurement:	Licensing, EIM/ESM, and complaint data; RFR data; Number of meetings with the Mass League of Community Health Centers regarding OBOTs and licensing.
First-year target/outcome measurement:	Alert all licensed treatment programs emphasizing the regulatory requirements and consequences for non-compliance; Review data for treatment providers and create action plans for intervention; Write and post the RFR to increased funded OBOTs; Meet with the Mass League of Community Health Centers to regulatory or payment/reimbursement barriers

Second-year target/outcome measurement: Review trend data and evaluate the action plans from year 1; Assess best interventions and build upon them to increase positive outcomes; With regard to CHC and OTPs, if there are reimbursement or regulatory barriers to increasing access to all FDA approved medications, meet with the relevant agencies to resolve integration barriers.

Data Source:

EIM/ESM; RFR; Licensing and complaint data; Meeting notes

Description of Data:

Number of clients in BSAS funded treatment programs receiving MAT and concurrent care
Number of programs that over time have not demonstrated compliance – EIM/ESM, complaint and licensing data
Number of meetings with the Mass League
Number of meetings with agencies relevant in resolving regulatory and reimbursement integration barriers
Number of CHCs offering OBOTs
Number of new OBOTs funded by BSAS

Data issues/caveats that affect outcome measures::

EIM/ESM data only provides information from funded licensees

Priority #: 5

Priority Area: Substance abuse prevention, intervention, treatment, and recovery support for justice-involved individuals.

Priority Type: SAP, SAT

Population(s): PP, Other (Criminal/Juvenile Justice)

Goal of the priority area:

Goal 1: Increase participation in substance abuse programming and referrals to aftercare services

Goal 2: Increase participation in substance abuse programming and referrals to aftercare services for civilly-committed individuals in the DPH system.

Objective:

Goal 1 objective: Increase referrals to aftercare from DAE by 15% over FY15

Goal 2 objective: Increase the percentage of Section 35 discharges in the DPH system referred to medication assisted treatment by an additional 2%

Strategies to attain the objective:

Goal 1 strategy: Work with programs to focus on assessments and discharge plans on the continuing treatment needs for those involved in DAE intervention services; Hold regional meetings with DAE providers to have a consensus on goals; Develop and share strategies or "best practices" among providers

Goal 2: Increase participation in substance abuse programming and referrals to aftercare services for civilly-committed individuals in the DPH system

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Goal 1: Aftercare referrals to outpatient treatment and other substance abuse treatment from Driver Alcohol Education (DAE) programs

Baseline Measurement: Referrals to outpatient treatment and other substance abuse treatment in FY14: 5.89%

First-year target/outcome measurement: Increase referrals to aftercare from DAE by 2% over FY14

Second-year target/outcome measurement: Increase referrals to aftercare from DAE by 4% over FY15

Data Source:

ESM reports

Description of Data:

ESM Disenrollment 4th quarter reports

Data issues/caveats that affect outcome measures::

Standardized interpretation of completion by all providers
Standardized definition of what constitutes a referral

Indicator #:	2
Indicator:	Goal 2: Increase admissions to medication assisted therapy that were civil commitments
Baseline Measurement:	FY 14 – Referred to Opioid Treatment – 4.88%
First-year target/outcome measurement:	Increase the percentage of Section 35 discharges in the DPH system referred to medication assisted treatment by 2% over FY 14
Second-year target/outcome measurement:	Increase the percentage of Section 35 discharges in the DPH system referred to medication assisted treatment by 4% over FY 14 baseline

Data Source:

ESM Disenrollment data , billing data, and Section 35 tracking logs

Description of Data:

ESM, Contract billing for civil commitment services, monthly program reports

Data issues/caveats that affect outcome measures::

Staff turnover that impact proper coding and entry of data

Priority #:	6
Priority Area:	Reduced disparities in access to substance abuse prevention, intervention, treatment, and recovery support for at-risk populations.
Priority Type:	SAP, SAT
Population(s):	PWWDC, PP, IVDUs, HIV EIS, Other (Adolescents w/SA and/or MH, LGBTQ, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Goal 1: Increase capacity of the OYYAS and its provider system to offer culturally competent care to LGBTQ youth and young adults

Goal 2: Address the treatment needs of older adults with focus on physical/psychosocial barriers

Goal 3: Increase the number of new active members of faith-based coalition each year.

Objective:

Goal 1 objective: Develop guidelines for OYYAS provider system to be LGBTQ culturally competent

Goal 2 objective: Identify age appropriate, evidence-based practices for treatment of adults 55 and older

Goal 3 objective: Add three additional new active members to the faith-based coalition including at least one representing currently under-represented groups

Strategies to attain the objective:

Goal 1:
- Work with BSAS-funded consultant to review policies, procedures and practices, and make revisions or draft policies as necessary.
- Develop a training curriculum for OYYAS providers to increase capacity to offer culturally competent care to LGBTQ youth and young adults.

Goal 2:
- Collaborate with organizations focused on older adults, including the Elder Mental Health Collaborative, and the Balanced Incentive Program, to learn about existing access to treatment barriers.
- Strengthen ties with State agencies, such as the Office of Elder Affairs, and national organizations, such as the American Geriatrics Society, to assess,

adopt and/or develop appropriate, evidence-based practices on addressing aging issues pertaining to substance use.

Goal 3:
- Build on the success of the 2015 faith-based conference by inviting those interested participating to join the coalition.
- Seek opportunities to inform, educate, and interact with populations who are traditionally underserved in the faith-based community in the City of Boston.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Goal 1: 1) Development of an OYYAS LGBTQ cultural competency capacity building plan; 2) Development/approval of LGBTQ cultural competence training curriculum; 3) Increase in the number of LGBTQ young persons admitted to OYYAS programs; 4) OYYAS staff and the OYYAS provider system trained in LGBTQ cultural competency
Baseline Measurement:	Number of LGBTQ youth/young adults enrolled into OYYAS services; Number of OYYAS staff receiving LGBTQ cultural competency training; Number of provider agencies receiving LGBTQ cultural competency training
First-year target/outcome measurement:	Complete the development of guidelines for the OYYAS provider system to be LGBTQ culturally competent
Second-year target/outcome measurement:	OYYAS provider system trained in LGBTQ cultural competency

Data Source:

Enterprise Service Management system data – BSAS Office of Data Analytics and Decision Support (ODADS)

Description of Data:

Enrollment data from the OYYAS service providers that capture LGBTQ identification during intake/enrollment into a program.

Data issues/caveats that affect outcome measures::

Delays in acquiring site data needed to determine program training needs; challenges with scheduling time for training at designated sites.

Indicator #:	2
Indicator:	Goal 2: Number of EBPs found, Number of existing sites providing older adult 'friendly' treatment, Number of sites/providers trained
Baseline Measurement:	Review existing state data on the number of adults aged 55 and older who utilized the substance abuse treatment system in FY15. Quantify the number of existing EBPs focused on treating older adults that would be applicable in MA. Conduct state-wise needs assessment to determine which geriatrics practices/providers need information/guidance on linking older adults to substance abuse treatment providers.
First-year target/outcome measurement:	Identify age appropriate, evidence based practices for treatment of adults 55 and older.
Second-year target/outcome measurement:	Train BSAS provider system in evidence-based practices for adults 55 and older.

Data Source:

Patient level data: State treatment data set
Data on existing EBPs focused on older adults: Publically available electronic databases such as the National Library of Medicine's PubMed, the MedEd Portal, and the Portal of Online Geriatrics Education
Provider needs assessment

Description of Data:

Patient level: descriptors including age, gender, site(s) of care, duration of care, services provided.
EBPs: Professional and academic literature and publications on substance use disorder prevention, treatment and services pertaining to adults age 55 and older.

Data issues/caveats that affect outcome measures::

Timeliness of receiving data; delays in conducting literature review and search for relevant publications due to competing priorities.

Indicator #:	3
Indicator:	Goal 3: Number of new, active members of the Faith-Based Coalition
Baseline Measurement:	12 members of the coalition
First-year target/outcome measurement:	Add six new active members, at least four representing currently under-represented groups
Second-year target/outcome measurement:	Add three additional new active members, at least one representing currently under-represented groups.

Data Source:

Attendance at coalition meetings, as recorded in the meeting minutes
Records of coalition activities, including, outreach and community engagement activities.

Description of Data:

Coalition membership and participation records

Data issues/caveats that affect outcome measures::

None

Priority #:	7
Priority Area:	Substance abuse prevention, intervention, treatment, and recovery support of pregnant women and women with dependent children
Priority Type:	SAP, SAT
Population(s):	PWWDC, PP

Goal of the priority area:

Increase the number of pregnant women accessing the BSAS treatment system

Objective:

Increase the total number of pregnant women enrolled in the BSAS treatment system by an additional 10%

Strategies to attain the objective:

• Within the working group for pregnant and postpartum women consisting of staff from BSAS and from IHR, collect monthly data on numbers of pregnant and postpartum women seeking treatment with a focus on residential treatment and Opioid Treatment Programs (OTP);
• Track the number of admissions of pregnant and postpartum women to BSAS funded treatment programs;
• Provide capacity building TA to improve treatment access and increase the number of treatment slots for pregnant and postpartum women.
• Do another mass mailing of the posters to community locations notifying pregnant women that they have priority access to treatment. Recovery Support Centers can assist with placement of posters in their communities.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of pregnant and postpartum women enrolled annually in the BSAS funded treatment system based on ESM Enrollment data.
Baseline Measurement:	The total number of pregnant women enrolled in the BSAS treatment system in FY14 was 736.
First-year target/outcome measurement:	Increase the total number of pregnant women enrolled in the BSAS treatment system by 10% of the baseline in FY14.
Second-year target/outcome measurement:	Increase the total number of pregnant women enrolled in the BSAS treatment system by an additional 10%.

Data Source:

Client Enrollment data submitted by providers of BSAS-funded treatment programs via ESM/EIM

Description of Data:

Providers indicate upon enrollment whether or not the client is pregnant.

Data issues/caveats that affect outcome measures::

This data only captures women that are known to be pregnant upon enrollment.

Indicator #:	2
Indicator:	Increase the number of women with dependent children (WDC) accessing the BSAS treatment system.
Baseline Measurement:	Number of WDC enrolled annually in the BSAS funded treatment system based on ESM Enrollment data
First-year target/outcome measurement:	Increase the total number of WDC enrolled in the BSAS treatment system by 10% of the baseline in FY14
Second-year target/outcome measurement:	Increase the total number of WDC enrolled in the BSAS treatment system by an additional 10%

Data Source:

Client enrollment data submitted by providers of BSAS-funded treatment programs via ESM/EIM.

Description of Data:

Providers indicate upon enrollment whether or not the client has dependent children.

Data issues/caveats that affect outcome measures::

This data is only captures women that are known to have dependent children upon enrollment.

Priority #:	8
Priority Area:	Substance abuse prevention, intervention, treatment, and recovery support as part of workforce development
Priority Type:	SAP, SAT
Population(s):	PP

Goal of the priority area:

Goal 1: Partner with the MA Substance Abuse Counselor Certification Board on the certification for recovery coaches

Goal 2: Increase number of Approved Addiction Education Providers (AAEPs) that prepare individuals to become LADCs.

Goal 3: Increase the capacity of BSAS-funded treatment programs to provide trauma-informed care (TIC) by providing staff training and intensive technical assistance

Objective:

Goal 1 objective: Measure the number of certified Recovery Coaches

Goal 2 objective: At least 2 new AAEPs will have completed the application and approval process

Goal 3 objective: At least 3 adult and 3 adolescent treatment programs will receive individualized training and TA to support program-wide understanding of TIC per year.

Strategies to attain the objective:

Goal 1:
- Partner with the MA Board of Substance Abuse Counselor Certification (MBSACC) to develop and implement requirements and processes for certifying recovery coaches.

Goal 2:
- Recruit Continuing Education (CE) Providers, Community Colleges, Social Work Schools, and other institutions that provide coursework required for

licensure, to apply for Approved Addiction Education Provider (AAEP) status.

Goal 3:
- Work with Regional Managers to identify programs that have not already received training/TA on TIC and encourage participation
- Overview/Exposure meetings for Administrators provided either in-person or as a webinar, will be held.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Goal 1: Year one: finalization of certification requirements and “grandparenting” process; Start of grandparenting period. Year two: number of recovery coaches certified.
Baseline Measurement:	No Recovery Coach Certification currently exists in MA.
First-year target/outcome measurement:	Develop and implement a process for certification, and begin grandparenting period.
Second-year target/outcome measurement:	Measure the number of certified recovery coaches.

Data Source:

MBSACC

Description of Data:

Number of Recovery Coaches certified.

Data issues/caveats that affect outcome measures::

The grandparenting period will last for one year, after that the number of individuals applying for recovery coach certification may decrease because an exam will be required.

Indicator #:	2
Indicator:	Goal 2: New CE providers, community colleges, SW schools, etc. apply to BSAS for AAEP status.
Baseline Measurement:	There are currently 9 BSAS-Approved AAEPs.
First-year target/outcome measurement:	At least 2 new AAEP’s will have completed the application and approval process.
Second-year target/outcome measurement:	At least 2 additional new AAEP's will have completed the application and approval process.

Data Source:

BSAS licensing data.

Description of Data:

Number of AAEPs applying and approved.

Data issues/caveats that affect outcome measures::

Application process is somewhat long and programs that have no prior relationship with BSAS may be hesitant to apply.

Indicator #:	3
Indicator:	Goal 3: Number of programs trained/receiving TA.
Baseline Measurement:	4 adult and 8 adolescent BSAS-funded treatment programs received individualized training and TA to support program-wide understanding of TIC in FY15
First-year target/outcome measurement:	At least 3 adult and 3 adolescent treatment programs will receive individualized training and TA to support program-wide understanding of TIC.
Second-year target/outcome measurement:	At least 3 additional adult and 3 additional adolescent treatment programs will have received individualized training and TA to support program-wide understanding of TIC.

Data Source:

IHR quarterly and annual reports on services provided

Description of Data:

Number of meetings and trainings provided during specified time period.

Data issues/caveats that affect outcome measures::

None

Priority #: 9

Priority Area: Substance abuse prevention, intervention, treatment, and recovery support of youth and young adults

Priority Type: SAP, SAT

Population(s): PP, IVDUs, Other (Adolescents w/SA and/or MH, Students in College)

Goal of the priority area:

Goal 1: Create an infrastructure that allows meaningful input for youth and young adults regarding the policies and programming developed and managed by OYYAS

Goal 2: Develop developmentally appropriate strategies to address opioid use among transitional age youth and young adults (TAYYA) to meet the needs of TAYYA who are using opioids

Objective:

Goal 1 objective: Establish a centralized Statewide Young Adult Recovery Community Advisory Board.

Goal 2 objective: Create policies and infrastructure that would support the sustainability of the community-based A-CRA/ACC and MAT collaborations

Strategies to attain the objective:

Goal 1:
Create regional meetings for youth and young adults to give feedback to the OYYAS; train young adults to build leadership skills, select members for Statewide Board.

Goal 2:
Develop policies to better address the needs of TAYYA who use opioids; foster collaboration between providers of evidence-based practices A-CRA/ACC and Medication Assisted Treatment (MAT) to meet the needs of TAYYA who are using opioids.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Goal 1: Year one: communities are identified and regional meetings held; Year two: trainings held at regional meetings, and leaders are identified for participation in Statewide Board

Baseline Measurement: Number of regional meetings held; Number of participants at each meeting; Number of trainings offered, and number of participants at each training

First-year target/outcome measurement: Host regional Youth and Young Adult Recovery Community Advisory Group meetings for outreach and engagement

Second-year target/outcome measurement: Establish a centralized statewide Young Adult Recovery Community Advisory Board

Data Source:

Project coordinator will collect meeting and training attendance records which will be recorded in a secure excel spreadsheet.

Description of Data:

BSAS will initially collect process measurement data, but will move into collecting member demographic data once membership has been established.

Data issues/caveats that affect outcome measures::

Collecting member/participant specific data while building / developing the regional meetings and Statewide board may create a barrier for certain interested participants.

Indicator #:	2
Indicator:	Goal 2: Identified and selected strategies and policies that integrate A-CRA/ACC and MAT Treatments
Baseline Measurement:	Number of youth enrolled simultaneously in A-CRA/ACC and MAT treatment
First-year target/outcome measurement:	Identify and fund providers to help create community supports that integrate A-CRA/ACC and MAT Treatments to address the needs of TAYYA.
Second-year target/outcome measurement:	Create policies and infrastructure that would support the sustainability of the community-based A-CRA/ACC and MAT collaborations.

Data Source:

BSAS ODADS ESM provider service data

Description of Data:

This is the data set that BSAS uses regarding enrollment in BSAS funded treatment services.

Data issues/caveats that affect outcome measures::

None

Priority #:	10
Priority Area:	Infectious disease prevention and treatment needs of clients in substance abuse treatment
Priority Type:	SAP, SAT
Population(s):	PP, IVDUs, HIV EIS, TB

Goal of the priority area:

Assist treatment providers in understanding the added risks of individuals with Substance Use Disorders who also have infectious diseases such as TB, HIV/AIDS, Hep C, and sexually transmitted diseases and the impact on health and recovery

Objective:

Develop training for BSAS provider system on the Infectious Disease Practice Guidance

Strategies to attain the objective:

1) A Practice Guidance will be developed on wellness and recovery that will focus on the additional risk of chronic infectious disease for this population, how assessment for risk and education can reduce such risk, the synergistic effects of these infections on wellness and recovery including the impact of nicotine use, the role of the addictions specialist in integrating this as part of a wellness approach, and resources.
2) Licensing Inspectors and Contract Managers will review client records and agency protocols for compliance with requirements related to client education, risk assessment, and coordination of care and follow up.
3) Exploration of the development of webinars for addictions providers.
4) Development of training sessions that assists health care professionals in educating, assessing risk and in coordinating care for individuals with chronic infections.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Create and distribution of Practice Guidance; Number of citations issued to treatment programs for not being in compliance; Creation of webinar; Number of training sessions provided that focus on this goal
Baseline Measurement:	Licensing inspection currently includes review of client records and agency protocols for the assessment of risk of TB, HIV/AIDS, Viral Hepatitis, and sexually transmitted diseases and education and referrals provided.

First-year target/outcome measurement: Create a Practice Guidance on Infectious Diseases

Second-year target/outcome measurement: Develop training for BSAS provider system on the Infectious Disease Practice Guidance

Data Source:

Quality Assurance and Licensing (QAAL) Unit reports
Workforce Development Reports on AdCare Training Sessions, including the webinar use

Description of Data:

Licensing applications and licensing and contract management site visit reports contain documentation of compliance with requirements. Workforce Development Reports will include the number of training sessions provided, webinar created, and number of users/attendees.

Data issues/caveats that affect outcome measures::

None

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$55,424,281		$0	$15,100,795	$190,661,802	$0	$0
a. Pregnant Women and Women with Dependent Children*	$3,502,062		$0	$1,500,000	$18,746,112	$0	$0
b. All Other	$51,922,219		$0	$13,600,795	$171,915,690	$0	$0
2. Substance Abuse Primary Prevention	$15,835,509		$0	$3,631,006	$0	$0	$0
3. Tuberculosis Services	$0		$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$3,958,877		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$3,958,877		$0	$0	$0	$0	$0
11. Total	$79,177,544	$0	$0	$18,731,801	$190,661,802	$0	$0

* Prevention other than primary prevention

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	$
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	$

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	$
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	$
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	$
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	$
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	$
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	$
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	$
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	$
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	$
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	$
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	$
Total	$0

Footnotes:

The Massachusetts Table 3 and Program Summaries are posted in the Attachments Section

Service Type	FY16 Projected Block Grant Expenditures
Prevention Technical Assistance	$1,200,000.00
Prevention Community-Based Prevention Programs	$3,000,000.00
Prevention - MOAPC Opioid Prevention Coalitions	$1,400,000.00
Media Campaigns	$200,000.00
Educational Materials	$390,000.00
Prevention - PFS II Grant	$412,000.00
SBIRT Trainning and Technical Assistance	$630,000.00
Acute Treatment Services (ATS)	$1,200,000.00
ATS - Section 35	$70,000.00
Clinical Stabilization Services (CSS)	$26,000.00
Transitional Support Services (TSS)	$1,200,000.00
CSS/TSS - Section 35	$70,000.00
Youth Stabilization	$335,000.00
Youth Residential	$1,100,000.00
Recovery High Schools	$400,000.00
Residential Recovery Services	$950,000.00
Pregnant Post-Partem Residential	$590,000.00
Specialized Residential Services for Women	$100,000.00
Residential Recovery Services - Section 35	$235,000.00
Family Residential Treatment	$900,000.00
Family-Centered Home-Based Treatment	$70,000.00
Outpatient Counseling	$350,000.00
Opioid Treatment Services (Methadone)	$730,000.00
Office Based Opioid Treatment (OBOT)	$150,000.00
Case Management - Section 35	$110,000.00
Substance Abuse Shelters for Individuals	$100,000.00
Supportive Case Management in Housing	$260,000.00
Outreach to Homeless Youth and Adults	$65,000.00
Community Based Case Management for Homeless Families	$26,000.00
Recovery Support Centers	$200,000.00
Consumer Education	$50,000.00
Services in County Houses of Correction	$15,000.00
Court Diversion Programs	$96,000.00
Second Offender OUI 14-day Residential	$35,000.00
Substance Abuse Information and Referral Helpline	$440,000.00
Women's Services Capacity Building	$655,000.00
OBOT Technical Assistance	$40,000.00
Tobacco Training & Technical Assistance	$60,000.00
HIV/HVC /OD Training & Technical Assistance	$43,000.00
Statewide Logistics for Training	$1,000,000.00
HIV Prevention and Naloxone Distribution	$850,000.00
Synar Support	$736,000.00
Inter-Agency Service Agreements	$106,000.00

Bureau of Substance Abuse Services
Program Descriptions

BSAS
Bureau of Substance Abuse Services
Prevent • Treat • Recover • For Life
www.mass.gov/dph/bsas

Prevention Services:

The Bureau of Substance Abuse Services (BSAS), through Federal Block Grant funding, from the Substance Abuse Mental Health Services Administration (SAMHSA), implements a series of initiatives to increase the capacity of Communities and other service systems to prevent substance abuse while also strengthening linkages to needed services. BSAS emphasizes evidence-based primary prevention strategies at both local and state levels.

Community-Based Prevention Programs

BSAS, through Federal Block Grant funding, funds community-based prevention programs statewide. All programs, utilizing SAMHSA's Strategic Prevention Framework, implement evidence-based programs and strategies to prevent alcohol, marijuana, and other drug use with a particular focus on the under 21 population. Each community program focuses on a specific municipality or neighborhood and is carried out by a coalition comprised of organized community members that have an interest in helping their community prevent substance abuse.

Massachusetts Opioid Abuse Prevention Collaborative (MOAPC)

The purpose of the Massachusetts Opioid Abuse Prevention Collaborative (MOAPC) funding is to support clusters of communities to implement local policy, practice, systems and environmental change to prevent the misuse/abuse of opioids, prevent/reduce unintentional deaths and non-fatal hospital events associated with opioid poisonings. Another goal is to increase both the number and capacity of municipalities across the Commonwealth addressing these issues.

Public Information Campaign to Prevent Alcohol and Other Drug Abuse

The goal of the Bureau of Substance Abuse Services Prevention Unit Public Information Campaigns is to prevent and decrease the rate of misuse of alcohol and prevent the use of other drugs. Campaigns are based on the science of preventing and intervening in problematic use. TV, radio, transit, web, and public relations initiatives bring effective messages to youth, parents, other adults, and those who serve them.

All BSAS printed materials are available in bulk quantities at no charge from the Massachusetts Health Promotion Clearinghouse: www.maclearinghouse.com.

Screening and Early Intervention Services:

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT is an integrated approach that allows early identification of people who use alcohol and/or drugs in ways which may put them at risk for social or health consequences; encourages them to change their behavior; and refers them for assessment or treatment as appropriate.

Primary care, hospital emergency rooms, trauma centers, and other health care and community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

Universal screening identifies the level of risk and severity of substance use.
Brief intervention focuses on increasing patient insight and awareness about risks related to substance misuse and motivation toward behavioral change.
Referral to treatment provides those identified as needing more extensive help with access to specialty assessment and care.

MASBIRT Training and Technical Assistance

The Boston Medical Center and the BNI Art Institute are funded by BSAS to provide MASBIRT Training and Technical Assistance (TTA) to build capacity to implement SBIRT in primary care, hospital, private practice, and emergency room settings. MASBIRT TTA works with healthcare sites and with communities, employers and other DPH departments to train health care and other professionals and to integrate SBIRT into the healthcare setting and to broaden healthcare professionals' skills and expertise. BSAS through the MASBIRT TTA project is engaged in building SBIRT capacity across the state.

Acute Treatment Services:

Acute Treatment Services (ATS) (Detoxification Level 3.7)

ATS programs are community-based medically monitored detoxification services. Programs provide 24-hour nursing care, under the consultation of a medical director, to monitor an individual's withdrawal from alcohol and other drugs and alleviate symptoms.

Section 35 Programs

Section 35 Treatment Services provide secure acute residential treatment services for court-mandated civilly-committed individuals. State law allows for individuals who are deemed to be a danger to themselves or others due to their substance use to be civilly-committed to treatment by a district court for up to 30 days. The program for women is in New Bedford, and the program for men is in Brockton.

Short Term Stabilization Services for Adults:

Clinical Stabilization Services

Clinical Stabilization Services provide clinical support in an inpatient setting for those clients leaving detox or for those clients who need acute treatment but do not meet criteria for medically-necessary services.

Transitional Support Services

Transitional Support Services (TSS) are short-term residential, support services for clients who need a safe and structured environment to support their recovery process after detoxification. These programs are designed to help those who need services between acute treatment and residential rehabilitation.

Tewksbury Stabilization Program

The Tewksbury Stabilization Program provides a structured, residential, and substance-free environment for homeless and imminently homeless chemically dependent men in Tewksbury, MA. Services include case management for a variety of service needs, psycho-educational groups, and connections with self-help groups. Referrals to placements that support ongoing recovery are provided.

Youth Intervention and Treatment Services:

Youth Intervention

BSAS provides funding to Department of Youth Services (DYS), the state's juvenile justice agency, to implement an intervention strategy that employs case managers who work intensively with the DYS-committed youth upon their reentry to the community. These case managers become intimately involved with the youth and their families, providing and arranging the model's eight core services: specialized education and family services; an expanded network of extensive social support; out-of-school activities; one-on-one mentoring; customized behavioral incentives; expanded community policing and active arbitration of the child's contact with the juvenile justice and child and family services system as necessary.

Youth Stabilization and Detoxification Units

These 24 hour units provide youth in crisis with a safe, temporary, protective environment in which they can receive the care, supervision, assessment, and medical monitoring necessary to facilitate stabilization of their physical and emotional states. Once stabilized, youth receive a comprehensive bio-psycho-social assessment of their substance use, social, emotional, behavioral, and mental health needs. With this information, staff can identify appropriate aftercare resources and referrals for adolescents and their family. The youth stabilization and detoxification services are for males and females between the ages of 13 and 17. Their length of stay is determined on their individual assessment and treatment planning needs, (an average stay is 14 days). Insurance may cover the cost of these services.

Youth and Young Adult Residential

The youth and young adult residential substance abuse treatment programs are short-term residential treatment services for medically stable youth and are appropriate for youth experiencing health, emotional/behavioral, family, developmental and/or social problems as a result of alcohol and other drug use, and whose issues have not been resolved in less intense, community-based levels of care. There are currently five gender-specific residential programs (three male and two female programs). Four of the programs serve youth between the ages of 13 and 17, with one program serving female young adults. A youth's length of stay (up to 90 days) in the program varies based on their treatment needs. Qualified staff create an individualized treatment plan for each adolescent. There is a Central Intake and Care Coordination component for families, other state agencies, schools, and other referral sources to access to the Youth Residential programs operated by the Institute for Health and Recovery at (617) 661-3991.

Young Adult Recovery Homes

Recovery homes offer a structured transitional living setting, for young people aged 16 to 19, working towards independent sober living. There are two gender-specific residential programs in South Boston that utilize a recovery home model. Operated by the Gavin Foundation, Inc., the Cushing Houses provide a stabilizing transitional care residence for young men and women experiencing substance abuse problems. The programs provide a nurturing, structured and safe environment for young people while promoting self-care, self-reliance, and community responsibility, through structured activities and the experience of living in a residential milieu.

Recovery High Schools

Recovery High Schools are four-year, non-traditional public high schools for youth who are experiencing a substance use disorder. The Massachusetts schools have the capacity to serve approximately 30-50 students each, and each of the schools utilizes a slightly different operational model. The schools provide a comprehensive academic curriculum that is consistent with Massachusetts State Standards, MCAS testing protocols, and course requirements of the students school district. All of the schools have the capacity to serve students who have individualized education plans (IEP). The schools actively support students in their recovery by providing smaller class sizes, individualized attention, licensed counseling services, and daily group meetings where students have the opportunity to process issues related to both education and recovery. The schools strongly encourage and provide opportunities for parent involvement and are jointly funded by the Massachusetts Department of Public Health, Bureau of Substance Abuse Services and local school districts.

Youth Outpatient Services

Outpatient programs across the state have been approved as Adolescent Outpatient Substance Abuse Treatment Providers by newly incorporated regulations under MGL 105 CMR 164.00. These outpatient treatment programs have received training in the GAIN, a nationally recognized model for substance use assessment for adolescents. These sites provide assessment for adolescents from other state systems to determine the most appropriate level of care, as well as, individual and group counseling designed for young people and their families.

Adult Residential Treatment:

Adults Residential Treatment are services for individuals who have recently stopped using alcohol and/or other drugs, have been stabilized medically and are able to participate in a structured residential treatment program. Adult Residential Treatment includes Recovery Homes, Social Model Recovery Homes, Therapeutic Communities, and Specialized Residential Services for Women. Pregnant women in early recovery who need assistance in developing and maintaining life skills necessary to implement drug-free living are eligible for the programs that offer enhanced services for pregnant and postpartum women and their infants.

Recovery Home

Recovery Homes provide a structured, sober environment for individuals recovering from addiction to alcohol and/or other drugs. These programs emphasize recovery and treatment within a structured, therapeutic setting. Residents are encouraged to integrate with the community and to access community resources, including self-help groups and employment. Some Recovery Homes offer enhanced services for pregnant and post-partum women and their infants, which include coordination of prenatal/pediatric care.

Therapeutic Community

Therapeutic Communities provide a highly structured environment that emphasizes resident treatment and recovery within the parameters of the program structure. The residents take an active role in this mode of treatment helping them to take responsibilities and become positive role models. Some Therapeutic Communities offer enhanced services for pregnant and post-partum women and their infants, which include coordination of prenatal/pediatric care.

Social Model Recovery Homes

Social Model programs emphasize a sober living environment, peer counseling and case management. The emphasis of these programs is to assist residents to provide each other with a culture of recovery, support, sharing and positive role modeling. Residents are expected to be involved in the external community (through work, education, volunteer activities, etc.).

Specialized Residential Services for Women

These programs provide a safe and structured therapeutic environment where women may obtain residential substance abuse treatment services while still maintaining custody and care of their children. Reunification with children can occur while the mother is staying at the program.

Family Services:

Family Residential Treatment

Family Residential Treatment Services provide a safe and supportive treatment environment for families when the caretaking parent(s) has a chronic substance abuse problem. Programs provide housing, individual and family treatment and case management and other services for families in

order to support and sustain sobriety. The Institute for Health and Recovery at (617) 661-3991 coordinates access to the Family Residential Treatment Programs.

Supportive Housing Services for Families (Sober Living)

The overall goal for Supportive Case Management for Families is to assist families in recovery to help them achieve self-sufficiency. This goal is achieved through the provision of case management services within a safe and supportive alcohol and drug-free living environment that reinforces recovery through establishing community-based supports to maintain ongoing goals in the recovery process.

Family-Centered Home Based Treatment (Family Recovery Project)

The Family Recovery Project (FRP) promotes building relationships with "at risk" or "hard to reach" individuals and families involved in the child welfare and substance use disorders treatment systems. FRP provides intensive, home-based substance use and co-occurring disorders treatment and collaborative case management services in Hampden County and in Southeastern Massachusetts. The approach is family-centered, strengths-based, and trauma-informed. It uses Motivational Interviewing and the Stages of Change Model to help engage clients in treatment. The Institute for Health and Recovery at (617) 661-3991 coordinates access to the Family Recovery Project.

Family Intervention

In an effort to increase the opportunities for family members and concerned significant others to take an active role in helping their loved ones enter and engage in treatment, MDPH/BSAS is supporting five Family Intervention two year pilot programs in the Commonwealth. The programs utilize SAMHSA approved evidence based models (A-CRA/ACC, ARISE) to engage adolescents, young adults, and families, along with a focus of providing ongoing support, skill building, and resource development for the individual's family. This pilot includes an evaluation component provided by an independent evaluator (Brandeis) and supported by BSAS.

Outpatient Services:

Outpatient Counseling

Outpatient Counseling provides treatment for adults and adolescents, their families, and/or their significant others who are affected by the use of alcohol or other drugs. Clients are assisted in gaining and maintaining skills for a substance-free lifestyle. Services include assessment and treatment planning, individual, group, and family counseling.

Day Treatment / Intensive Outpatient Treatment

Day Treatment and Intensive Outpatient Treatment are more intensive than Outpatient Treatment. Programs provide each client with several hours of counseling per day, up to four days a week including: individual, group and family counseling, relapse prevention, communicable disease prevention, case management, and encouragement of the use of self help groups.

Acupuncture Services

Acupuncture and recovery maintenance programs provide services for individuals with histories of substance abuse that require treatment for mild to moderate withdrawal symptoms. Services include limited medical screening and intake, motivational counseling/case management and acupuncture treatments.

Compulsive Gambling Treatment Services

Compulsive Gambling Services are specialized outpatient services for compulsive gamblers and their families. These programs include individual, family, and group counseling and case management services.

Opioid Treatment

Opioid Treatment provides medically monitored treatment services for clients who are addicted to opiate drugs such as heroin or pain medications and have a history of chronic relapse. Opioid Treatment services combine medical and pharmacological interventions (such as methadone or buprenorphine) with professional outpatient counseling, education, and vocational services. Services are offered on both a short- and longer-term basis.

Office-Based Opioid Treatment (OBOT)

Office based opioid treatment allows primary care physicians to provide prescribe Suboxone (Buprenorphine) treatment for opioid dependence in community based clinical and health care settings. DPH has funded Community Health Centers to hire Nurse Case Managers so that the Health Centers can increase the number of patients they are able to serve. DPH has also awarded a contract to Boston Medical Center to provide statewide training and technical assistance to the contracted OBOT provider agencies. The goal is to support the development and replication of effective models of induction, stabilization and maintenance services associated with office based opioid treatment.

Housing and Homeless Services:

Substance Abuse Shelters for Individuals

Substance Abuse Shelters for Individuals (SASI) provide shelter for substance abusing homeless individuals whose behavior is difficult to manage and less appropriate for shelter in the general shelter system due to their current substance use. The SASI shelters also maintain a number of stabilization beds for those who seek a referral for substance abuse treatment and demonstrate a desire to remain substance free.

Post Detox-Pre-Recovery Programs (PDPR)

PDPR is a HUD-funded low threshold permanent supportive housing program that provides subsidized SRO's with case management services to individuals in a Housing First setting focused on recovery using a risk reduction approach

Supportive Case Management

The overall goal for Supportive Case Management is to assist adults and/or families in recovery to help them achieve self-sufficiency. This goal is achieved through case management services in a recovery-oriented environment

Outreach, Engagement, and Housing Search and Stabilization to Homeless Adults

The Bureau funds community-based homeless service providers to provide outreach and substance abuse treatment engagement services to homeless unsheltered adults in downtown Boston.

Recovery Support Services:

Recovery Support Centers

The Bureau funds community-based peer-led recovery support centers in each region to provide people in recovery with a welcoming and supportive environment that supports their recovery. The centers provide information, referral, self-help groups, and access to treatment services in addition to support that helps prevent relapse and promote sustained recovery from alcohol and drug use disorders in the form of support from peers and the opportunity to volunteer and give back.

The Recovery Support Centers (RSC) are based on an empowerment model through use of a participatory process, wherein community involvement, volunteerism, peer support, and opportunities to take on valued social roles are seen as the foundation of the centers. Participants can expect to both receive and be a part of offering emotional, information, instrumental and affiliational support to peers at the centers.

Consumer Education

The Bureau funds the Massachusetts Organization of Addiction Recovery (MOAR) to provide coordination and capacity-building for the recovery community statewide. The primary function of MOAR is to empower the recovery community and increase knowledge and awareness about needs relating to addiction treatment and ongoing recovery support. A primary vehicle for raising this awareness is in training volunteers to speak in a variety of contexts to use their lived experience of addiction and recovery to show that treatment works and that recovery is not only possible but a reality for individuals, families and communities.

Access to Recovery (ATR) Grant

Massachusetts is an *Access to Recovery Grant (ATR)* awardee (SAMHSA/CSAT – ATRIII and IV). The primary focus of Massachusetts ATR (MA/ATR) is to foster choice among clients enrolled in the program to choose their recovery services and providers based on their own individual needs and preferences while incorporating community integration and social inclusion.

MA/ATR is the first and only ATR awardee to implement the grant within a 'Health Care Reform System'. As such, MA/ATR cannot support clinical treatment as part of the grant. MA/ATR focuses exclusively on providing services that are not covered by insurance; including but not limited to housing, clothing, education and training support, transportation, recovery coaching and other services that may address barriers and assist a person during their recovery. All of these services are predicated on consumer choice, integration and inclusion.

Criminal Justice Programs:

Services in County Houses of Correction

The Bureau of Substance Abuse Services funds all of the Massachusetts counties' Houses of Correction to provide substance abuse treatment programming. These programs operate like outpatient treatment programs inside the correction facility, offering individual and group counseling.

Court Diversion Programs

Treatment services and treatment referral alternatives for non-violent court involved individuals located at selected courts in the state.

First Offender Driver Alcohol Education (DAE)

The Driver Alcohol Education (DAE) programs are available to those individuals who agree to the alternative sentencing sanction as specified within Massachusetts General Laws for the offense of driving under-the-influence. Specifically, each DAE program participant is provided with a structured group where they receive educational material to help them identify and understand alcohol abuse issues and drinking-and-driving behaviors. While the major focus of these programs is on alcohol, other substances of abuse are also discussed. The program provides 40 hours of services conducted over 16 weeks and includes an assessment, participation in self-help and victim-impact community meetings.

Second Offender 14-Day Residential Program for Driving Under the Influence of Liquor (DUIL)

Considered phase one of the three-phase treatment model, the Second Offender Residential Programs are 14-day residential programs targeted towards individuals convicted of their second driving-under-the-influence offense. These services include: medical evaluation, individual and group counseling, educational sessions including the introduction to self-help, recreation, and assurance that assignment has been made to an approved Second Offender Aftercare Program.

Second Offender Aftercare (SOA)

The Second Offender Aftercare (SOA) Programs continue the treatment efforts of those convicted of their second driving-under-the-influence offense. SOA programs conduct phases two and three of the overall three-phase treatment model. In phase two, each program provides 8 weeks of group/individual services in order to assess the risk and needs of the client. After phase two is completed, an individual treatment plan will be developed that will serve as the basis of

phase three. Each client will be involved in treatment for the length of probation (2 years).

Training, Technical Assistance and Support Services:

The following services provide a combination of training, technical assistance and support to Bureau of Substance Abuse Services funded programs and to the general public, municipalities, and to other partners and health care providers statewide.

- Substance Abuse Information and Education Helpline
- Problem Gambling Information, Training and Referral Helpline
- Tobacco Training and Technical Assistance in BSAS Programs
- Women's Services Capacity Building
- HIV/HEP C, and Overdose Prevention Training and Technical Assistance
- Continuing Education and Training Coordination
- Office-based Opioid Treatment Helpline, Training and Technical Assistance
- MASBIRT Training and Technical Assistance
- Massachusetts Prevention Technical Assistance

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$29,691,568
2 . Substance Abuse Primary Prevention	$7,917,751
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	$1,979,438
6. Total	$39,588,757

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

$4,137,826 out of the $7,917,751 budgeted for substance abuse primary prevention will be used for prevention oriented resource development.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Section 1926 Tobacco	Universal	$736,500
	Selective	
	Indicated	
	Unspecified	
	Total	$736,500
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Total Prevention Expenditures		$736,500
Total SABG Award*		$39,588,757
Planned Primary Prevention Percentage		1.86 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$3,562,988	
Universal Indirect	$3,167,101	
Selective	$1,029,307	
Indicated	$158,355	
Column Total	$7,917,751	
Total SABG Award*	$39,588,757	
Planned Primary Prevention Percentage	20.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	b
Tobacco	c
Marijuana	b
Prescription Drugs	b
Cocaine	c
Heroin	b
Inhalants	b
Methamphetamine	c
Synthetic Drugs (i.e. Bath salts, Spice, K2)	c
Targeted Populations	
Students in College	b
Military Families	b
LGBT	b
American Indians/Alaska Natives	b
African American	b
Hispanic	b
Homeless	b
Native Hawaiian/Other Pacific Islanders	c
Asian	b
Rural	b
Underserved Racial and Ethnic Minorities	b

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$904,211	$3,616,845	$0	$4,521,056
2. Quality Assurance	$463,678	$1,854,711	$0	$2,318,389
3. Training (Post-Employment)	$818,344	$3,273,378	$0	$4,091,722
4. Education (Pre-Employment)	$0	$0	$0	
5. Program Development	$1,111,411	$4,445,644	$0	$5,557,055
6. Research and Evaluation	$403,944	$1,615,778	$0	$2,019,722
7. Information Systems	$436,238	$1,744,951	$0	$2,181,189
8. Total	$4,137,826	$16,551,307		$20,689,133

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

Please indicate areas of technical assistance needed related to this section.

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[26] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013;91:102–123

http://www.who.int/bulletin/volumes/91/2/12-108282.pdf; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52–77

[27] Research Review of Health Promotion Programs for People with SMI, 2012, http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper; About SAMHSA's Wellness Efforts,

http://www.promoteacceptance.samhsa.gov/10by10/default.aspx; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, http://www.integration.samhsa.gov/health-wellness/samhsa-10x10 Schizophrenia as a health disparity, http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml

[28] Comorbidity: Addiction and other mental illnesses, http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; http://www.samhsa.gov/co-occurring/

[29] 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); JAMA. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

[30] A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk; http://circ.ahajournals.org/

[31] Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39;

http://www.cdc.gov/socialdeterminants/Index.html

[32] Depression and Diabetes, NIMH, http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5;Diabetes Care for Clients in Behavioral health Treatment, Oct. 2013, SAMHSA, http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780

[33] J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, Journal of Clinical Psychology Practice, 2011 (2) 33-40

[34] C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, Diabetes Care, 2010; 33(5) 1061-1064

[35] TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671

[36] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf;. Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges.* Baltimore, MD: The Hilltop Institute, UMBC.

http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf; American Psychiatric Association, http://www.psych.org/practice/professional-interests/integrated-care; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, http://nasadad.org/nasadad-reports

[37] Health Care Integration, http://samhsa.gov/health-reform/health-care-integration; SAMHSA-HRSA Center for Integrated Health Solutions, (http://www.integration.samhsa.gov/)

[38] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361; Telebehavioral Health and Technical Assistance Series, http://www.integration.samhsa.gov/operations-administration/telebehavioral-health State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8; National Telehealth Policy Resource Center, http://telehealthpolicy.us/medicaid; telemedicine, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

[39] Health homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

[40] New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

[41] Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html;Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

[42] What are my preventive care benefits? https://www.healthcare.gov/what-are-my-preventive-care-benefits/; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

[43] Medicare-Medicaid Enrollee State Profiles, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html; About the Compact of Free Association, http://uscompact.org/about/cofa.php

[44] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, http://www.cbo.gov/publication/44308

[45] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[46] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[47] http://www.nrepp.samhsa.gov/

[48] Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

[49] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, http://annapoliscoalition.org/?portfolio=publications; Creating jobs by addressing primary care workforce needs, http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html

[50] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[51] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

1. The Health Care System and Integration

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2016?

In Massachusetts, Medicaid (MassHealth) and private insurers have covered medically necessary inpatient and outpatient substance abuse treatment services for many years. From the MA Plan Table 3, these services include: Acute Treatment Services, Clinical Stabilization Services, Outpatient Counseling, Opioid Treatment Programs and Office-Based Opioid Treatment. The MassHealth Behavioral Health benefit is quite robust, but coverage by private insurers varies. Massachusetts' 2012 Cost Containment legislation (Chapter 224) as well as the 2008 Behavioral Health Parity legislation (Chapter 256) required coverage of additional behavioral health services, such as case management. In August 2014, then Governor Deval Patrick signed into effect Chapter 258 of the Acts of 2014: An Act to Increase Opportunities for Long-Term Substance Abuse Recovery, which further expanded Massachusetts' robust continuum of care. Chapter 258 removed preauthorization for substance abuse treatment for medically necessary treatment, as determined by the treating clinician. Chapter 258 also designated medication-assisted opioid therapy as a mandated benefit, thereby requiring insurance companies and MassHealth to reimburse for methadone, buprenorphine and extended-release naltrexone.

2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

As the first state in the nation to undertake Health Care Reform, Massachusetts QHPs have a longer history of providing ACA EHBs. Over the years, BSAS has worked closely with the MassHealth Behavioral Health team on determining covered services. BSAS was also involved in the state's Behavioral Health Integration Task Force (BHITF). The BHITF was created as a result of Chapter 224 of the Acts and Resolves of 2012, a comprehensive law designed to bring health care spending in balance with the state's economy and to contain health care costs. Section 275 of Chapter 224 established a "special task force to examine behavioral, substance use disorder, and mental health treatment, service delivery, integration of behavioral health with primary care, and behavioral, substance use disorder and mental health reimbursement systems. BSAS staff and providers were active on the BHITF which submitted a comprehensive report to the legislature in July of 2013.

BSAS was also involved in developing the first State Behavioral Health Plan, which included statewide behavioral health service maps for substance abuse treatments.[1] In addition, the Center for Health Information and Analysis (CHIA) recently released a study on access to substance use disorder treatment.[2] The report detailed the Commonwealth's SUD continuum of

[1] http://www.mass.gov/eohhs/docs/dph/health-planning/hpc/deliverable/behavioral-health-state-health-plan.pdf

[2] http://www.mass.gov/courts/docs/csat-access-to-substance-use-disorder-treatment-in-mass.pdf

care and evaluated service coverage across payers, including commercial health insurance, MassHealth and BSAS. In addition, the regular meetings of MassHealth and the state's Medicaid managed care entity (MCE) presents opportunities for further monitoring behavioral health access.

Lastly, Massachusetts is pursuing a SAMHSA planning grant to prepare a demonstration grant for Certified Community Behavioral Health Centers (CCBHCs), an initiative that requires broad-based interagency collaboration. Prospective CCBHCs will be selected, certified and trained to provide more coordinated, integrated and evidence-based services. The certification process involves stringent monitoring and a requirement to provide core services, which includes serving and engaging underserved populations.

3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.

BSAS works closely with the MA behavioral health trade association, the Association for Behavioral Health Care, to monitor addiction treatment service coverage in our funded programs. When problems arise, BSAS works with Medicaid as well as with individual health plan representatives towards resolution. Additionally, BSAS personnel meet with Medicaid behavioral health directors as a group on a regular basis. Several years ago, BSAS and the provider association worked together to address a problem arising from a MCE using a detoxification admission criteria that did not comply with ASAM criteria and did not meet parity by requiring preauthorization for detoxification services. Following discussions with BSAS and providers, the MCE revised its admission criteria.

In addition, the Massachusetts Division of Insurance (DOI), which maintains authority over health plans, requires QHPs to report on utilization of MH/SUD quarterly. These reports include detailed descriptions of inpatient, intermediate care and outpatient behavioral health utilization data. DOI and BSAS also meet on a regular basis to discuss a range of issues.

Division on Insurance will be posting a Q&A about coverage of MH/SUD services for health insurance carriers and works in partnership with BSAS related to responding to inquiries and tracking trends.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?

The DOI and the Attorney General's Office monitor parity compliance in Massachusetts, by requiring detailed filings from carriers on their policies and procedures related to behavioral health parity. In 2014, the Massachusetts Commissioner of Insurance issued a report summarizing a study on the differences between behavioral health and non-behavioral health treatment records in referrals from emergency departments.[3] While the report found differences in outcomes for the BH patients as compared to the non-BH patients, it was unable to draw clear

[3] http://www.mass.gov/ocabr/docs/doi/examination-of-carriers-compliance.pdf

conclusions about the reasons for delays, largely due to lack of standardized record reporting requirements. One recommendation suggested that DOI work with carriers, providers, consumer advocates and other stakeholders to develop standards for provider and carrier records. The 2013 Behavioral Health Integration Task Force report to the Legislature and the Health Policy Commission also included guidelines for the DOI to follow in order to achieve behavioral health parity.[4]

In addition to steps taken by the DOI, BSAS has begun providing technical assistance around behavioral health parity. This includes technical assistance for DOI and MassHealth about appropriate coverage for substance abuse treatment and what should be covered under parity laws.

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

MA has had health care reform since April 2006. While the plan is not identical to the ACA, it is very similar. Given that, MA has offered robust substance use disorder treatment services through the EHB package for some time. Possible areas of expansion being considered by Medicaid may include reimbursement for Recovery Coaching, SBIRT and the expansion of case management services. With the introduction of Chapter 258, Massachusetts expanded medication assisted treatment, among commercial insurers not currently covering the services. According to the recent CHIA report, "as of July 1, 2015, all commercial health insurers will also reimburse for methadone maintenance services."[5]

6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?

Massachusetts has a long history of interagency collaboration and care coordination. BSAS has been supporting primary care providers in expanding and improving identification and early intervention of SUD, through the use of SBIRT. BSAS is also collaborating with the Division of Health Quality to license primary care clinics in SUD settings as well as to license SUD clinics in Federally Qualified Health Centers (FQHCs). The state is also undertaking efforts to support behavioral health care integration within the Massachusetts Patient Centered Medical Home Initiative.

Another area of multiagency coordination is around the state's Prescription Monitoring Program (PMP). Massachusetts is now working to enforce its mandatory PMP for physicians and pharmacies. Chapter 258 required DPH's Drug Control Program (DCP) to submit a report to the Massachusetts General Court on the implementation of the PMP, issued in February 2015.[6] Statewide efforts to enroll providers and pharmacies are ongoing.

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[4] http://www.massneuropsych.org/wp-content/uploads/2013/06/Behavioral-Health-Integration-Task-Force-Final-Report-and-Recommendations_July-2013.pdf
[5] http://www.chiamass.gov/assets/Uploads/SUD-REPORT.pdf
[6] http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/dph-pmp-report-final-2-12-15.pdf

Building upon findings from the Opioid Task Force, Governor Charlie Baker launched an Opioid Addiction Working Group shortly after taking office. Earlier this year, this 18-member interagency panel conducted a listening tour across the state, releasing its recommendations[7] and action plan[8] in June 2015. BSAS continues to give regular updates to DPH Commissioner Monica Bharel on progress toward the goals outlined in the action plan.

Lastly, in submitting its proposal for a CCBHC planning grant, Massachusetts assembled an executive team comprised of staff from BSAS, MassHealth and the Department of Mental Health. If funded, this team will lead a larger CCBHC Planning Team which includes organizational advisors and community stakeholders. The advisors include members of the Executive Office of Health and Human Services Technology Office, the Bureau of Health Care Safety and Quality, CHIA, and the Health Policy Commission, as well as members of several other support agencies.

7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?

BSAS has working relationships with the Massachusetts Medical Society, Massachusetts League of Community Health Centers, as well as access to other health-related professional organizations. BSAS also works regularly with publicly-funded substance use disorder treatment providers, particularly around the implementation of SBIRT. The BSAS-funded Massachusetts Technical Assistance Partnership for Prevention provides substance abuse prevention support, technical assistance and resources for communities and coalitions across the state. Through a SAMHSA SPF- Partnerships for Success II grant, BSAS worked with communities to address prescription drug misuse and abuse.

In administering DPH's Overdose Education and Naloxone Distribution (OEND) program, a pilot program to distribute intra-nasal Narcan along with opioid overdose prevention materials, BSAS works closely with community providers and law enforcement agencies. BSAS also funds 14 Office-Based Opioid Treatment (OBOT) programs in community health centers across the state, including centers offering OBOT with Buprenorphine as an evidence-based primary care model for patients with opioid addiction.

BSAS has been participating in meetings with the Mass League of Community Health Centers which include discussions of implementation of SBIRT and OBOT programs in order to improve identification, intervention, referral and access to treatment. BSAS offers technical assistance related to co-licensure with Substance Abuse, Mental Health and Primary Care to providers seeking to co-locate services. In addition, BSAS funds Boston Medical Center to provide statewide training and technical assistance for and referral to BSAS-funded OBOT programs. They also provide training and technical assistance on starting an OBOT program in a Federally Qualified Community Health Center.

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[7] http://www.mass.gov/eohhs/images/dph/stop-addiction/recommendations-of-the-governors-opioid-working-group.pdf

[8] http://www.mass.gov/eohhs/images/dph/stop-addiction/opioid-epidemic-action-plan.pdf

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?

BSAS has taken a number of steps over the past twenty years to encourage substance use treatment providers to address nicotine dependence. These efforts have included:

- Funding for a training and technical assistance vendor to train and work closely with treatment providers on addressing nicotine dependence.
- A provider advisory group called the Council to End Nicotine Addiction in Recovery.
- Questions on tobacco use are incorporated into the client data collection instruments.
- BSAS Tobacco Policies on addressing nicotine addiction that were subsequently largely incorporated into the substance abuse treatment program Regulations.
- Regulations include the requirement for each program to designate a Tobacco Education Coordinator to receive additional training and support the program in addressing nicotine dependence among other requirements.
- Statewide conferences on addressing nicotine addiction that were annual conferences for many years and are now bi-annual conferences. These conferences provide an opportunity to bring in expert speakers and hold a series of workshops for providers.
- Funding for purchasing Nicotine Replacement Therapy (NRT) patches and gum which are given to selected substance abuse treatment programs to facilitate nicotine addiction treatment in substance abuse treatment settings. The programs receiving NRT from BSAS receive additional training and technical assistance on nicotine addiction treatment.
- Funding for printing of an educational pamphlet entitled *"12 Questions about Smoking from People in Recovery".* This is available to be ordered in bulk for free from the Massachusetts Health Promotion Clearinghouse.
- BSAS also provides funding for scholarships for substance abuse treatment providers to participate in the University of Massachusetts Tobacco Treatment Specialist courses.

9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

BSAS client enrollment and disenrollment forms include questions on tobacco use so all clients are screened for tobacco use including age of first use, last use, frequency of use, route of administration, and number of cigarettes smoked per day.

Substance Abuse Treatment Program Regulations also include the following definitions and requirements:

Definitions:

- Substance Use Disorder: the range of conditions associated with alcohol, tobacco and other drug use, including substance dependence, abuse and withdrawal as defined by the American Psychiatric Association
- Tobacco Free: an environment free of tobacco use including the use of smokeless tobacco, such as snuff and chewing tobacco. (required of all programs)

Requirements:

- Assessment: Must include a history of the use of alcohol, tobacco and other drugs, including age of onset, duration, patterns and consequences of use; use of alcohol, tobacco and other drugs by family members; and types of and responses to previous treatment.
- Treatment Service requirements: Tobacco education and counseling must be provided directly by licensee
- Annual Staff Training on addressing nicotine dependence
- Designation of a Tobacco Education Coordinator

Massachusetts recently released a manual for Substance Use Treatment Providers titled *"Integrating Tobacco Education & Treatment into Substance Use Treatment"* which is available on the website of the Institute for Health and Recovery under Services and Products. This manual is a comprehensive guide for substance use treatment providers on tobacco use assessment, education, treatment and program policies.

BSAS recently participated in a Tobacco Summit along with the Massachusetts Tobacco Cessation and Prevention Program (MTCP), the Department of Mental Health (DMH) and SAMHSA. The Commissioners of DMH and DPH participated in this collaborative effort initiated by DMH. The goal of the Summit was to develop a plan for Massachusetts to address the high percentage of people who use nicotine who have histories of mental health and substance use disorders and high rates of suicide.

As a result of the Summit, the BSAS-funded Technical Assistance provider for addressing nicotine addiction, the TAPE Project, met with regional staff about supporting Tobacco Education Coordinators in their roles. All licensed programs are required to identify Tobacco Education Coordinators and provide them with training and support related to addressing nicotine use and addiction in each program.

BSAS is currently developing a Practice Guidance related to addressing nicotine addiction in treatment and recovery as well as one on co-morbidities including nicotine addiction for BSAS providers.

10. Indicate tools and strategies used that support efforts to address nicotine cessation.

In addition to the resources described in question 8, Massachusetts has a Smoker's Quitline (1-800-QUIT-NOW) http://makesmokinghistory.org/quit-now/

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

2. Health Disparities

1. Does the State track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

Yes. BSAS-funded programs are required submit data on each enrollment to their program to the on-line EIM/ESM system. The enrollment form includes detailed questions that include but are not limited to:

- Gender
- Race/Ethnicity
- Language
- Education
- Age
- Sexual orientation

BSAS began to collect data on sexual orientation in the FY 2014-15 reporting period. We continue to train providers on how to ask the sexual orientation and gender identity/expression questions on the ESM forms. Efforts to have the responses to these questions included in the standard ESM reports that BSAS staff and programs review are ongoing.

2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above sub-populations.

To reduce health disparities and make services more accessible, the Massachusetts Department of Public Health (DPH) remains committed to implementing the National Culturally and Linguistically Appropriate Services (CLAS) Standards. Within BSAS, the goal of adopting CLAS Standards is to make substance abuse treatment services more culturally competent, through instituting change at all levels of the organization.

For more information, please see the DPH staff CLAS training manual is located here: http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/making-clas-happen.html

With regards to the LGBTQ population, BSAS supports improving access to and quality of services for the LGBTQ communities through the following efforts:

- BSAS staff continue to participate in the Homeless Youth Provider Network which meets monthly and has a focus on serving the disproportionate number of LGBT homeless youth

BSAS has plans to develop new trainings focused on cultural competency for working with the LGBTQ population through a partnership with MayBright, a technical assistance and advocacy organization that include conducting a system-wide review of policies, practice and training initiatives to assess for LGBTQ cultural competency. Additional training will be implemented for all clinical and intake staff on clinical skills as pertaining to youth and young adults, and includes a pre/post evaluation to address change in attitudes and behaviors.

The DPH-wide LGBTQ Health Data Collection in Massachusetts and Opportunities to Enhance Health Surveillance and Achieve Health Equity group meets periodically for the purpose of developing data collection measures and standards for the state. This group is part of a larger network in the State focused on exploring health disparities as related to the LGBTQ community.

The data collection group continues to guide DPH in the following initiatives:

- Collection of sexual orientation and gender identification/expression within BSAS standard service data collection instruments.
- Development and dissemination of sub-regulatory Practice Guidance documents for providers that offer best practices and resources to improve quality of care in BSAS licensed and contracted programs for both adult and youth/young adult LGBTQ populations (see here for more information: http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html). Of note, the BSAS Treatment Services Guidelines, found on the Practice Guidelines website, serve as a model for other work being done to address disparities in the state.

We continue to examine the populations accessing Office-Based Opioid Treatment from the BSAS-funded Federally Qualified Health Centers (FQHC) to assess initiation and engagement in this treatment modality and improve access.

Finally, in addition to the LGBT goal, two other goals in the MA 2016-2017 SAPT Block Grant plan relate to access for under-served populations, one is related to increasing the membership of the Faith Based Coalition, and the other related to substance abuse prevention and treatment engagement for older adults. One of the goals of the partnership with the Faith Based Coalition is to increase collaboration and partnership with faith organizations and the communities they serve. Ultimately we hope to increase their capacity to address substance use as a component of their ministerial work from their own faith perspective. Access to services for a broad range of populations in Massachusetts is a priority for BSAS. Progress on the specific goals will be monitored for the next two years.

3. Are linguistic disparities/language barriers identified, monitored, and addressed?

Yes. BSAS continues to fund and manage an interpreter pool that BSAS treatment providers can access at no cost to them. BSAS works with companies that maintain trained interpreter pools covering a wide range of languages and reimburses interpretation for substance abuse treatment. Efforts to examine how interpreter services are being used across the state, and which languages are being requested, are underway.

BSAS also continues to provide funding to the Commission for the Deaf and Hard of Hearing (CDHH) to pay for a pool of American Sign Language (ASL) interpreters. BSAS providers can contact the CDHH when they need ASL interpreters at their programs. ASL interpreters are also funded to provide interpretation for recovery support services, events and self-help meetings. This past year the first deaf Recovery Coach was trained so the Commission for the Deaf and Hard of Hearing is working with him on the best way he can be a resource to the deaf community. BSAS also remains committed to funding a residential treatment program in Rhode Island that serves deaf men.

4. Is there state support for cultural and linguistic competency training for providers?

As previously reported, BSAS has funded a *Latino Counselor Training Program* for many years. This program provides the training hours required for a Licensed Alcohol and Drug Counselor (LADC) in addition to support with test preparation and internships. This program has helped many bi-lingual individuals get the training needed to work professionally in the field, helping to meet a tremendous need among substance abuse treatment providers.

In FY 2014, BSAS began to develop the *African-American Counselor Training Program* modeled on the successful Latino Counselor Training Program. Curriculum development is underway and meetings with key personnel are being held to continue to move this important initiative forward. This program will provide opportunities for development of the African-American substance abuse treatment counselor workforce.

Finally, we continue to require all contracted agencies to do a CLAS self-assessment and evaluate how well their agency accomplishes various aspects of CLAS, and they are asked to use the assessment to identify areas for growth and improvement, and create plans to bridge any knowledge gaps. BSAS Contract Management staff follow up with BSAS providers during site visits on their plans, including areas of progress and areas for improvement, in adopting the CLAS Standards, and how BSAS can support their work.

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

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[59] Ibid, 47, p. 41

[60] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[61] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[62] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

3. Use of Evidence in Purchasing Decisions

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.

Many staff of the Bureau of Substance Abuse Services, as well as contracted training and technical assistance vendors, are involved in tracking and disseminating information regarding evidence-based practices.

For Prevention services, the Director of the Prevention Unit, Jose Morales is the point person for tracking and disseminating information regarding evidence-based or promising practices. BSAS has a technical assistance contract with the Education Development Center, Inc. (EDC), which BSAS has named the Massachusetts Technical Assistance Partnership for Prevention (MassTAPP). MassTAPP helps to identify evidence-based and promising practices and disseminates them to the field through regional meetings, state-wide programs and technical assistance. In addition, many other staff are involved with the promotion of evidence-based prevention, intervention and treatment practices, including bureau and department leadership, project/program directors, managers and coordinators, grant writers, training developers, program evaluators, data managers, and fiscal managers.

For Intervention, Treatment and Recovery Support Services the work of tracking and disseminating information regarding evidence-based practices fall on staff in both the Planning and Development unit and the Office of Youth and Young Adults. Workforce Development and Training and Procurement Efforts all focus on dissemination and implementation of evidence-based practices. In addition, BSAS contracts with Training and Technical Assistance vendors who track evidence based and promising practices and provide training and TA on their areas of expertise.

2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

BSAS funds a number of evidence based models, such as: Adolescent Community Reinforcement Approach/Assertive Continuing Care, Mission Model, Seeking Safety, Screening, Brief Intervention and Referral to Treatment, Motivational Interviewing, and Medication Assisted Treatment, among others. Procurements that allow vendors to select preferred treatment models always specify that BSAS will only consider funding evidence-based models.

BSAS has a comprehensive procurement process aimed at making the most informed, evidence based decisions when purchasing services. This procurement process has two levels of review, each one using quantitative methods of analysis.

- The first review level evaluates the content of applicants' proposals, using a numeric scoring system as a basis for determining which providers will offer the highest quality services if funded.
- The second level evaluates additional variables relevant to the procurement including, but not limited to, facility/site review, fiscal and contractual record of the applicant and programmatic

outcomes. After all of these factors are quantified, a final score determines the vendor(s) from which BSAS will purchase service.

BSAS implements the same competitive RFR process for all prevention programs. Any program funded by BSAS for prevention is required to use the Strategic Planning Framework as part of that process, and to choose evidence-based strategies to reduce alcohol and drug use (AOD). Regular analysis of Quarterly Narrative Reports and site visits assist in and monitor implementation.

BSAS has collaborated with the Department of Elementary and Secondary Education (DESE) and the School Health Unit to develop a school nurse and health educator training process which focuses on "Effectively Preventing Prescription Drug Misuse and Other Drug Use." In choosing the programs for the trainings BSAS used NREPP ratings as well as information from the December 2, 2014 SAMHSA program, "Learn About Effective Programs for Preventing Drug Misuse among Youth" to identify the most powerful evidence-based programs to address the most pressing AOD use in the state of Massachusetts.

BSAS has provided three Certification trainings in the most powerful evidence-based programs (All Stars and Life Skills Training) and plan at least two more in FY16. The curricula, student materials and the Strengthening Families DVDs are offered free of charge to the trainees. BSAS has received positive training evaluations and is assessing this initiative to potentially offer more training in FY16-17.

Meetings with the School Health Unit and DESE enabled them to have input into the choice of evidence-based program training. Native American tribal representatives are involved in the choice/adaptation of an evidence-based program for their youth as well (See section 8. Tribes).

Booklets, pamphlets and weekly Facebook posts help to disseminate information to consumers, and direct them towards effective resources and services. The printed materials and the Facebook posts are positive and strive to empower people to make positive changes in their lives and the lives of their children.

BSAS is piloting brief a survey within schools that have SAPCs in their communities to look at AOD rates. When data is available it will be possible to compare AOD trends in middle schools and high schools over time.

3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?

The Director of Prevention is involved in all purchasing decisions. BSAS invests human and financial resources in purchasing strategies -- planning, implementing and assessing evidence-based trainings. Trainings are subsidized and Program Directors and staff are strongly encouraged to attend.

Related to educating State Medicaid and health care providers, BSAS has been promoting Screening, Brief Intervention and Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT).

BSAS has done presentations on the effectiveness of these models and continues to fund Training and Technical Assistance Providers to deliver hands-on support to health care providers on integrating SBIRT and OBOT into their practices. SBIRT is included in the recommendations of the Behavioral Health Integration Task Force.

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Footnotes:

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

7. Program Integrity

The Bureau of Substance Abuse Services (BSAS) has a "Payer of Last Resort" policy that is monitored by the BSAS electronic invoice system ESM/EIM and during site visits by Regional Management staff. ESM/EIM rejects billing for clients who are insured. BSAS contract management staff also monitor program compliance with on-site record reviews. These policies and practices have been aimed at ensuring that BSAS funds, including the SAPT Block Grant, are not used to cover treatment episodes that could be billed elsewhere. This has been the long-standing practice of BSAS well prior to the passage of Health Care Reform in Massachusetts, as MassHealth and private Payers have covered substance abuse treatment services for many years. The role of BSAS has been to pay for the uninsured. As this pool of individuals shrinks statewide, the pool within the population of those seeking substance abuse treatment remains large enough to continue to fill the "BSAS-funded" beds at programs statewide.

Related to how the state ensures that payment methodologies are reasonable and appropriate, Massachusetts has been engaged in a vigorous process of rate review for all of the rates of reimbursement across the Executive Office of Health and Human Services. This initiative, named after the law that now requires it, is called "Chapter 257." Every direct-service purchased is required to have a standard rate of reimbursement that is calculated based on true costs and updated every three years. BSAS has used unit rates for reimbursement for many years, but with Chapter 257 they have been updated and in most cases increased.

BSAS uses its leverage as the regulatory and licensing authority for substance abuse treatment in Massachusetts to ensure that providers adopt practices that promote compliance with program requirements, including quality and safety standards. All providers of substance abuse treatment must be licensed by BSAS. Many program requirements and quality and safety standards are written into the licensing regulations. BSAS has a team of regional licensing inspectors, as well as two complaint investigators.

In addition, BSAS has published a series of Practice Guidance modules on a range of topics, and will continue to publish more. These are written to guide providers toward best practices and provide numerous resources. They can be found at http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html

Related to non-regulatory requirements, BSAS Regional Managers and other contract management staff monitor the programs with regular site visits and regular communication. In the Bureau of Substance Abuse Services, many staff are involved with ensuring program integrity, there is not one specific staff person assigned to program integrity activities.

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

8. Tribes

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.

The Massachusetts Department of Public Health Bureau of Substance Abuse Services (BSAS) shared Native American data from the Youth Health Survey with representatives who collaborated with us on a prevention of substance abuse project. Native American outreach included the Wampanoag of Mashpee and Martha's Vineyard, as well as all of the other Tribal Councils and Inter-Tribal Councils that we could identify. We worked with UMASS Boston Institute for New England Native American Studies to identify representatives to collaborate with us on the prevention of substance abuse. Together we conducted four discussion groups and created "Coming Home," a culturally-specific guide for parents. See http://massclearinghouse.ehs.state.ma.us/BSASYTH/SA3528.html.

2. Describe current activities between the state, tribes and tribal populations.

In FY15, BSAS continued to distribute "Coming Home," and discuss how it could be used in communities. The well-received guide was distributed at pow-wows, tribal gatherings, art shows, health centers and other venues. The four roundtable groups identified the need for an effective prevention curriculum to use with youth.

Consultants from various tribes recommended that we create a locally based, yet effective curriculum. Native American adults were invited to an evidenced-based training on the prevention of substance abuse in FY15 (2/28/15). Prior to the training native Culture Keepers and elders were invited to meet with the trainer, and offer input. Twenty-six Native Americans were trained in the curriculum. A subset of that group is now advising BSAS on a cultural adaptation during weekly conference calls. We incorporate the best information from other Native curricula, as well as local culture, stories and illustrations. We are working with the developers of "Life Skills Training" to ensure that the cultural adaptation remains highly effective in preventing substance abuse. We are now beginning to meet with youth for concept testing of the draft curriculum. When it is complete, the plan is that Tribal members will offer the curriculum to groups of middle school youth and BSAS will assist in the dissemination. The adapted curriculum will also be shared with other youth-serving professionals. The BSAS representative and members of our Team will be attending the 2-day Wampanoag Nation strategic planning session co-sponsored by the federal Tribal Training and TA Center of SAMHSA.

Our Treatment Unit invited tribal members to the five day Recovery Coach Training. Two Wampanoag Tribe-specific Trainings are planned for this fiscal year. Adaptations to the curricula will be made to ensure that it is culturally sensitive. Experts will be available to provide TA throughout the coming years. Recovery coaches will be invited to attend the two day Ethical Considerations for Recovery Coaches. Tribal members will continue to be offered Scholarships to a range of general prevention and treatment trainings throughout the year.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BSAS Grants*	
Fiscal Agent	**Funded**
City of Barnstable	Yes
Bay Cove Human Services, Inc.	Yes
City of North Adams	Yes
City of Boston (Boston Public Health Commission)	Yes
City of Brockton	Yes
Dukes County/Martha's Vineyard	Yes
Stanley Street Treatment and Resources	Yes
City of Fitchburg	Yes
Franklin Regional Council of Governments - North Quabbin Region	Yes
City of Gardner	Yes
City of Gloucester	Yes
Collaborative for Educational Services/Hampshire County	Yes
Town of Hudson	Yes
City of Lynn	Yes
City of Melrose	Yes
Family Services of Merrimack Valley	Yes
Town of Needham	Yes
New Bedford Health Department	Yes
Peabody Police Department	Yes
High Point Treatment Center	Yes
Bay State Community Services	Yes
Railroad Street Youth Project/The South Berkshire Community Health Advisory Coalition	Yes
City of Somerville	Yes
City of Springfield	Yes
Stoughton Youth Commission	Yes
Town of Tewksbury	Yes
Wayside Youth & Family Support Network	Yes
City of Worcester	Yes
Boston Public Health Commission	Yes
City of Worcester Dept. of Public Health	Yes
City of Springfield Dept. of Health & Human Services	Yes
City of Brockton	Yes
City of Gloucester Health Department	Yes
City of Fitchburg	Yes
City of Medford	Yes
City of Revere	Yes
City of Cambridge	Yes

City of Lowell	Yes
City of Lynn	Yes
City of Quincy	Yes
Berkshire Public Health Alliance	Yes
Barnstable County	Yes
City of Fall River	Yes
City of Lawrence	Yes
City of New Bedford	Yes
City of Northampton	Yes
Causemedua	yes
Education Development Center	Yes
Health Resources in Action	Yes

*A town or city may have more than one contract, so this is different than our total number of p

Catchment Area
Barnstable, Harwich, Yarmouth
Chelsea, Revere, Winthrop
North Adams, Florida, Clarksburg, Adams, Cheshire, Savoy, Williamstown, New Ashford, Hancock, Lanesboro
Dorchester, Allston/Brighton, Boston-Chinatown, South Boston
Brockton, Bridgewater, Whitman, East Bridgewater, Rockland
Edgartown, Aquinnah, Chilmark, West Tisbury, Tisbury, Oak Bluffs, Gosnold (the Elizabeth Islands)
Fall River, Taunton, Dighton
Fitchburg, Clinton, Leominster, Princeton, Sterling
Montague, Orange, Buckland, Charlemont, Gill, Hawley, Heath, Leyden, Monroe, Conway, Deerfield, Shelburne
Gardner, Athol, Phillipston, Royalston, Templeton, Westminster
Gloucester, Beverly, Essex, Manchester-by-the-Sea, Rockport
Northampton, Hadley, South Hadley, Ware, Amherst
Hudson, Framingham, Southborough, Northborough
Lynn, Swampscott, Salem, Marblehead
Melrose, Medford, Malden, Winchester, Wakefield, Stoneham
Lawrence, Methuen, North Andover, Andover, Haverhill
Needham, Dedham, Norwood, Westwood
New Bedford, Dartmouth, Rochester, Marion, Wareham, Westport
Peabody, Danvers, Boxford, Middleton, Topsfield
Plymouth, Middleborough, Carver
Quincy, Braintree, Milton, Weymouth
Great Barrington, Stockbridge, West Stockbridge, Sheffield
Somerville, Arlington, Cambridge, Everett
Springfield, Chicopee
Stoughton, Walpole, Holbrook, Canton
Tewksbury, Dracut, Chelmsford, Lowell
Watertown, Waltham, Brookline, Belmont
Worcester, Shrewsbury, Grafton, Leicester
All Boston Neighborhoods
Worcester, Shrewsbury, West Boylston, Leicester, Grafton, Holden, Millbury
Springfield, Chicopee, Holyoke, East Long Meadow
Brockton, Rockland, East Bridgewater, Whitman
Gloucester, Beverly, Danvers
Fitchburg, Gardner, Leominster, Athol
Medford, Malden Melrose, Stoneham, Wakefield, Reading
Revere, Chelsea, Saugus, Winthrop
Cambridge, Everett, Somerville, Watertown

Lowell, Billerica, Chelmsford, Tewksbury, Dracut, Westford and Wilmington
Lynn, Peabody, Salem
Quincy, Braintree, Randolph, Stoughton, Weymouth
All Communities in Berkshire County
Barnstable, Bourne, Falmouth, Yarmouth, Harwich, Sandwich, Mashpee
Fall River, Taunton, Dighton
Lawrence, Methuen, Andover, Haverhill
New Bedford, Dartmouth, Wareham, Marion, Rochester
Northampton, Easthampton, South Hadley, Amherst, Belchertown, Pelham, Ware
Statewide
Statewide
Statewide

rograms

Bystander Distribution Sites		
Corporation Name	**Funded**	**Program Name**
Center for Human Development	Yes	
Boston Public Health Commission	Yes	AHOPE
Brockton Area Multi-Services, Inc.	Yes	The COPE Center
AIDS Action Committee	Yes	
Seven Hills Behavioral Health	Yes	
Tapestry Health	Yes	
Holyoke Health Center	Yes	
Tapestry Health	Yes	
AIDS Support Group of Cape Cod	Yes	
Greater Lawrence Family Health Center	Yes	
Lowell Community Health Center	Yes	
Lowell House	Yes	
Health Innovations, Inc.	Yes	Healthy Streets Outreach Program
Seven Hills Behavioral Health	Yes	
Tapestry Health	Yes	
Center for Human Development	Yes	
AIDS Support Group of Cape Cod	Yes	
Manet Community Health Center	Yes	
North Suffolk Mental Health	Yes	
Tapestry Health	Yes	La Voz
AIDS Project Worcester	Yes	

First Responder Grant Communities		
Corporation Name	**Funded**	**Department**
Town of Barnstable	Yes	Barnstable Police Department
City of Boston	Yes	Boston Police Department
City of Brockton	Yes	Brockton Police and Fire Department
City of Chelsea	Yes	Chelsea Police and Fire Departments
City of Everett	Yes	Everett Police and Fire Department
City of Fall River	Yes	Fall River Police Department
City of Fitchburg	Yes	Fitchburg Police and Fire Department
City of Framingham	Yes	Framingham Fire Department
City of Haverhill	Yes	Haverhill Police and Fire Department
City of Holyoke	Yes	Holyoke Fire Department
City of Lowell	Yes	Lowell Police and Fire Department
City of Lynn	Yes	Lynn Police and Fire Department
City of Malden	Yes	Malden Police and Fire Department
City of New Bedford	Yes	New Bedford Police and Fire Deparment
City of Quincy	Yes	Quincy Police and Fire Department
City of Revere	Yes	Revere Police and Fire Department
Town of Saugus	Yes	Saugus Fire Department
City of Somerville	Yes	Somerville Police and Fire Department
Town of Stoughton	Yes	Stoughton Police and Fire Department
City of Taunton	Yes	Taunton Fire Department
Town of Weymouth	Yes	Weymouth Police and Fire Department

Town of Winthrop	Yes	Winthrop Police Department
City of Worcester	Yes	Worcester Fire Department

Address	City	Zip Code
357 Main Street	Athol	01331
774 Albany Street	Boston	02118
81 Pleasant Street	Brockton	02301
359 Green Street	Cambridge	02139
310 South Main Street	Fall River	02724
80 Sanderson Street	Greenfield	01307
230 Maple Street	Holyoke	01040
15A Main Street	Holyoke	01040
428 South Street	Hyannis	02601
100 Water Street	Lawrence	01841
161 Jackson Street	Lowell	01854
555 Merrimack Street	Lowell	01854
100 Willow Street, 2nd Floor	Lynn	01901
1173 Acushnet Avenue	New Bedford	02745
16 Center Street, Suite 423	Northampton	01060
131 West Main Street	Orange	01364
336 Commercial Street, Unit #10	Provincetown	02657
1193 Sea Street	Quincy	02169
265 Beach Street	Revere	02151
130 Maple Street	Springfield	01105
85 Green Street	Worcester	01604

Address	City	Zip Code
1200 Phinneys Lane	Barnstable	02601
1 Schroeder Plaza	Boston	02128
7 Commercial Street	Brockton	02302
19 Park Street	Chelsea	02150
45 Elm Street	Everett	02149
685 Pleasant Street	Fall River	02724
20 Elm Street	Fitchburg	01420
1 William H Welch Way	Framingham	01702
40 Bailey Boulevard	Haverhill	01830
138 Appleton Street	Holyoke	01040
50 Arcand Drive	Lowell	01852
300 Washington Street	Lynn	01902
200 Pleasant Street #700	Malden	02148
871 Rockdale Avenue	New Bedford	02740
1 Sea Street	Quincy	02169
400 Revere Beach Parkway	Revere	02151
120 Essex Street	Saugus	01906
93 Highland Avenue	Somerville	02143
26 Rose Street	Stoughton	02072
23 Summer Street	Taunton	02780
140 Winter Street	Weymouth	02188

3 Metcalf Square	Winthrop	02152
9-11 Lincoln Square	Worcester	01601

Corporation Name	Funded	Address
Baystate Medical Center	Yes	380 Plainfield Street
Boston Medical Center	Yes	725 Albany Street, Suite 5C
Cambridge Health Alliance	Yes	26 Central Street
		119 Windsor Street
		454 Broadway Street
Dimock Community Health Center	Yes	45 Dimock Street
Duffy Mental Health Center	Yes	94 Main Street
Family Health Center of Worcester	Yes	26 Queen Street
Greater Lawrence Family Health Center	Yes	34 Haverhill Street
		150 Park Street
		700 Essex Street
		73D Winthrop Avenue
Boston Health Care for the Homeless	Yes	444 Harrison Avenue
		39 Boylston Street
Holyoke Health Center	Yes	230 Maple Street
		505 Front Street
Lowell Community Health Center	Yes	161 Jackson Street
Lynn Community Health Center	Yes	280 Union Street
Massachusetts General Hospital	Yes	151 Everett Avenue
		300 Ocean Avenue
South Boston Community Health Center	Yes	409 W Broadway
Stanley Street Treatment	Yes	386 Stanley Street
Brockton Neighborhood Health	Yes	63 Main Street
Harbor Health Services, Inc.	Yes	10 Cordage Park Circle
Community Healthlink	Yes	162 Chandler Street

City	Zip Code
Springfield	01107
Boston	02118
Somerville	02143
Cambridge	02139
Revere	02151
Roxbury	02119
Hyannis	02601
Worcester	01610
Lawrence	01840
Lawrence	01841
Lawrence	01841
Lawrence	01843
Boston	02118
Boston	02116
Holyoke	01040
Chicopee	01013
Lowell	01852
Lynn	01901
Chelsea	02150
Revere	02151
Boston	02127
Fall River	02720
Brockton	02301
Plymouth	02360
Worcester	01608

Corporation Name	Funded	Program Name	Address
Western Massachusetts Training Consortium	Yes	RECOVER Project	68 Federal Street
Spectrum Health Systems, Inc.	Yes	Everyday Miracles	25 Pleasant Street
Spectrum Health Systems, Inc.	Yes	The Recovery Connection	31 Main Street
Spectrum Health Systems, Inc.	Yes	New Beginings	489 Essex Street
Gandara Center	Yes	Stairway to Recovery	142 Crescent Street
North Suffolk Mental Health	Yes	STEPRox	9 Palmer Street
Gavin Foundation	Yes	Devine Recovery Center	70 Devin Way
Bay State Community Services	Yes	Quincy Recovery Support Center	85 Quincy Avenue
Gandara Center	Yes	Hope for Holyoke Recovery Support Center	100 Suffolk Street
Gandara Center	Yes	Hyannis Recovery Support Center	209 Main Street

City	Zip Code
Greenfield	01301
Worcester	01608
Marlborough	01752
Lawrence	01840
Brockton	02301
Roxbury	02119
South Boston	02127
Quincy	02169
Holyoke	01040
Hyannis	02601

Corporation Name	Funded
Action for Bridgeport Community Development, Inc.	Yes
North River Collaborative	Yes
North Shore Education Consortium	Yes
City of Springfield	Yes
Central Massachusetts Special Education Collaborative	Yes

Program Name	Address	City	Zip Code
William J. Ostiguy High School	19 Temple Place	Boston	02111
Independence Academy	460 Belmont Street	Brockton	02301
North Shore Recovery High School	502 Cabot Street	Beverly	01915
Liberty Prepatory Academy	37 Alderman Street	Springfield	01108
TBD	20 Rockdale Street	Worcester	01606

Corporation Name	Funded	Program Name**
Supportive Case Management Services		
John Ashford Link House	Yes	Progress House
John Ashford Link House	Yes	The Elms
Bridge Over Troubled Waters	Yes	Bridge Eliot
Bridge Over Troubled Waters	Yes	Trinity House
YMCA of Greater Boston	Yes	Dennis McLaughlin House
Casa Esperanza	Yes	Nueva Vida
Children's Services of Roxbury	Yes	Second Home
Dimock	Yes	Sheila Daniels House
Dimock	Yes	Ummi's
Victory Programs	Yes	Victory Supportive Case Management
Mass Housing & Shelter Alliance	Yes	Journey to Success
Gandara	Yes	Serenity Program
Steppingstone	Yes	Transition House
Steppingstone	Yes	Graduate House
Our Fathers House	Yes	Elizabeth House
South Middlesex Opportunity Council	Yes	Crossroads I
South Middlesex Opportunity Council	Yes	Supportive Housing
South Middlesex Opportunity Council	Yes	YARCM
GAAMHA	Yes	Pathway House
John Ashford Link House	Yes	Moore's Way
Gandara	Yes	Jarvis Heights
Gandara	Yes	Leeds Village
Gandara	Yes	Community Housing
Gandara	Yes	Miracle House
Institute for Health and Recovery	Yes	Julie House
Lowell House	Yes	Supportive Case Management
Project COPE	Yes	Transitional Support
SEMCOA	Yes	Unity House
SEMCOA	Yes	Wrap House
South Middlesex Opportunity Council	Yes	Crossroads II
Brien Center	Yes	Safe Harbor
Brien Center	Yes	Supportive Housing
John Ashford Link House	Yes	Maris Center
CASPAR	Yes	Hagan Manor
Somerville Homeless Coalition	Yes	Sobriety & Stability
Community Counseling of Bristol County	Yes	Dr. Robert Smith House
Servicenet	Yes	Moltenbrey
Community Healthlink	Yes	North Village (RAD)
Community Healthlink	Yes	Community Housing
Community Healthlink	Yes	Brookside Terrace
South Middlesex Opportunity Council	Yes	Footsteps
South Middlesex Opportunity Council	Yes	TIDES

Southern Middlesex Opportunity Council (Worcester PIP)	Yes	Aurora House
Family Sober Living		
Victory Programs	Yes	Portis House
Citizens for Adequate Housing	Yes	Inn Transitions
Substance Abuse Shelters for Individualts		
Bay Cove Human Services	Yes	
Psychological Center	Yes	
Stabilization		
Lahey Health Behavioral Services	Yes	Tewksbury Transitions
Street Outreach/Supportive Case Management/Housing Stabilization		
Pine Street Inn	Yes	Night Center
Pine Street Inn	Yes	Common Ground
Youth Search / Outreach		
Bridge Over Troubled Waters	Yes	
ROCA Inc.	Yes	

Address	City	Zip Code
39 High Street	Amesbury	01913
53 Friend Street	Amesbury	01913
68 &70 Waverly Street	Brighton	02111
3 & 5 Abbey Road	Brighton	02111
150 3rd Avenue #214	Charlestown	02129
290 1/2 Eustis St, Roxbury 24 Dunmore St	Roxbury	02119
9 Codman Park	Roxbury	
142 Walnut Ave.	Roxbury	02119
8 Fort Ave.	Roxbury	02119
250/252 Warren St.	Roxbury	02119
scattered site	Revere Chelsea	
1 Robinson Drive	Chicopee	01310
542 North Main Street	Fall River	02720
North Main Street	Fall River	02720
76 Mechanic Street	Fitchburg	01420
75 Hollis Street	Framingham	01702
Scattered site	Framingham	01702
14 Gorgon Stret 73 Hollis Street	Framingham	01702
16 West Broadway/101 Oak Street	Gardner	01440
23 Duncan Street	Gloucester	01930
	Holyoke	
	Northampton	
	Holyoke	
114 Calhoun Street	Springfield	01107
1 Riverplace Towers	Lowell	01852
	Lowell	Scattered Site
	Lynn	Scattered Site
74 Penniman Street	New Bedford	02740
81 Austin Street	New Bedford	02470
1509 North Main Street	Palmer	01069
184 Bradford Street	Pittsfield	01201
202 bradford Street	Pittsfield	01201
197 Elm Street	Salisbury	01952
268 Washington Street	Somerville	02143
19 Walnut Street 19 Grove Street	Arlington	
314 Somerset Ave.	Taunton	02780
239 Main Street	Greenfield	01301
18 Village Way #1	Webster	01570
	Worcester	
	Worcester	
7 Woodland Street	Worcester	01610
6 Wyman Street	Worcester	01610

25 Queen Street	Worcester	01610
226 Huntington Ave.	Boston	
42 Washington Street	Peabody	
240 Albany Street	Cambridge	
19 Winter Street	Lawrence	
365 East Street	Tewksbury	
444 Harrison Ave.	Boston	02118
444 Harrison Ave.	Boston	02118
47 West Street	Boston	
101 Park Street	Chelsea	

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

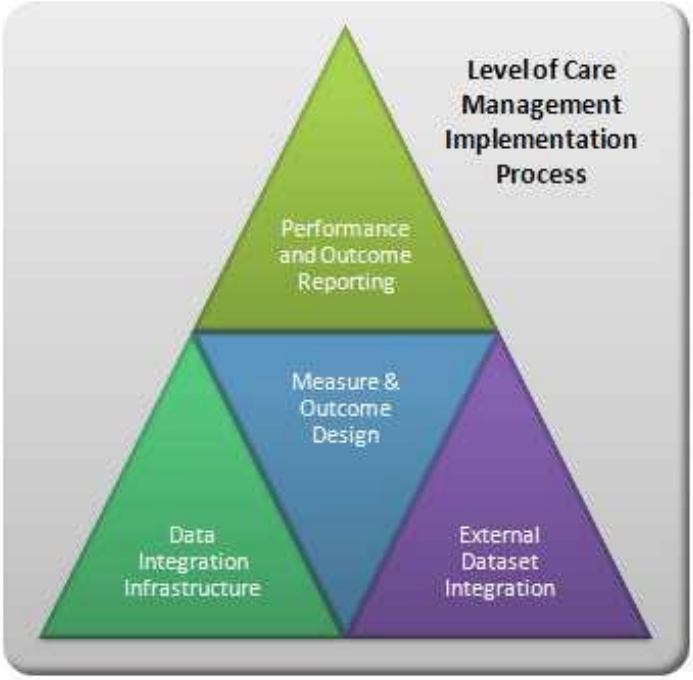
10. Quality Improvement Plan

Overview

The Commonwealth of MA Bureau of Substance Abuse Services (BSAS) has created an ongoing operational framework to support performance improvement within the state funded substance abuse treatment system. Working with the provider community, BSAS has identified and implemented measures of interest, retooled its data infrastructure, and is actively involved in the process of utilizing a data driven strategy for continuous improvement of performance.

Implementation of performance management and pay for performance within the substance abuse treatment system is an emerging science. As the underlying data infrastructure and methodology mature, BSAS has continually gained insight into the most desirable developments leading to effective implementation. Of note, BSAS has focused on several key issues including:

- Measure relevance and utility within and across each level of care. The BSAS Performance Management Framework can be characterized as having four main components all working together within the context of Level of Care (LOC) management:
    - Measure and Outcome Design – Identification and categorization of the specific measures that will be used (e.g. financial, structural, process, and outcome) and their information requirements.
    - Performance and Outcome Reporting – Determination of who the users of the data are, how they will receive/interact with the data, and what kinds of data presentation (e.g. dashboards) will be made available.
    - Data Integration & Infrastructure – The overall architecture for acquiring, mapping/transforming, integrating and augmenting the data necessary to create the measures.
    - External Dataset Integration – The identification of need for and integration of secondary or external datasets including other substance abuse treatment data, medical data, criminal justice data, and vital records data.



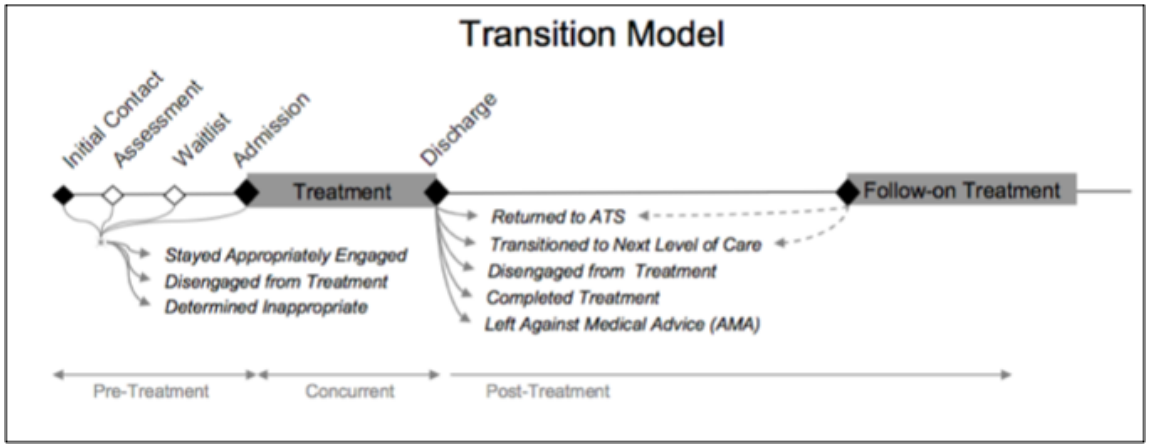
Performance Management Goals

In order to maximize the effectiveness of the Performance Management Framework, the Bureau identified a series of goals to be achieved which enable:

- The ongoing use of meaningful data to ensure continuous quality improvement;
- An in-depth understanding of the populations served including descriptive characteristics of the clients, services provided to them and treatment outcomes;
- Continuously reviewing and making informed resource allocation decisions that satisfy federal reporting requirements while targeting services that improve health quality and cost outcomes;
- Identifying and making efforts to achieve cost-offsets across agencies, through shared roles and responsibilities, that better serve vulnerable populations;
- Ongoing performance management across the continuum of care including measurement and evaluation as well as performance-based contracting;
- Consumer access to in-depth information about treatment options and specific providers including customer satisfaction survey data to aid in the selection of treatment programs (consumer directed care);
- Customer experience research data shared with individual programs so they can continually enhance and improve their client services;
- And most importantly, performance management and continuous quality improvement that are part of doing everyday business.

Measure Definition and Design

Performance/outcome measures are complex and continually evolving. As background to the design of the measures, a model was created which reflects the client's transition through the continuum. It is easiest to start by looking at a single treatment event1 (note that BSAS is currently working on augmenting this model at the episodic level). The following model diagram reflects the simple activities prior to, concurrent with and post treatment. A client contacts the 'system' looking for help, they are assessed for need and appropriate placement; they are waitlisted and then enrolled for treatment. Upon discharge, the client might return to the same type of treatment, step down to a less intensive level of care or, in some cases, step up to a higher level of care. The model creates index events (diamond shapes) along an individual client's continuum of care which reflect a key step in the treatment process.



Performance Measure Grouping

The following measures (which include process and outcome measures) are characterized into groups that are meaningful to the treatment system. Because substance abuse is a chronic and reoccurring disease, one of the key measures of a client's management of their condition is their commitment to ongoing treatment which is indirectly measured by initiation and engagement. Treatment disposition is a process measure; transition of care combines process and outcome measures; and client outcome measures are true outcome measures reflecting improvement in health/life status.

Measure Type	Individual Program Level Measures (Measured at the client-program-enrollment Level)	System Level Measures (Measured at the client-episode Level)
Engagement and Retention • Initiation Rate • Engagement Rate	Measure the effectiveness of the individual program in keeping clients involved in treatment at that program.	Measure the effectiveness of the system in keeping individual clients who have started treatment involved in receiving treatment at the same or subsequent programs.
Treatment Disposition • Completion Rate • Dropout/AMA Rate • Administrative Discharge Rate	Measure the client's disposition at the time of discharge from a specific enrollment period. These measures are reported by the providers and are subject to variation due to interpretation and process differences between providers.	TBD Measures the Disposition at the end of an episode not specific to the programs providing treatment within the episode.
Transition of Care •Transition Down Rate • Transition Same Rate • Transition Up Rate	Measure the rate at which clients transition to other levels of care after discharge. These measures are NOT self reported but calculated using administrative enrollment data.	Measure transitions to medical treatment or criminal justice services (e.g. the rate at which episodes transition outside of the system to ED).
Client Outcomes (including NOMs) • Change in Employment Status • Change in Living Status • Change in Abstinence Status • Change in Arrest Status • Change in Social Support Status • Change in Self Help Involvement	Measures the change in client level outcomes from admission to discharge for a specific enrollment period. As defined by NOMs, these measures may be more appropriate for treatment programs with longer treatment periods such as residential, opioid treatment, and other ambulatory programs.	TBD Measures the change in client level outcomes from the start to end of an episode of care – possibly over an extended period of a client's life. These measures are useful for evaluating the performance of episodes of longer duration (typically 30 days or more).

Measure	Program Level
Initiation Rate	Rate at which clients have "initiated" treatment at an individual program or system (episode) level. The number of days (n) indicating initiation is defined independently for each category of service.
Engagement Rate	Rate at which clients have "engaged" in treatment at an individual program or episode of care level. The number of days (n) indicating engagement is defined independently for each category of service.

Measure	Program Level
Transition Up (TU_n) Rate	Rate at which client enrollments transition clients to more intense levels of care within n days.
Transition Same (TS_n) Rate	Rate at which client enrollments show the return of clients the same level of care within n days.
Transition Down (TD_n) Rate	Rate at which client enrollments transition clients to less intense levels of care within n days.

Transition measures are calculated using the same algorithm at both the program and system levels. As shown in the table below, an enrollment or episode is considered to have transitioned up, transitioned to the same level of care or transitioned down if there is a subsequent enrollment for the same client within n days of discharge for that enrollment.

Level of Care	ED/ Inpatient	ATS	CSS	TSS	RES-A	RES-Y	Youth Stabilization	OTP	Recovery Support Ctrs
Acute Treatment Services	TU	TS	TD	TD	TD	TD	TS	TD	TD
Youth Stabilization	TU	TS	TD	TD	TD	TD	TS	TD	TD
Clinical Support Services	TU	TU	TS	TD	TD	TD	TU	TD	TD
Transitional Support Services	TU	TU	TU	TS	TD	TD	TD	TD	TD
Residential (Adult)	TU	TU	TU	TU	TS	TS	TD	TD	TD
Residential (Youth)	TU	TU	TU	TU	TS	TS	TD	TD	TD
OTP	TU	TU	TU	TU	TU	TU	TU	TS	TD
Outpatient	TU	TU	TU	TU	TU	TU	TU	TS	TS
Recovery Support Centers	TU	TU	TU	TU	TU	TU	TU	TS	TU

Total Quality Management /Continuous Quality Improvement (TQMCQI)

- **Program Evaluation**
  As part of an ongoing TQM/CQI effort, BSAS has developed Performance Review Instrument (PRI) tool to evaluate treatment programs. The PRI is used to review program performance and allows for comparison of programs both absolutely and relatively to each other in the same level of care. Within each level of care, programs are measured on multiple process and outcome indicators, such as rates of transitions, program completion, administrative discharge and special populations. Some of these indicators require continuous work. For example, the development of the transitions indicator requires preliminary review by subject matter experts in assessing the direction of the transitions along the continuum of care from one level of care to another and a continuous improvement in calculation methodology that takes into account the optimal number of days between disenrollment from one level of care to enrollment based I current best practices as well as system configuration. The transitions indicator in the residential level of care has been reviewed and re-categorized to improve its accuracy for outcome evaluation and for use in the PRI. Review of transitions for ATS, CSS and TSS are currently underway. PRI combines these quantitative indicators with programmatic information, such as regulatory and licensing compliance, complaints, and accounting and finance information. The PRI comprises of these quantitative and qualitative measures and thus, allows BSAS program managers and contract managers to evaluate and monitor treatment programs.

- **Client Outcomes**
  Previous work from Washington Circle, Healthcare Effectiveness Data and Information Set (HEDIS), and the literature were reviewed to determine appropriate measures to assess client outcomes. Client outcome measures are being evaluated for their technical definitions, usefulness to programmatic and policy decisions and their adaptability for the public-funded treatment system. We currently are piloting initiation, engagement and transitions for clients enrolled in residential treatment programs. This stage of the project requires data cleaning, manipulation and programming. Upon completion of this phase, measures will be evaluated and reviewed for adaptability for other levels of care and across levels of care. Also, service specific outcome measures will be explored. The results of client outcome analysis will be utilized to inform policy decisions and program development.

Data Governance

BSAS houses a management information system (the Data Mart) that contains substance abuse treatment data as well as integrated Vitals Registry and Hospital Discharge Datasets. Providers of substance abuse treatment services submit data obtained through interviewing clients using Intake forms as well as Enrollment, Disenrollment and Periodic Assessment forms. Information about billing and services provided is also included in the Data Mart.

As BSAS is continually striving to improve the quality of the data collected, the Office of Data Analytics and Decision Support established a standing Data Governance committee in September 2014. Although Data Governance consists of many components, initial efforts are focused on Data Standards and Definitions, Metadata Taxonomy, and Cataloging and Classification because of their fundamental and overall importance.

The first project undertaken is the investigation and analysis of enrollment data related to variables that are frequently used in reporting, including SABG reporting. The purposes are:

- To determine the reliability and quality of the data through research, in-depth querying of the data, and analysis of the results.
- To identify any issues or problems that might exist.
- To locate where in the data flow process the problems occur (from Data Collection through and including end-user analysis).
- To remediate the problems through changes in the data collection process, changes in the data mart, or the development of new standards in reporting.

Twenty-six variables were investigated during the first two phases of the project, resulting in:

- Recommendations for changes in the Data Collection process including Intake and Enrollment Assessment Forms and Manuals.
- Recommendations for enhanced training of provider staff conducting interviews with clients and inputting information.
- Implementation of changes in the Data Mart including mapping, application of new logic in developing indicators, reclassification of drug types and service categories, and the creation of new variables.

- Development of a Data Governance Information Repository including an expansive Data Dictionary and Supporting Documentation.
- Development of standardized Reporting Rules and Footnotes to improve the quality and consistency of reporting.
- Identification of additional issues related to the variables that will be prioritized and addressed as time and resources permit.

The information in the Data Mart is constantly evolving as improvements are made to the Forms and Manuals used, new Service Types and Programs are added to the treatment system, and improved logic is applied to the data cleansing processes. These constant changes, along with the importance of using the data to make decisions about program development , and the assessment of client and program-level outcomes, make the ongoing efforts to continually improve the quality and reliability of the data through the Data Governance process vitally important.

Consumer Satisfaction Survey

In order to improve the quality of care in the BSAS service system, BSAS is collaborating with providers and with John Snow Inc. (JSI), a public health research and training organization, to conduct a consumer oriented satisfaction survey with all BSAS-funded substance abuse treatment programs statewide. The survey was developed with feedback from the Consumer Advisory Board (CAB), providers, and community stakeholders. The survey is conducted with clients at the program site to assess their experience and satisfaction with the program according to the following indicators: Access to care, quality/appropriateness of care, general health and safety, quality of physical space etc. Upon completion of the survey, JSI shares the results with all participating service providers. The goal of the survey is to facilitate transparency among programs, clients, and individuals seeking treatment. Also, the survey aims to promote quality assurance and best practices. JSI completed the first round of the survey at all "bedded" programs (ATS, CSS, TSS, RRS) and shared the results with providers and BSAS. JSI subsequently conducted the survey at Opioid Treatment Programs (OTP) and Driver Alcohol Education (DAE) programs.

After the first round of surveys was completed, BSAS and JSI collected feedback on the process from providers and incorporated suggested changes to the process and the questionnaire. The second round of surveying has begun in the "bedded" programs and will be completed in several phases during FY16.

Complaint System

In addition to the Quality Improvement Reporting described above, BSAS routinely reviews complaints, critical incidents and grievance as a way to monitor quality. In 2014, BSAS created a Complaint Investigation Unit as part of the Quality Assurance and Licensing Unit and currently have two Complaint Investigators.

When a complaint comes in to BSAS from either a consumer, family member, attorney, or provider etc… the caller is referred to the BSAS Complaint Line (617-624-5171). Once a message is received, an intake process is initiated. The Complaint Investigation Specialists follow-up on all complaints and determine whether or not the complaint is valid (a valid

complaint has a regulatory or contractural basis that would allow BSAS the authority to investigate). If the complaint is invalid because it should be directed to another regulatory authority, the complainant is notified of this and given contact information for the appropriate regulatory body.

Valid complaints are prioritized based on the urgency and seriousness of the complaints, for example, complaints about health and safety conditions (ie: no food in a residential program, bedbugs) are investigated promptly. The web based internal system allows for authorized investigators and the Director of Quality Assurance and Licensing to view and share information in real time. Once complaints are investigated findings of "substantiated", "partially substantiated" or "not substantiated" are made. Substantiated and partially substantiated findings that are regulatory or contractual violations are accompanied by Deficiency Correction Orders (DCO) that programs are required to comply with. Once a satisfactory DCO response has been received, the complaint is closed. Complaint investigation report findings and DCOs are shared with the program at the end of the investigation.

Complaints are tracked and trended. This information is utilized to identify which programs need additional oversight or technical assistance or programs or what reoccurring issues can be addressed through a statewide training initiative. A program's level of compliance is also weighed into the process of awarding contracts.

In addition to investigating complaints, BSAS requires all programs to provide us with written notification of critical incidents, including deaths of clients in treatment, any allegations of abuse of clients, any lawsuits or arrests of staff members, etc. BSAS staff review all Required Notifications and determine what if any further action is needed. BSAS routinely reviews any death of a client that occurs onsite at a program, any client death in an OTP that occurs in the first month of treatment and any client suicide. The data is reviewed to allow for trending and tracking of these issues and has resulted in the identification of either the need for individual provider interventions or system wide training needs. For example, in reviewing OTP deaths in the first month of treatment, BSAS staff convened a meeting of all OTP physicians to review these deaths and to discuss best practice dosing schedules during the induction phase of treatment. Finally, BSAS has enlisted Department of Public Health colleagues with expertise in suicide prevention to review records of patients who have suicided and develop resources, including training sessions, for best practices.

DPH and BSAS are also participating in an EOHHS-wide initiative to review and improve the customer experience with interacting with state agencies including consumer complaint processes. Statewide policies and procedures that support effective response and engagement with consumers will be considered and may impact the BSAS procedures.

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

75 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

11. Trauma

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?

Yes, Massachusetts substance abuse treatment regulations (105 CMR 164.00) and contractual Standards of Care require providers to assess each client's trauma history (Regulation 164.072 (C) and address trauma in the treatment plan. AOD treatment services must be provided in a trauma-informed manner. BSAS principles emphasize that all provider contact with clients be driven by person-centered care. Such care requires providers to recognize and respond effectively to trauma.

2. Describe the state's policies that promote the provision of trauma-informed care.

Massachusetts substance abuse treatment regulations require providers to maintain Qualified Service Organization Agreements with licensed Mental Health Providers in order to provide individual and/or group counseling for mental health issues such as childhood or adult sexual abuse, depression, domestic violence and traumatic stress symptoms. Further, as noted above, treatment regulations require trauma to be assessed, and addressed, in the client's treatment plan.

3. How does the state promote the use of evidence-based trauma-specific interventions across the life-span?

- BSAS expects all Vendors that provide AOD service to children, youth, young adults and elders will deliver those services in a trauma-informed manner, which includes:
  - identifying and treating through appropriate referrals children of AOD clients who have witnessed violence or suffered direct abuse;
  - reporting suspected child or elder abuse as mandated reporters; and
  - providing trauma-sensitive services that do not re-traumatize children or elders

- Trauma-informed and trauma sensitive services utilize evidence-based techniques that promote AOD recovery in an environment that provides safety, support, understanding, and consistency that builds trust.

- Massachusetts provides a wide range of training to substance abuse treatment providers on the topic of trauma-specific care. Training is provided on a regular basis through a contract with the Institute for Health and Recovery (IHR). IHR has long served the Bureau as a statewide training source on the topic of trauma. IHR provides on-site trauma training and capacity building to train all staff at programs and to provide planning support and technical assistance and further identify trauma-sensitive and trauma-informed evidence based practices and then implement these practices at the programs. In addition, IHR is now finalizing an online, four-module; four hour training: *A Comprehensive Introduction to Psychological Trauma for Substance Use Disorder Treatment Professionals.* This new

training package will serve to further expand, refine, and develop the work that IHR performs for the Bureau.

- The Bureau of Substance Abuse Services (BSAS) has a contractual Standards of Care document that clearly and strongly promotes the provision of trauma-informed care across the lifespan. All providers must be able to provide trauma informed treatment, which includes:

  - understanding multiple and complex links between trauma and addiction;
  - understanding trauma related symptoms as attempts to cope;
  - understanding that the counselor may not be aware of a client's trauma background, and that a client does not have to disclose a trauma history in order to receive trauma-sensitive services, which include a treatment plan and counseling techniques and approaches that are sensitive to trauma issues;
  - staff who are knowledgeable about the impact of violence and are trained to behave in ways that are not re-traumatizing; and
  - full access for clients to avail themselves of trauma specific services.

Among the efforts Massachusetts has made to promote the use of evidence-based trauma-specific interventions across the lifespan are:

For Adult Women:

Seeking Safety

- Developed by Lisa Najavits, Ph.D.
- A curriculum for conducting highly structured group or individual treatment for individuals with SUDs and trauma histories
- Focuses on building skills for dealing with the impact of trauma in the present
- Has been used effectively with a wide range of populations in both outpatient and residential settings
- Listed on SAMHSA's National Registry of Evidence-based Programs and Practices

Nurturing Program for Families in Substance Abuse Treatment and Recovery

- Adapted by Norma Finkelstein of the Institute for Health and Recovery from the Nurturing Program curriculum
- Psycho-educational, 20 session, group-based parenting curriculum
- Specifically addresses the impact of substance use, mental illness, and trauma on parents and children
- Listed on SAMHSA's National Registry of Evidence-based Programs and Practices

For Adult Men

Helping Men Recover

- Developed by Dan Griffin, Rick Dauer, and Stephanie Covington
- A gender-specific, trauma-informed curriculum for men with SUDs
- Based on the Evidence-Based Practice of Helping Women Recover developed by Stephanie Covington

- Addresses the ways in which cultural expectations of men conflict with skills needed for SUD recovery

Nurturing Program for Families in Substance Abuse Treatment and Recovery

- See above for full description
- The 3rd edition includes three new segments specifically designed for men and fathers

For Youth and Young Adults

- BSAS, through the BSAS Office of Youth and Young Adult Services (OYYAS) also funds providers who are using Attachment, Self Regulation, and Competency (ARC) Clinical Services, a promising practice of the National Child Traumatic Stress Network.
- ARC is a comprehensive framework for intervention with youth who have a history of exposure to severe or complex trauma. Intervention is client-centered and client-specific (tailored to each client's needs), and may include individual and group therapy for children, education for caregivers, parent-child sessions, and parent workshops.
- ARC is grounded in attachment theory and early childhood development and addresses how a child's entire system of care can become trauma informed to better support trauma focused therapy. The approach provides a framework for both trauma informed and trauma specific therapeutic intervention.

4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

The Bureau of Substance Abuse Services (BSAS) provides a range of trainings to help treatment providers deliver interventions with trauma-specific excellence. This fall, a new round of both in-person and online training will bring providers up-to-date materials and information on trauma-informed care. The trainings include:

Single day, level-of-care focused trainings: Including:

- Introduction to Trauma-Informed Care
- Implementing Trauma-Informed Services
- Providing Trauma-Informed Supervision

Intensive, focused in-depth work with individual programs. The training and technical assistance components for this include:

- Introductory trauma informed treatment training
- Introductory trauma informed treatment training for a program's Trauma Strategic Planning Committee members
- Program Self-Assessment on Trauma Informed Treatment
- Four hour training on Trauma Informed Treatment for all staff
- Strategic Planning support including any training and technical assistance necessary to implement trauma-informed treatment
- Training in trauma-specific EBPs *Seeking Safety* and *Helping Men Recover*
- Co-facilitation of trauma-specific groups for one round of implementation, followed by six months of supervision for trauma-specific groups

This in-depth, onsite training involves:

- Multiple trainings with all staff at each site ensuring an infusion of the theory and practice behind offering trauma informed care,
- Creation of a trauma informed care implementation team
- Development of a trauma informed improvement plan and identification of evidence-based trauma models for each implementation team to use at their program; and
- Follow-up post implementation to evaluate progress

To make screening for trauma part of all work, the Office of Youth and Young Adult Services (OYYAS) has undertaken a multi-year trauma training initiative: Through this initiative the BSAS OYYAS is:

- Working with an adolescent trauma specialist to train the entire youth system regarding the development of trauma informed policies and practices in treatment settings
- Reviewing the completed needs assessment which included all of the providers in our youth system
- IHR continues to provide on-site trauma training and capacity building to train all staff at Youth and Young Adult programs. IHR provides planning support and technical assistance as programs identify the trauma sensitive and trauma informed evidence-based practice that works best for them, their setting, and their clients

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

[82] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

12. Criminal and Juvenile Justice

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as part of coverage expansion?

- Across the state, the County Houses of Corrections and the Department of Corrections facilities attempt to enroll inmates in health insurance prior to their release.
- If released without enrollment, Parole Re-Entry Programs also provide case-management services that will assist in insurance enrollments.
- Additionally, BSAS providers are instructed to enroll uninsured individuals who present for treatment in Medicaid and any other appropriate health insurance.

2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

- BSAS provides funding for the Juvenile Diversion Program (JDP) in the Essex County District Attorney's office. The JDP is an innovative model designed for first time, non-violent juvenile offenders (ages 7-17) and their families. The program offers an alternative to the Juvenile Court system. The Juvenile Diversion Program provides these youth with the opportunity to receive prevention and intervention services in lieu of going through the traditional court process.
- The Bureau also provides funding for clinicians in the Boston Municipal Court system to provide screenings and assessments pre adjudication.
- BSAS also collaborates with the Mass Trial Court on providing assessments and treatment services to operating Drug Courts and participates on a steering committee on the development of future new Drug Courts.

3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?

Youth Diversion Program

- The Bureau funds the Massachusetts Department of Youth Services (DYS) through an Interagency Service Agreement (ISA) to provide MassSTART. MassSTART is a community-based program model designed to reduce and/or eliminate substance use and keep high-risk 13- 17 year-old youths free of further criminal/court involvement.
- There are currently three Juvenile Drug Courts.
- BSAS also collaborates with DMH on operating Mental Health and Juvenile Courts.

BSAS and criminal justice system partnerships

- The BSAS provides funding to substance abuse treatment programs at all of the Houses of Corrections in Massachusetts.

    - This funding helps support substance abuse treatment staff within each House of Correction. The programs consist of mainly segregated substance abuse units. Where separate housing units cannot be accommodated the services are available to general populations.
- Upon release, BSAS admits approximately 900 people per year into residential programs directly from state correctional facilities and county Houses of Corrections.
- As evidence of the partnerships and collaborations the following are percentages from FY 2014 of the percentages and numbers of individuals on probation in some of our funded levels of care:

Level of Care	Probation	Number
Recovery Home	28.5%	1,474
Transitional Support Services	21.0%	870
Outpatient treatment	26.8%	3,684
Social Model (residential)	30.6%	171
Therapeutic Community (residential)	31.2%	191

Overall across a number of levels of care approximately 24.4% are involved with Probation representing 23,114 enrollments. Further examples would be:

- 76.2% in youth residential programs that are involved with probation.
- 5,057 civil commitments to BSAS/DPH programs of which 35% of male and 44% of females had criminal charges pending and approximately 20% had probation violation

Although many of the services could be considered a viable method of diversion from incarceration, BSAS does also fund a specific Jail Diversion Program where all enrollments would be incarcerated if not in the program.

- The Jail Diversion program offers substance abuse treatment in lieu of incarceration for drug-related offenses.
- The program serve both males and females referred by courts from across the state and (1) provides clinical assessments according to ASAM patient placement criteria to all clients referred by the courts, and makes appropriate placements; (2) provides structured, gender-specific, trauma-informed clinical inpatient treatment for up to 90 days to appropriate clients, and (3) provides ongoing case management services for up to one year to all clients referred by the courts.
- Non-violent offenders with substance use disorders are offered diversion to substance abuse residential rehabilitative treatment in lieu of incarceration. District Attorneys or Probation Officers determine public safety appropriateness of client for participation. Once the individual is assessed, the jail diversion program determines clinical appropriateness. If the client agrees to treatment, and signs a contract, he/she will then be required to participate in the program and adhere to his/her individualized treatment plan. The plan outlines and takes into consideration recovery goals, obligations to the court, as well as the terms, conditions and sanctions prescribed by the court
- An FY 13 report on cost benefit analysis estimates that the commonwealth saved approximately $4.6 million by having the offenders in treatment vs incarceration

Re-Entry Initiatives:

- BSAS is a grantee for an Access to Recovery (ATR) grant. In MA, the program is designed to assist individuals with re-entry post-incarceration. ATR Coordinators enroll individuals into ATR and eligible individuals are assisted in obtaining services to help overcome barriers to their re-entry.
    - ATR provides critical basic needs such as clothing, personal hygiene products, and other personal items needed for job interviews, for employment, and for obtaining housing.
    - ATR also helps ease the individual's re-entry by providing a number of services, including assisting in finding housing, obtaining identification cards and a driver's license.
    - ATR offers transportation.
    - Additionally, ATR providers help individuals develop a Recovery Plan that will outline what services will help them overcome barriers on their road to recovery.
    - Some are referred to traditional treatment providers, others to 12-step programs, and others to faith-based services. Individuals have the final choice in stating which of the array of services will best facilitate their road to recovery.
    - ATR also offers job readiness programs and job training skills are also offered to those ready to commit to serious programs that will make them more employable.
- BSAS provides support for eight parole re-entry centers and provides funding for a substance abuse coordinator (SAC) at each center. Assessment and referrals are conducted by the SAC at each site. Referrals to BSAS-funded treatment centers takes place as appropriate. (1,309 enrollments in FY 14)

Driving Under the Influence Programs

- BSAS pays for indigent participants of first offender Driver Alcohol Education (DAE) programs for those who face Driving Under the Influence of Liquor (DUIL) charges.
- Furthermore, BSAS pays for individuals who are indigent and are required to participate in second offender DUIL programs. Second offender programs include a 14-day DUIL residential program and up to five months of aftercare on an outpatient basis.

Drug Courts

- BSAS has a statewide Drug Court and Criminal Justice Coordinator on staff.
- BSAS helps support Drug Courts in the state by providing funding for three clinical staff positions that provide clinical and level of care assessments for Drug Court participants in Boston Municipal Courts.
- BSAS provides treatment services to Drug Courts participants and a number of BSAS funded treatment providers work directly with drug court teams.
- BSAS currently participates in two Department of Justice grants to enhance collaboration and treatment services in Drug Courts.
- There are 34 Specialty Courts state-wide that all use our services. Specialty Courts are Veterans' Courts, Drug Courts, Juvenile Courts, and Mental Health Courts. These courts serve specialized offenders in such a manner so as to help them stay out of custody and often, prevent them from having a criminal record, if they complete recommended treatment.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?

- As previously noted approximately 76% of admissions to BSAS Youth Residential programs are involved with Probation. Probation officers provide screening, assessment, case management and follow-up related to issues specific to individuals involved in the criminal justice system. Additionally, in FY 14 there were 53 civil commitments from Juvenile Court and approximately 22% of enrollments to the Youth Stabilization programs are also involved with Probation.
- BSAS is currently involved with three Juvenile MH/Drug Courts.

5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

- BSAS has presented on the continuum of services and effectiveness of Medication Assisted Treatment at trainings for the Drug Court judges and probation officers in FY 15.
- BSAS in collaboration with Trial Court of Massachusetts sponsored the New England Association of Drug Court Professionals Conference in September 2015.
- The BSAS has, through ATR, offered specialized training to the faith-based ministries that go into prisons and jails. Training focuses on topics such as substance abuse, recovery, treatment options, and Recovery Coaching.
- BSAS, through the Access to Recovery program, has offered training to the staff at Houses of Correction as well as Re-entry programs in:
    a) Substance abuse fundamentals (Substance Abuse 101),
    b) General recovery themes
    c) Techniques in conducting and approach to providing motivational interviewing, and
    d) The range and variety of services available to those in recovery
- BSAS has also provided training for correctional settings staff on opioid overdose prevention and response. Such trainings also provided information on how staff can teach inmates about overdose prevention and response.
- BSAS has also been a regular presenter on a number of occasions at the Probation Training Academy.

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Massachusetts 2015-2016 SAPT Plan and Report

14. Medication Assisted Treatment

1. **How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment (MAT) for substances use disorders?**

   Massachusetts has a long history of funding and emphasizing the importance of MAT in treating individuals with opioid use disorders. BSAS also provides training and technical assistance on MAT to both treatment and healthcare providers. There is a standing regulatory requirement that substance abuse treatment programs cannot deny access to treatment to individuals who are on MAT. Recently, BSAS issued a letter to all treatment providers to reinforce this mandate.

   In FY16 BSAS will provide regional trainings on Medication Assisted Treatment that all treatment provider staff working in adult, youth and family residential programs, as well as in Transition Stabilization Services (TSS), are required to attend. Plans are underway to develop training for other levels of care in FY17.

   In addition, BSAS is partnering with one of our training vendors, the Center for Social Innovation to provide on-going on-site training on Medication Assisted Treatment for staff working within the BSAS system. These trainings will complement the mandatory trainings mentioned above. In addition, BSAS contracts with the Center for Social Innovation to develop a series of on-line training modules for other systems of care and service, including the Department of Mental Health, the Department of Child and Families, and the Drug Courts. These modules will include one on Medication Assisted Treatment.

2. **What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?**

   In July 2015, the Governor rolled out a statewide plan in response to the opioid crisis, (http://www.mass.gov/governor/press-office/press-releases/fy2015/governor-releases-opioid-working-group-recommendations.html) which are steps towards broad and strategic outreach to a variety of relevant audiences across the spectrums of prevention and treatment and which includes the following recommendations,

   - Provide state funding for evidence-based opioid prevention programs in schools.
   - Create a public awareness campaign focused on reframing addiction as a medical disease.
   - Appoint addiction specialists to state medical boards of registration for medicine, nursing, physicians assistants and dentistry.

- Implement a training program about neonatal abstinence syndrome and addiction for the Department of Children and Families (DCF) and improve outreach to prenatal and postpartum care providers to increase training on screening, intervention and care for substance use disorder (SUD).
- Encourage the American College of Graduate Medical Education to adopt requirements for pain management and substance use disorder education.

In addition to these goals, BSAS has a goal to increase the number of pregnant women accessing substance use disorder treatment. The standard of care for opioid dependent pregnant women is medication assisted treatment. The strategies that BSAS will employ to achieve this goal include distribution of posters in public places that notify pregnant women that they have priority access to treatment. BSAS is also engaged in a number of other initiatives related to treatment access for pregnant women as well as related to addressing the needs of substance exposed newborns and their families.

3. **What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substances use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?**

   BSAS licenses all of the Opioid Treatment Programs in the Commonwealth and also funds many community-based Office Based Opioid Treatment Programs. These programs are all required to follow regulations and guidelines related to best practices for Medication Assisted Treatment including appropriate use of the medication for a substance use disorder, requiring participating in counseling, urine testing, and other safeguards against misuse and diversion. BSAS will increase the number of funded OBOT programs in Community Health Centers in FY16. The successful Massachusetts OBOT model employs a nurse case manager and provides the needed support and wrap-around services to support patients.

   Further, BSAS remains committed to supporting efforts to provide training and technical assistance necessary for Obstetrics and Gynecology, Family Practice, Internal Medicine and other primary care physicians to obtain Drug Enforcement Agency “X” waivers needed to prescribe buprenorphine.

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

16. Recovery

Moving toward a Recovery Oriented System of Care:
In the Commonwealth's work in the field of substance use and addiction, Massachusetts has focused on making the system one that is seen as moving more toward a Recovery Oriented System of Care (ROSC). In SAMHSA's ROSC Resource Guide, published in 2010, a ROSC is defined as a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems. The central focus of a ROSC is to create an infrastructure or system of care with the resources to effectively address the full range of substance use problems within communities. Massachusetts has sought to do just this.

Peer Involvement:
Massachusetts has adopted SAMHSA's statement of recovery and recovery values. The four major dimensions that have been identified as critical for supporting a life lived in recovery are health, home, purpose, and community. The state has a strong history of hiring people in recovery in leadership roles. In fact, four leading Bureau of Substance Abuse Services employees are people who are in recovery.

The Bureau's Strategic Plan Supports a range of recovery-oriented elements, including use of peer supports in engagement and in aftercare. The Plan emphasizes the utilization of new technologies to engage individuals and families and support recovery in the community. The state has incorporated a range of important peer support services across the continuum of care. These services include ten Recovery Support Centers (RSCs), peer operated and peer advised centers that serve as a recovery oriented sanctuary where individuals can find peer-to-peer recovery support from the volunteers and members of each center.

Peer Involvement through Recovery Support Centers across the Commonwealth:
RSCs operate on a member-driven schedule where recovery related workshops, trainings, services, meetings and social events are consistently delivered. These Recovery Support Centers offer a safe environment where shared experience leads to empowerment, respect, growth, recovery, and a sense of wellness. RSCs function on a shared peer participatory model.

Consumers playing big roles:
The Bureau has an active Consumer Advisory Board (CAB) and includes consumers on nearly all procurement technical review teams. The Bureau has been a strong proponent of peer recovery coaching and peer support services. All services are geared around person centered planning and feature extensive use of shared decision-making in treatment planning.

Treatment services and recovery support services are part of a strong ASAM-oriented treatment planning process. BSAS focuses on using evidence based practices and careful efforts are made to collaboratively develop treatment goals and service plans. The client is the focus and the central component of all work done at BSAS.

Guiding Principles:
SAMHSA's ten key guiding principles to recovery are: 1) Hope; 2) Relational; 3) Person-Driven; 4) Culture; 5) Many Pathways; 6) Addresses Trauma; 7) Holistic; 8) Strengths /Responsibility; 9) Peer Support; and, 10) Respect. All ten of these principles are embodied in BSAS's Standards of Care, treatment regulations, and in all policies and practices promulgated by the Bureau.

Health Equity for all:
Recovery is not merely targeted at the individual who is struggling with a substance use disorder. Peer delivered services are made available to a wide range of groups, from those who have suffered from trauma to underserved groups from racial or ethnic minorities. In fact, the Health Equity Learning Collaborative is a group that BSAS convened several years ago, aimed at helping agencies with a mission to super-serve traditionally underserved populations. The Collaborative enabled agencies that provide service to specific ethnic and racial groups an opportunity to adopt process improvement principles to enhance treatment, client access, and billing. Programs that are mission-driven to serve the Portuguese, Hispanic, and African-American populations, among others, had the opportunity to grow and take advantage of the state's resources around Process Improvement, NIATx, and Rapid-Cycle Change.

Peers and Veterans:
BSAS has participated in a SAMHSA Policy Academy through the Service Members, Veterans, and their Families (SMVF) Technical Assistance Center, focused on substance use disorders. This activity has led to a plan for enhancing existing peer-oriented efforts to meet the needs of SMVF. A planning session has occurred that included representatives from veteran peers, mental health peers, and addiction recovery peers. Next steps will include assessment of on-going peer initiatives, gap analysis, and cross-training activity.

Peer Coaching:
The state has just completed a certification program for peer recovery coaches. The new certification level will be called a Certified Addiction Recovery Coach (CARC). The certification is in the final stages of approval. Standards for peer run services in the state are strictly guided through Requests for Responses (RFRs) with clear standards, values and requirements for such services.

Research on peer recovery services:
The state does not have empirical research on peer recovery services, but currently is finishing a new assessment form designed to gather information on the peer recovery support centers. Peer members will be asked to complete the assessment form which is being disseminated every six months at all ten Recovery Support Centers statewide. The data will be analyzed and used to gather and compile recovery capital as well as other vital information used for planning future activities and program development.

Recognition for Recovery Support Centers:
The Bureau of Substance Abuse Services has drawn policies and best practices from other Recovery support organizations nationwide and has integrated these in all ten Massachusetts Centers. The success of the centers is evidenced by the one Massachusetts center that was

recently awarded accreditation from CAPRSS, the Council on Accreditation of Peer Recovery Support Services.

Stairway to Recovery Center is the first Recovery Support Center in Massachusetts to be so honored. This program, part of Gandara Mental Health Center, provides services to individuals in all phases of recovery from alcohol and/or drug abuse, including those who have not yet engaged in recovery, individuals who have relapsed, individuals in Methadone programs, and individuals in recovery. The Center also includes activities that engage family members. The Recovery Center serves the larger communities from which the members come including the Latino, African American, Haitian, Cape Verdean, Portuguese, and Brazilian communities. Stairway to Recovery is but one of ten RSCs statewide. More of Massachusetts Recovery Centers are working to complete the accreditation process for CAPRSS.

Peer involvement in planning, operationalizing and evaluating new services:
Individuals in recovery as well as family members of those in recovery are intimately involved in planning, delivering and evaluating behavioral health services. All of BSAS's funded programs are required to have a consumer advisory board as a condition of being a contracted provider. It is a requirement that each review team that reads and reviews, then judges, Requests for Requisition must contain at least one peer recovering individual. New programs and new levels of care are planned with the important input from members of the state's substance abuse Consumer Advisory Board.

Peer Support Centers look forward and seek to grow and improve:
The Bureau of Substance Abuse Services convenes bi-monthly Level of Care (LOC) meetings with Recovery Support Centers (RSCs) (as well as most other Levels of Care in the system). These RSC Level of Care meetings are a means of continually strengthening our RSCs and exploring ways to improve the peer services offered. Recently the Bureau conducted a two-day retreat for all Massachusetts RSCs to review the impact of recovery capital and to update the peer participatory process model. The retreat also provided the groundwork for new recovery support services in the future.

Support for the Recovery Community:
BSAS supports and helps strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services by:

- Enhancing funding for "Learn to Cope," a parent and family support organization offering meetings, education, and emotional support to family members of individuals with substance use disorders.
- Supporting, through Access to Recovery, the Recovery Coaching effort that is rapidly growing across the state. BSAS is actively involved in providing training for Recovery Coaches
- Through funding MOAR – the Massachusetts Organization for Addiction Recovery (www.moar-recovery.org). Through involvement with MOAR, the organization and the state collaborate on a variety of recovery education and legislative statewide events. BSAS has expanded its support of MOAR in recent years. The organization has recently been supported with funding to hire regional state coordinators as well as a state Operations Manager.

- By developing and operating Recovery Support Centers – Ten centers throughout the state that are peer run using the participatory process model. The RSCs are strong voices in supporting and sustaining recovery for clients in all phases of recovery – early, middle, or sustained.
- Through funding the five Recovery High Schools in the state.

The Access to Recovery (ATR) Program provides important supports to men and women who have faced the challenge of substance abuse as well as incarceration. Recovery coaching has been provided to a number of these individuals who have recently left incarceration. Employment is a vital focus for those in ATR.

Consumer Helpline:
BSAS tracks the efforts of its Helpline, which provides information on treatment and support services both over the telephone and online. Trained specialists are available to offer assistance for those who need help with an addiction. BSAS is now tracking calls and web-hits daily. The Stop Addiction Campaign is supporting this vital analysis of Helpline impact. The Helpline also has hired a new marketing director who is currently attending some 15-20 community events each month, working to spread the news of recovery and to make people aware of the Helpline resource.

Recovery is about the whole person growing in health:
Promoting wellness is part of recovery. BSAS funds the TAPE (Tobacco, Addictions, Policy and Education) Project of the Institute for Health and Recovery to work across provider agencies and modalities, as well as with senior staff and providers of the Massachusetts Tobacco Cessation and Prevention Program (MTCP), to build the capacity of the substance use disorders treatment system to address nicotine dependence. TAPE also serves as staff to the Council to End Nicotine Addiction in Recovery (CENAR), a BSAS provider advisory group, which works on systems and program issues for integrating nicotine dependence treatment.

TAPE Project staff conduct trainings at treatment sites, orient and train Tobacco Education Coordinators (TEC) at each agency site and hold bi-annual regional TEC meetings to provide support for these staff charged with running groups and promoting tobacco awareness, education and cessation. TAPE produced a manual and has recently been able to promote a website with resources for TECS.

BSAS also supports Nicotine Replacement Therapy for a number of sites which applied to participate. Since this program began, there have been changes in the ways that patches and gum are used and paid for, and a program revision is under discussion which will involve putting out a call for new applications.

All clients at our treatment programs also must be assessed for and provided access to/links to services for HIV and Viral Hepatitis. All of BSAS's funded programs are required to have an HIV coordinator. BSAS, through its partner C-4, the Center for Social Innovation, provides programs the important technical assistance needed to help address client needs.

Serving the Deaf and Hard of Hearing Community:

BSAS has been a strong proponent for the Deaf and Hard of Hearing (DHOH) community. BSAS trained the DHOH population on the use of naloxone (Narcan), the overdose reversal drug. Extensive care coordination led to needed resources for this community both in treatment as well as recovery support services. BSAS helped to provide assisted listening devices to a number of members of the DHOH population. This was done through an Apple Computer initiative which enabled users to view, through video-relay, the American Sign Language translation of many recovery support tools.

Employment and Education:
Massachusetts Residential Programs provide a stable, drug-free environment that enables individuals to develop skills for drug-free living. Treatment and service plans are developed that include strategies for achieving short and long-term goals, leading to independent living. Important elements in this process are educational and vocational counseling and services. Residential programs enhance these in-house efforts through formal affiliations with community resources such as Career Centers, Massachusetts Rehabilitation Commission and Adult Literacy Programs.

Housing:
Finding safe, affordable, secure housing is a vital component of one's recovery, as noted above. BSAS currently funds the following Supportive Case Management services within housing:

- Supportive Case Management services delivered within 471 Permanent housing units, of which 51 are Low Threshold units, and 373 Transitional housing units.
- The housing units are further broken down into 701 units for adult individuals (including 66 for young adults), 143 families (including 7 young adults with children).
- Housing is primarily funded by HUD or state/local agencies with housing vouchers.
- Low threshold units are for individuals who require a housing environment that does not discharge solely for relapse with substances. These services are focused on engagement and retention with a goal of long term recovery in stable housing.
- The major goals of these programs are a) housing stabilization within permanent housing, b) recovery maintenance, c) improved health, d) stable income supports and e) utilization of local community social and health care services

BSAS has organized contracted Supportive Case Management services within housing settings to support the movement to permanent housing for all participants.

There are no plans at this time to increase the amount of Supportive Case Management services within housing supported by BSAS. However, there is consideration for expanding Medicaid benefits for supportive case management services.

Exemplary Recovery Initiatives:

a. Consumer Experience Evaluation Project:

- This initiative, conducted in conjunction with John Snow Inc., (JSI) evaluates the experience of potential consumers attempting to gain information about admission to various programs.
- After being trained, members of BSAS's Consumer Advisory Board placed calls to programs posing as potential consumers or family members of consumers.
- They then filled out a quantitative and qualitative evaluation of their experience speaking with the program.
- The purpose of this project was to identify policies and practices regarding the front end experience providers may be employing.
- This project was especially empowering for consumers who saw how their participation can lead to improvement in the way providers offer service to those in need of treatment.
- This initiative has led to training and technical assistance and policy development around improving the experience of consumers seeking treatment

b. Recovery High Schools

- In Massachusetts there are now five geographically dispersed Recovery High Schools.
- These High Schools provide an opportunity for young people to continue their education in a safe, supportive, recovery-oriented environment.
- The schools' mission is to help support both a student's recovery from drug or alcohol abuse as well as their educational attainment.
- The Recovery High Schools in Massachusetts incorporate a strong peer culture of recovery. Students identify as recovering individuals and are committed to supporting each other as they face the challenges of early recovery.

c. Recovery Conference

- A bi-annual Recovery Conference is held every two years
- This conference is largely planned by and run by consumers
- The purpose of the event is to engage, entertain, and educate consumers
- The conference draws around 500 people
- The Conference is one of the year's highlights for many people in recovery.

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[92] Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[93] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[94] Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010.

[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

18. Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?

The state will utilize several strategies to establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders. Below is a list of several initiatives:

- The state will continue to convene the Transitional Age Youth and Young Adult (TAYYA) Work Group to help address the needs of TAYYA including a perspective that incorporates prevention, intervention, treatment, and ongoing recovery support.
- BSAS is participating in several strategic planning meetings relating to the Children's Behavioral Health Initiative a Medicaid supported continuum of care designed primarily to meet the MH needs of children and adolescents. Through this collaboration, the partnership has brought opportunities to offering Substance Use capacity building training to the CBHI provider system, and has allowed including the Implementation Team and the Advisory Council Interagency Team to address implementation of the CBHI continuum of care for children and adolescents.
- The BSAS Office of Youth and Young Adult Services (OYYAS) is continuing to convene the Youth Interagency Work Group with members of multiple child serving state agencies. This is further detailed in question 3 below.
- BSAS and MassHealth are actively participating in a strategic dialogue to identify existing service gaps with respect to treatment and recovery supports for youth and young adults that Medicaid could cover. One model in particular being explored is coverage of the evidence-based practice A-CRA/ACC (Adolescent Community Reinforcement Approach and Assertive Continuing Care). Delivery of this model resembles many aspects of the mainly mental health treatment and wrap around supports covered as part of the Children's Behavioral Health Initiative.
- BSAS continues to support training and certification of clinicians in the state to offer and be reimbursed for A-CRA/ACC services.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use, and co-occurring disorders?

- As part of the growing series of practice guidance modules the Bureau has developed a Practice Guidance: *Treatment Services for Youth and Their Families* and will soon release a practice guidance that includes developmentally appropriate considerations, strategies and resources for working with young adults. This tool will be released in calendar year 2015. Both were developed to help guide those working with adolescents and young adults and the complex set of family and system involvement issues as well as developmental consideration inherent to the work.

- The Office of Youth and Young Adult services is actively planning capacity building efforts to ensure OYYAS policies, procedures, standards and overall operations are LGBTQ competent. This capacity building will extend through the entire treatment and recovery support system for youth and will allow for more individualized and competent care offered to LGBTQ Youth. This is covered in more detail in the disparities section of this response.
- State regulations have been promulgated that outline developmentally appropriate services for 13- to 17-year-olds, including residential, outpatient, and stabilization services.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

- The Youth Inter-Agency Working Group (IWG) monthly meetings historically have been a vehicle to inform the planning and redesign of the Youth Residential System, development of the Recovery High School model, and development of the two Youth Stabilization Programs. Similarly, it has been used to strategize on meeting the training and capacity building needs of other state agencies serving youth with substance use disorders.
- The BSAS Office of Youth and Young Adults works closely through an ISA with the Department of Youth Services (DYS) (juvenile justice) to serve youth in the juvenile justice with substance use needs. The MassStart model is used to engage youth and families and the Parent Time curriculum provides support and education to parents whose children are involved in the juvenile justice system and experiencing problems with drugs and alcohol. The SSA is in the early stages of supporting an overdose prevention training of the trainers capacity building initiative with DYS, which will likely be carried out in the life of this grant cycle.
- BSAS developed communication guidelines and protocols with Department of Youth Services (DYS) (juvenile justice) and Department of Children and Families (DCF) (child welfare) that outlines the roles and responsibilities of each state agency and provider organization as it relates to the care of youth in the BSAS substance abuse residential treatment system.
- The Youth IWG is currently acting as an implementation advisory board/steering group for the State Adolescent Treatment Enhancement Dissemination (SAT-ED) SAMHSA grant utilizing the ACRA-ACC model and will serve in a similar capacity for the SAMHSA SYT-I grant.
- BSAS will offer and convene trainings on Substance Use Disorders and Treatment for workers from other state agencies like DYS, DCF, DMH, Juvenile Treatment (Drug) Courts, CBHI providers and schools.
- BSAS collaborates with judicial partners in addressing the needs of youth in the court system through Reclaiming Futures, juvenile treatment (drug) court, and screening for youth in the courts.
- The Office of Youth and Young Adult Services participates, as needed, in case conference calls for youth with particularly complex and multi-system involved lives.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

In addition to offering general substance use related trainings throughout the state for interested clinicians on a variety of developmentally appropriate topics (e.g. Youth and Chronic Marijuana Use, Substance Use and the Developing Brain of Youth, etc.) the Office of Youth and Young Adult Services (OYYAS) support the following specific projects:

- BSAS developed and is implementing a multi-year, intensive onsite trauma training initiative for our youth providers. Within this project a youth trauma specialist is training all staff at each of the OYYAS youth providers on understanding and delivering trauma-informed care. Once all staff have a baseline understanding of how to create a trauma-informed culture, the TA provider meets with a team at each program to identify a trauma-informed evidence-based practice (e.g. ARC) and plan to implement it in the program. Lastly, the trainer provides TA and consultation during the implementation and adoption process.
- During the life of the SAT-ED Grant, which utilizes the Evidence-Based Practice (EBP), ACRA-ACC and GAIN assessment, opportunities will be made available for interested providers to receive training in this model. During the life of the grant the Bureau will be exploring ways to create and galvanize the infrastructure and resources necessary to sustain this EBP. The Bureau is maintaining continued dissemination of the A-CRA/ACC model via SAMHSA's SYT-I grant and other state funding. The state has negotiated with the developers of ACRA to allow for an in state ACRA trainer / TA specialist that will support sustainability of the practice.
- The recently awarded SYT-I grant will allow the office to creatively meet the needs of transitional age youth and young adults (TAYYA), ages 16-25, who are using opioids and are in need of developmentally appropriate services. The funding will allow for a collaboration of A-CRA/ACC and Mediation Assisted Treatment models for opioid abusing TAYYA, something we hope will show great effectiveness in working with this population.
- To address the high prevalence of marijuana use among youth and young adults in our treatment system, the Bureau is implementing an onsite Marijuana training initiative at all of our youth treatment settings and recovery high schools that incorporates elements of harm reduction, motivational interviewing and cognitive behavioral theory into the training. The training is aimed at having realistic dialogue with youth / young adults around how marijuana use is impacting their lives, despite an often held belief among many clients and some staff that marijuana use is not risky since it is less risky than other drug use. As mentioned above, this training is also offered to more general audiences that work with youth to develop capacity among MH and other youth workers.

As part of its ongoing workforce development the Bureau offers many regional training opportunities throughout the year that staff can attend on the theory and practice behind many evidence based practices (e.g. Motivational Enhancement / Motivational Interviewing and Cognitive Behavioral Therapy).

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

- The Bureau utilizes an on-line data and invoicing submission system to track spending and service utilization. All providers are required to utilize both systems which allow the Bureau timely access to track patterns in service utilization as well as spending. This data system is also used for outcomes analysis. This current fiscal year, the Office of Youth and Young Adult Services has begun creating a data and outcome measurement form with data elements and fields that are more youth and young adult centered. Formerly all of the youth programs were using a more generic adults data entry form. Implementing this newer data collection tool will allow the Office to track outcomes with more realistic youth related measures as indicators of progress.
- The state will be piloting a quarterly data collection tool to utilize with the five currently funded Recovery High Schools in addition to the above referenced data system. Given the current system captures data at enrollment and disenrollment, that period may be several years apart for more lengthy levels of care such as Methadone services and Recovery High Schools which can span years. As such, the state will be piloting a data collection tool to be administered quarterly to better assess the effectiveness and outcomes of recovery high schools.
- Additionally, as part of the SAT-ED Grant, a state resource financial mapping component of this work will allow for a multiservice agency perspective on spending in the state targeted toward addressing youth related substance use. While this grant will be wrapping up in the early period of the Block Grant, the state has received an additional SYT-I grant to allow further mapping for the 16-25 year old population.
- BSAS tracks reimbursable units of service specific to the A-CRA/ACC model as part of efforts to address future sustainability. During the life of the grant, that Massachusetts team created a crosswalk of the CBHI services referenced above, and A-CRA/ACC. This will prove to be a useful tool in this dialogue about service gaps for which Medicaid could potentially reimburse. While the collaborative dialogue is continuing, the SSA has developed a unit rate to support aspects of the A-CRA/ACC model which are currently not reimbursed via Medicaid to sustain the model and system created under state and SAT-ED funding.

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

- We do not have an identified person with this role.
- The Office of Youth and Young Adults continues to collaborate with other Bureau staff on the following two projects with schools:
    - Screening in the state funded school based health center system. The aim of this project is to provide refresher training for Nurse Practitioners and Social Workers at School-Based Health Centers on implementation of Screening, Brief Intervention and Referral for Treatment (SBIRT), utilizing the CRAFFT Screening Tool and Pediatric Toolkit. FY13 was the first year that SBHC were required by contract to provide the screenings and collect data. Training is provided by the DPH/BSAS-funded SBIRT Trainer.

- OYYAS and the SBIRT Coordinator are working with School Health Services training middle and high school Nurses on a pilot basis to implement universal screening grant using the SBIRT model. Four schools piloted the grant in one grade per school in FY13.

7. What age is considered the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Given the state behavioral health system has yet to become truly integrated, the answer to "cut-off" age depends on the service system. Within the Children's Behavioral Health Initiative, youth and young adults with mental health related services needs can be enrolled until the age of 21. For youth specific substance abuse services, the adolescent system generally serves youth who are 13-18, with the exception of four residential treatment programs serving transitional age youth and young adults who are 16-25 years old. There is also an entire array of substance use related treatment and recovery support services available to adults over the age of 18. Many of these programs have begun to create special units or programming for young adults aged 18-25 to offer more developmentally appropriate services for all adults receiving services and supports.

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

19. Pregnant Women and Women with Dependent Children

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.

Massachusetts uses a variety of strategies to ensure awareness regarding both availability of treatment options and required treatment priority for pregnant and parenting women. Outreach materials include packets developed by the state and available through the state's information clearinghouse, with information specifically geared to pregnant women in need of substance abuse treatment, including a poster in English and Spanish, brochures and pocket cards for pregnant women and their families, and materials for treatment professionals as well. By state requirement, treatment programs with state and federal funds must prioritize pregnant women for admission and must have a plan in place to serve pregnant women in all modalities. In addition, according to the regulations treatment programs may not decline prospective clients (especially pregnant women) solely based on medications they are taking.

MA DPH/BSAS also funds two positions exclusively focused on pregnant women at the Institute for Health and Recovery (IHR), the state's vendor for Central Intake and Targeted Capacity Building for pregnant and parenting women.

- The Pregnant Women's Access Coordinator responds to calls from pregnant women seeking treatment, and works to place them within 48 hours, and/or to provide telephone counseling when women are awaiting placement or are in a short term placement. She works closely with each treatment program in the state that takes pregnant women, attends quarterly meetings with all women's treatment programs, and receives regular reports from them on open beds. Women obtain the telephone number from posters and materials mentioned above, by calling the MA Substance Abuse helpline, which refers all pregnant women to IHR's Access Coordinator, or from Department of Children and Families, the state's child welfare agency
- The Pregnant Women's Systems Specialist works across systems to ensure awareness of the treatment need and use of best practices to serve pregnant and parenting women affected by substance use disorders, and their children. Her work includes technical assistance to treatment programs regarding use of best practices for pregnant women and Substance Exposed Newborns, as well as work internally with DPH in both the Bureau of Substance Abuse Services and Bureau of Family and Community Health, which has selected services for women of childbearing age affected by substances as its Block Grant priority this year (Title V Block grant). She also works closely with numerous task

forces formed by county court districts in response to the state's opioid epidemic, and with the state's child welfare agency, Department of Children and Families.

2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.

The state tracks placement of pregnant women in treatment through the central 800 pregnant women's access telephone line, and through its Enterprise Service Management (ESM) system, which requires reporting on all treatment enrollments. At IHR, the Pregnant Women's Access Coordinator performs a brief phone assessment with each pregnant woman and determines the level of care she may require for treatment. She makes referrals and follows up with each one, providing interim telephone counseling when a woman cannot be placed immediately. She handles approximately 200 unduplicated calls per month regarding pregnant women.

The Coordinator maintains a list of programs, by region, that provide effective service to pregnant and parenting women and she is in weekly contact with these programs to determine their current capacity. After giving referrals to individual women, she follows up with each woman within 24 hours to determine the outcome of referrals that have been made. If a woman has not been able to access a treatment bed or has not followed through on the referrals, the access coordinator offers motivational counseling to encourage women to access treatment.

3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

To ensure the provision of interim services for women who are unable to access treatment placement within 48 hours or who do not follow through on referrals, the Pregnant Women's Access Coordinator is required to follow through on each call. The Pregnant Women's Access Coordinator is a member of IHR's Family Central Intake team, which coordinates access to eight family residential treatment programs and two family sober living programs statewide. Often, pregnant women seek residential treatment and are eligible for it, though occasionally they may need to enroll in a detoxification program prior to accessing residential care. In these cases, the Access Coordinator describes the family residential programs to the pregnant woman, and immediately places her on the waiting list. Interim telephone counseling is provided during the waiting period (these programs generally maintain close to 100% occupancy), but as openings occur, pregnant women are prioritized. For those pregnant women who want family treatment, every effort is made to have them enter as quickly as possible, generally within one to two weeks of their initial phone call. In the interim, referral is made to local outpatient programs and interim motivational counseling is provided by phone.

For pregnant women who are addicted to opiates, they may already have medication assisted treatment in place when they call for a referral. In these cases, the Pregnant Women's Access Coordinator works with the MAT provider and the receiving treatment provider to transfer the woman's MAT to a program in the vicinity of the receiving treatment program, including arranging guest dosing for a period of time at new program if needed.

4. Discuss who within your state is responsible for monitoring the requirements in 1-3.

The Department of Public Health, Bureau of Substance Abuse Services, Planning and Development unit under the leadership of Karen Pressman, Director of Planning and Development, monitors these requirements.

5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)

Bureau of Substance Abuse Services funded services for Pregnant Women and Women with Dependent Children include:

- 10 residential programs statewide serve families including pregnant and parenting women with or without other children.
- 13 adult residential programs statewide include specific beds for pregnant women or those with infants, classified as "pregnancy-enhanced" beds.
- 11 detoxification (Acute Treatment Services) programs have the capacity to serve pregnant women, either directly or through referral.
- 43 programs statewide offer methadone maintenance treatment, all with capacity for pregnant and parenting women.
- 14 OBOT programs based in Community Health Centers statewide offer buprenorphine treatment

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

Please indicate areas of technical assistance needed related to this section.

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

MASSACHUSETTS STRATEGIC PLAN FOR SUICIDE PREVENTION

"It is the hope that the plan will bring attention to the public health problem of suicide and the reality that there is a great deal that we can do to prevent it."

Timothy P. Murray,
Lieutenant Governor
September, 2009

"Suicide remains the sorrow that still struggles to speak its name."

Eileen McNamara
Boston Globe
December, 2007

MASSACHUSETTS COALITION FOR SUICIDE PREVENTION
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH

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I. INTRODUCTION

It is our goal that suicide and suicidal behavior be prevented and reduced in Massachusetts. With prevention strategies grounded in the best evidence available, the support and involvement of all stakeholders, and the guidance offered by this plan, we are confident we can make significant progress toward this goal over the next several years.

In Massachusetts:

- In 2007, there were 504 suicides in Massachusetts —more than deaths from homicide (183) and HIV/AIDS (143) combined[1].
- Most Massachusetts ' suicides occur in the middle age population; 43.8% of all suicides in 2007 were among those ages 35-54 years (N=221, 11.3 per 100,000)[2].
- Male suicides exceeded female suicides by more than 3 to 1 (in MA)[3].
- Both nationwide and in Massachusetts, youth suicide is the third leading cause of death for young people ages 15 – 24[4].
- Although the highest number of suicides among males occurred in mid-life ages 35-44 years (N=92, 19.2 per 100,000), the highest rate of suicide occurred among males 85 and older (N=16, 38.9 per 100,000)[5].
- The highest number and rate of suicides among females were among those ages 55-64 years (N=25, 6.6 per 100,000)[6].
- Nonfatal self-injury also burdens the Commonwealth's health care system— there were 4,305 hospital stays[7] (66.7 per 100,000) and 6,720 emergency department discharges[8] (104.2 per 100,000) for nonfatal self-inflicted injury in FY2007[9].

Experts agree that most suicides can be prevented. Suicide is less about death and more about the need to overcome unbearable psychological pain.

There is also general agreement that suicide and suicide attempts are under-reported at present, due to lack of data standards, pressure from some survivors, and stigma. Similar to other previously under-recognized problems (e.g. intimate partner violence, child abuse), as awareness of the scope of the problem rises and more people feel comfortable with reporting the event, rates may increase for a time. We anticipate that the same thing may happen with suicide; that is, as suicide and suicidal behavior become more recognized and is reported more frequently, rates will actually increase for a time.

The Massachusetts Strategic Plan for Suicide Prevention (State Plan) is an initiative of the Massachusetts Coalition for Suicide Prevention, working in collaboration with the Department of

[1] Registry of Vital Records and Statistics, Massachusetts Department of Public Health
[2] *Op. cit*.
[3] *Op. cit*.
[4] WISQARS, National Center for Health Statistics (NCHS), National Vital Statistics System
[5] Registry of Vital Records and Statistics, Massachusetts Department of Public Health
[6] *Op. cit*.
[7] Massachusetts Inpatient Hospital Discharge Database, Division of Health Care Finance and Policy
[8] Massachusetts Outpatient Emergency Department Database, Division of Health Care Finance and Policy
[9] Massachusetts Observation Stay Database, Division of Health Care Finance and Policy

Public Health (DPH) and the Department of Mental Health (DMH). As the recipient of legislative funding for suicide prevention, the Department of Public Health also provided financial support and resources for the development of the plan.

The field of suicidology uses common words that have specific definitions relevant to the diagnosis, intervention and prevention of suicide; such words used in this document are defined in the Glossary in Appendix B.

The Massachusetts Coalition for Suicide Prevention

The Massachusetts Coalition for Suicide Prevention (MCSP) is a broad-based inclusive alliance of suicide prevention advocates, including public and private agency representatives, policy makers, suicide survivors, mental health and public health consumers and providers and concerned citizens committed to working together to reduce the incidence of self-harm and suicide in the Commonwealth. From its inception, the Coalition has been a public/private partnership, involving government agencies including the Department of Public Health and Department of Mental Health working in partnership with community-based agencies and interested individuals.

The MCSP's mission is to support and develop effective suicide prevention initiatives by providing leadership and advocacy, promoting collaborations among organizations, developing and recommending policy and promoting research and program development.

Massachusetts Department of Public Health Suicide Prevention Program

The Massachusetts Suicide Prevention Program, in the Division of Violence and Injury Prevention, provides support, education, and outreach to all Massachusetts residents, especially those who may be at increased risk, have attempted suicide, or have lost a loved one to suicide. Through education and outreach efforts, this program develops and disseminates materials designed to increase awareness and knowledge, provides community grants, and develops and evaluates training modules for populations at increased risk for suicide or suicidal behavior. This initiative educates professionals and the general public on the scope of suicide, self-inflicted injuries, and suicide prevention. Staff also can provide data, resources and support to communities and agencies which are either working to prevent suicide or coping in the aftermath of a suicide. The program has received state funding for implementation since FY2002.

The Suicide Prevention Program provides training to a broad array of individuals, including public health and mental health professionals, social workers, nurses, public safety officials, first responders, law enforcement officers, emergency medical technicians, corrections personnel, community leaders and advocates, survivors, counselors, clergy and faith community leaders, educators and school administrators, elder service staff, persons working with youth programs, advocates for the gay, lesbian, bisexual, and transgender communities and allies, and anyone interested in preventing self-harm and suicide in the Commonwealth of Massachusetts.

II. THE STRATEGIC PLANNING PROCESS

Massachusetts' first state plan for suicide prevention was completed and issued in 2002. Modeled on the National Strategy for Suicide Prevention, the State Plan offered a blueprint for the Commonwealth and collaborating partners for establishing priorities and implementing new, coordinated programming and services.

When the first State Plan was completed, there were no state funds for suicide prevention. However, the legislature appropriated $500,000 in funding for suicide prevention in FY 2002, and the line-item has grown, reaching a $4.75 million appropriation for FY09.

In 2007, recognizing that it was time to update and enhance the plan, the MCSP convened a seven-member Steering Committee to guide development of a new State Plan. Utilizing funding from legislatively appropriated resources for suicide prevention, the Department of Public Health provided financial support and resources to the development process.

Information Gathering

The Steering Committee committed to an extensive data-gathering process to assure inclusive information collection. Methods included a survey, an Electronic Town Meeting, stakeholder interviews, and focus groups. In addition, members of the MCSP were given the opportunity to offer feedback at several points in the plan's development. Over 500 individuals contributed their comments; this number accounts for the fact that any one person may have participated in multiple methods (for example, responded to the survey, participated in the electronic town meeting, and participated in a focus group).

Survey

As a key step in the planning process, a survey was developed to learn more about constituents' thoughts, suggestions, priorities, and vision on this public health issue.

The survey was conducted during May and June, 2007. Surveys were distributed at the DPH/DMH/MCSP Statewide Suicide Prevention Conference in May and the survey was publicized through the MCSP website and listserv. An online survey link was provided through the MCSP website.

There were a total of 189 responses to the survey: 102 paper surveys were completed at the conference and entered into the results database, 87 surveys were completed online.

Electronic Town Meeting

On June 6, 2007, the MCSP hosted an Electronic Town Meeting to solicit broad input on strategic planning priorities. The E-Town meeting attracted 280 participants, including 110 on-site at the meeting and 170 online.

Participants engaged in an interactive panel discussion and answered questions on key aspects of the previous State Plan, including:

- Reducing access to lethal means and methods of self-harm

- Improving access to and community linkages with mental health and substance abuse services
- Developing and implementing community-based suicide prevention programs
- Strategies to reduce the stigma associated with suicide and with being a consumer of mental health, substance abuse, and suicide prevention services

Interviews

Twenty individuals were interviewed in person or by telephone, including representatives from state agencies, MCSP leadership, members of the legislature, and survivors.

Focus Groups

Seventy-two individuals participated in eight focus groups:

- Consumers (individuals currently utilizing mental health services or who have received such services in the past)
- Survivors
- MCSP Members (Eastern Massachusetts)
- MCSP Members (Western Massachusetts)
- Elder Services Providers
- Veterans Services Providers
- Staff of the Massachusetts Department of Public Health
- Staff of the Garrett Lee Smith Project Grant (a federally-funded suicide prevention project focused on youth in state custody)

Both the interviews and focus groups asked for feedback on a number of questions, including:

1. What are the needs of you and or / your constituency around suicide prevention?
2. Do you have the data you need?
3. What are the challenges and barriers to suicide prevention?
4. What are the top three things that would need to happen for more forward movement on this issue?
5. In what areas are current efforts working well? Not working well?
6. Are you familiar with the current state plan? If so, how does it address your needs?
7. What has been the impact of the work coming out of the most recent state plan?
8. What are your suggestions for how the future strategic plan might best be circulated and used?

III. KEY FINDINGS FROM THE INFORMATION GATHERING

The comments, suggestions, and other information gathered during this outreach process were synthesized and integrated. They yielded a wealth of information and numerous suggestions about what might be included in the plan. Given the breadth of comments, it is not possible to highlight every single one. However, a number of **common themes** emerged that merited reflection and consideration for inclusion in the new state plan.

1. People don't think of suicide as a preventable public health problem.

2. There is a need for culturally competent, community-based training on suicide prevention that reaches broadly across the state to address the needs of survivors, consumers, caregivers, and targeted populations.

3. Stigma associated with suicide (either discussing feelings of suicide, loss to suicide, or experience with suicide) and/or with mental illness/substance abuse is a significant barrier to prevention and help-seeking.

4. Stigma may be associated with long and complex histories of oppression in some communities that take specific cultural forms, e.g. racial/ethnic communities, GLBT communities, etc.

5. Poor linkages exist at the state and community level between mental health, substance abuse, and community health services as well as with schools, faith-based organizations, and first responders.

6. There are barriers to accessing appropriate mental health care due to numerous obstacles including:
   - Lack of transportation, particularly in suburban and rural areas;
   - Interrupted or inconsistent care due to lack of standardized assessment protocols, problems with the Emergency Service Program (ESP) system, a shortage of trained mental health clinicians, HIPAA[10] rules restricting sharing of information, and complicated insurance and reimbursement regulations that often limit access to care, especially mental health treatment.
   - Inability or reluctance of many primary care physicians to address mental health issues with patients.
   - Cost.
   - Lack of culturally and linguistically appropriate mental health resources for racial, ethnic minority and GLBT consumers.

7. There is limited awareness about the effectiveness of reducing access to lethal means and methods of self-harm.

[10] P.L. 104-191, Health Insurance Portability and Accountability Act (HIPAA), 1996. The law includes protection of confidentiality and security of health data through setting and enforcing standards among other provisions.

At the same time, participants in the information gathering want the **infrastructure** to support undertaking these priorities to include:

1. Increased public awareness of suicide and suicide prevention
2. Stronger collaboration among state agencies
3. Consumer and survivor engagement at all levels of decision-making
4. Ongoing, coordinated advocacy for resources to support plan implementation, including alternative options to state funding
5. Commitment to addressing specific needs of higher risk populations and the creation of appropriate services and strategies
6. Continued investment in surveillance along with improved and expanded data collection
7. Regular evaluation of progress in plan implementation
8. Increased presence of additional regional and local suicide prevention coalitions and strengthening the state-wide coalition

.

IV. USING THE STRATEGIC PLAN, AND MONITORING, EVALUATING, AND REPORTING PROGRESS

Using the Strategic Plan

The purpose of the Massachusetts Strategic Plan for Suicide Prevention is to provide a framework for identifying priorities, organizing efforts, and contributing to a state-wide focus on suicide prevention, over the next several years.

The State Plan is designed to be accessible to all stakeholders in the Commonwealth; stakeholders include individuals, groups, communities, organizations, institutions, and all levels of government. Understandably, this is a very broad and diverse group. And, by necessity, preventing suicide must be a very broad effort with diverse approaches. The MCSP hopes that all of those involved with suicide prevention will assume collective ownership of the Plan and use it to guide their efforts. With a variety of stakeholders acting together and using the state plan as a common point of reference, there is a vastly increased likelihood of achieving the Vision of Success (see Section V) for suicide prevention in Massachusetts.

Data-gathering and outreach during the strategic planning process helped identify a range of issues, and the Plan establishes a framework for specific goals related to suicide prevention. While the MCSP initiated efforts to begin development of the Plan, along with the Department of Public Health as the lead state agency and the Department of Mental Health, it does not assume that a specific agency or organization has the overall responsibility or capacity to address all, or even the majority, of these goals. Rather, this State Plan holds many opportunities for individuals, groups of people, communities, institutions, and organizations to make contributions toward achieving goals, individually and collectively. Collaborating and partnering with others can result in significantly greater impact. Likewise, this Plan does not assume that current state government funding will be the only resource for realizing these goals. Therefore, to ensure sustainability of all efforts, organizations must advocate for and pursue diversification of funding.

For those actively involved in suicide prevention, the Massachusetts Strategic Plan for Suicide Prevention can provide guidance and a framework as you proceed with your work. The State Plan can assist in identifying priorities as you develop an organizational strategic plan, an annual work plan, or specific action plans for your organization's efforts in suicide prevention. In this way, you can chart your organization's progress as well as measure your contributions against the overall goals of the statewide strategic plan. In addition, you are encouraged to coordinate with other organizations state-wide that may be working toward the same and/or complementary goals as presented in the State Plan.

Monitoring, Evaluating, and Reporting Progress

While the collective ownership and inclusive nature of the Massachusetts Strategic Plan for Suicide Prevention is a great strength, it also presents challenges because of the dispersed nature of the effort. For this reason the MCSP will take the lead in monitoring, evaluating, and reporting on the progress and implementation of the Plan.

MCSP will connect with stakeholders to track progress on implementation of the Plan, the status and success of specific goals and actions, and to solicit feedback on the strengths and weaknesses of the Plan itself. As with other organizations which must stay accountable to supporters and funders on an annual basis, MCSP will develop an annual progress report on the State Plan; this will be shared with the state legislature, appropriate state agencies and other stakeholders. The Plan and progress reports will serve as valuable resources to track and communicate progress and outcomes.

What This Plan Does Not Address and Next Steps

The scope of this plan is limited to statewide suicide prevention efforts across Massachusetts. We did not attempt to do an inventory of the significant suicide prevention activities already in place at various stages of implementation. Furthermore, because the Department of Public Health publishes 'Suicide and Self-Inflicted Injuries in Massachusetts' annually, we did not include a data report as part of the Plan.

This State Plan includes broad strategies appropriate to the statewide population. Examples of possible actions are general and not meant to be exhaustive. We recognize that some populations are at higher risk of suicide than others, including (but not limited to) consumers of mental health services, veterans, gay/lesbian/bisexual and transgender youth, survivors of trauma, and others.

Targeted population-based strategies are necessary and appropriate. While the Plan acknowledges that implementation will involve development of culturally specific and appropriate strategies and models for those at higher risk, the Plan does not identify targeted needs of populations known to be at increased risk of suicide, nor of specific geographic regions or communities. As part of implementing this Plan, it is our hope groups associated with both populations at increased risk of suicide, and coalitions addressing suicide prevention for regions, or cities and towns will use this Plan as a starting point to develop their own population-specific, more tailored plans.

Representatives of populations at increased risk have participated throughout the process of development the State Plan. As groups work to develop their own more targeted plans, the MCSP and the Department of Public Health will provide technical assistance to address suicide prevention for those groups at increased risk of suicide.

V. VISION OF SUCCESS AND GUIDING PRINCIPLES FOR SUICIDE PREVENTION PLANNING

A Vision Statement is a description of the desired future; it describes what success will look like at some future time. A Vision is an expression of possibility, based in reality yet far enough of a "stretch" that people are inspired to help make it happen despite the challenge and uncertain prospects for success.

The Vision gives a sense of direction. It presents a realistic, credible and attractive future.

Provided below are the components of the Vision of Success for Suicide Prevention.

Vision of Success

- Suicide is viewed as a preventable public health problem.
- Individuals experiencing mental illness, substance abuse, or feelings of suicide feel comfortable asking for help, and have access to culturally appropriate services in their communities.
- Suicide prevention services are provided in an integrated manner so that people receive the comprehensive coverage and support best suited for their individual needs.
- Suicide prevention activities incorporate elements of resiliency and protective factors as well as risk factors.
- Prevention strategies grounded in the best evidence available are used in cities and towns across the Commonwealth.
- There is a strong, diverse, state-wide suicide prevention coalition with regional coalitions in every part of the state, as well as local community coalitions.
- Institutions and organizations include mental health, suicide prevention, and risk and resiliency efforts as part of their health and wellness benefits, policies, curricula, and other initiatives.
- Suicide prevention is supported by public and private funding sources.
- There is a general public awareness of suicide prevention efforts in the Commonwealth and willingness to assist those who may be in need of help.

GUIDING PRINCIPLES

The guiding principles listed below reflect the beliefs of those who have contributed to the development of this State Plan. We hope these principles will continue to be reflected in the implementation of the plan.

We believe:

- Suicide affects people of all ages and must be addressed across the lifespan.
- Stigma and discrimination prevents open acknowledgment of mental illness and suicidal behavior, and this inhibits successful prevention, intervention, and recovery.
- Some populations are at higher risk of suicide than others; therefore, targeted population-based strategies and models are necessary and appropriate.
- Every person should have a safe, caring, and healthy relationship with at least one other person.
- Prevention should take into account both risk and resiliency of individuals and populations.
- All suicide prevention materials, resources, and services should be culturally and linguistically competent, and developmentally and age appropriate.
- Consumers and target groups should have input and participate in all levels of suicide prevention planning and decision-making.
- Information-sharing and collaboration must occur between all stakeholders in suicide prevention.
- The best evidence available should be used, to the extent possible, when planning, designing, and implementing suicide prevention efforts.
- More research and evaluation of suicide and suicide prevention programs, including innovative approaches and best evidence available, should be undertaken.
- To ensure sustainability of suicide prevention efforts, there should be advocacy for diverse funding and other resources.
- Comprehensive coverage, accessibility, and continuity of physical and mental health care services should be ensured.

VI. FRAMEWORK

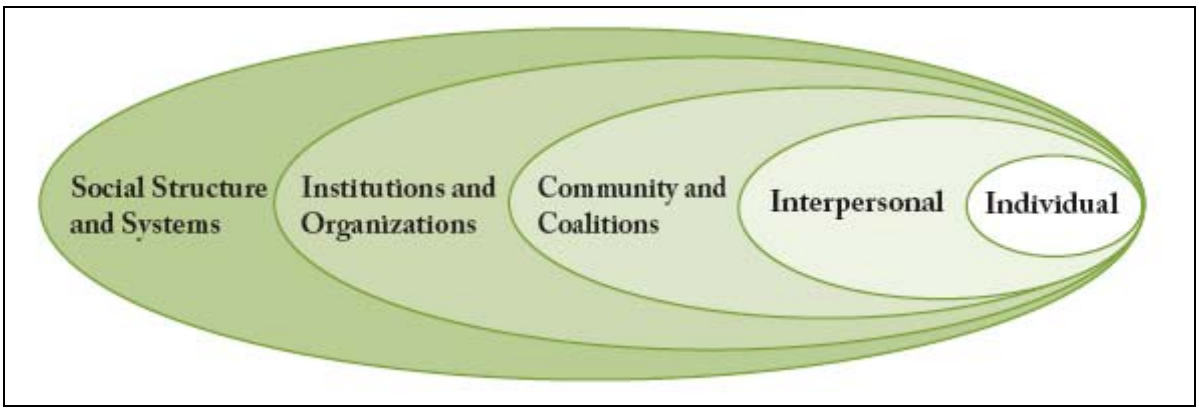
The Massachusetts Strategic Plan for Suicide Prevention recognizes the complex interplay between the various stakeholders (individuals, groups, communities, government, organizations, and institutions) in society that are involved with and, indeed, required for successful suicide prevention efforts. The Plan acknowledges this interdependency; it encourages and requires a connected and common effort among all stakeholders.

The framework for planning provides a basic structure for defining, organizing, and supporting the Massachusetts Strategic Plan for Suicide Prevention. This framework was derived primarily from two well-known public health models: the Spectrum of Prevention and the Social-Ecological model.

The Massachusetts Strategic Plan for Suicide Prevention is organized around five dynamic and interactive Levels, designed to include and represent all stakeholders:

I. Individual
II. Interpersonal
III. Community and Coalitions
IV. Institutions and Organizations
V. Social Structure and Systems

These Levels represent a continuum from a specific individual (Level I) to the society in which that individual lives (Level V). The graphic below illustrates this continuum.



For the Plan to be successful, significant activity is required in each of the five Levels. The synergy of the Levels will result in increased awareness, momentum, and integration of suicide prevention efforts. The framework for the Plan is based on the assumption that action must occur within each of the five Levels. The Plan encourages information-sharing and collaboration between and among stakeholders. With a variety of stakeholders acting together in a concerted effort, there is an increased likelihood of success.

Each of the five Levels includes several components:

- **Theme:** A description of the overall purpose of the Level.

- **Audience:** The stakeholders at whom the Theme is aimed; those who will be affected by and those who will be involved with implementing the Goals. The Audience list for each Area is not intended to be exhaustive; it is presented to provide examples of possible stakeholders.

- **Goals:** Major long-term aims, and an articulation of the desired achievements for each Theme. The Goals for each Theme are not presented in any particular order. It is understood that many of the Goals, due to the structural and systemic complexity of the issues and the many stakeholders involved, will take more than five years to attain. In addition, some Goals may be on-going and never fully completed.

- **Examples of Possible Actions:** Actions are specific acts or activities that can be used to make progress toward a Goal. In this plan, the Actions presented are examples only; they are not meant to be prescriptive. Each stakeholder should make decisions about Actions to take and how to approach implementation based on their unique and specific situation. Creativity, innovation, and finding the best "fit" is encouraged.

Beyond presenting an overall Vision of Success for suicide prevention in Massachusetts (Section V), this Plan does not articulate specific outcomes desired and measures of success for each Goal and Possible Action. To identify specific measures of success for Goals and Actions was beyond the scope and time of this effort, and complicated by the multiplicity of stakeholders and decentralized nature of the work to be done. However, measuring progress and outcomes of specific Goals and Actions will be a key part of evaluating and reporting on the implementation of the Plan. As noted in Section IV, MCSP will take the lead in this effort and develop appropriate documentation.

The Goals, Strategies, and Actions in the Massachusetts Strategic Plan for Suicide Prevention have been developed based on suggestions from outreach and information gathering. To the extent possible, they were compared against the current growing knowledge base on suicide and suicide prevention and have met the criteria of being evidence-based; that is, they represent approaches to suicide prevention that have been developed and evaluated using scientific processes and have been found to be credible and sustainable.

Some of the Actions listed are already in various stages of implementation – some just beginning and others have been used for several years. Other Actions are examples that have not yet begun to be implemented. Still other Actions may be currently implemented by some stakeholders with others looking to replicate them.

The above components for each of the five Levels are presented in matrices on the following pages.

VII. MATRIX

LEVEL I: INDIVIDUAL

Theme

Promote the well-being, safety, and resiliency of individuals who may be at higher risk of suicide, and those whose lives have been touched by suicide

Audience (including, but not limited to): Suicide attempt survivors, survivors, people at higher risk, populations at higher risk

Goals	Examples Of Possible Actions
1A. Increase self-awareness of risk and protective factors and encourage help-seeking and support during a crisis and over the long-term	1. Promote public testimony from credible spokespeople, including those well-known, who have received help 2. Promote crisis plans for individuals who need them, their providers and support system 3. Develop plans/protocols for survivors: immediately following a suicide (e.g. a survivor contacts a survivor); in-person and on-line support groups, other specialized services 4. Disseminate appropriate materials and resources to individuals 5. Encourage evidence-based therapeutic treatment
1B. Educate providers and private and public funders on suicide risk and protective factors, warning signs, and available resources	1. Target education and training at professionals serving those at increased risk (primary care providers, mental health clinicians, caseworkers, nurses, and others) 2. Promote information on mental health and emergency resources available to assist individuals at risk of suicide and providers who serve them 3. Promote awareness of the differences between ongoing mental illness and situational stress, e.g. divorce, bereavement, academic problems, financial or professional loss, or other circumstantial stressors
1C. Support resiliency for those at risk through sustainable, skill-building efforts and resources	1. Conduct resiliency training across the life-span, including good decision-making, values clarification, coping mechanisms, impulse control, role models and mentors 2. Build individual help seeking and self-help skills 3. Increase awareness of how / where to get help

Goals	Examples Of Possible Actions
1D. Address ongoing needs of those at higher risk of suicide	1. Promote support groups, peer-to-peer training and outreach, and other avenues of peer education and support 2. Identify best venues for education to reach those most in need, e.g. home-based programs for elders, at the time of demobilization for members of the US military, safe schools programs for youth 3. Address environmental factors that contribute to suicidal behavior, such as discrimination, limited understanding of coping with those with mental illness, and lack of access to support and services 4. Educate individuals at higher risk on resources and help available including warm lines and hot lines

LEVEL II: INTERPERSONAL

Theme
Support and educate people to cultivate helping relationships and address suicide risks with awareness and sensitivity **Audience** (including, but not limited to): mental health consumers, survivors, suicide attempt survivors, families, including foster parents; friends; partners; peer groups; health care providers (nurses, doctors, therapists, counselors; emergency personnel (fire, police, EMTs); all personnel in health care, clinical, social and human service settings; HELP lines; clergy; school personnel; funeral directors; human resource staff

Goals	Examples Of Possible Actions
2A. Promote and develop systems of care that utilize the best evidence available to identify and help those at risk	1. Develop comprehensive protocols for service providers (health care, public safety, social service, educational institutions) in recognizing and treating suicidal behavior 2. Recognize those at risk through best available assessment tools; screening/checklist approaches (depression, behavioral health) 3. Incorporate "Lethal means counseling" into the existing suicide prevention protocols of gatekeepers and health/mental health providers
2B. Promote access to and continuity of care for individuals at risk through sustainable service linkages at the local, regional, and state level with all relevant providers	1. Support transitions and postvention services: re-entry plans for students and adults; step down from in-patient care; ensure a connection with a professional service provider is made 2. Identify needs and provide services to people in non-clinical environments, including caregivers 3. Increase face-to-face contact with those at risk through mentoring, visiting, volunteer advocates, and peer support groups 4. Identify and access approaches and avenues (that respect privacy and build trust) that increase the likelihood that those who are in need will ask for help
2C. Implement sustainable, replicable, and evidence-based training programs in recognizing and treating suicidal behavior	1. Encourage consistency of trainings where possible and appropriate 2. Conduct " gatekeeper" awareness and training programs for the lay and professional population

Goals	Examples Of Possible Actions
2D. Recognize and address the commonalities and the barriers (language, approaches, stigma, goals, training) that exist between professionals in different disciplines who are working with those at risk, so they can better connect and integrate prevention services	1. Increase opportunities for professionals serving higher risk populations to work more collaboratively 2. Provide training opportunities on collaborating and connecting suicide prevention to mental health, substance abuse prevention, and other related health issues 3. Create connections between community-based organizations and mental health professionals in providing a spectrum of appropriate and affordable services 4. Address the shortage of service providers who reflect characteristics of the populations served
2E. Design and implement multi-disciplinary protocols for all personnel and institutions who respond to individuals in crisis	1. Encourage appropriate and sensitive treatment of people with mental illness, in all settings 2. Ensure continuity of care for each individual in crisis and/or for people in treatment, by linking the individual with a service professional for a follow-up visit 3. Maintain, disseminate, and publicize resource directories (hard copy and web-based) for suicide prevention providers and others 4. Increase crisis intervention training; recognizing the fragility of people in crisis

LEVEL III: COMMUNITY AND COALITIONS

Theme
Create collaborations and foster networks to achieve broad impact through common goals in suicide prevention **Audience** (including, but not limited to): families, including foster parents; friends; partners; peer groups; survivors; consumers; neighborhoods; workplaces; faith communities and places of worship; sports teams; social and cultural clubs; professional networks, associations, and labor unions; local, regional, and statewide coalitions and networks; philanthropic organizations and funders; local government; local and county elected and appointed officials

Goals	Examples Of Possible Actions
3A. Advance and sustain local, community-based, and regional coalitions for suicide prevention, with connections to the state-wide coalition (MCSP)	1. Increase the number of community and regional suicide prevention coalitions while strengthening the statewide coalition; offer technical assistance and resources while affirming that each coalition is unique 2. Provide information about the availability of local grants for community-based efforts via community and regional coalitions 3. Build relationships and connections with existing networks to further efforts, e.g. Community Health Network Areas (CHNAs) and Regional Centers for Healthy Communities 4. Educate local government, elected and appointed officials and engage in community planning and prevention activities 5. Educate public and private funders and engage them in community planning and prevention activities
3B. Promote suicide prevention education and training for groups, communities and coalitions, and potential funders	1. Publicize trainings on the MCSP website and other websites 2. Create an MCSP listserv, and encourage regional and local coalitions to develop listserves or other communication systems 3. Develop, disseminate and share materials, technical assistance, and programs as needed, e.g., local resource guides, wellness campaigns, web-based tools 4. Facilitate networking and referrals through conferences and other convening approaches 5. Conduct education and outreach to local elected and appointed officials and potential funders

Goals	Examples Of Possible Actions
3C. Strengthen access to and collaboration among suicide prevention, mental health and health, substance abuse, crisis lines, and other prevention and advocacy services	1. Identify services available and service gaps in communities 2. Improve communication among service providers to support access and collaboration 3. Create and support avenues for open, multi-directional communication among Coalition members, including listservs and other venues 4. Integrate suicide prevention planning with planning for prevention and intervention of other health issues that share similar risk and protective factors, including mental health, substance abuse, and interpersonal violence, among others 5. Document successful community-wide approaches
3D. Support local data collection as part of suicide surveillance systems, and align with statewide efforts	1. Increase community awareness of available data 2. Train community members on how to locate and analyze available data, as needed
3E. Promote and support suicide prevention planning	1. Educate community and regional coalitions about the Massachusetts Strategic Plan for Suicide Prevention 2. Involve regional and local coalitions in implementing the Massachusetts Strategic Plan for Suicide Prevention 3. Increase engagement in suicide prevention activities through outreach to groups and constituencies at risk 4. Guide coalitions in developing suicide prevention plans tailored to their own specific needs 5. Encourage all communities to have a crisis plan and protocol, a review process/system for when a suicide occurs
3F. Develop additional primary prevention strategies	1. Increase awareness of the impact of violence and oppression on mental health 2. Collaborate with those developing trauma-informed care strategies within health and human service systems

LEVEL IV: INSTITUTIONS AND ORGANIZATIONS

Theme
Implement policies, procedures, initiatives, programs, and services in support of suicide prevention **Audience** (including, but not limited to): public, private, and non-profit organizations and institutions including educational institutions; health care providers; businesses, service-specific systems of providers (e.g., child care agencies, domestic violence shelters, elder care, homeless shelters); state and federal agencies and personnel (e.g. correctional facilities, veterans facilities), elected and appointed officials

Goals	Examples Of Possible Actions
4A. Address comprehensive continuity of physical and mental health care services	1. Promote case management and smooth referral systems to facilitate treatment access and treatment maintenance 2. Promote transportation services to providers, specifically for veterans, elders, homeless, people in rural areas 3. Address resource shortages (e.g., rural isolation and limited services, outpatient day programs, adolescent psychiatric beds, etc.) 4. Create incentives for treatment of patients with dual diagnosis issues (e.g. substance abuse and mental health) 5. Develop comprehensive protocols for service providers (health care, public safety, social service) in recognizing and treating suicidal behavior 6. Ensure statewide access to crisis support hot lines

Goals	Examples Of Possible Actions
4B. Support inclusion of mental health, suicide prevention, and resiliency efforts, and other initiatives into health and wellness benefits, policies, and curricula	1. Promote multiple mechanisms for delivering suicide prevention services; use schools and workplaces as access and referral points for services 2. Promote collaboration and integration among health issues in recognition of how experiences of violence and suicide can intersect. 3. Provide and improve prevention, intervention, and postvention services in the workplace and in workforce development and training programs 4. Promote state-wide K – 12 and college/university prevention, intervention, and postvention support and educational programs 5. Train employees in recognizing the warning signs and getting help for themselves and others
4C. Increase cultural competence among institutions and organizations and promote culturally diverse services	1. Connect with outreach efforts to community-based, racially, culturally and ethnically diverse groups and organizations 2. Equip organizations to provide culturally competent services 3. Increase the number of culturally competent mental health providers through workforce development, particularly those with expertise in adolescent and older adult mental health issues, and target geographically underserved areas 4. Provide suicide prevention training for medical interpreters
4D. Reduce access to and implement restrictions for methods of self-harm	1. Increase awareness of the effectiveness of means restriction as a suicide prevention strategy 2. Continue Massachusetts' successful gun safety regulations 3. Review train crossings where there have been suicides to assess safety features 4. Review major bridges and overpasses to assess safety features 5. Train health and mental health professionals to discuss risks of access to lethal means with their clients

Goals	Examples Of Possible Actions
4E. Support and focus the Massachusetts data-collection and suicide surveillance system at the state and local levels	1. Explore data on: passive suicide as an unrecognized cause of death; linkages between suicide and substance abuse overdoses 2. Improve documentation of race, ethnicity and language; secure data on certain populations (refugees); and distinguish rural, suburban, and urban data 3. Address under-reporting and nomenclature issues 4. Develop and share data on effectiveness and success of prevention programs and services; including costs of prevention vs. cost of crisis care 5. Explore approaches to make information sharing under HIPAA less difficult to ensure that services and resources are available for individuals in need 6. Include questions on suicidal behaviors, related risk factors and exposure to suicide on data collection instruments 7. Assess implementation of suicide prevention efforts in other states for possible application within the Commonwealth 8. Evaluate the impact and effectiveness of the Massachusetts Strategic Plan for Suicide Prevention in reducing suicide morbidity and mortality
4F. Promote the adoption of "zero suicide" as an aspirational goal by health care and community support systems that provide services and support the defined patient populations	1. Educate health care systems on the concept and dimensions of "zero suicide" 2. Establish a suicide prevention task force among state agencies to address the goal of reducing suicides and suicide attempts 3. Work with community support systems including state agencies that serve high risk populations to adopt a "zero suicide" policy

LEVEL V: SOCIAL STRUCTURE AND SYSTEMS

Theme

Reduce the stigma and discrimination associated with suicide, and promote healthy and help-seeking behaviors in society, with supportive policy, regulation, and law.

Audience (including, but not limited to): any individual of any age; society at-large; the media; philanthropic organizations and funders; state elected and appointed officials

Goals	Examples Of Possible Actions
5A. Maintain and promote political will and ongoing support for suicide prevention and resiliency building	1. Create a joint legislative, executive, and private sector commission to study and implement strategies to prevent suicide and self-harm 2. Implement mental health parity through federal and state legislation 3. Assess and address policies, programs, and procedures of public and private health insurance regarding suicide prevention and mental health services 4. Educate philanthropic organizations and funders about suicide and related prevention and engage them in policy and planning activities
5B. Reduce stigma associated with mental illness, substance abuse, violence and suicide	1. Promote help-seeking as a healthy behavior 2. Promote awareness that suicide is a preventable public health problem and that mental illness is treatable 3. Raise awareness and understanding of the mental health consequences of oppression and violence 4. Promote a multi-media public information campaign to dispel myths and increase awareness 5. Identify and develop credible advocates, prominent people, speakers bureau 6. Foster partnerships with and involve news media in public awareness efforts 7. Promote appropriate media reporting on and portrayals of suicide and mental illness and collaborate with the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) stigma reduction campaign 8. Develop, implement, monitor and update guidelines on the safety of online content for new and emerging communication technologies and applications

Goals	Examples Of Possible Actions
5C. Increase broad based support for suicide prevention	1. Conduct education and outreach on suicide and related prevention to elected and appointed officials at all levels of government 2. Increase outreach to cities and towns through the statewide coalition and the development of regional and local suicide prevention coalitions 3. Raise awareness of suicide as a public health problem among philanthropic organizations and funders and engage their support for suicide prevention activities 4. Disseminate the national suicide prevention research agenda 5. Foster sharing of research and data within the state
5D. Strengthen suicide prevention efforts at all state agencies, and ensure collaboration among and coordination within state agencies	1. Increase the numbers of people on state commissions and councils with suicide prevention expertise and include perspective representing youth, suicide loss survivors and suicide attempt survivors 2. Promote cross-agency dialogue within EOHHS 3. Implement recommendations of the January 2007 report to prevent suicide in Massachusetts prisons[11] 4. Align suicide prevention planning and implementation with Federal and State health and human services initiatives

[11] Hayes, Lindsay M. *Technical Assistance Report on Suicide Prevention Practices within the Massachusetts Department of Correction.* National Center on Institutions and Alternatives, January 31, 2007.

VIII. LOGIC MODEL

We are incorporating a logic model as part of the Massachusetts Strategic Plan for Suicide Prevention. A logic model communicates the logic or rationale behind a plan or program. It illustrates the relationship between inputs, processes, and outcomes—showing the chain of "logic", or what causes what toward the desired goal or outcome. Logic models are presented as a visual schematic, although there is no proscribed formula.

Included in this section of the State Plan are three sets of Logic Models, each based on the "Theory of Change Logic Model:"

A.) A model for the overall plan captures how implementing this planning framework of Levels/Themes will lead to the reduced incidence of suicide and self harm through short-term, then intermediate, and then finally, long-term outcomes.

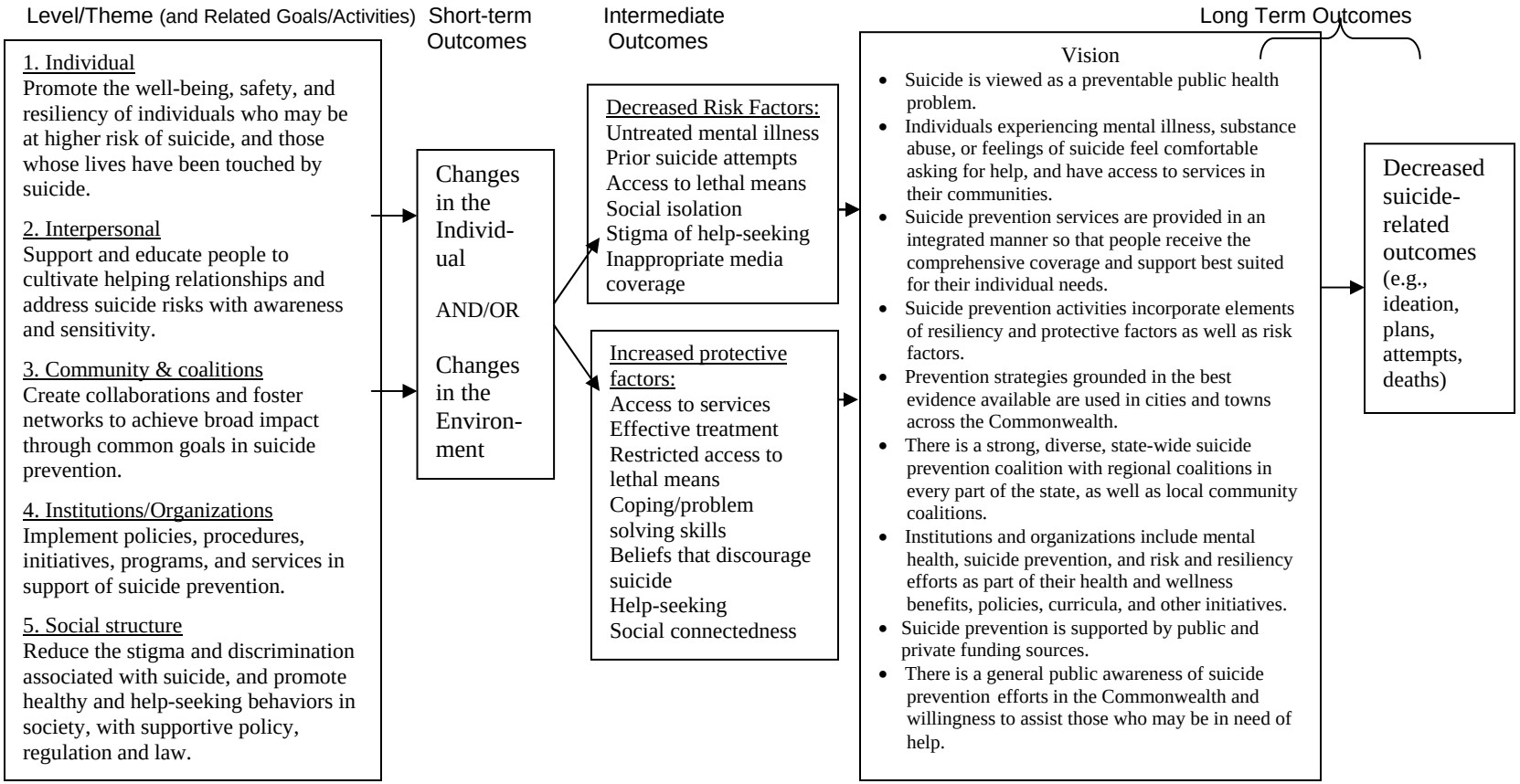
B.) There are logic models for each of the five Levels of the framework—individual, interpersonal, community and coalitions, institutions and organizations, and social structures and systems. These illustrate how implementation of Possible Actions will result in the realization of each Level/Theme.

C.) A final set of logic models will be developed in the future to address Possible Actions. A sample Action logic model is included here, for Level III, Goal 3A, Action 1. Other models will be developed in collaboration with MCSP members as we begin to implement the plan.

For more information on logic models, see 'Everything You Wanted To Know About Logic Models But Were Afraid to Ask' (Schmitz and Parsons,) at http://www.insites.org/documents/logmod.pdf

If you'd like more detailed information about logic models and other ways to evaluate suicide prevention programs, visit the website of the National Center for Suicide Prevention Training at http://training.sprc.org/. The workshop entitled 'Planning & Evaluation for Youth Suicide Prevention' includes a section on 'Using Logic Models for Plan Implementation'. Their online courses are free and self-guided, though electronic registration is required.

A. Logic Model for Overall Plan



Guiding Principles:

- Suicide affects all ages and must be addressed across the lifespan
- Stigma and discrimination prevents open acknowledgment of mental illness and suicidal behavior, and this inhibits successful intervention, prevention, and recovery
- Some populations are at higher risk of suicide than others; therefore, targeted population-based strategies and models are necessary and appropriate
- Every person should have a safe, caring, and healthy relationship with at least one other person
- Prevention should take into account risk and resiliency of individuals and populations
- All suicide prevention materials, resources, and services must be culturally and linguistically competent, and developmentally and age appropriate
- Consumers and target groups must have input and participate in all levels of suicide prevention planning and decision-making
- Information sharing and collaboration must occur between all stakeholders in suicide prevention
- The best evidence available must be used, to the extent possible, when planning, designing, and implementing suicide prevention efforts
- More research and evaluation of suicide and suicide prevention programs , including innovative approaches and best evidence available, must be undertaken
- To ensure sustainability of suicide prevention efforts, there must be advocacy for diverse funding and other resources
- Comprehensive coverage, accessibility, and continuity of physical and mental health care services should be ensured

B. Level I-Individual

Activities	Short-term Outcomes/Goals	Long-term Outcomes/Theme
1. Promote public testimony from credible spokespeople, including those well-known, who have received help. 2. Promote crisis plans for individuals who need them, their providers and support system. 3. Develop plans/protocols for survivors: immediately following a suicide (e.g. a survivor contacts a survivor); in-person and on-line support groups, other specialized services. 4. Disseminate appropriate materials and resources to individuals 5. Encourage evidence-based therapeutic treatment.	1A.Increase self-awareness of risk and protective factors and encourage help-seeking and support during a crisis and over the long-term	Promote the well-being, safety, and resiliency of individuals who may be at higher risk of suicide, and those whose lives have been touched by suicide
1. Target education and training at professionals serving those at increased risk (primary care providers, mental health clinicians, caseworkers, nurses, and others.) 2. Promote information on mental health and emergency resources available to assist individuals at risk of suicide and providers who serve them. 3. Promote awareness of the differences between ongoing mental illness and situational stress, e.g. divorce, bereavement, academic problems, financial or professional loss, or other circumstantial stressors.	1B. Educate providers and private and public funders on suicide risk and protective factors, warning signs, and available resources.	
1. Conduct resiliency training across the life-span, including good decision-making, values clarification, coping mechanisms, impulse control, role models and mentors. 2. Build individual help seeking and self-help skills. 3. Increase awareness of how/where to get help.	1C. Support resiliency for those at risk through sustainable, skill-building efforts and resources	
1. Promote support groups, peer-to-peer training and outreach, and other avenues of peer education and support. 2. Identify best venues for education to reach those most in need, e.g. home-based programs for elders, at the time of demobilization for members of the US military, safe schools programs for youth 3. Address environmental factors that contribute to suicidal behavior, such as discrimination, limited understanding of coping with those with mental illness, and lack of access to support and services. 4. Educate individuals at higher risk on resources and help available including warm lines and hot lines.	1D. Address ongoing needs of those at higher risk of suicide.	

B. Level II-Interpersonal

Activities	Short-term Outcomes/Goals	Long-term Outcomes/Theme
1. Develop comprehensive protocols for service providers (health care, public safety, social service, educational institutions) in recognizing and treating suicidal behavior. 2. Recognize those at risk through best available assessment tools: screening/checklist approaches (depression, behavioral health) 3. Incorporate "Lethal means counseling" into the existing suicide prevention	2A.Promote and develop systems of care that utilize the best evidence available to identify and help those at risk	Support and educate people to cultivate helping relationships and address suicide risks with awareness and sensitivity
1. Support transitions and postvention services: re-entry plans for students and adults; step down from in-patient care; ensure a connection with a professional service provider is made. 2. Identify needs and provide services to people in non-clinical environments, including caregivers 3. Increase face-to-face contact with those at risk through mentoring, visiting, volunteer advocates, and peer support groups 4. Identify and access approaches and avenues (that respect privacy and build trust) that increase the likelihood that those who are in need will ask for help.	2B.Promote access to and continuity of care for individuals at risk through sustainable service linkages at the local, regional, and state level with all relevant providers	
1. Encourage consistency of trainings where possible and appropriate 2. Conduct "gatekeeper" awareness and training programs for the lay and professional population	2C. Implement sustainable, replicable, and evidence-based training programs in recognizing and treating suicidal behavior	
1. Increase opportunities for professionals serving higher risk populations to work more collaboratively 2. Provide training opportunities on collaborating and connecting suicide prevention to mental health, substance abuse prevention, and other related health issues 3. Create connections between community-based organizations and mental health professionals in providing a spectrum of appropriate and affordable services 4. Address the shortage of service providers who reflect characteristics of the populations served.	2D.Recognize and address the commonalities and the barriers (language, approaches, stigma, goals, training) that exist between professionals in different disciplines who are working with those at risk, so they can better connect and integrate prevention services.	
1. Encourage appropriate and sensitive treatment of people with mental illness, in all settings 2. Ensure continuity of care for each individual in crisis and/or for people in treatment, by linking the individual with a service professional for a follow-up visit. 3. Maintain, disseminate, and publicize resource directories (hard copy and web-based) for suicide prevention providers and others 4. Increase crisis intervention training; recognizing the fragility of people in crisis.	2E.Design and implement multi-disciplinary protocols for all personnel and institutions who respond to individuals in crisis	

B. Level III-Community and Coalitions

Activities	Short-term Outcomes/Goals	Long-term Outcomes/Theme
1. Increase the number of community and regional suicide prevention coalitions while strengthening the statewide coalition; offer technical assistance and resources while affirming that each coalition is unique 2. Provide information about the availability of local grants for community-based efforts via community and regional coalitions. 3. Build relationships and connections with existing networks to further efforts, e.g. Community Health Network Areas (CHNAs) and Regional Centers for Healthy Communities. 4. Engage local government, elected and appointed officials in community planning and prevention activities. 5. Educate public and private funders and engage in community planning and prevention activities.	3A. Advance and sustain local, community-based, and regional coalitions for suicide prevention, with connections to the state-wide coalition (MCSP)	Create collaborations and foster networks to achieve broad impact through common goals in suicide prevention
1. Publicize trainings on the MCSP website and other websites 2. Create an MCSP listserv, and encourage regional and local coalitions to develop listservs or other communication systems 3. Develop, disseminate and share materials, technical assistance, and programs as needed, e.g., local resource guides, wellness campaigns, web-based tools 4. Facilitate networking and referrals through conferences and other convening approaches 5. Conduct education and outreach to local elected and appointed officials and potential funders.	3B. Promote suicide prevention education and training for groups, communities, coalitions, and potential funders.	
1. Identify services available and service gaps in communities. 2. Improve communication among service providers to support access and collaboration. 3. Create and support avenues for open, multi-directional communication among Coalition members, including listservs and other venues 4. Integrate suicide prevention planning with planning for prevention and intervention of other health issues that share similar risk and protective factors, including mental health, substance abuse, and interpersonal violence, among others. 5. Document successful community-wide approaches.	3C. Strengthen access to and collaboration among suicide prevention, mental health and health, substance abuse, crisis lines, and other prevention and advocacy services	
1. Increase community awareness of available data 2. Train community members on how to locate and analyze available data, as needed	3D. Support local data collection as part of suicide surveillance systems, and align with statewide efforts	
1. Educate community and regional coalitions about the Massachusetts Strategic Plan for Suicide Prevention 2. Involve regional and local coalitions in implementing the Massachusetts Strategic Plan for Suicide Prevention 3. Increase engagement in suicide prevention activities through outreach to groups and constituencies at risk 4. Guide coalitions in developing suicide prevention plans tailored to their own specific needs 5. Encourage all communities to have a crisis plan and protocol, a review process/system for when a suicide occurs.	3E. Promote and support suicide prevention planning	
1. Acknowledge and increase awareness of the impact of violence and oppression on mental health 2. Collaborate with those developing trauma-informed care strategies within health and human service systems	3F. Develop additional primary prevention strategies	

B. Level IV-Institutions and Organizations

Activities	Short-term Outcomes/Goals	Long-term Outcomes/Theme
1. Promote case management and smooth referral systems to facilitate treatment access and treatment maintenance. 2. Promote transportation services to providers, specifically for veterans, elders, homeless, people in rural areas. 3. Address resource shortages (e.g. rural isolation and limited services, outpatient day programs, adolescent psychiatric beds, etc.) 4. Create incentives for treatment of patients with dual diagnosis issues (e.g. substance abuse and mental health). 5. Develop comprehensive protocols for service providers (health care, public safety, social service) in recognizing and treating suicidal behavior. 6. Ensure statewide access to crisis support hot lines	4A. Address comprehensive continuity of physical and mental health care services	Implement policies, procedures, initiatives, programs, and services in support of suicide prevention.
1.Promote multiple mechanisms for delivering suicide prevention services; use schools and workplaces as access and referral points for services. 2. Promote collaboration and integration among health issues in recognition of how experiences of violence and suicide can intersect. 3.Provide and improve prevention, intervention, and postvention services in the workplace and in workforce development and training programs 4. Promote state-wide K-12 and college/university prevention, intervention, and postvention support and educational programs. 5. Train employees in recognizing the warning signs and getting help for themselves and others.	4B. Support inclusion of mental health, suicide prevention, and resiliency efforts, and other initiatives in health and wellness benefits, policies, and curricula.	
1. Connect with outreach efforts to community-based, racially, culturally and ethnically diverse groups and organizations. 2. Equip organizations to provide culturally competent services. 3. Increase the number of culturally competent mental health providers through workforce development, particularly those with expertise in adolescent and older adult mental health issues, and target geographically underserved areas. 4. Provide suicide prevention training for medical interpreters	4C.Increase cultural competence among institutions and organizations and promote culturally diverse services	
1. Increase awareness of the effectiveness of means restriction as a suicide prevention strategy 2. Continue Massachusetts' successful gun safety regulations. 3. Review train crossings where there have been suicides to assess safety features. 4. Review major bridges and overpasses to assess safety features. 5. Train health and mental health professionals to discuss risks of access to lethal means with their clients.	4D. Reduce access to and implement restrictions for methods of self-harm	
1. Explore data on: passive suicide as an unrecognized cause of death; linkages between suicide and substance abuse overdoses. 2. Improve documentation of race, ethnicity and language; secure data on certain populations (refugees); and distinguish rural, suburban, and urban data. 3. Address under-reporting and nomenclature issues. 4. Develop and share data on effectiveness and success of prevention programs and services; including costs of prevention vs. cost of crisis care 5. Explore approaches to make information sharing under HIPAA less difficult to ensure that services and resources are available for individuals in need. 6. Include questions on suicide behaviors, related risk factors and exposure to suicide on data collection instruments. 7. Assess implementation of suicide prevention efforts in other states for possible application within the Commonwealth. 8. Evaluate the impact and effectiveness of the Massachusetts Strategic Plan for Suicide Prevention in reducing suicide morbidity and mortality.	4E.Support and focus the Massachusetts data-collection and suicide surveillance system at the state and local levels	
1. Educate health care systems on the concept of dimensions of "zero suicide". 2. Establish a suicide prevention task force among state agencies to address the goal of reducing suicides and suicide attempts. 3. Work with community support systems including state agencies that serve high risk populations to adopt a "zero suicide" policy.	4E. Promote the adoption of "zero suicide" as an aspirational goal by health care and community support systems that provide services and support the defined patient populations	

B. Level V-Social Structure and Systems

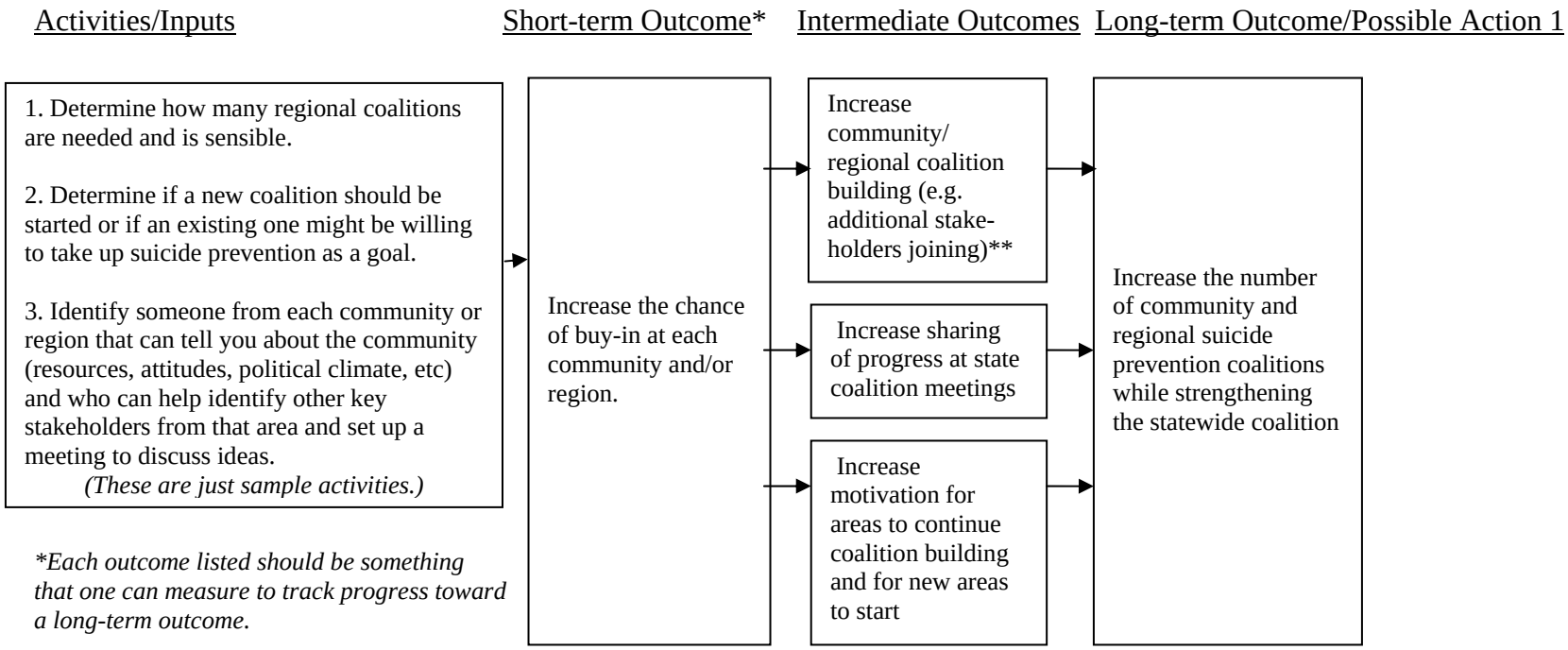
Activities	Short-term Outcomes/Goals	Long-term Outcomes/Theme
1. Create a joint legislative, executive, and private sector commission to study and implement strategies to prevent suicide and self-harm. 2. Implement mental health parity through federal and state legislation 3. Assess and address policies, programs, and procedures of public and private health insurance regarding suicide prevention and mental health services 4. Educate philanthropic organizations and funders about suicide and related prevention and engage them in policy and planning activities.	5A. Maintain and promote political will and ongoing support for suicide prevention and resiliency building	Reduce the stigma and discrimination associated with suicide, and promote healthy and help-seeking behaviors in society, with supportive policy, regulation, and law.
1. Promote help-seeking as a healthy behavior. 2. Promote awareness that suicide is a preventable public health problem and that mental illness is treatable. 3. Raise awareness and understanding of the mental health consequences of oppression and violence. 4. Promote a multi-media public information campaign to dispel myths and increase awareness. 5. Identify and develop credible advocates, prominent people, speakers bureau. 6. Foster partnerships with and involve news media in public awareness efforts. 7. Promote appropriate media reporting on and portrayals of suicide and mental illness and collaborate with the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) stigma reduction campaign. 8. Develop, implement, monitor and update guidelines on the safety of online content for new and emerging communication technologies and applications.	5B. Reduce stigma associated with mental illness, substance abuse, violence and suicide	
1. Conduct education and outreach on suicide and related prevention to elected and appointed officials at all levels of government. 2. Increase outreach to cities and towns through the statewide coalition and the development of regional and local suicide prevention coalitions. 3. Raise awareness of suicide as a public health problem among philanthropic organizations and funders, and engage their support for suicide prevention activities. 4. Disseminate the national suicide prevention research agenda. 5. Foster sharing of research and data within the state.	5C. Increase broad based support for suicide prevention	
1. Increase the numbers of people on state commissions and councils with suicide prevention expertise and include perspective representing youth, suicide loss survivors and suicide attempt survivors. 2. Promote cross-agency dialogue within EOHHS. 3. Implement recommendations of the January 2007 report to prevent suicide in Massachusetts prisons[1]. 4. Align suicide prevention planning and implementation with Federal and State health and human services initiatives.	5D. Strengthen suicide prevention efforts at all state agencies, and ensure collaboration among and coordination within state agencies.	

C. Example of a Logic Model for a Possible Action found in Level III, Goal A.

The first step is to ask, "What are your goals and what do you hope to accomplish?" For the purposes of Level III, Goal A, Possible Action 1, we hope to accomplish the following:

"Increase the number of community and regional suicide prevention coalitions while strengthening the statewide coalition"

Ideally, the activities (sometimes called *inputs and resources*) selected will be based on best practices in the field (e.g. practices that other communities have used and found to be effective) and the long-term outcome (sometimes called *outputs*) that one strives towards will be based on a need that was identified in the community or via a collaborative process.



**Each outcome listed should be something that one can measure to track progress toward a long-term outcome.*

*** One may wish to have a subsequent logic model for coalition building and how that will be achieved.*

IX. TWO EXAMPLES OF HOW THE PLAN COULD WORK

A. Introduction

The Massachusetts Strategic Plan for Suicide Prevention (State Plan) does not address the specific targeted needs of specific geographic regions or communities, or of populations known to be at increased risk of suicide (e.g., consumers of mental health services, veterans, gay/lesbian/bisexual, transgender youth, and others). As part of implementing this State Plan, it is our hope that planning groups associated with both populations at increased risk of suicide, and coalitions addressing suicide prevention for regions, or cities and towns will use this Plan as a starting point to develop their own population-specific, more tailored plans.

The following two summaries are provided as examples of how planning can advance suicide prevention for communities. These summaries are not intended as models to be followed, but as samples of how planning can advance suicide prevention for different kinds of communities. The first addresses a community of interest statewide—suicide among older adults, for which a working group developed a plan for services and needed resources. The second example features a geographic community—a suburban town that formed a local coalition and planned activities as a strategy for coping with a series of youth suicides.

The State Plan can assist in identifying priorities as you develop a strategic plan, an annual work plan, or specific action plans for your community or area of interest in suicide prevention. It can help you can chart progress as well as measure your contributions against the overall goals of the overall State Plan.

We look forward to hearing how planning is helping your community or interest group as we begin implementing the Massachusetts Strategic Plan for Suicide Prevention.

B. Older Adult Summary

According to vital records, obtained from death certificates, Massachusetts adults 65 and older account for 15.8% of suicides yet comprise only 13.5% of the population. Historically there has been significant interest in preventing suicide among older adults, and legislative language in the FY 08 budget called for a study to address suicide among elders / older adults.

To develop this report, the Department of Public Health (DPH) pulled together a team representing their healthy aging and suicide prevention staff, the Executive Office of Elder Affairs (EOEA), the Department of Mental Health (DMH), and providers serving older adults throughout the Commonwealth. They are currently working on a plan to address suicide among those older residents of Massachusetts. As part of informing the State Plan, a focus group targeted elder service agencies and older adults.

Current service areas are divided into community services, gatekeeper training and clinical training, and collaboration with EOEA.

Community Services—Older adults were identified as a priority population in a Request for Proposals, and this generated lots of interest from community providers. DPH funds are supporting grants to several community-based agencies serving elders. Services in different communities include: awareness and intervention training for senior service staff; depression screening; care management; elder

diagnostic assessments for homebound seniors; survivor support and outreach for bereaved elders; and specialized survivor support for bereaved gay / lesbian/ bisexual / transgender elders.

General Training—Training has been targeted directly at elder serving agencies through conferences and outreach to elder service programs. Current training in place includes: comprehensive suicide prevention and education; training for gatekeepers and elder service support staff; and training in suicide assessment and screening. The Question, Persuade and Refer curriculum (QPR) trained 40 new trainers serving older adults throughout Massachusetts. In addition, the annual suicide prevention conference featured a track on elder suicide, and suicide prevention workshops were integrated into Massachusetts Council on Aging conferences and the Aging with Dignity conference.

Clinical Training— It has been recognized that there is a shortage of mental health clinicians with expertise in suicide prevention. Clinicians representing elder services in different parts of the state participated in "Assessment and Management of Suicide Risk" training developed by the American Association of Suicidology and the Suicide Prevention Resource Center. Additional training has targeted primary care physicians and nurses, visiting nurses, and other clinicians serving older adults.

Collaboration with EOEA—To support mental health services for older adults DPH provides funding to the EOEA. Services include medication management; home-based mental health counseling; and training towards certification in geriatric mental health.

C. Example of a Massachusetts Community Suicide Prevention Coalition

In response to several youth suicides over several years, a suburban Boston community mobilized a suicide prevention coalition. Members represented local elected and appointed officials, school faculty and administrators, health and mental health services, public safety, clergy, students, parents, the District Attorney's office, and the local preschool consortium. They reached out to the Massachusetts Coalition for Suicide Prevention, and were linked with many suicide prevention resources. They also established cooperative relationships with the town police, fire department, clergy, school, and mental health agencies and individuals to plan for a more coordinated and effective response to individuals in need. This community coalition focused on both school and community based efforts. Their efforts have been featured in several local newspapers and television programs.

In schools, a psychologist worked with high school students at risk for depression or suicide. Faculty and staff were trained in the 'Question, Persuade, and Refer' (QPR) curriculum on identifying warning signs of suicide and options for intervention, and school counselors and nurses received training in self-injury. The coalition also worked with a local drug and alcohol prevention program to provide education and support related to alcohol and drug use among youth.

Several suicide prevention curricula were implemented with students. The Signs of Suicide curricula (SOS) taught 8-11th graders how to respond to a suicide attempt. And a pilot program taught students to resist risky behavior through coping skills such as impulse control, social problem solving, anger management, media resistance, and enhanced communication skills. The coalition also looked at school policy and adopted a crisis management model for contingency planning if a school or community crisis occurs, including when school is not in session.

Outside of the schools, the Coalition conducted a series of focus groups on suicide-related concerns. They implemented a town-wide action campaign to raise awareness on suicide and depression, including: town-wide posting of an informational poster; designating a weekend when all churches and synagogues discussed depression and suicide; and a "One-Town/One-Book" reading and discussion of William Styron's *Darkness Visible* on his struggles with depression. Community and school protocols for emergencies to prevent rumors and provide accurate information were updated.

A variety of community members were QPR-trained, including representatives of the District Court, community and civic organizations, town department employees, clergy, parents, and other interested residents. The coalition also launched a website. They adopted guidelines for appropriate memorials following a suicide or other traumatic death, and met with local journalists to promote responsible media reporting on suicide.

This community coalition continues to focus on preventing youth suicide, but has expanded its focus to include depression and suicide among elders, middle-aged men, and veterans.

APPENDIX A: RESOURCES FOR COMMUNITY AND GROUP SUICIDE PREVENTION

The list below represents a sample of resource materials useful to communities and groups starting to plan for suicide prevention. A comprehensive library of suicide prevention materials is available from the website of the Suicide Prevention Resource Center at www.sprc.org.

Data

Data-Driven prevention planning model
URL: http://www.sprc.org/library/datadriven.pdf
A suicide prevention planning model by Richard Catalano and David Hawkins is outlined in five steps. The model assumes that a broad-based coalition has been formed and is sufficiently organized to support the infrastructure necessary for this plan.

Finding data on suicidal behavior
URL: http://www.sprc.org/library/datasources.pdf
Sources for collecting suicide and suicidal behavior data at both the local and national level are listed.

Means Matter
http://www.hsph.harvard.edu/means-matter/
A website devoted to restricting access to lethal means as an evidence-based suicide prevention strategy. Includes a section on Recommendations for Communities and Suicide Prevention Groups under 'Taking Action'.

National Violent Death Reporting System (NVDRS)
http://www.cdc.gov/ncipc/profiles/nvdrs/default.htm
The National Violent Death Reporting System (NVDRS) seeks to provide communities with a clearer understanding of violent deaths so they can be prevented. NVDRS accomplishes this goal by informing decision makers and program planners about the magnitude, trends, and characteristics of violent deaths so appropriate prevention efforts can be put into place; and evaluating state-based prevention programs and strategies. Suicide is included in violent deaths, and Massachusetts is one of the participating states.

Program Planning and Implementation

Community coalition suicide prevention checklist
URL: http://www.sprc.org/library/ccspchecklist.pdf
This document is a result of a Scientific Consensus Meeting, sponsored by several of the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and Centers for Disease Control and Prevention through grants to the University of Rochester Center for the Study and Prevention of Suicide. The checklist contains ideas for whom to include in coalitions for suicide prevention in different settings.

Feasibility tool for the implementation of prevention programs
URL: http://www.sprc.org/library/feasibility_tool.pdf

Each page contains a chart to fill in to determine the feasibility of different elements of a prevention program, including: Resources, Target Populations, Organizational Climate, Community Climate, Evaluability, and Future Sustainability

Funding your program, determining your needs and developing a plan
URL: http://www.sprc.org/library/fundingtips.pdf
Contains tips, as well as websites for government grants, foundations, and statement research.

Leaving a legacy: Sustaining change in your community
URL: http://www.sprc.org/grantees/pdf/2006/legacywheel2.pdf
State/Tribal/Adolescents at Risk Suicide Prevention Grantee Technical Assistance Meeting, December 12–14, 2006, North Bethesda, MD. Explains the "Legacy Wheel" model of program planning, implementation, and evaluation.

Suicide prevention community assessment tool
URL: http://www.sprc.org/library/catool.pdf
Adapted from: Community Assessment Tool developed by the Suicide Prevention Program at the Massachusetts Department of Public Health. This assessment tool is targeted for "prevention networks," coalitions of change-oriented organizations and individuals working together to promote suicide prevention. It is comprised of four sections intended to gather information on: a) each community addressed; b) all agencies and individuals within the prevention network; c) target populations; and d) community suicide risk factors and prevention resources.

Awareness and Education

National Center for Suicide Prevention Training (NCSPT) workshops.

http://training.sprc.org/

NCSPT provides educational resources to help public officials, service providers, and community-based coalitions develop effective suicide prevention programs and policies. Workshops are free of charge, online, and self-paced. Topics include: Locating, understanding, and presenting youth suicide data; Planning and evaluation for youth suicide prevention; an introduction to gatekeeping; the research evidence for suicide as a preventable public health problem.

Suicide prevention: The public health approach
URL: http://www.sprc.org/library/phasp.pdf
Defines the five main steps of the public health approach and applies it toward suicide prevention.

Warning Signs for Suicide Prevention from The American Association for Suicidology
http://www.sprc.org/featured_resources/bpr/PDF/AASWarningSigns_factsheet.pdf
The warning signs were developed by an expert working group convened by the American Association of Suicidology. Citing the importance of distinguishing warning signs from risk factors, the group defined warning signs as the earliest detectable signs that indicate heightened risk for suicide in the near-term (i.e., within minutes, hours, or days), as opposed to risk factors which suggest longer-term risk (i.e., a year to lifetime.)

APPENDIX B:
DEFINITIONS AND GLOSSARY

Provided on the following pages is a glossary of terms used in the plan.

Some of the terms in this glossary are adapted from one published in the *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001.

Best practices/best evidence available – activities or programs that are in keeping with the best available evidence regarding what is effective

Consumer – A person who currently receives mental health services or who received such services in the past

Culturally appropriate – the ability of an organization or program to be effective across cultures, including the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services

Depression – a constellation of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure; a medical condition requiring diagnosis and treatment

Education – the teaching, learning, and understanding of specific facts, concepts and abstract principles, related to suicide prevention that can be applied in a variety of settings.

Effective – prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial outcome in the target group more than in a comparison group

Evaluation – the systematic investigation of the value and impact of an intervention or program

Evidence-based – programs that have undergone scientific evaluation and have proven to be effective

Gatekeepers (suicide gatekeepers) – individuals trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate; gatekeepers can be non-professionals who work with at-risk populations including administrators, coaches, home health aides, and others

HIPAA – The Health Insurance Portability and Accountability Act of 1996 enacted by the US Congress to ensure security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present or future.

Intervention – a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as strengthening social support in a community)

Means – the instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication)

Means restriction – activities designed to reduce access or availability to means and methods of deliberate self-harm

Methods – actions or techniques which result in an individual inflicting self-harm (i.e., asphyxiation, overdose, jumping)

Mood disorders – mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states, or, if in the opposite direction, depressed emotional states. Included are Depressive Disorders, Bipolar Disorders, mood disorders due to a medical condition, and substance-induced mood disorders

Outcome – a measurable change in the health of an individual or group of people that is attributable to an intervention

Postvention – a strategy or approach that is implemented after a crisis or traumatic event has occurred

Prevention – a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors

Protective factors – factors that make it less likely those individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment

Public information campaigns – efforts designed to dispel myths and provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines, and billboards

Public health approach – the systematic approach using five basic evidence-based steps that are applicable to any health problem that threatens substantial portions of a group or population. The five steps include defining the problem, identifying causes, developing and testing interventions, implementing interventions and evaluating interventions

Resilience – capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes

Risk factors – factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment

Screening – administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment

Social support – assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services, and include support from family, friends, religious communities and other affiliation groups

Stakeholders – entities including organizations, groups, and individuals that are affected by and contribute to actions and decisions

Stigma – an object, idea, or label associated with disgrace and reproach

Suicidal act (also referred to as suicide attempt) – potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death or injuries.

Suicidal behavior – a spectrum of activities related to suicide and self-harm, including self injury, attempted suicide, or suicide

Suicidal ideation – self-reported thoughts of engaging in suicide-related behavior

Suicidality – a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide

Suicide – death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death

Suicide attempt – a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in physical injuries

Suicide attempt survivors – individuals who did not die from an attempt to take their own life

Surveillance – the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings

Survivors/Suicide survivors – family members, significant others, or acquaintances who have experienced the loss by suicide of someone in their life

Training – teaching people to use specific skills, for the specialized tasks of suicide intervention and prevention, which are not generally used in other situations, and can not be used by unqualified individuals.

Warning signs – signals that can be verbal, non-verbal or behaviors that a person uses to indicate that they are at risk of suicide

ABOUT US

The Massachusetts Coalition for Suicide Prevention (MCSP) is a broad based inclusive alliance of suicide prevention advocates, including public and private agency representatives, policy makers, survivors of suicide loss, suicide attempt survivors, mental health and public health consumers and providers and concerned citizens committed to working together to reduce the incidence of self-harm and suicide in the Commonwealth.

http://www.masspreventssuicide.org/

mcsp
Massachusetts Coalition for Suicide Prevention

Massachusetts Strategic Plan for Suicide Prevention

Evaluation Summary: FY14

mcsp
Massachusetts Coalition for Suicide Prevention

LEVEL I: Individual

Promote the well-being, safety, and resiliency of individuals who may be at higher risk of suicide, and those whose lives have been touched by suicide

The efforts documented reflect suicide prevention efforts supported by state funding in Massachusetts for the fiscal year FY14 (the most recent completed fiscal year when information was being collected)

Education, Self-awareness & Help-seeking

*In 2014 over **46,500 individuals** were reached through various awareness events*

Over 2500 individuals were reached through *COMMUNITY EDUCATION* efforts, including education about mental health risks in the elderly, life skills for managing stress and other challenges to mental health, supporting resilience it the LGBTQ community

Over 925 individuals were provided access to suicide prevention resources through 12 *HEALTH FAIRS* across the commonwealth

Over 4,000 individuals engaged in community outreach events.

1860 individuals were *TRAINED* as gatekeepers to identify those at risk of suicide (120 were trained in the two-day ASIST model) (**60 mental health clinicians** participated in the same non-clinical gatekeeper trainings)

AWARENESS ACTIVITIES PARTICIPANTS:
[7,725+]

TRAINING PARTICIPANTS:
1,860

Audience: Elders, Youth, Law Enforcement, Working Adults, General Population

Provider Education and Resource Identification

Training for medical and mental health professionals (including school personnel and EMTs) on screening, risk assessment and treatment of suicidal risk

Trainings on understanding risk factors in special populations (ie. Imigrants, elders, suicide survivors, veterans.)

Over **250 mental health professionals** working with veterans, youth or mental health consumers were *TRAINED* in *CLINICAL PRACTICE TO ADDRESS RISK FACTORS FOR SUICIDE.* An additional **70 non-clinical personnel** who work with these populations were also trained

234 professionals were TRAINED TO FACILITATE SKILL BUILDING in elders, youth and veterans

39 elder care professionals were TRAINED in RECOGNIZING AND ADDRESSING THE NEEDS OF ELDERS WHO ARE AT RISK OF SUICIDE

24 mental health professionals were *TRAINED* as HOTLINE clinicians

Over 100 elder care workers (not all numbers available) were *EDUCATED* about the *EARLY WARNING SIGNS OF SUICIDE RISK IN THE OLDER POPULATION* through 7 art/performance or community education events

Over **135 professionals from a domestic violence shelter, a community college and medical residents** at a hospital were *EDUCATED* about *SIGNS OF SUICIDE RISK AND AVAILABLE RESOURCES, HOW TO ACCESS EMERGENCY SERVICES, AND WHAT CAN BE LEARNED FROM PARENTS WHO HAVE EXPERIENCED SUICIDE LOSS OF A CHILD*, respectively, through attendance at three education events.

Over **140 professionals who work with elders** were *TRAINED* in *RECOGNIZING SUICIDE RISK IN THE ELDERLY* and in recognizing and managing other problematic behaviors in this population

26 fire fighters were *TRAINED* in QPR

Over **80 members of the faith communities and school personnel** were *TRAINED* in POSTVENTION practices

NON MEDICAL/ MENTAL HEALTH TRAINEES:
~588

MEDICAL/ MENTAL HEALTH TRAINEES:
508+

Audience: Elders, Youth, Law Enforcement, Veterans, General Population, Middle-aged Men

Skill Building and Support for Individuals at Risk

50 individuals at risk of suicide engaged in *ALTERNATIVES TO SUICIDE GROUPS*

Over 300 individuals engaged in ONGOING GRIEF/SURVIVOR SUPPORT GROUPS

Over 15 individuals were trained in *FACILITATING SURVIVOR SUPPORT GROUPS* across the commonwealth

296 individuals were supported through *DIRECT OUTREACH* efforts

INDIVIDUALS RECEIVING SKILL BUILDING SUPPORT:
661+

Audience: Elders, GLBT Youth, Law Enforcement, Veterans, Working Adults

Direct Service Provision

Legislative appropriations supported direct counseling services over **750 Individuals** through contracts with various elder services providers

About **100 adults** received *DIRECT COUNSELING SERVICES*

Over **650 elders** received *DIRECT COUNSELING SERVICES*

Berkshire Medical Center was supported in introducing a new treatment protocol for clinically working with suicide attempt survivors. In its initial experimental phase it worked directly with three individuals, but may be expanded

Over **240 suicide loss survivors** engaged in seven *SURVIVOR SUPPORT GROUPS*

Over **60 elders** participated in two LIFE-SKILLS GROUPS

Almost 39,000 individuals accessed information on mental health resources and education through the MSPP PROJECT INTERFACE WEBSITE, which aims to educate parents and encourage help seeking for youth who may be at risk. Through funding of this service **1658 youth** were *CONNECTED WITH MENTAL HEALTH SERVICES*

85 Samaritan Survivor Care Packages were distributed to individuals/ families impacted by a suicide death

Consultation and postvention services provided.

2825 individuals benefited from postvention services including

- **10 schools** received *POSTVENTION CONSULTATION* following a tragic death.
- **50 agencies** received **over 70** *POSTVENTION SERVICE RESPONSES* including
- **380 hours** of CRISIS RESPONSE
- **160 hours** of INDIVIDUAL COUNSELING

RECEIVING SUPPORT GROUPS/ EVENTS/ DIRECT COUNSELING:
1,135

RECEIVING SUPPORT THROUGH OUTREACH/ REFERRAL:
1,658

ACCESSED INFORMATION RE: MENTAL HEALTH/ RESOURCES:
~39,000

RECEIVING POST-VENTION/ CONSULTATION:
2,825

Audience: Survivors, Elders, GLBT, Schools, Veterans

For the fiscal year included in this report (FY14), state funded suicide prevention activities and services reached over 132,726 people—an average of 1 person for every $30 spent.

LEVEL II: Interpersonal

Support and educate people to cultivate helping relationships and address suicide risks with awareness and sensitivity

Best Practices in Screening and Service Provision

Over ***9000 individuals*** were reached through support services, not including the Samaritan's hotline, with almost ***2000 referrals*** for services being made as a result

47,224 individuals were served through the four *HOTLINES* run by Samaritans of Merrimack Valley, Cape Cod, Fall River/New Bedford and Boston/Framingham

Legislative appropriations helped support screening programs aimed at identifying those at risk for suicide and other mental health issues. In total almost ***7700 individuals*** participated in screening activities.

651 elders engaged in *SCREENING ACTIVITIES*, resulting in at least **183 early identifications of risk** and *REFERRALS* to services

4767 individuals engaged in *ONLINE MENTAL HEALTH SCREENING*, with 74% (3518) rate of early identification of risk

939 individuals in the general public engaged in FACE TO *FACE SCREENINGS*

1020 youth participated in school SCREENINGS

SCREENED:
~7,700

REFERRED AS A RESULT OF SCREENING:
~2,000

RECEIVING DIRECT SERVICE:
9,000 plus 47,224 hotline calls

Audience: Survivors, Elders, GLBT, Schools, Veterans

Sustainable Provision of Integrated Care

Facilitation of service linkages for veterans through the S.A.V.E. Line referral service

127 individuals (102 of which were first responders) were trained in CONNECT Prevention, a Best Practices model for *ENGAGING SYSTEMS IN RECOGNIZING AND ADDRESSING SUICIDE*

Over 300 Elder Care workers were trained in Samaritan Senior Outreach Gatekeeper Training, to *IDENTIFY ELDERS AT RISK AND CONNECT THEM TO NEEDED SERVICES*

74 outpatient medical clients SCREENED for depression, all received referrals. It is unknown how many of these patients pursued additional mental health services

307 medical inpatients were *SCREENED* as pat of depression case management; 169 screened positive, 46 followed through with treatment

500 individuals were *SCREENED* through the work of Riverside trauma, service outcomes are not known for this population

747 individuals (most of whom were elders) received *DIRECT COUNSELING SERVICES* as a result of efforts to identify those who are at-risk

270 elders were engaged in CASE MANAGEMENT SERVICES; **700** TELECONNECT CALLS were made to maintain service connections to elders

122 medically involved patients engaged in *CASE MANAGEMENT SERVICES* to improve continuity and success of care

6680 *OUTREACH CONTACTS* were made to veterans resulting in 200 referrals to services

860 professionals that work with elders were trained to *RECOGNIZE AND WORK WITH ELDER WHO MAY BE AT RISK OF SUICIDE*

CONSUMERS SCREENED/ RECEIVING OUTREACH:

~7,400

WORKERS TRAINED:

1,287

RECEIVED DIRECT SERVICE:

1,139

Audience: Elders, Medical Patients

Evidence-based Suicide Prevention Training Programs

16 SOS programs were distributed to schools

11 ASIST kits were purchased, enabling 11 communities to provide two-day trainings in suicide prevention

176 clinicians were trained in *SUICIDE PREVENTION TRAINING FOR GATEKEEPERS OF OLDER ADULTS*

522 clinicians and 20 non-clinicians were trained in "BEST PRACTICES IN SUICIDE ASSESSMENT AND INTERVENTION", a training developed by Riverside Trauma Center

19 clinicians were trained in *QPRT*

16 clinicians and 4 non-clinicians were trained in SUICIDE RISK TRAINING- EMERGENCY ASSESSMENTS AND LEVELING CARE

Facilitator's Guide was developed to accompany a curriculum on social bullying in elder populations

Continued evaluation of a new clinical practice training, "Best Practices in Suicide Assessment and Intervention" developed and delivered by River Side Trauma Center

PROFESSIONALS TRAINED:

733
(*clinical trainings documented under a previous objective)

Crisis Response Protocol Implementation

127 individuals (102 of which were first responders) were trained in CONNECT Prevention, a Best Practices model for *ENGAGING SYSTEMS IN RECOGNIZING AND ADDRESSING SUICIDE*

31 Department of Corrections staff were *TRAINED TO RECOGNIZE SUICIDE RISK FACTORS* in older incarcerated individuals, an expanding demographic within corrections facilities

30 police were trained in how to *RECOGNIZE AND WORK WITH ELDER WHO MAY BE AT RISK OF SUICIDE*

22 Police/Corrections personnel participated in a week-long *CIT TRAINING* that incorporated issues of assessing and managing suicide risk.

Over 450 first responders were trained in *QPR* and/or understanding mental health issues in the clientele they serve

TRAUMA RESPONDERS TRAINED:

635+

In 2012 there were 624 suicide deaths in Massachusetts. That number nearly 3 times higher than the number of homicide deaths for that year.

LEVEL III: Community & Coalitions

Create collaborations and foster networks to achieve broad impact through common goals in suicide prevention

Statewide and Regional Coalitions

MCSP continued to bring together stakeholders from across the Commonwealth to work together to reduce the incidence of suicide through advocacy, education and collaboration

- Annual kickoff event, bi-monthly General Membership meetings, State House Awards event, co-sponsored Annual Suicide Prevention Conference
- Advocated for suicide prevention line item
- Continued expansion of dues paying membership, now at 21 organizations and 50 individuals
- Sponsored regional forum to share suicide prevention best practices and disseminate information about collaborative opportunities to expand suicide prevention programming
- Worked toward each of the Coalitions' 5 main priorities: Advocacy, Membership, Structural Development, Strategic Plan Evaluation and Regional Coalitions

Continuing work of *seven existing regional coalitions* in the Pioneer Valley, Berkshire County, Northeast Region, Central Massachusetts, Greater Boston, Bristol County, and the Cape and Islands and development of two *new regional coalitions* in Plymouth County and MetroWest

- Each regional coalition supported suicide prevention efforts and activities within their own communities

Staff support for the MCSP (Managing Director and part time Legislative Advocate—funded by member dues), as well as for the Cape and Islands Training Coordinator and an AFSP Massachusetts Area Director

Support for *11 local coalitions* in Barnstable, Concord, Falmouth, Gardner, Haverhill, Nantucket, Needham, Somerville, South Hadley, Taunton, and Wellesley.

Community Suicide Prevention Education and Training

13th Suicide Prevention Statewide Conferences (Sponsored by DPH, DMH and MCSP) providing education to 700+ professionals and community members

Trauma treatment and postvention as suicide prevention (except where noted, sponsored by Riverside Trauma Center)

NCSP awarded 2 grants to agencies to support training and implementation of SOS programs in Needham area schools

Funding supports a partnership with the Interagency Task Force to Improve Employment Opportunities for Veterans to provide Battleminds training and support job fair as a primary prevention effort for veterans

Funding supports a partnership between Advocates (a funded contract) and several regional coalitions to deliver ASIST, Safe TALK and More than Sad trainings in their regions

Pioneer Valley Regional Coalition co-sponsored one-day conference with Springfield College School of Social Work with a focus on Suicide Prevention and addiction

Interagency collaboration for prevention and advocacy services

The Department of Public Health has been working with five other state agencies and private organizations to coordinate services for known at-risk populations.

Elders- Collaboration with Department of Mental Health, Executive Office of Elder Affairs and the MA Partnership on Substance Abuse in Older Adults to address elder mental health

- **77 professionals**, participating in one of three educational events were *EDUCATED ABOUT THE INTERSECTIONS BETWEEN VIOLENCE PREVENTION, ELDER SUBSTANCE ABUSE, RECOVERY AND SUICIDE*
- Funding supports a collaboration between Advocates (a funded contract) and MA Partnership on Substance Use in Older Adults to address the integration of substance abuse and elder services

Survivors of Suicide-Partnerships with Samaritans and AFSP to provide hotline access for all in crisis as well as survivor supports

Trauma Survivors- Partnership with DMH Self inflicted Violence/Trauma Sensitive Care project and Riverside Trauma Center to improve mental health outcomes of those who have experienced trauma.

Veterans- Collaboration with Department of Veterans' Services funded the SAVE (Statewide Access for Veteran's Empowerment) Initiative which provides outreach and case management services for veterans and their families. As part of this collaboration Riverside Trauma Center provides clinical support to a veterans-specific crisis line.

- Funding supports a partnership with the Interagency Task Force to Improve Employment Opportunities for Veterans to provide Battleminds training and support job fair as a primary prevention effort for veterans

Working Adults- Partnerships with CMG Associates, Families for Depression Awareness and Screening for Mental Health forming the MA Workplace Mental Health Initiative, working with -corporations to incorporate mental health screening and education into their companies' workplace culture.

Statewide data collection

The Department of Public Health continues to refine data collection and suicide surveillance efforts, including:

Collection of self-injury data from hospital emergency departments and the poison control center

Collect data related to suicidal behavior using the Behavioral Risk Factor Surveillance System

Fund staff for the Injury Surveillance Program and Boston Police

Disseminate annual findings through published reports and live presentations

Consultation to the Child Fatality Review Committee so as to better inform the understanding of questionable youth deaths

Massachusetts has one of the lowest suicide rates in the country: 47th out of 50 states and the District of Columbia.

LEVEL IV: Institutions & Organizations

Implement policies, procedures, initiatives, programs, and services in support of suicide prevention

Integration of physical and mental health care

Berkshire Medical Center continues to implement *DEPRESSION CARE MANAGEMENT* for inpatient clientele (numbers related to services reported under previous goals)

Funding supports partnerships between AFSP and 6 major area hospitals to support continuity of care and resource sharing

Integration of veterans services through the SAVE initiative—(*ongoing initiative; data not available for SAVE efforts for FY14*)

Training of medical professionals in depression screening and identification of suicide risk

Screening of medically involved individuals

Referral of individuals for depression care management services

Engagement or re-engagement of participants in follow-up services

Integration of suicide prevention into existing programs, policies and curricula

Over **200 employees** were given access to *COPING WITH STRESS* workshops through their employer

2 employers supported the training of **21 trainers** to continue to deliver *COPING WITH STRESS* workshops for their employees

LEVEL V: Social Structures & Systems

Reduce the stigma and discrimination associated with suicide, and promote healthy and help-seeking behaviors in society, with supportive policy, regulation, and law.

Statewide Suicide Prevention Advocacy

Legislative advocacy resulted in the inclusion of a provision allowing DPH to collect information on all suicides in the House Bill: *An Act Relative to a Reduction in gun Violence*

MCSP coordinated panel testimony before the Joint Committee on Education in support of passage of HB443—*AN ACT RELATIVE TO SUICIDE PREVENTION TRAINING IN SCHOOLS*. As a result teacher training requirements for teacher training in suicide prevention were written into *HOUSE BILL: AN ACT RELATIVE TO A REDUCTION IN GUN VIOLENCE*

Legislative breakfasts held by Regional Coalitions--**250 citizens and lawmakers** participated in two *LEGISLATIVE BREAKFASTS* (Bristol and Berkshire counties) and one LEADERSHIP BREAKFAST (Middlesex county) aimed at increasing legislative and community support for regional suicide prevention initiatives, including those within schools

MCSP Annual State House Awards event engages Regional Coalitions, Legislators and public officials and the public and recognizes outstanding suicide prevention efforts across the state

Continued advocacy with state and local officials and policy makers for suicide prevention

MCSP generated revenue from membership dues for the purposes of contracting with a legislative advocate to support advocacy efforts for suicide prevention (funded solely through membership dues)

Stigma Reduction

Regional coalitions incorporate stigma reduction in their own strategic plans

MCSP website, as well as the websites for other state funded organizations delivering suicide prevention services, provide information about suicide and suicide prevention, including resources for survivor support groups, facts about suicide and accepted/ de-stigmatizing terminology

3500 suicide loss survivors participated in one of 6 Out of the Darkness Walks through which they *RECEIVED INFORMATION ABOUT SUICIDE RISK, AVAILABLE RESOURCES* and were encouraged to support help seeking behaviors

4 staff of local media outlets in the Berkshires were trained in *SAFE MESSAGING*

2 Online courses were developed:

"Bullying, Suicide and the Police", to be included National Suicide Prevention Video Library for Law Enforcement. Will be available to thousands of law enforcement personnel.

"Suicide Prevention Among Older Immigrants and Refugees", as part of a well-received blended model of face to face and online learning for elder workers.

2 videos were created:

- A video on suicide in veteran populations was created and will be launched in training court personnel
- "A Voice at the Table: A Call to Action" was created to help further the movement toward including the experience of suicide attempt survivors in suicide prevention planning. Both the National Action Alliance and the National Suicide Prevention Lifeline added the link to their Facebook pages

Increase broad-based support for suicide prevention

Expansion of regional coalitions to include 9 regional coalitions and 10 local coalitions

- **Regional Coalitions:** Berkshires, Pioneer Valley, Central MA, Northeast, Greater Boston, MetroWest, Plymouth, Bristol County, Cape and Islands
- **Local Coalitions:** Barnstable, Concord, Falmouth, Gardner, Haverhill, Nantucket, Needham, Newton, Somerville, South Hadley, Taunton, and Wellesley

Thank you

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Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Massachusetts 2016-2017 SAPT Plan and Report

22. Comment on the State SAPT Block Grant Plan

A solicitation for comment on the FY 2016-2017 Massachusetts SAPT Block Grant Plan was posted on the Bureau of Substance Abuse Services website prior to the finalization of the plan. The solicitation notification and the draft of the plan that were posted for comment are available in the attachment section. The plan and any revisions will be posted again after final submission.

Bureau of Substance Abuse Services
Substance Abuse Prevention and Treatment Services
Public Comment Request

September 2015

2016-2017 Substance Abuse Prevention and Treatment Block Grant
Substance Abuse and Mental Health Services Administration

The Massachusetts Department of Public Health, Bureau of Substance Abuse Services (BSAS) receives an annual Block Grant award from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This Block Grant is titled the Substance Abuse Prevention and Treatment Block (SAPT) Block Grant and it funds the infrastructure and services for the prevention and treatment of substance abuse in all states and territories.

BSAS is requesting comments from the public related to the block grant plan to address substance abuse prevention, intervention and treatment in Massachusetts for the two year period of FY2016-FY2017. A draft of priority areas and goals for the Block Grant for 2016-2017 is available here for your review.

The priority areas and goals will be a component of the SAPT Behavioral Health Assessment and Plan for FY2016-FY2017. More information is available for review online (click here).

We invite members of the public to submit comments on what should be the state priorities for substance abuse prevention, intervention and treatment services for the 2016-2017 Block Grant Application and State Plan and the proposed priority areas and goals. Please submit comments to Sarah Ruiz by **9/30/2015** at Sarah.Ruiz@state.ma.us, or by Fax # 617-624-5185, or by US mail at:

Sarah Ruiz
MA DPH/ BSAS
250 Washington Street, 3rd Fl
Boston, MA 02108

Substance Abuse Prevention and Treatment (SAPT) FY16-17
Block Grant Goals by Bureau of Substance Abuse Services (BSAS) Priority Area
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No.	Summary	Priority Area	Goal	Year 1 - FY2016	Year 2 - FY2017
I. Prevention of fatal and non-fatal opioid overdoses					
1.	Recovery Coaches in Emergency Departments	Prevention of fatal and non-fatal opioid overdoses	Implement a Recovery Coach intervention pilot in Emergency Departments for individuals who have come in for an overdose	Plan, procure, and begin implementation of Recovery Coaching in Emergency Departments	Pilot recovery coaches in emergency departments program
2.	Pharmacy access to Naloxone	Prevention of fatal and non-fatal opioid overdoses	Promote pharmacy access to naloxone in partnership with pharmacies, communities, and treatment providers	Increase the number of pharmacies that have established a naloxone standing order by 10%	Increase the number of pharmacies that have established a standing order by an additional 10%
II. Identification of high-risk populations using data from multiple sources					
3.	Link Massachusetts state police data on suspected Heroin overdoses to treatment data and identify intervention opportunities in treatment settings and communities	Identify high-risk populations using data from multiple sources	Identify high risk population groups with unmet treatment needs.	Streamline the process of incorporating state police data into data mart	Analyze linked dataset, identify high risk treatment settings and communities, develop intervention strategies

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No.	Summary	Priority Area	Goal	Year 1 - FY2016	Year 2 - FY2017
4.	Link Massachusetts trial court data for clients admitted to drug courts to BSAS and CHIA data	Identify high-risk populations using data from multiple sources	Improve treatment outcomes for clients enrolled in specialty courts.	Streamline the process of incorporating trial court data into data mart	Analyze linked dataset. Outcome analysis to inform the trial court on the development of drug court policies and procedures, propose treatment matching based on risk factors and client characteristics
III. Improved and enhanced substance abuse primary prevention in Massachusetts					
5.	Develop policy/practice change interventions	Improved and enhanced substance abuse prevention in Massachusetts	Develop policy/practice change interventions for Substance Abuse Prevention Collaborative Programs (SAPC)	Each SAPC community propose 1 policy/practice change	Each SAPC community accomplish 1 policy/practice change
6.	Develop policy/practice change interventions	Improved and enhanced substance abuse prevention in Massachusetts	Develop policy/practice change interventions for Massachusetts Opioid Abuse Collaborative Programs (MOAPC)	Each MOAPC community accomplish 1 policy/practice change and propose one for FY17	Each MOAPC community accomplish 1 additional policy/practice change
IV. Substance abuse screening, intervention and treatment integration with health care					
7.	SBIRT for Health Care Integration	Substance use screening, intervention and treatment integration with health care	Incorporate SBIRT concepts and skills into routine health care practice	10 new sites implement SBIRT	10 more new sites implement SBIRT

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No.	Summary	Priority Area	Goal	Year 1 - FY2016	Year 2 - FY2017
8.	Improve access to treatment by enforcing regulatory requirement that programs accept people on Medication Assisted Treatment (MAT)	Substance use screening, intervention, and treatment integration with health care	Increase and improve access to medication assisted treatment (MAT)	Increase the number of clients in residential treatment in the BSAS system that are on MAT by 5%.	Increase the number of clients in residential treatment in the BSAS system that are on MAT by an additional 5%.
V. Substance abuse prevention, intervention, treatment, and recovery support for justice-involved individuals					
9.	Increase aftercare referrals from DAE	Substance abuse prevention, intervention, and treatment for justice-involved individuals	Increase participation in substance abuse programming and referrals to aftercare services	Increase referrals to aftercare from DAE by 30% over FY14	Increase referrals to aftercare from DAE by 15% over FY15
10.	Increase referrals to medication assisted treatment for Section 35 civilly committed clients	Substance abuse prevention, intervention, and treatment for justice-involved individuals	Increase participation in substance abuse programming and referrals to aftercare services for civilly-committed individuals in the DPH system.	Increase the percentage of Section 35 discharges in the DPH system referred to medication assisted treatment by 2%	Increase the percentage of Section 35 discharges in the DPH system referred to medication assisted treatment by an additional 2%
VI. Reduced disparities in access to substance abuse prevention, intervention, treatment and recovery support for at-risk populations					
11.	Reduce disparities for LGBTQ youth and young adults	Reduced inequities in access to substance abuse prevention, intervention, treatment and recovery support for at-risk populations	Increase capacity of the OYYAS and its provider system to offer culturally competent care to LGBTQ youth and young adults	Develop guidelines for OYYAS provider system to be LGBTQ culturally competent	Train OYYAS provider system in LGBTQ cultural competency

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No.	Summary	Priority Area	Goal	Year 1 - FY2016	Year 2 - FY2017
12.	Reduce disparities for older adults with substance use disorders	Reduced inequities in access to substance abuse prevention, intervention, treatment and recovery support for at-risk populations	Address the treatment needs of older adults with focus on physical/psychosocial barriers	Identify age appropriate, evidence-based practices for treatment of adults 55 and older	Train BSAS provider system in evidence-based practices for adults 55 and older
13.	Increase the number of new active members of faith-based coalition each year.	Reduced inequities in access to substance abuse prevention, intervention, treatment and recovery support for at-risk populations	Increase the number of new active members of faith-based coalition each year	Add six new active members, at least four representing currently under-represented groups	Add three additional new active members at least one representing currently under-represented groups
VII. Substance abuse prevention, intervention, treatment, and recovery support of pregnant women and women with dependent children					
14.	Pregnant and Parenting Women:	Substance Abuse Prevention, Intervention, Treatment, and Recovery Support needs of Pregnant Women and Women with Dependent Children	Increase the number of pregnant women accessing the BSAS treatment system.	Increase the total number of pregnant women enrolled in the BSAS treatment system by 10% of the baseline in FY14.	Increase the total number of pregnant women enrolled in the BSAS treatment system by an additional 10%.
VIII. Substance abuse prevention, intervention, treatment, and recovery support workforce development					
15.	Recovery Coach Certification	Substance abuse prevention, intervention, treatment, and recovery support workforce development	Partner with the MA Substance Abuse Counselor Certification Board on the certification for recovery coaches	Implement a process for certification and begin grand-parenting period	Measure the number of certified Recovery Coaches

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No.	Summary	Priority Area	Goal	Year 1 - FY2016	Year 2 - FY2017
16.	Increase number of Approved Addiction Education Providers (AAEPs) that prepare individuals to become LADCs.	Substance abuse prevention, intervention, treatment, and recovery support workforce development	Recruit Continuing Education Providers, Community Colleges, Social Work Schools, etc., that provide coursework required for licensure, to apply for Approved Addiction Education Provider status.	At least 2 new AAEPs will have completed the application and approval process.	At least 2 additional new AAEPs will have completed the application and approval process.
17.	Trauma-Informed Care in BSAS licensed and funded programs	Substance abuse prevention, intervention, treatment, and recovery support workforce development	Support programs to increase their capacity to provide trauma-informed care (TIC) by providing staff training and intensive technical assistance	At least 3 adult and 3 adolescent treatment programs will receive individualized training and TA to support program-wide understanding of TIC	At least 3 additional adult and 3 additional adolescent treatment programs will receive individualized training and TA to support program-wide understanding of TIC
IX. Substance abuse prevention, intervention, treatment, and recovery support of youth and young adults					
18.	Youth and Young Adult Advisory Group	Substance abuse prevention, intervention, treatment, and recovery support of youth and young adults	Create an infrastructure that allows meaningful input for youth and young adults regarding the policies and programming developed and managed by OYYAS	Host Regional Youth and Young Adult Recovery Community Advisory Group meetings for outreach and engagement.	Establish a centralized Statewide Young Adult Recovery Community Advisory Board.
19.	Transitional Age Youth and Young Adults who use opioids	Substance abuse prevention, intervention, treatment, and recovery support of youth and young adults	Develop developmentally appropriate strategies to address opioid use among transitional age youth and young adults (TAYYA) to meet the needs of TAYYA who are using opioids	Identify and fund providers to help create community supports that integrate A-CRA/ACC and MAT treatments to address the needs of TAYYA	Create policies and infrastructure that would support the sustainability of the community-based A-CRA/ACC and MAT collaborations

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X. Infectious disease prevention and treatment needs of clients in substance abuse treatment					
20.	Evidence Based Practices for the treatment of infectious diseases	Health and treatment needs of substance abuse clients at risk for infectious diseases.	Assist treatment providers in understanding the added risks of individuals with Substance Use Disorders who also have infectious diseases such as TB, HIV/AIDS, Hep C, and sexually transmitted diseases and the impact on health and recovery	Create a Practice Guidance on Infectious Diseases	Develop training for BSAS provider system on the Infectious Disease Practice Guidance

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Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2018

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
No Data Available				

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2018

Type of Membership	Number	Percentage
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)		
Family Members of Individuals in Recovery* (to include family members of adults with SMI)		
Parents of children with SED*		
Vacancies (Individuals and Family Members)		
Others (Not State employees or providers)		
State Employees		
Providers		
Federally Recognized Tribe Representatives		
Vacancies		
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Persons in recovery from or providing treatment for or advocating for substance abuse services		

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes: