Commonwealth of Massachusetts

Community Mental Health Block Grant

FY26/FY27

DRAFT for Public Comment Review – 06.12.2025

MASS DMH HOPE • EQUITY • SERVICE
Department of Mental Health

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Land and Water Acknowledgement

The Massachusetts Department of Mental Health acknowledges the traditional territory and homelands of the original people of Massachusetts past and present, and honor with gratitude the land, water, and the people who have stewarded them throughout the generations. Let this acknowledgement serve as a reminder of our ongoing efforts to recognize, honor, reconcile, and partner with the people whose lands and water we benefit from today.

Step 1: Assess the Strengths and Organizational Capacity of the Service System to Address the Specific Populations

Overview of State's Mental Health System

The mission of the Massachusetts Department of Mental Health (DMH) is to assure and provide access to services and supports to meet the mental health needs of individuals of all ages, enabling them to live, work, and participate in their communities. It envisions mental health as an essential component of health care. DMH is committed to promoting recovery and empowerment by providing services that promote a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Consistent with SAMHSA's definition of recovery, services are oriented toward the four major dimensions that support a life in recovery: health, home, purpose and community.

Epidemiology

The 2020 United States Census (Census) and 2022 American Community Survey (ACS) estimates differ slightly for the Massachusetts population, with the ACS estimate being less than 1% lower. Given the ACS estimates are inclusive of calendar year 2020, the decennial Census data collected in 2020 and released at the state level in 2022 is reported in this section. The Commonwealth is relatively small in land mass with a net area of 7,801 square miles, but populous particularly in the larger eastern municipalities. The average population density is 914.8 per square mile. Among all states, MA is the 5th smallest in total land area yet 3rd in population density.

The Department of Mental Health divides the Commonwealth into five Areas each containing at least one of the ten most populous cities. The population distributions across these Areas are shown in Tables 1 and 2. The three largest cities in Massachusetts are Boston (Metro Boston Area), Worcester (Central Area), and Springfield (Western Area). Table 1 below displays the five DMH Service Areas with the distribution of the ten largest Massachusetts cities and their population.

Table 1: DMH Areas' Large Cities with 2020 Census Population

DMH Area/Population	Large Cities	2020 Population	% MA Total
Metro Boston 1,060,575	Boston	675,647	9.6%
	Cambridge	118,403	1.7%
Northeast 1,829,343	Lowell	115,554	1.6%
	Lynn	101,253	1.4%
Southeast 1,689,544	Brockton	105,643	1.5%
	Quincy	101,636	1.4%
	Fall River	94,000	1.3%
Central 1,614,281	Worcester	206,518	2.9%
	Newton	88,923	1.3%
Western MA 856,174	Springfield	155,929	2.2%

The U.S. Census 2024 population estimates for Massachusetts[1] further report that 79.0% of the population is White, 9.6% are Black/African-American, 0.6% are Native American, 7.9% are Asian, 2.8% identify as multiracial with 13.5% identifying as Hispanic or Latino. Immigrants from Africa, Southeast Asia, Central America, the Caribbean Islands, and Eastern Europe continue with foreign-born persons representing 17.7% of the Commonwealth's population. While English remains the most commonly spoken language, 24.8% of households have another language spoken at home. Spanish and Portuguese are the non-English languages spoken by the largest group of non-English speakers. Other languages commonly spoken include Chinese dialects, French, French Creole, Italian, and Russian but a larger variety of languages spoken exists.

[1] https://www.census.gov/quickfacts/fact/table/MA#

Massachusetts Department of Mental Health - The State Mental Health Authority

As the State Mental Health Authority, the Department of Mental Health (DMH) assures and provides access to services and supports to meet the mental health needs of individuals of all ages, enabling them to live, work, and participate in their communities. Through licensing, regulation, and policy, DMH establishes standards to ensure effective and culturally responsive care to promote recovery. DMH promotes self-determination, protects human rights, and supports mental health training and research. This critical mission is accomplished by working in partnership with other state agencies, individuals, families, and communities. DMH licenses acute psychiatric hospitals and acute psychiatric units in medical facilities. Furthermore, DMH provides a system that is person-centered and family-centered, trauma informed, and recovery-oriented for a defined service population including adults with a qualifying mental disorder accompanied by functional impairments and children with serious emotional disturbance. The DMH service planning regulations establish a service authorization process for matching consumers with the right care at the right time and place.

The DMH system of care emphasizes treatment, clinical services, rehabilitation, and recovery for its service population. The central aim of DMH service delivery is to integrate public and private services and resources to provide optimal community-based care and opportunities for its clients. Services are designed to meet the behavioral health needs of individuals of all ages, and delivered flexibly thus enabling them to live, work, attend school, and fully participate as valuable, contributing community members. DMH works toward reducing the need for hospitalization and out-of-home placement by improving the integration of acute diversionary services with community support programs, including collaboration with sister agencies such as the Department of Children and Families (DCF) and MassHealth, the Commonwealth's Medicaid agency.

DMH directly provides and/or funds a range of services for 27,562 adult, adolescent and child clients per year. These services include inpatient continuing care, case management, and other community clinical, rehabilitative, and recovery-based services. Although publicly funded acute-care services, including inpatient, emergency and outpatient services are managed by MassHealth, DMH operates some acute inpatient and outpatient services in the Southeast and Metro Boston Areas. The central aim of DMH service delivery is to integrate public and private services and resources to provide optimal community-based care and opportunities for its clients.

MassHealth: Massachusetts' Medicaid Authority

Beginning with its initial 1996 Medicaid Section 1115 waiver, Massachusetts has led the United States in health reform, creatively expanding eligibility for Medicaid and implementing the nation's first healthcare marketplace to provide increased coverage and improved access.

Massachusetts insures almost two million residents (over 25% of its population) through Medicaid, and was an early implementer of parity rules and mandates that expanded coverage for individuals with a substance use disorder. In Massachusetts, Medicaid and the Children's Health Insurance Program are together called MassHealth. DMH exercises its role as the State Mental Health Authority through partnership with MassHealth, including its Office of Behavioral Health Unit (OBH) to ensure compliance on an array of program standards, clinical criteria and protocols, policies, performance incentives, and quality improvement goals that ensure the MassHealth.

In SFY18, MassHealth, through the 1115 waiver, was authorized to receive $1.8 billion over five years for new Delivery System Reform Incentive Program (DSRIP) funding. DSRIP funds are supporting the restructuring of MassHealth's delivery system to promote integrated, coordinated care and hold providers accountable for quality and total cost of care. Specifically, DSRIP is supporting MassHealth's transition to Accountable Care Organizations, including funding for Community Partners to integrate behavioral health, long-term services and supports, health-related social needs, and funding to support statewide investments to efficiently scale up statewide infrastructure and workforce capacity, including behavioral healthcare capacity, in support of MassHealth restructuring. MassHealth received an approved 1115 demonstration extension to continue progress in improving health outcomes and closing health disparities for members, in concert with other MassHealth efforts. The new demonstration extends and expands reforms through December 2027.

MassHealth also provides integrated care delivery option to MassHealth members who are dually eligible for Medicaid and Medicare. These options include One Care, Program of All Exclusive Care for the Elderly (PACE), and Senior Care Options. One Care is an integrated care delivery option that allows people ages 21-64 who are eligible for both MassHealth and Medicare to receive care as part of a single plan offering comprehensive benefits. These benefits are delivered through a care team and provider network that integrates primary care, specialty care, behavioral health, and long-term services and supports through a person-centered assessment, planning and service delivery using medical home or health home models as the foundation.

DMH works closely with MassHealth to improve the integration of the health care system in two broad areas. First, DMH serves in its role as the State Mental Health Authority by engaging in a host of planning activities with MassHealth and other state partners and stakeholders related to the design and delivery of health care to improve integration and outcomes of residents of the Commonwealth.

Second, DMH aims to improve the integration of behavioral health, medical, and specialty services provided directly to people who receive services as DMH clients. DMH supports clients in receiving education and counseling on MassHealth benefits and assistance in enrolling in eligible plans and benefits, including care coordination resources. DMH meets regularly with the MassHealth Behavioral Health Community Partners (BH CP) program and One Care plans to

address care coordination needs of DMH clients and to implement and improve operational processes to promote integrated care. DMH is also working closely with MassHealth to ensure continuity of MassHealth coverage with the end of continuous coverage requirements in April 2023.

Within DMH community-based adult services, contracted providers are required to provide clinical, rehabilitative, and support services that enhance the physical health and well-being of people served through the following: wellness promotion and support of the management of medical conditions; assistance and support in accessing psychiatric and medical services as needed; and development of linkages and working relationships with community providers, including health providers.

Health, acute-care mental health services, and some intermediate care services for youth who are DMH clients are provided through public and/or private insurance, with virtually all children in the state having access to some primary care coverage. Part of the responsibility of case managers and program staff is to work with parents and youth to help them get connected and stay connected to appropriate mental health and other health services. Eligibility staff work with DMH applicants to ensure they are enrolled for all benefits to which they are entitled, and case managers and provider staff advocate with insurers on questions of coverage.

Substance Abuse Authority

The Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) is the Single State Authority, overseeing the Commonwealth's addiction services as well as tobacco and gambling prevention and treatment services. BSAS' responsibilities include licensing programs and counselors; funding and monitoring prevention, intervention, and treatment services; providing access to treatment for the indigent and uninsured; developing and implementing policies and programs; and tracking substance abuse trends in the state. DMH and BSAS collaborate on several initiatives related to the planning of services for people with co-occurring substance use and mental health conditions with current emphasis on implementing the Behavioral Health Roadmap. BSAS representatives also participate in the State Mental Health Planning Council.

Of note is the Recovery from Addiction Program (RAP), a collaboration between DMH and DPH BSAS. It provides services related to substance use disorders as well as specialized mental health treatment for co-occurring disorders for individuals who are civilly committed by the courts for substance use treatment for up to 90 days (i.e. section 35 commitment). RAP provides administrative, medical, clinical, and non-clinical services via quality client-centered care and recovery-oriented treatment. The program provides acute detoxification and early clinical stabilization services as clients develop community-based linkages to outpatient supports and substance use disorder treatment providers. Individuals treated within RAP will be linked upon discharge to a range of services within the DMH and DPH continuum of care.

Other initiatives addressing care for persons dually diagnosed with mental health and addiction disorders are described throughout this Plan document.

Organization of the Department of Mental Health

DMH is organized into a Central Office (CO) and five geographic regions: Central, Western, Northeast, Metro Boston, and Southeast Areas. The Central Office in Boston is organized into eight Divisions in addition to the Commissioner's Office: Mental Health Services; Children, Youth, and Family Services (CYF); Clinical and Professional Services (CPS); Forensic Services Management and Budget; Data and Analytics; the Office of the General Counsel (Legal) and the Office of Behavioral Health Promotion. The Central Office coordinates planning sets and monitors attainment of broad policy and standards, and performs certain generally applicable fiscal, personnel, and legal functions. Additionally, the Central Office provides liaison to the Executive Office of Health and Human Services, which maintains consolidated human resources, information technology, and revenue functions. Central Office manages some specialized programs, such as the Expedited Psychiatric Inpatient Admission program, forensic mental health services, adolescent extended stay inpatient units, and child and adolescent intensive residential treatment programs. Within Central Office, there are Offices of Communication; Human Rights; Investigation; Recovery and Empowerment; and Race, Equity and Inclusion. Quality improvement activities, data analytics, and liaison to the Executive Office of Health and Human Services Information Technology Services (EHS-IT) are also coordinated through the Central Office Division of Clinical and Professional Services, which has primary responsibility for the Mental Health State Plan.

Each DMH Area is managed by an Area Director and Area leadership teams, including Area Adult and Child Medical Directors; Child and Adolescent Psychiatrists; Directors of Community Services; Directors of Children, Youth, and Family Services; and Quality Directors. All Area Directors report to the Deputy Commissioner for Mental Health Services. The five DMH Areas are further subdivided into 27 local Service Site Offices located in 25 places across the Commonwealth. Each Service Site Office is overseen by a Site Director. The Sites authorize services for individuals, provide case management, and oversee an integrated system of state- and vendor-operated adult and child, adolescent, and transition age youth community mental health services. Most service planning, service and contract performance management, quality improvement, and citizen monitoring services emanate from Site and Area offices, with Central Office oversight and coordination.

Each Area and Site has a citizen advisory board, appointed by the Commissioner and comprised of consumers, family members, professionals, interested citizens, and advocates. Board members assess needs and resources and participate in planning and developing programs and services in their geographic domain. Additionally, a Mental Health Advisory Council (MHAC), appointed by the Secretary of EOHHS and comprised of consumers, family members,

professionals, interested citizens, and advocates, receives data pertaining to the entire system and advises the Commissioner on mental health policy and priorities. The State Mental Health Planning Council (SMHPC) is established as a subcommittee of the MHAC. In addition, there is a statewide Human Rights Advisory Committee, and each hospital has a board of trustees appointed by the Governor and a trustee's seat on the Area board in the DMH Area where the hospital is located. Although not mandated by statute or regulation, there is also a Professional Advisory Committee on children's mental health, comprised of advocates, professionals, family members, and state agency representatives.

All of the state hospitals, Community Mental Health Centers (CMHC), adolescent inpatient units, and child and adolescent intensive residential treatment programs are accredited by the Joint Commission and certified by the Center for Medicare and Medicaid Services (CMS). DMH has the statutory responsibility for licensing all non-state-operated general and private psychiatric inpatient units and adult residential programs in the state. Children's community residential programs are licensed by the Department of Early Education and Care (EEC). As of May 2025, DMH licenses 3,218 inpatient beds including 202 adolescent beds, 63 children's beds, 213 child/adolescent beds, and 423 geriatric beds. Children, adolescents, and most adults receive acute inpatient care in these private or general hospitals, with the exception of adult admissions to the CMHC acute units and some forensic admissions. Additionally, there are 32 DMH operated acute inpatient psychiatric beds at CMHCs in the Southeast Area.

Each of the five DMH Areas includes a major population center (see Table 1), and each of DMH's 27 Sites has at least one town or incorporated city with a population greater than 15,000 that is considered the site's center of economic activity. None of the local service Sites' catchment area has a population density below 100 people per square mile. Hence, DMH has not designated sites as "rural" or developed a separate division or special policies for adults, children, or adolescents who reside in the less densely populated areas of the state. However, access to services in these areas continues to pose a challenge to Area planners and providers, in particular access to transportation. DMH has collaborated with the Department of Public Health's State Office of Rural Health in its planning efforts. Each Site plan identifies target population, needs, available services and resources, gaps in services and resources, and barriers to implementation of a local service delivery system.

Massachusetts Behavioral Health Roadmap

While Massachusetts has long provided an array of community-based outpatient, diversionary, and inpatient behavioral health treatment services, many of these services are not fully integrated, and the system often proves challenging for individuals and families to navigate. To address these challenges, DMH has worked in close collaboration with other Executive Office of Health and Human Services (EOHHS) agencies in the redesign of the behavioral health system across Massachusetts. The multi-year plan – Roadmap for Behavioral Health Reform: Ensuring the right treatment when and where people need it – launched in February 2021 and was

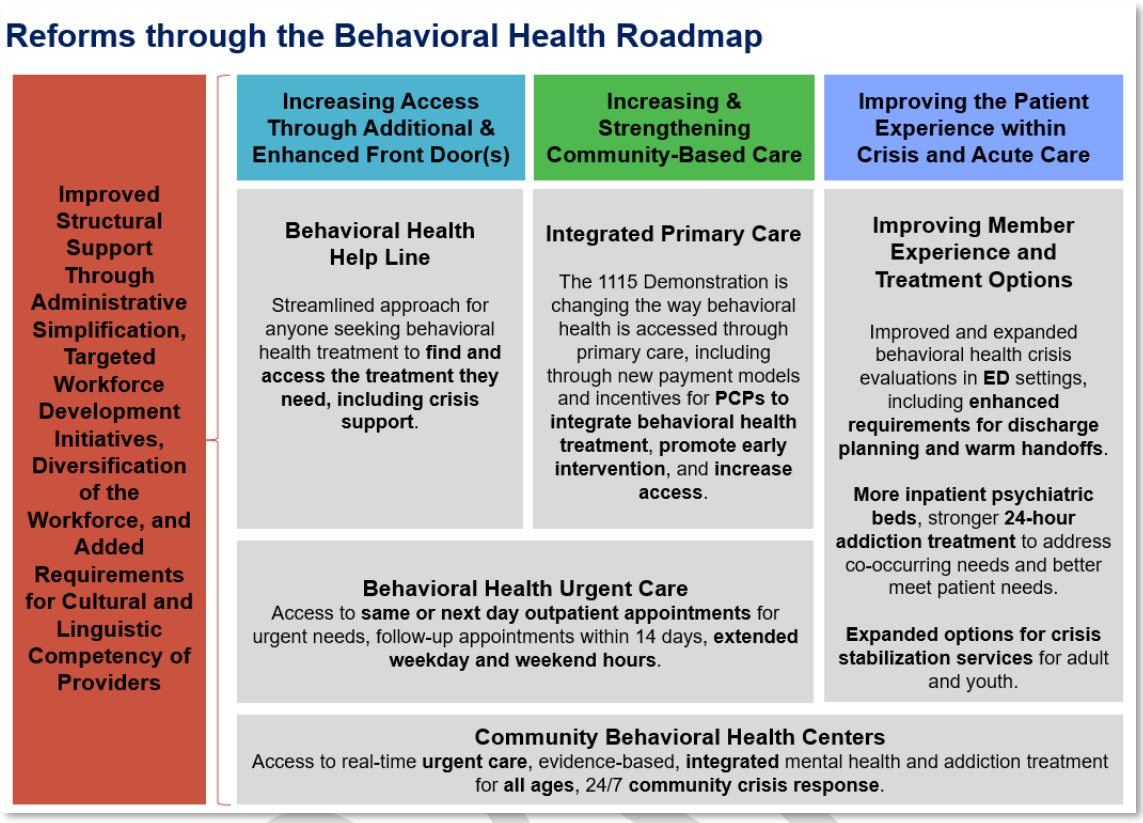
based on listening sessions and feedback from nearly 700 individuals, families, providers, and other stakeholders who identified the need for expanded access to more effective treatment and improved health equity.

A critical piece of the Roadmap is the creation of a "front door" to treatment – a new, centralized service for people to call or text to find the right treatment for mental health and behavioral health when and where they need it. The front door helps people connect with a provider before there is a mental health emergency, for routine or urgent help in their community or even right at home. Additional critical behavioral health system reforms throughout the Roadmap include:

- Readily available outpatient evaluation and treatment, including in primary care;
- Increasing availability of mental health and addiction services through primary care, supported by new reimbursement incentives;
- Same-day evaluation and referral to treatment, evening and weekend hours, timely follow-up appointments, and evidence-based treatment in person and via telehealth at designated Community Behavioral Health Centers throughout the Commonwealth;
- Better, more convenient community-based alternatives to the emergency department for urgent and crisis intervention services;
- Urgent care for behavioral health at Community Behavioral Health Centers and other community provider locations; and
- A stronger system of 24/7 community and mobile crisis intervention.

The Roadmap also proposes to:

- Advance health equity to meet the diverse needs of individuals and families, particularly from historically marginalized communities;
- Encourage more providers to accept insurance by reducing administrative and payment barriers;
- Broaden insurance coverage for behavioral health; and
- Implement targeted interventions to strengthen workforce diversity and competency.



These reforms do not replace or disrupt existing services or provider relationships – rather they aim to help individuals and families more quickly and easily fully access the range of comprehensive services offered across the Commonwealth. The Roadmap provides more convenient community-based alternatives to the emergency department for urgent and crisis intervention services and more readily available outpatient services, including same-day evaluation and referral to treatment, and ensures residents can access integrated behavioral health care which serves the entire person. In short, the Roadmap creates a no-wrong door approach to treatment by encouraging multiple points of entry with same-day access, integrating addiction and mental health services, and providing community-based crisis response while upholding evidence-based practices.

As noted in the image above, the Behavioral Health Help Line (BHHL) is one of the “front doors” developed by the Roadmap. An EOHHS cross-agency collaboration, the BHHL provides a centralized access point for all Massachusetts residents to connect to mental health and substance use disorder treatment and services across crisis, urgent, and routine needs.

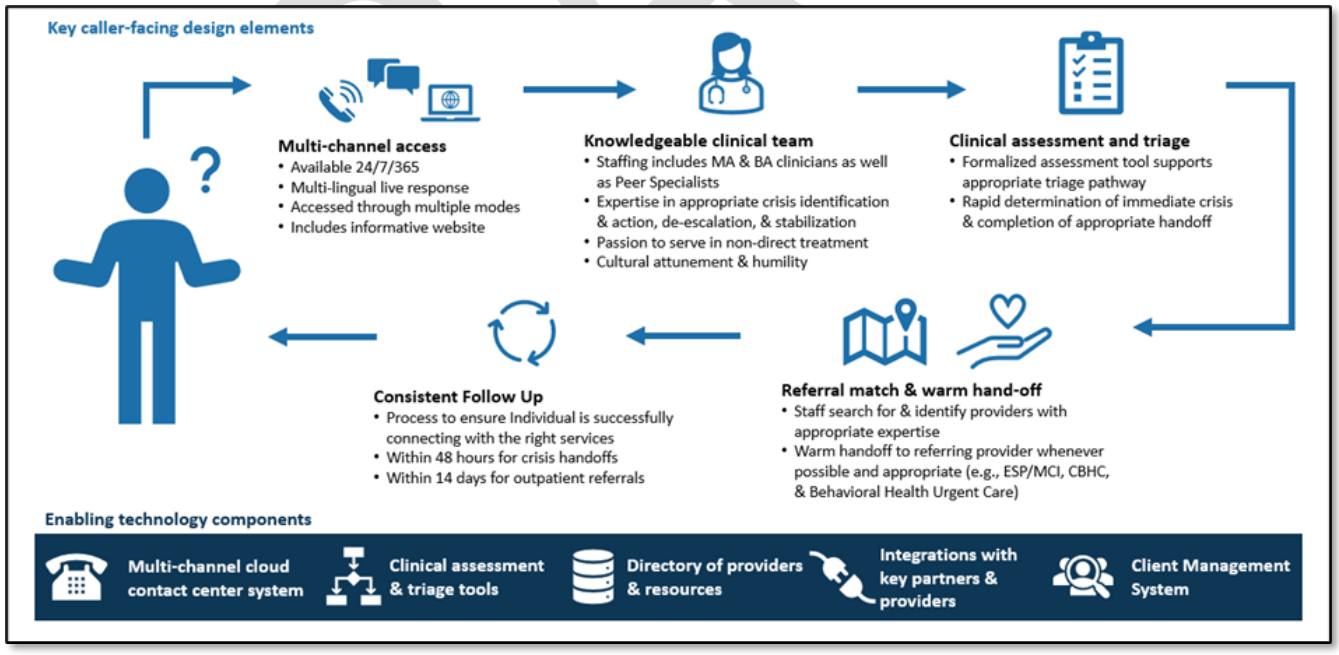
The BHHL operates as a multi-channel contact center, staffed by a knowledgeable and culturally competent clinical team. This team, composed of Master’s and Bachelor’s level clinicians, , Follow-up Specialists as well as Peer Specialists, provides clinical assessment and triage, referral

match, warm handoffs, and closed-loop follow-up to ensure individuals seeking support are connected successfully to appropriate services across the continuum of behavioral health needs.

The key BHHL elements and enabling technology components include:

- Live response 24/7/365 to ensure immediate transfer to treatment;
- Non-Insurance driven service with support navigating insurance coverage for services;
- Multi-channel (i.e., phone, text, webchat) access with appropriate linguistic and cultural capacity;
- Public-facing website with full compendium of treatment resources;
- Interactive clinical triage and service navigation in multiple languages;
- Referrals to behavioral health and social determinant of health resources for all ages;
- Peer Specialist staff supporting BHHL operations; and
- Follow up process to ensure connection to referred providers.

The chart below describes an individual's journey throughout the BHHL process:



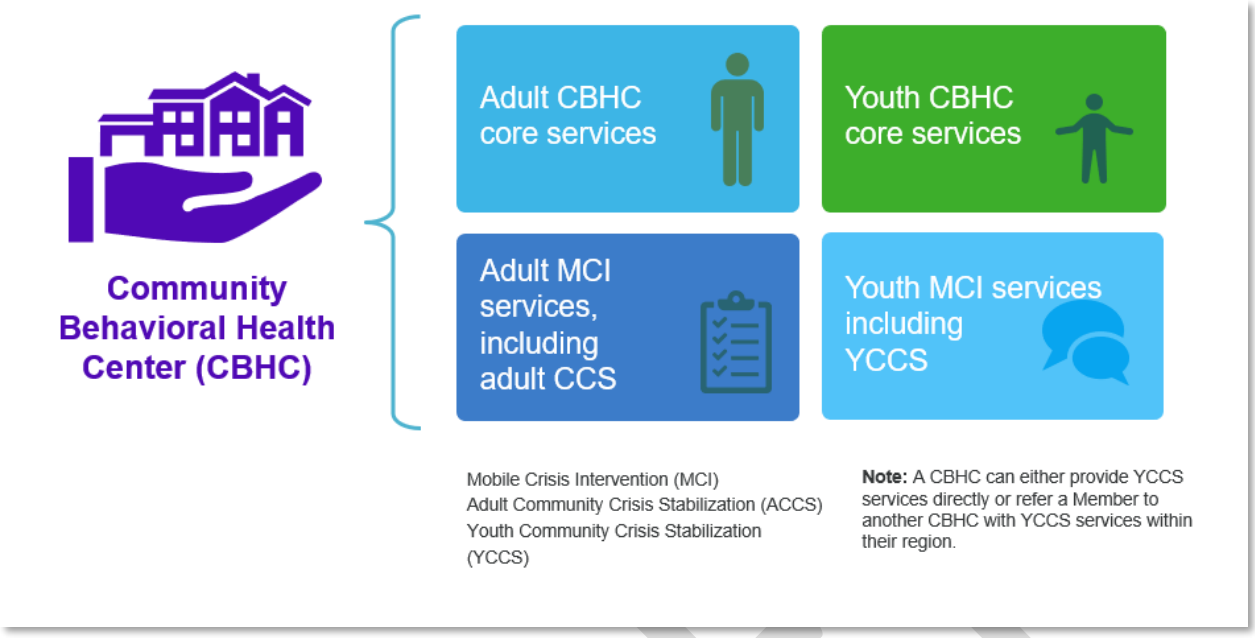
Given the launch of 988 during this time period, it is important to note that Behavioral Health Help Line leadership worked closely with the 988 Suicide and Crisis Lifeline team to ensure

coordination between the two services. Through regular meetings to discuss operations, incidents, and workflow, the teams offer seamless and complimentary services to the residents of Massachusetts. Staff for both the BHHL and 988 have protocols in place which outline warm handoffs as appropriate between the two lines. BHHL specifically refers to a caller to 988 when a caller asks about 988, has a history of support from 988, or if a caller is looking for suicidal crisis support or support for emotional distress for themselves or a loved one.

The second pillar of the Roadmap is the establishment of a statewide network of 27 Community Behavioral Health Centers (CBHCs), providing integrated behavioral health services accessible to individuals in all cities and towns in Massachusetts. CBHCs provide 24/7 mobile crisis intervention, urgent care for behavioral health, same and next day evaluation and referral to treatment with expanded evening and weekend hours, and integrated behavioral health services, including addiction services. The goal of CBHCs is to ensure a seamless, predictable, consistent experience for individuals and families, enabling them to quickly and easily get connected to the treatment they need, in one location in their community, 24/7/365.

Although CBHCs were not established until January 2023, there are already early indicators of their positive impact across the Commonwealth including:

- Reduction in Section 12s from the community to Emergency Departments;
- Reduction in wait times for Mobile Crisis Intervention because people are able to access other urgent/same/next day treatment when they need it;
- Increased police drop off to CBHCs vs. Emergency Departments, and an increase in partnerships/relationships including co-response programming between CBHCs and Police Departments;
- Increased Ability to engage people in the variety of core services (including peer/recovery supports and groups which are clinician, peer, or RN led) has allowed people to access the support that works for them outside of ongoing outpatient services and/or while they wait for those services; and
- Expanded hours of operation allow people to attend intakes outside of typical business hours, thus accessing needed services that did not fit into their schedules previously.



Finally, in addition to the CHBCs, there are community behavioral health providers across the Commonwealth providing a range of urgent care services. Behavioral Health Urgent Care Centers (BH UC) are mental health centers that provide services more urgently, including same or next day access, with extended hours compared to traditional clinics. They also provide more integrated addiction treatment with mental health services.

A unique feature of the Behavioral Health Help Line is its close integration with Community Behavioral Health Centers, Behavioral Health Urgent Care, and Mobile Crisis Intervention (MCI) services to offer holistic crisis response services. Together, the BHHL, CBHCs, and other urgent care locations are creating a no-wrong door approach to treatment with multiple points of entry for same-day access, integrated addiction and mental health services, and community-based crisis response across the Commonwealth.

Since its launch in January 2023, the Behavioral Health Help Line (BHHL) has had several accomplishments:

a. The BHHL Leadership team designed and facilitated a training on Behavioral Health and The Behavioral Health Roadmap (covering BHHL and CBHCs) for a new cohort of 911 dispatchers. In a collaboration between Massachusetts Behavioral Health Partnership (MBHP), DMH, and MassHealth/Office of Accountable Care and Behavioral Health (ACBH, formerly the Office of Behavioral Health), the web-based Roadmap Feedback Portal was implemented, providing a pathway for providers and consumers to report issues, incidents, and concerns regarding Roadmap services.
b. The OpenBeds Standards and Usage Guidelines for Urgent Access Referral Platform for BHHL/CBHCs was developed. Workflows were developed.

c. The BHHL leadership team, along with ACBH at MassHealth and MBHP, planned and facilitated a Roadmap meeting for all CBHC executive leadership, promoting alignment and collaboration prior to the launch of the OpenBeds referral platform.

d. The BHHL Resource Directory was developed and readied for large-scale data transfer from other repositories. The BHHL Resource Directory successfully received large-scale data transfer and continued development. Quality control and auditing processes addressed irregularities and bugs for soft launch at the end of the year and public launch in early 2024.

e.

f. The BHHL leadership team designed and launched a series of Roadmap trainings to be offered to all MA first responders through the State 911 Department to explore the intersection between law enforcement and mental health and the potential solutions that Roadmap services offer.

g. The BHHL leadership team finalized the BHHL Advisory Council Charter, identified members, and held the first BHHL Advisory Council held in September with diverse representation from many important stakeholder groups, including consumers, law enforcement, schools, commercial payors, community providers, hospitals, and state agencies.

h. The Phase 1 BHHL marketing campaign ran through July 2023 and was successful in dramatically increasing traffic to the BHHL website. It performed well on social media platforms, particularly in reaching Spanish and Portuguese-speakers.

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a. Workflows between BHHL and 988 call centers were updated to improve warm transfers; the BHHL began utilizing dedicated and prioritized 10-digit numbers that directly connected to local centers (and by-passed the national re-route).

b. The language selection IVR (Interactive Voice Response) and consumer satisfaction survey both went live. The language selection IVR provides a multi-lingual menu that includes the top seven languages used in Massachusetts and allows callers to select a language of their choice, thereby expediting connection to the appropriate interpreter. The consumer satisfaction survey is available as an option to callers at the end of initial calls (routine risk-rated only) or follow-up calls.

Regulations

The Department's enabling statute is M.G.L. Chapter 19 and mental health commitments to facilities operated or licensed by DMH are governed by M.G.L. Chapter 123. DMH has promulgated a comprehensive set of regulations governing its state-operated, contracted, and licensed facilities, which are found in Chapter 104 of the Code of Massachusetts Regulations (104 CMR). These regulations outline the Department's authority, mission, and organizational structure, citizen participation, licensing, and operational standards for service planning, fiscal administration, research, investigation procedures, and designation and appointment of

professionals to perform certain statutorily authorized activities. Licensing and operational standards apply to all inpatient facilities (DMH-operated and other licensed inpatient facilities) as well as community programs.

DMH continuously reviews all its regulations to identify those in need of revision. Through this effort, DMH assures adequate agency oversight and monitoring of the programs and services it provides, contracts for, or licenses while also seeking to streamline administrative processes and to reduce the regulatory burden for providers. DMH recent regulatory amendments have included provisions to assure the facilities it licenses meet the needs of the Commonwealth. DMH regulations also support implementation of telemedicine under clinically safe and appropriate circumstances.

DMH continues to support efforts in its own facilities and those it licenses to reduce or eliminate the use of restraint and seclusion. DMH's restraint and seclusion regulations emphasize prevention but address use. The prevention focus of the regulations incorporates the six principles of the National Association of State Mental Health Program Directors' Six Core Strategies. DMH regulations are compatible with the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission standards on restraint and seclusion, thus easing the reporting burden on facilities (DMH state-operated facilities and DMH licensed facilities) subject to all three sets of requirements.

Massachusetts has made it a priority to strengthen and reform the behavioral health system in the Commonwealth. Policy changes across DMH, MassHealth, and the MassAbility (formerly known as Massachusetts Rehabilitation Commission (MRC)) worked to improve health outcomes and quality of life for individuals with serious mental illness. As the State Mental Health Authority, DMH delivers specialized, high intensity services to individuals with the most serious mental illness that complement MassHealth-funded services.

DMH is in the process of promulgating regulations that will assure individuals in long-term care facilities (nursing homes) who have been determined to meet federal PASRR criteria for Serious Mental Illness, and to potentially be able to be served in the community, receive Transitional Case Management services to assist in service identification, coordination, and transition to appropriate community services.

In addition to DMH regulations, DMH and its providers are subject to the regulations issued by the Commonwealth's Executive Office of Health and Human Services. These regulations include requirements for conducting Criminal Offender Record Checks on potential employees, trainees, and volunteers.

Defining the Target Population

The DMH policy defining "priority clients" was developed in response to a legislative mandate narrowing the DMH service mission to adults with Serious Mental Illness (SMI) and children

with Serious Emotional Disturbance (SED). DMH's Service Authorization regulations were updated in 2018 to conform to changes in the DSM-V and to provide a more gradual transition from child and youth services into adult services. Specifically, the broader clinical criteria for children and youth have been extended to apply to young adults up to their 22nd birthday. More young adults ages 19 through 21 will be able to access DMH services and they will have access, as appropriate, to services from both the child and youth serving system as well as the adult serving system.

Human Rights

DMH is both a monitor and promoter of the use of the legal processes that exist pursuant to DMH regulation, state law, and federal law to protect the rights of service recipients. The DMH Director of Human Rights oversees the Office of Human Rights and provides supervision and support to the DMH Inpatient Human Rights Officers and the DMH Assistant Human Rights Director. The Assistant Human Rights Director provides support and oversight to the DMH Area Human Rights Coordinators, DMH Vendor Human Rights Officers and Coordinators, and Child/Adolescent Human Rights Officers across the Commonwealth. Regulation and policy require that Human Rights Officers and Human Rights Committees be active in public and private inpatient settings as well as in state-operated and contracted community programs. Additionally, there is a statewide Human Rights Advisory Committee that advises and assists the Commissioner in matters regarding the human and civil rights of people served by DMH.

The Statewide Human Rights Team promotes advocacy for individuals served at DMH facilities as well as in state-operated and contracted community programs. The team engages each DMH state-operated facility to meet a person's cultural and linguistic needs while respecting and promoting the needs of every individual in the DMH service system. Human Rights Officers escalate issues and concerns as they occur, bringing them to the attention of the Director of Human Rights. The Director of Human Rights meets regularly with leadership at the DMH operated facilities to assist in addressing issues as they relate to human rights and provide support as needed. The Statewide Human Rights team continues to build a rapport with staff at the facility level and community programming ; and the Assistant Director of Human Rights continues to provide support and Human Rights training for the Child, Youth, and Family Services programs.

Additionally, DMH has developed a human rights handbook, human rights brochure for parents and children, and human rights videos for children and adolescents and for the Deaf and Hard of Hearing. DMH sponsors Area-based Human Rights training with an emphasis on skill building for Human Rights Officers, Coordinators, and Committee members. Collaboration between the Office of Human Rights and DMH Staff Development has produced an annual Human Rights review course, mandated for DMH personnel.

The Office for Human Rights has successfully worked with DMH to contract with 2 diverse vendors who now supply hair care and body care products and different tools for clients of color in DMH facilities that meet the hair and body care needs of each client. In order to best advocate, the Director of Human Rights has worked collaboratively with key DMH stakeholders at levels of the agency, as well as the facility Chief Operating Officers to order these products and make them available to all clients. The Office of Human Rights was also able to successfully work with DMH to contract a traveling barber. The barber has hair stylists and other barbers on staff who has been traveling to each of the different DMH inpatient facilities to cut and style clients hair.

The Human Rights Department also develops the Human Rights Annual Review course for all DMH staff which focuses on a variety of different topics related to human rights while making a connection to the Six Fundamental Rights. As a standard of practice, the HR Department believes the Department cannot be intentional in its effort to meet the racial, cultural, and linguistic needs of each individual served if DMH does not first understand what a person's basic needs are, and the individual's right to have their most basic needs met according to their background, religion, and culture. In doing so, ensures that dignity and respect for all individuals served by DMH are always at the forefront and are supported and upheld.

Office of Race, Equity and Inclusion

The DMH Office of Race, Equity and Inclusion (OREI), formerly the Office of Multicultural Health, has the structural and functional responsibility for implementing the Department of Mental Health's mission of providing culturally competent care. OREI works collaboratively with DMH area leadership and staff including area diversity committees, and divisions within DMH to deliver culturally and linguistically appropriate services in DMH-operated and DMH-funded programs. The purpose of culturally and linguistically appropriate services is to promote recovery, improve access to quality mental health care, and reduce mental health disparities among diverse racial, ethnic, and linguistic populations in Massachusetts.

The OREI focuses on the following areas:

- **System Transformation** – Policies and practices that promote race equity and social justice in all DMH programs and services;
- **Community Partnerships** – Partner with mental health providers, community organizations, DMH area staff, and government agencies to raise multicultural communities' awareness of mental health issues and provide information on where to seek help. Continue to develop relationships with community organizations that have expertise in serving or outreaching to multicultural communities;

- **Services** – Strengthen culturally and linguistically competent services throughout the entire DMH service delivery system. Ensure DMH-operated programs are linguistically competent by providing a variety of language access resources that help DMH staff communicate with non-English speaking clients (such as in-person interpreting, phone interpreting, document translation, and bilingual flashcards);

- **Training and Education** – Integrate mental health disparities and cultural and linguistic competence into trainings and staff development for DMH employees;

- **Data and Research** – Use of analyses of DMH client population census, client satisfaction surveys, language access utilization reports, and outcome measures to inform policy, research, program development, clinical practice, and recruitment and retention of diverse DMH workforce; and

- **Information** – Promote communication and information dissemination on issues of health and mental health disparities, mental illness prevention and wellness promotion, and cultural and linguistic competent practices.

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The OREI was established to lead DMH in its work to become an agency where all people are welcomed and valued, and to advance and integrate Race, Equity, and Social Justice into all programs and services. The office is the merger of the Office of Diversity and the Office of Multi-Cultural Affairs with the goal of advancing and supporting all persons who are in a protected class. This is a much-needed opportunity to bring together REI issues in a broader context and to connect the work of the field to DMH's Central Office and the work of EOHHS to DMH. Led by a Director with over 30 years of tenure at the agency, the office is able to incorporate historical macro-level systemic issues as well as micro-level details into its work on equity and inclusion. Additionally, the office offers perspectives and knowledge that are cross-generational, LGBTQ-competent, and linguistically diverse. All members of the office are People of Color.

To ensure the delivery of culturally competent services to Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ) persons and their families, DMH has launched an LGBTQ Initiative. As an initial first step, DMH held interviews with key informants, as well as focus groups with clients who self-identify as LGBTQ. The DMH also conducted an all-employee survey to assess LGBTQ environment and needs. The results of these discussions and survey developed the DMH LGBTQ policy and training activities. This culminated in the establishment of an official DMH LGBTQ Non-Discrimination Policy issued in January 2021, making it the second agency in the Secretariat to do so. A guidance for the policy was developed to assist with implementation, and a Train-the Trainer series was conducted to ensure internal capacity to provide the necessary training to all DMH staff. Training on the policy was delivered initially to all managers, supervisors, and community staff. ~~To date, approximately half of the facility staff have been trained. The last stage of training will be for inpatient staff~~.

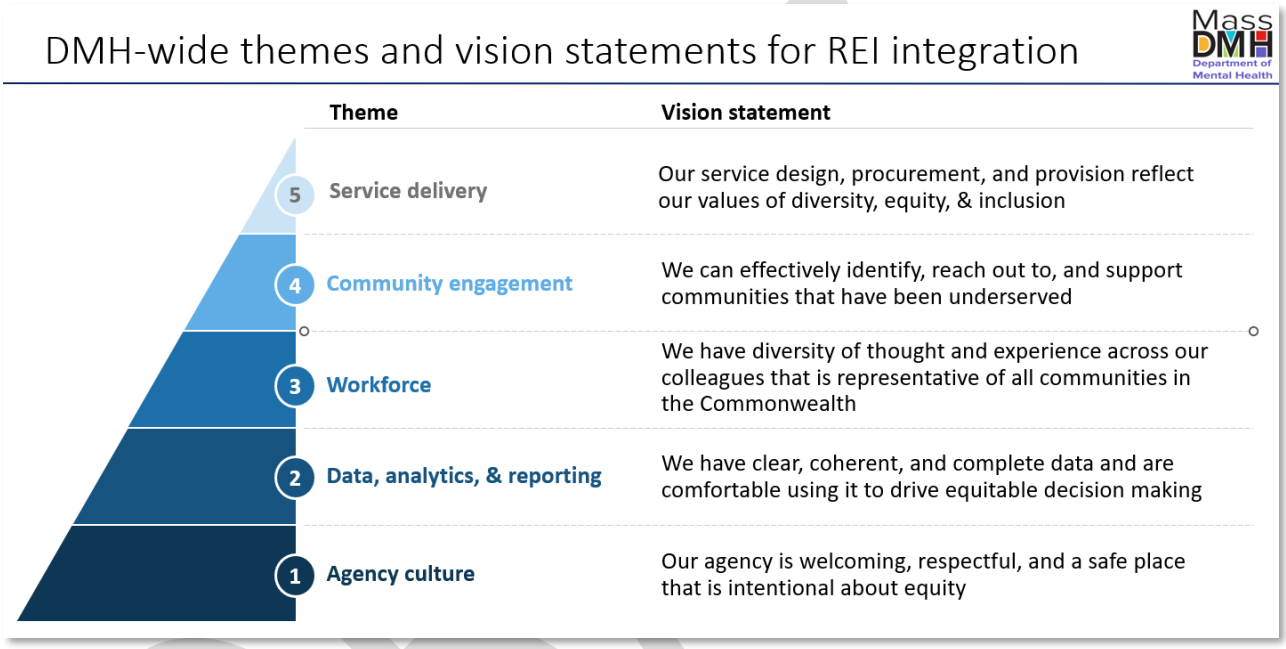
Further, DMH amended the gender reporting fields within its Mental Health Information System (MHIS) to better reflect an individual's identification. Once implemented, DMH will be enabled to target services based on the needs of its persons served. The new fields include gender identity, sexual orientation, and pronouns. Any new clients will have this information included in their medical record, and the goal is to update the records for all current clients by the end of the year.

DMH has standardized the collection of clients' race and ethnicity in MHIS, basing the manner of collection on the Institute of Medicine's recommendations and Office of Management and Budget guidelines. OREI regularly reviews population census data for DMH and also reviews service enrollment data and studies on prevalence rates of mental illness based on race and ethnicity. OREI has worked closely with DMH's two Centers of Excellence to identify social, cultural, environmental, and economic determinants that have an effect on the prevalence of mental illness among racial, ethnic and culturally diverse populations.

Although DMH's mission includes culturally competent services to all individuals, this goal continues to be a challenge. While we can point to specific communities with unmet service needs, the strategies to address those needs often falls back on the workforce itself. Thus, OREI has been involved in:

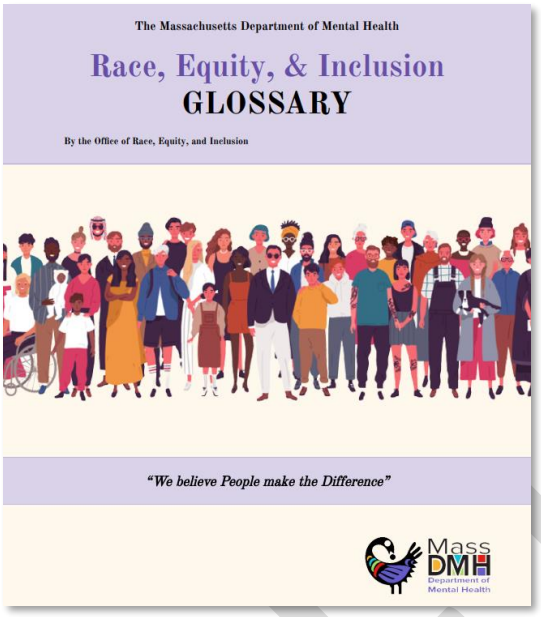
- Trainings for hiring managers to promote diversity and address implicit bias;
- Professional development and retention strategies such as development of a pipeline into a career with DMH via internships for students of color from local colleges and universities;
- Development of trainings to promote respect and civility in the workplace and address microaggressions;
- Equity review for all current DMH staff trainings to better incorporate REI principles and for better compliance with CLAS standards. There is a plan to develop a protocol for future learning and development offerings.
- ~~Listening Sessions for staff of color following the murder of George Floyd and the shooting in Atlanta of the Asian women; and~~
- Recognition and promotion of staff via mini-presentations to support specific events, including but not limited to Black History Month, Deaf History Month, Pride, etc.;
- Development and implantation of a new procurement boilerplate that incorporates equity principles and a new evaluation tool for RFIs, RFRs, and RFPs to increase accountability to our equity goals. ~~Procurement of DMH services and the development and review of for services~~;
- Development of an online REI resource library that is available to anyone at DMH to support their work with trainings, articles, book lists, etc. on a variety of topics.
- ~~Working with Service Authorization to ensure that staff were accurately collecting race data for applicants; and~~
- ~~Providing training for all Service Authorization staff which will extend to Case Management staff.~~

OREI has made a concerted effort to make equity and inclusion a part of DMH, both internally and externally. This work is not considered a "special project" that people will only see as a task to be completed or as another edict that may fall by the wayside. Instead, steps have been taken to make equity and inclusion a part of DMH's daily mission and a part of the agency's identity. To illustrate this vision, OREI created a REI pyramid which outlines its vision for agency culture, data and analytics, workforce, community engagement, and service delivery.



The infographic above details the vision for REI integration. It has been translated into the new Vision and Mission Statement for DMH and the department's new strategic plan. For every strategic priority, there is a spotlight on how equity/CLAS principles are being embedded.

The office has also developed a *Race, Equity, and Inclusion Glossary* to assist staff on their collective journey towards race equity and social justice:



The planning and execution of DMH's Behavioral Health Help Line (BHHL) is OREI's most significant accomplishment as both a service initiative and an equity initiative. The BHHL is available in 200 languages and marketing materials have been created in 13 languages to date. All efforts intended to create easier access as well as broader access to all Massachusetts residents. This pairs with the new Community Behavioral Health Centers in communities around the Commonwealth, including in some traditionally underserved communities. Activities related to this work include:

- In addition to the Spanish website, DMH has expanded its efforts to include a Portuguese website. We are in discussion about creating sites in Haitian Creole and Chinese.
- Translating all public-facing DMH forms into 13 languages;
- Addition of Language Access Coordinator;
- Inclusion of REI goals in all DMH activities (e.g. REI spotlights in Communications newsletters, events);
- Maintained 3-5 contracted ASL interpreters and added 2.5 FTE of ASL interpreters to increase access for Deaf and Hard of Hearing staff.
- Launched new scheduling software to improve and increase requests for interpreters, as well as provide data that can inform language access for clients in DMH services;
- Offered introductory language classes for DMH staff in American Sign Language, Spanish and Haitian Creole;
- Revision of the Language Access Plan;
- Development of race/ethnicity and sexual orientation/gender identity data collection training;
- Launch of the Vendor Diversification Project; and

- Continued efforts of DMH Area REI committees to develop activities and review their practices.

Leveraging the requirement that all DMH employees must take an Annual Review training, OREI created a module for the training that supplements the existing mandatory Diversity Training requirement, and delves deeper into issues of race, equity, and inclusion. Past modules have examined white privilege and implicit bias, for example, while the current module focuses squarely on race, racism, and microaggressions. In general, these have received a very positive response and have been deemed a well-produced substantive addition to the Annual Training.

DMH has the oldest and largest interpreter service program of all state agencies (based on oral interpreting versus written translation). As such, DMH provides language access to clients at various points throughout their treatment, including both inpatient and outpatient services. Supplementing the provision of interpreter services is the provision of translated versions of key documents. We continue to improve our outreach to some particularly underserved populations, including Deaf and Hard of Hearing persons and populations with cultural considerations that often preclude them from engaging with behavioral health services, such as the Haitian community. Additionally, DMH provides interpreter services to the general public for any community events, as well as translations of educational materials that are for public consumption.

Although DMH has always provided interpreter services for Deaf and Hard of Hearing clients, it had previously been challenged with fully integrating its Deaf Case Managers into the workplace. DMH recently contracted with four part-time ASL Interpreters who report to the Director of OREI to fill this gap. Not only has their presence allowed the case managers to be more productive, but it has led to a fuller integration of the case managers into the office milieu. At the same time, however, this presence has also highlighted the ongoing for language access for this community.

In order to ensure that Limited English Proficient (LEP) clients continued to receive language access in their DMH services, OREI was able to quickly pivot at the outset of the pandemic to amend existing contracts with interpreter services providers. While the practical logistics of service delivery during a pandemic resulted in a decrease in the requests for interpreter services, OREI made all efforts to maintain the availability of language access throughout this time.

Finally, DMH conducts a Consumer Satisfaction Survey each year. As part of this effort, OREI facilitates the translation of the survey, and any responses, into multiple languages including Spanish, Portuguese, Cape Verdean, Haitian Creole, Chinese (Traditional and Simplified), Vietnamese, and Khmer. This survey is conducted for both adult consumers as well as consumers in the Child, Youth, and Family division.

Training for Mental Health Providers

The Office of Learning and Development (L&D) at DMH is committed to building a responsive, person-centered workforce grounded in evidence-based practices, recovery-oriented care, and a deep understanding of the intersectional factors that shape behavioral health.

Over the past two years, the Learning and Development (L&D) teams across the Department of Mental Health have made significant strides in advancing person-centered, trauma-informed, and evidence-based practices. These efforts have improved care, deepened staff expertise, and responded to emerging needs across diverse populations and service settings.

The Southeast Area has led extensive work in implementing the Zero Suicide framework, including staff-wide training in QPR (Question, Persuade, Refer), the Columbia Suicide Severity Rating Scale (C-SSRS), Safety and Wellness Action Plans (SWAP), and the CAMS model for treating individuals with suicidal thoughts and behaviors. L&D has also supported the development of site-based learning collaboratives and strengthened post-incident debriefing processes, showing a robust and sustained commitment to suicide prevention in both clinical and community settings.

The Northeast Area has successfully embedded the Safety and Wellness Action Plan (SWAP) into daily practice, promoting it as a practical, recovery-oriented tool that supports self-awareness and personalized relapse prevention. This achievement reflects a deep commitment to trauma-informed care, harm reduction, and empowering individuals to take ownership of their recovery journey.

Central Mass has made meaningful contributions in expanding staff capacity to serve deaf individuals with serious mental illness, including annual Deaf Symposiums and ongoing education about ASL and Deaf culture. Similarly, L&D has led education around dual recovery, addressing the intersection of mental illness and substance use through statewide conferences and practical training on tools like motivational interviewing.

A consistent focus has been placed on enhancing care for transition-age youth (TAY), particularly in Central Mass. Training has increased staff awareness of developmental needs, family engagement, and effective strategies to support youth navigating mental health and substance use challenges. Events like the annual Success-Fest have provided a platform to share resources and innovative practices in TAY engagement.

The Northeast has led efforts to educate staff on the complex interplay between trauma, brain health, and addiction, equipping the workforce to approach care from multiple, integrated perspectives. These trainings have expanded staff fluency in harm reduction strategies and

provided space for reflection and learning around complex clinical dynamics. These efforts have prepared staff to meet emerging challenges while centering on the voices and experiences of those we serve.

The Office of Learning and Development has provided extensive efforts to support and uplift DMH's diverse and multilingual workforce, many of whom bring international experience and unique cultural perspectives to behavioral health care. To further support equity, we've launched several BIPOC-focused development initiatives such as the Community Ambassador Program, William James College Fellowship, and partnerships with BIPOC vendors and trainers.

L&D staff have actively contributed to DMH-wide efforts to embed Race, Equity, and Inclusion (REI) into all training programs, including:

- Leading REI strategic planning and coaching programs,
- Organizing anti-racism conferences and Juneteenth events,
- Training by hiring managers in unconscious bias, and
- Ensuring inclusivity through EMR modifications and curriculum design.

Our collaboration extends across the agency:

- With the Office of Inpatient Management, we standardized training practices statewide;
- With Child, Youth, and Family Services, we co-developed programs to support transition-age youth, such as TIP and NACAC;
- And across all Areas, we supported cross-training and service alignment for young adults through the "Reframe the Age" initiative.

Despite significant staffing challenges and a near-tripling of hiring due to expanded inpatient and community programs, the L&D team maintained uninterrupted delivery of all core, mandatory, and onboarding trainings—both virtually and in-person—throughout the pandemic.

L&D continues to prioritize continuous quality improvement in our training systems. Our centralized Learning Calendar provides easy access to professional development opportunities for all staff and providers, including specialized offerings to support clinical growth and address broader systemic challenges such as racial inequity.

Looking ahead, L&D aims to focus on strengthening three strategic areas:

- Deepening REI integration across all learning environments,
- Expanding curriculum to better mitigate clinical and safety risks across settings, and
- Aligning workforce development with the Behavioral Health Roadmap, supporting DMH's future vision of care.

At every level, Learning and Development serves as a critical influence in building a prepared, compassionate, and inclusive mental health workforce. From advancing suicide prevention to embedding wellness planning, supporting marginalized communities, and enhancing developmental responsiveness, the Office Learning and Development accomplishments demonstrate innovation, equity, and a strong alignment with recovery-oriented values.

Data and Analytics

Established in 2023, the Data and Analytics Unit aims to develop and implement a comprehensive data strategy for DMH. This data strategy rests on four pillars:

a. Appropriate **Staffing**;
b. **Policy** adoption, Implementation and Enforcement;
c. Development and implementation of scalable and replicable **Processes**; and
d. Delivery of appropriate technology **Platforms**.

This approach is paired with the consolidation of targeted workstreams and focuses on providing better information to support a robust community-based mental health system that ultimately supports adults, children and youth with mental health conditions in the Commonwealth. Prior to this strategy's establishment, investments in previous data initiatives occurred in siloes. As a result, DMH's ability to maximize data usage to inform operational, policy and programmatic improvements on services provided to individuals and communities served. As the work on different processes continues, the D&A team is partnering with the other units and departments. Recently, the D&A team has continued partnerships with Mental Health Services and the Children, Youth and Families divisions to prioritize the intake, planning and implementation of projects that require informatics support.

Overall, the formalization of this process will allow DMH at large to optimize efficient resource use to develop and support scalable information organizational processes; which in turn would facilitate a holistic approach to data management.

COVID-19 Supplemental Funds and American Rescue Plan Act Funds

DMH has been successful in utilizing substantial COVID-19 Supplemental funds upon the end of the contract. DMH has spent about $15.8 million dollars in COVID-19 Supplemental funds on the identified priorities below. It And still continues remaining American Rescue Plan Act (ARPA) funds as guided by SAMHSA to augment services and system enhancements by the end of FFY25. These services span across the crisis services continuum, address First Episode

Psychosis (FEP) needs, and include with targeted for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). DMH is committed to serving marginalized populations (e.g. BIPOC, Latinx, and LBGTQ communities) that continue to be significantly impacted by aftermath ramifications of the COVID restrictions. and its aftermath ramifications. Furthermore, continued cross-agency collaboration with sister agencies, such as the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS), on the crisis services continuum warrant dual coordination of ARPA funds of said respective agencies. In the past, DMH has coordinated with MassHealth, the Commonwealth's Medicaid agency, to use ARPA funds awarded via CMS for services related to the Commonwealth's Behavioral Health Help Line.

After receipt of the COVID Supplemental funds, DMH issued a Request for Information (RFI) to seek feedback from various stakeholders including those with lived experience and their families, advocates, providers, and other state agencies. The purpose was to identify ideas for improving the Commonwealth's behavioral health prevention, intervention, treatment, and recovery support services systems in the context of COVID-19. DMH's interest centered on priorities that would utilize one time or time limited funding to address specific needs related to the development and delivery of crisis services.

Identified priorities included:

- Addressing the significant increase in behavioral health boarding episodes in Emergency Departments (EDs);
- Enhancing the crisis support service system in order to address the escalating need for urgent behavioral health care due to the impact of COVID-19;
- Addressing behavioral health needs of children and youth impacted by COVID-19, including strategies to support parents and schools;
- Expanding capacity to rapidly respond to youth experiencing psychosis and their families and to enhance access to specialized First Episode Psychosis services; and
- Addressing social determinants of health and racial equity in the delivery of behavioral health prevention, intervention, treatment, and recovery support.

These priority areas have the following correlating activities funded by COVID-19 Supplemental and American Rescue Plan Act funds:

Crisis Support Services – Within the past two years, DMH has utilized COVID Supplemental on a slew of services across the crisis services continuum, with plans to continue supporting this work with remaining ARPA and MHBG funds. This work includes supporting Emergency Respite programs to address continued increases in behavioral health boarding episodes in Emergency Departments. A few examples of the Emergency Respite programs being funded include Advocates, Community Counseling of Bristol County, and Eliot Community Human Services. All these programs provide behavioral health services to adults, children, and communities.

In addition to enhancing DMH's Emergency Respite programs, COVID-19 Supplemental funds were used for aiding Peer Respite capacity. This initiative- provided more timely access to short-term stabilization services while keeping individuals in the community. These diversion-focused services direct individuals from Emergency Departments and homeless shelters and facilitate safe transition plans for people with complex behavioral health needs. In addition, resources have been dedicated to the Mass 211 24/7 service to help connect callers to information about existing critical health and human services available in their communities.

DMH also used COVID-19 Supplemental funds to plan and establish the Behavioral Health Help Line as part of the Roadmap for Behavioral Health launched in 2022. As cited earlier, the BHHL connects individuals and families to the full range of treatment services for mental health and substance use offered in Massachusetts, including outpatient, urgent, and immediate crisis care.

Crisis Flexible Support Teams – The COVID Supplemental grant award supported crisis flexible support teams that serve youth and young adults. Programs funded included Youth Villages, the Justice Resource Institute, the Behavioral Health Network (BHN), and the Edinburgh Center. Youth Villages provides intensive in-home services across Massachusetts and focuses on helping young adults transition into adulthood. The Justice Resource Institute program incorporates trauma-informed care and serves the needs of underserved individuals, families, and communities throughout the state. BHN provides services in Western Massachusetts including comprehensive behavioral health services for adults, children, and families with life challenges due to mental illness. Finally, the Edinburgh Center offers an array of innovative services that help with adult mental health, children and families, autism, developmental disability, and more.

Summer Therapeutic Recreation Groups – During FY22, COVID supplemental funds supported summer therapeutic recreation groups and camps for youth. Two of the programs funded were Children Services of Roxbury and Doc Wayne Youth Services. Doc Wayne's program – *Heal and Strengthen At-Risk Youth* – disguises and destigmatizes therapy through sports for kids. Children Services of Roxbury's program – *Beats, Rhymes, and Life* – uses an evidence-based program that integrates music as a therapeutic resource for kids.

Programs for Assertive Community Treatment for Youth (PACT-Y) – COVID and ARPA funds have supported additional Programs for Assertive Community Treatment for Youth teams that are launching in Western Massachusetts. PACT-Y is a comprehensive service for individuals under the age of 22 with serious emotional disturbance who have not responded to traditional treatments and interventions. These individuals may benefit from intensive, coordinated, and comprehensive services. The services are provided by one integrated, community-based team.

Transition Aged Youth Services – ARPA funding supported Transition Aged Youth Services including young adult access centers and youth prevention groups. There are plans to fund two

young adult access centers every year of the ARPA award. Transitioned Age Youth services target current and former foster youth between 16 and 22 years of age. Depending on the program, eligibility can range from having been in care at some point or having been emancipated from the system.

The young adult access centers include the Gandara Mental Health Center and Kiva and Open Sky Community Services. Each program promotes the development and promotion of healing communities for families experiencing different social class impacts. DMH has provided funds to UMass Chan Medical School for REDCap work supporting data collection and evaluation efforts for young adult access centers. The prevention group for the youth program is called Living in Families with our Emotions (LIFE). This is a training program that helps youth with depression, anxiety, and works to prevent suicide.

Lifeline for Families UMASS Medical School fellowship program – During FY22 and FY24, The ARPA award has supported the Lifeline for Families UMASS Medical School fellowship program in early familial health. This is an 18-month fellowship program in which funding is used to help increase the number of BIPOC, bi-lingual infant, or early childhood mental health clinicians in the program.

First Episode Psychosis – DMH used COVID Supplemental and is further utilizing remaining ARPA funds for multiple First Episode Psychosis (FEP) activities to enhance the availability of these services. There are plans to fund First Episode Psychosis programs for every year in each award at a minimum to meet the required set-aside percentage.

This utilization includes the use of COVID Supplemental award funds for triage and navigation performed by four provider organizations. Triage and navigation in health care is the prioritization of individuals based on their need for emergency treatment. Each organization has their own triage system, which often includes color-coded categories. Once defined the patient can be navigated to the appropriate care. The four triage and navigation organizations supported by the awards are MGH (Massachusetts General Hospital), Boston Medical Center (BMC), Brookline Mental Health Center (BMHC), and Community Healthlink (CHL). The MGH, BMHC, and CHL programs are geared more toward early psychosis and youth experiencing the first signs of psychosis. The Boston Medical Center focuses on after-diagnosis management and treatment. For example, Boston Medical Center has a Wellness and Recovery After Psychosis Program.

Additionally, DMH used COVID Supplemental funds to support FEP staff enhancement for BAMSI, a provider in the Southeast area of Massachusetts, to expand their services. Currently, ARPA funds has in the past and will continue to support FEP coordinated specialty care in different areas across the state.

Workforce Development Paid Internships Program – Pertaining to workforce issues, DMH is implementing programs that will provide paid internships in outpatient and community-based

public sector behavioral health service settings for Massachusetts students enrolled in a Behavioral Health certificate or academic program. The overarching goal of the DMH Workforce Development initiative is to develop and maintain a public sector behavioral health (BH) workforce that represents all communities in the Commonwealth including but not limited to communities of color, LGBTQIA+ communities, and those that have the knowledge and skills necessary to work with children, youth, and adults living with serious emotional disturbance, severe mental illness, and/or substance use disorder and their families. DMH intends to use the remaining ARPA award funds for the internship programs.

The significant impact of COVID on health care workers, particularly in behavioral health settings, is resulting in a workforce crisis as workers are experiencing burnout, deciding to retire early, or taking on less demanding roles. Providers across all settings report challenges recruiting and retaining staff regardless of geographic location resulting in workforce shortages and other consequences of the pandemic. This impacts the ability to implement workforce development programming to recruit BH students who may be interested in obtaining the education and training necessary for licensure and employment within the public BH system. The behavioral health workforce crisis in Massachusetts will continue to grow overtime without intervention.

DMH recognizes the need to create a pathway to bring more people into the behavioral health workforce, particularly people who are from traditionally marginalized racial, ethnic, and cultural backgrounds. Several barriers have been identified that reduce the likelihood that people will choose to enter training programs and pursue careers in public sector behavioral health. All behavioral health degrees and credentials require substantial clinical training in direct care settings (i.e. internships) in order to fulfill degree requirements and to meet minimum credentialing requirements for most Behavioral Health licenses. Historically, these required internships in behavioral health, particularly in settings that serve people living with SMI/SUD, have been unpaid. As a result, many people are not able to complete the requirements for their degree because they cannot afford to work for 16 to 20 hours each week for 6 to 24 months with no compensation, and/or they choose not to enter the field.

With the paid internship opportunities this initiative will support, DMH aims to attract students to gain hands-on training within BH programs that serve children, youth, and adults living with serious emotional disturbance, severe mental illness, and/or substance use disorder and their families. Students who train in these BH programs will be exposed to and gain experience in the public sector behavioral health work. Organizations that take these students on as interns will increase their pool of potential permanent workers, which will help address the workforce crisis they are currently experiencing.

DMH will solicit applications from accredited Massachusetts colleges or universities offering Behavioral Health Academic-degree programs with the capacity to develop and administer a paid internship program that will prepare students to meet requirements for licensure and to work in the public-sector behavioral health system. DMH plans to provide funds to awardees

for the purpose of administering a paid internship program to recruit and engage diverse interns to complete internships in community-based and outpatient public sector behavioral health direct service settings necessary for fulfilling a behavioral health academic-degree or licensure requirements. Eligible organizations receiving grant awards will be required to certify that they will not use any grant payment received for uses other than those described in their grant applications.

Serving Underserved Communities – COVID-19 Supplemental funds were also used in collaboration between DMH and DeeDee's Cry, a community-based organization in Boston, DeeDee's Cry provides resources on suicide prevention, suicide loss, and mental health education and supports families impacted by suicide. Funds were used to provide training regarding black men's suicide prevention and mental well-being. DeeDee's Cry aims to create a space where conversations begin to lift the stigma on suicide and mental health within BIPOC communities. During SFY24, the organization provided its initial suicide prevention training – *Men's Mind, Body & Spirit Summit: Am I My Brother's Keeper* – in June with other trainings planned to start in SFY24. Each training session =was in person e with culturally responsive messaging.

Boston Children's Foundation is another program supported through the COVID and ARPA awards. The Foundation's work focuses on providing community care and outreach as well as training, consultation, and interventions with outpatient care providers. The Foundation provides trauma informed outreach to SMI and SED populations through consultation and training to providers, family members, and various school and community organization staff. These services include training and credentialing school staff in psychological first aid and toxic stress reduction to support social emotional learning in Boston public schools, providing trauma informed care-resiliency focused professional development seminars for behavioral health staff working in community programs, and providing training and consultation regarding suicide prevention gatekeeping, risk assessment, and EBP trauma response practices. This effort targets communities in the metro Boston area.

During SFY24 and FY25, ARPA funds were used to work with the Brookline Center to support a group of high schools with high proportions of high-needs students in planning, implementing, sustaining, and continuously improving school-based interventions grounded in the BRYT Model for supporting students with Serious Emotional Disturbances/Serious Mental Illness (SED/SMI). The signature BRYT Model for intensive mental health support helps districts in Massachusetts implement intensive interventions that support youth whose functioning in school has been impaired by SED/SMI. The BRYT Intervention brings new services supporting youth with SED/SMI to communities with high proportions of high-needs students and is aligned with BRYT's goal of making the intervention available to any Massachusetts student experiencing SED/SMI who needs intensive supports in order to achieve school success. The funds support high-quality initial implementation and long-term sustainability and continuous improvement.

IT Infrastructure – The initial ARPA proposal included funds for Information Technology Infrastructure (ITI) improvements. Improvements in DMH's IT infrastructure will help providers share information to aid care delivery. Enhancing the ability of providers to submit key encounter and utilization data to DMH will contribute to a more streamlined approach towards assuring persons receive the appropriate services at the appropriate time. In FY23, DMH started an initiative to develop an electronic health record system for its inpatient facilities and community programs. This multi-year effort will improve its data system for various operational processes leading to enhanced health information through data collection, storage, and analysis. The remaining ITI issues that fall outside of the scope of the EHR were planned to be addressed via ARPA funds. APRA funds would cover to enhance provider reporting and promote greater health information. DMH is continuing to assess these needs to determine the extent of the IT need beyond what the EHR will address the feasibility of remaining APRA funds towards IT endeavors.

Research

To carry out its statutory research mission, DMH has operated two Research Centers of Excellence for more than 25 years through contracts with Massachusetts' lead academic centers. These Centers have worked in close alignment with DMH to conduct research that furthers DMH's mission and service principles and advances the prevention, early identification, diagnoses, treatments, service programs, rehabilitation, and recovery of adults with serious mental illness and children and adolescents with serious mental illness or severe emotional disturbance. DMH funds are used to support the infrastructure of each Center of Excellence. Other funding is sought from public and private agencies and organizations for its core research, and to allow the Centers to engage in activities that traditional external funders don't currently support, e.g. time necessary to develop mutual partnerships with communities

The two current Centers of Excellence: Center of Excellence for Systemic and Psychosocial Research and Center of Excellence for Public Mental Health Services and Implementation Research were established in 2018. While both Centers rely primarily on federal research grants, DMH funds provide vital infrastructure support allowing both Centers to engage in activities central to DMH priorities.

Both Centers of Excellence are expected to:

- Leverage and enhance the impact of an Academic Center that has an active research portfolio focused on public mental health by funding research strategies and activities not supported by traditional basic research funding;
- Conduct research consistent with the DMH mission and service principles including person-centered outcomes research (www.pcori.org) and implementation research;
- Facilitate the rapid translation and dissemination of research findings for providers, persons served, and the larger community;

- Shift the culture and operation of research by actively engaging potential research users and beneficiaries, including DMH staff, its operated and contracted programs, mental health service users, family members, service delivery partners, and stakeholders from across the state in order to produce research that is both relevant and rigorous;
- Conduct research in real-world settings and with the specific communities and populations served by DMH and other providers across the state in the public mental health system;
- Provide avenues for graduate students, postdoctoral researchers, and new investigators to develop independent research careers as principal investigators with their own funding; and
- Collaborate with each other and the Children's Behavioral Health Knowledge Center (www.cbhknowledge.center), DMH service delivery partners, community-based organizations, advocates, and stakeholders across the state in the public mental health system on both the conduct and dissemination of research.

In FY20, DMH worked with the two Centers to develop a Racial and Ethnic Equity Evaluation Plan for use across both Centers of Excellence. In addition to standardized processes for evaluating equitable continuous quality improvement (to be used during the planning phase of research), equitable research (to be used before, during, and upon completion of a research project), and equitable stakeholder engagement, this work generated a tool for evaluating the Centers' operations and workforce development conditions through an equity lens. DMH has subsequently deployed this tool as part of the DMH contract procurement process and contract monitoring.

Finally, as required by federal law and state regulation, DMH's Institutional Review Board (IRB) reviews and approves all requests by researchers who seek to work with DMH clients, past or present, in their research. At any given time, there are approximately 50 research studies taking place within DMH facilities and around 20 new studies are reviewed and approved each year. The IRB Chair oversees the Research Centers of Excellence.

The Center of Excellence for Systemic and Psychosocial Research was awarded to Massachusetts General Hospital (MGH) directed by Cori Cather, PhD. The mission of the Center of Excellence for Systemic and Psychosocial Research is to advance the treatment, rehabilitation, and recovery of adults with serious mental illness and children and adolescents with serious mental illness or severe emotional disturbance through the conduct of psychosocial, forensic, and program/services research. The Center of Excellence for Systemic and Psychosocial Research is expected to provide broad leadership in conducting research that advances services for people at-risk for or experiencing serious mental illness or severe emotional disturbance, promote the rapid translation of research knowledge into practice, and inform health systems and policy.

MGH assumed the contract for the Center of Excellence (COE) for Systemic and Psychosocial Research in 2018 with a focus on person-centered outcomes research and racial equity and inclusion and a sub-specialty in early psychosis.

In 2022, the MGH COE obtained $9,982,228 in external grant funding, published 28 manuscripts, and delivered 65 presentations/posters (22 of which were by Center peer consultants). Most of the peer consultants direct Recovery Learning Communities (RLCs) funded by the DMH or have extensive ties to local and national organizations (e.g., National Alliance on Mental Illness, Depression and Bipolar Support Alliance, Hearing Voices Network). This enables rapid translation of their innovations into service delivery, without suffering from the "evidence-to-practice gap" so often seen in academic work not led by the voices of the communities it intends to benefit.

Examples of research projects with direct relevance to DMH priorities include:

- Dr. Oliver Freudenreich, MD, together with colleagues from the North Suffolk Mental Health Association (NSMHA) published an important study in which they described how they achieved COVID-19 vaccination rates among individuals receiving treatment in their clozapine clinic that exceeded those of the general population. In a broader context, this study shows that addressing infectious diseases in patients with serious mental illnesses is a legitimate concern for community psychiatry with the potential to reduce health inequities for disadvantaged populations;
- Dr. Abigail Donovan, MD, together with colleagues from the MGH Acute Psychiatry Service (APS) and MGH Child/Adolescent Psychiatry, participated in the redesign of the APS with a focus on improving the APS experience of youth and adults while partnering with the Youth Villages Intercept program, which provides rapid access to high-quality intensive in-home therapy and allows some youth to be discharged home and diverted from inpatient hospitalization; and
- Dr. Anne Whitman, PhD and other peer consultants together made significant advances in their innovative work on reducing stigma related to parenting with mental health and/or substance misuse challenges by designing, participating in, producing, and editing a video of first person accounts from the adult child perspective to serve as a companion piece to the video of first person accounts from the parent perspective that they had developed in 2021.

The Center of Excellence for Public Mental Health Services and Implementation Research (iSPARC) was awarded to the University of Massachusetts Medical School (UMMS) with Maryann Davis, PhD as the Center Director. The mission of the Center of Excellence for Public Mental Health Services and Implementation Research is to conduct, disseminate, and support the use of research in the public mental health system to improve the lives of adults with serious mental illness and children and adolescents with serious mental illness or severe emotional disturbance. The public mental health system is defined as all the public, private, and voluntary entities that contribute to the delivery of essential mental health services in the

Commonwealth. The iSPARC conducts research and evaluates the needs, practices, programs, and service delivery models that comprise the public mental health system. As funding allows, iSPARC provides technical assistance on the use of research evidence, implementation of research findings and evidence-based practices, and continuous quality improvement efforts.

In 2022, iSPARC obtained $10,396,644 in funding, was awarded 8 new grants and contracts, and published 59 peer-reviewed journal articles. Additionally, iSPARC regularly publishes translational materials accessible to the general population including 10 issue briefs and tip sheets such as:

- Emotional Support Animals: The Basics
- Child Talks+: A New Intervention to Support Families Affected by Parental Mental Illness
- Seven Tips Mental Health Care Providers Can Use to Address Patient Tobacco Use
- Adulting Shorts: The "TEA" on IEPs Part 1
- Creating Welcoming Environments for Workers with Disabilities: Managing Cognitive Demand
- The Impact of the COVID-19 Pandemic on the Clubhouse Model

Examples of research projects with direct relevance to DMH priorities include:

- Charting the Course for Patient-Centered Research to Address Inequities in Perinatal Mental Health & Maternal Mortality project with Nancy Byatt as Co-Investigator. The project began in December 2021 and will be completed in November 2023. Its goal is to build the capacity of relevant stakeholders and researchers to partner in the planning, completion, and dissemination of patient-centered outcomes research/comparative effectiveness research (PCOR/CER) studies to address perinatal mental health inequities among Black and Indigenous communities. During FY22, one of the major efforts of the PCORI Charting the Course team was to assemble a council of individuals with lived experience of a mental health condition during the perinatal period. Between December 2021 – February 2022, the Charting the Course team focused on starting this advisory council by recruiting a very diverse group of birthing individuals from communities which have been historically underserved by the mental and obstetric healthcare systems. The Lifeline for Moms Postpartum Mental Health Advisory Council is national and has 18 members and meets bi-monthly for 90-minutes;
- The National Institute on Alcohol Abuse and Alcoholism (NIAAA) funded Alexander Wilkins' K23 proposal, *Designing Deaf-MET: A Deaf-Accessible Pre-Treatment for Alcohol Use Disorder.* The U.S. Deaf community – a group of more than 500,000 Americans who communicate using American Sign Language (ASL) – experiences nearly triple the rate of lifetime problem drinking compared to the general population. Yet no therapy approaches have been developed and formally tested to treat problem drinking or alcohol use disorder among Deaf clients. This study will begin to address this gap by supporting the development and preliminary validation

of Deaf Motivational Enhancement Therapy (Deaf-MET), a Deaf-accessible pre-treatment for alcohol use disorder; and

- The DMH-funded Helping Youth on the Path to Employment (HYPE) Course is an adaptation of the HYPE model developed by Michelle Mullen. The HYPE manual articulates support strategies to help young adults who experience mental health conditions return to and/or maintain meaningful roles in school and work. The HYPE Course project offers a group intervention based on HYPE values and practices and has two objectives: 1) to offer group and individual services directly to young adults with mental health conditions to help them prepare for meaningful careers; and 2) to ensure sustainability throughout the Commonwealth by training other organizations/ agencies to deliver the HYPE Courses.

Addressing Early Serious Mental Illness

DMH has a rich history of partnering with academic research centers to develop, evaluate, and promote the use of evidence-based practices (EBPs) for those with ESMI. DMH utilizes the MHBG 10% Set Aside for Early Psychosis (EP) to unify these efforts and to develop a comprehensive approach to the dissemination of EP EBPs across the Massachusetts behavioral health system.

DMH has selected NAVIGATE as the core approach to Coordinated Specialty Care (CSC) in MA Early Psychosis programs. The MA EP Technical Assistance Center (MAPNET) is a partnership between DMH and the Psychiatry Department at Beth Israel Deaconess Medical Center (BIDMC). It serves as a statewide resource to coordinate NAVIGATE implementation and EP EBP training. Additionally, MAPNET provides dedicated EP CSC Learning Collaboratives, monthly webinars in specialized EP topics (e.g., EP and the military, Suicide Risk Assessment and EP, differential diagnosis EP and ASD), and regular trainings for community stakeholders, healthcare providers, and behavioral health providers. MAPNET operates a website which provides information and resources for youth, families, and providers including training materials. Additionally, DMH works with the Region 1 Mental Health Technology Transfer Center (MHTTC) to align available technical assistance in EP CSC and EP EBPs implementation. MAPNET-affiliated faculty and staff at BIDMC oversee the MHTTC EP Initiative and this has expanded their reach and enhanced their visibility in the Commonwealth and beyond.

Given workforce and sustainability challenges, DMH with MAPNET and the NAVIGATE trainers, has worked to more effectively support NAVIGATE implementation and the sustainability of EP CSC in real world community setting. DMH contracts with EBP-specific training and certification programs (e.g. the NAVIGATE program) to provide training and implementation support. MAPNET works closely with NAVIGATE and other EP EBP trainers to maintain a regular, predictable calendar of trainings and to ensure engagement of all EP CSC staff in ongoing role-specific supervision groups. The DMH Center of Excellence on Psychosocial and Systemic Research at Massachusetts General Hospital (DMH COE at MGH) collaborates with MAPNET

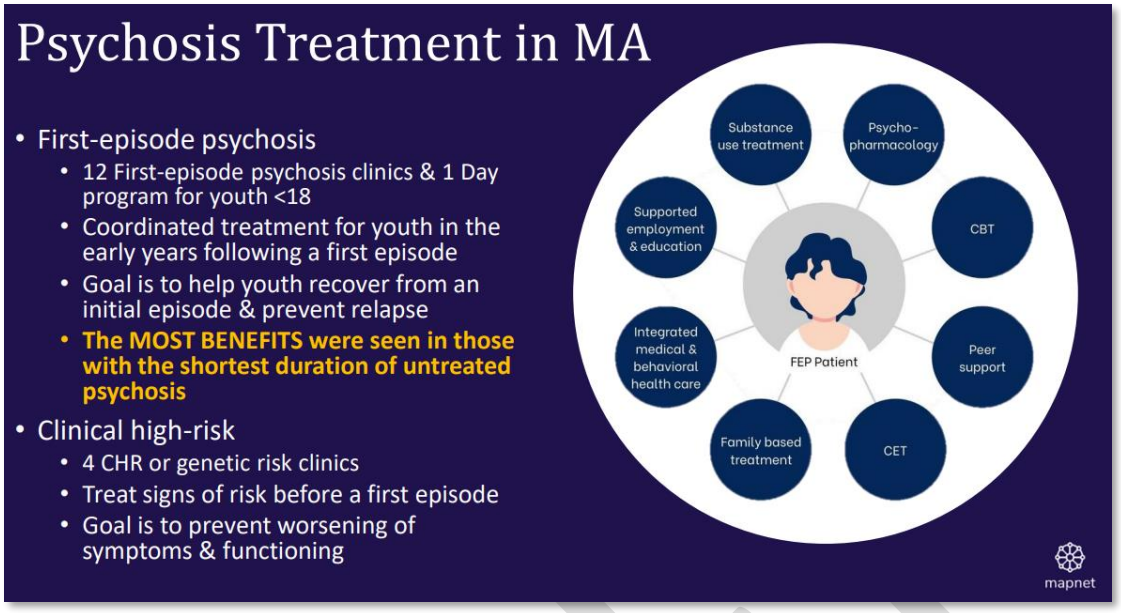
and the NAVIGATE trainers to examine different approaches to implementing NAVIGATE and teaching EP CSC and EP EBPs to community providers.

DMH has provided NAVIGATE training and implementation support to three cohorts of EP programs (Cohort 1, Cohort 2, and Cohort 3). Cohort 1 included five long standing MA EP CSC programs, four of which are affiliated with a medical school research program. Cohort 2 included one Boston hospital-based EP program and 4 new EP CSC programs in the Northeast Area of DMH with community clinics with no prior experience delivering early psychosis services. Cohort 3 represents the expansion into the Southeast Area of DMH with the establishment of two new EP CSC programs in community clinics. At this time, one program from each of the first two cohorts was not able to sustain operations largely due to staffing challenges.

DMH now has a better understanding of challenges to EP CSC operations in real world settings and has adapted use of MHBG funds to better assure sustainability of established programs in addition to supporting development of new programs. MHBG funds are used to support CSC required service components (e.g. education services, employment services, peer support) and activities essential to CSC model fidelity (e.g. team meetings, training, supervision) which are not third party reimbursable. New programs are brought on only as funds allow for sustainable commitment.

In addition to NAVIGATE and the associated EBPs including Individual Resilience Treatment (IRT), Family Psychoeducation, Supported Employment (SEE), and prescribing best practices, DMH provides training in a number of EBPs relevant to engaging and working with young adults and their families, including Cognitive Therapy for Psychosis (CTP), Dialectical Behavioral Therapy skills training (DBT), Acceptance and Commitment Therapy (ACT), Cognitive

Enhancement Treatment (CET), Motivational Interviewing (MI), and McFarlane Multi-Family groups.



There are a number of ways that DMH raises awareness and promotes the use of EBPs for individuals with ESMI including most recently our strategic planning process. The findings of the RAISE study galvanized interest in EP amongst policy makers, researchers, family members, advocates, and providers. And in recent years the DMH has been invited to support a number of federally-sponsored research projects related to EP and EP EBPs. DMH decided to embark on a strategic planning process in order to assure that the influx of funding and other resources to the state will effectively address the needs and priorities of all people experiencing early psychosis and their families with particular attention to communities impacted by health disparities and racial equity and inclusion.

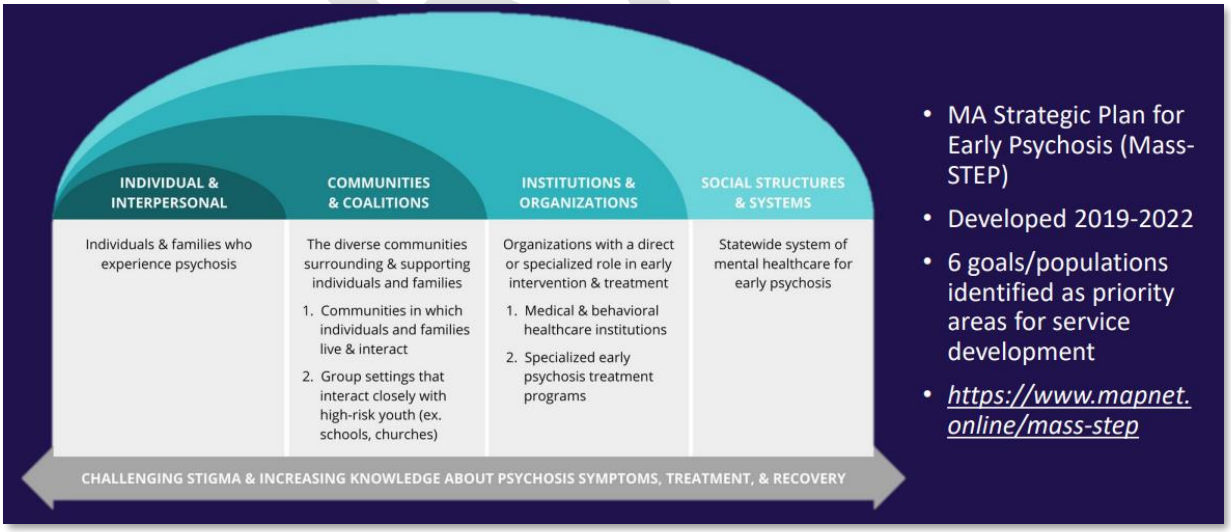
The Massachusetts Strategic Plan for Early Psychosis (Mass-STEP)

The Massachusetts Strategic Plan for Early Psychosis (Mass-STEP) provides the organizational mandate for activities to promote the use of evidence-based practices for individuals with ESMI and to provide comprehensive individualized treatment or integrated mental and physical health. DMH partnered with the Laboratory for Early Psychosis (LEAP) Center, the Massachusetts Psychosis Network for Early Treatment (MAPNET), and the Northeastern University Institute for Health Equity and Social Justice Research (IHESJR) to develop the Mass-STEP. The goal of this effort was to identify priorities for mobilizing actions centered around prevention efforts, early identification, treatment services, and the system-level coordination needed to build an equitable system of care for individuals living with psychosis in Massachusetts, developed with guidance from community members who have firsthand experience of psychosis as well as other expert stakeholders. The impact of stigma – a from internalized stigma to institutional bias – is highlighted at every level of the model as this was a recurring topic across populations. In addition to emphasizing attention to diversity in religion, spirituality, familial culture, language barriers, gender identity, sexuality, and youth culture, Mass-STEP includes an explicit acknowledgement of the difficult history of psychiatry and the

racialization of psychotic disorders which continues to serve as a barrier to trust and engagement with BIPOC communities.

Mass-STEP is organized by six over-arching goals with specific populations:

1) Assuring support for individuals who experience psychosis and their families through individual advocacy opportunities, community-building, and specialized early psychosis services;
2) Promoting early identification and intervention for psychosis through community education and awareness efforts across the diverse communities of Massachusetts, particularly among underserved groups who face multiple barriers in accessing mental healthcare;
3) Promoting early identification and intervention for psychosis through specialized supports for community members who are likely to interact with those experiencing psychosis;
4) Providing specialized support to medical and behavioral healthcare professionals in competencies related to early psychosis;
5) Supporting specialized early psychosis treatment teams in delivering high-quality, evidence-based care in a stepped framework that is culturally and linguistically appropriate, person centered, trauma informed, and recovery focused for people experiencing psychosis and their families; and
6) Supporting and developing the statewide system of services for early psychosis by fostering communication across programs and integrating systemic supports for early intervention and prevention.



Mass-STEP is intended to be a living document responsive to the changing needs of youth and their families and the Commonwealth behavioral health system. DMH, in partnership with MAPNET, the LEAP Center, and IHESJR hosts an annual meeting for stakeholders to spotlight

accomplishments, highlight opportunities for expansion, raise awareness, and engage stakeholders. Organizers, presenters, and attendees include people experiencing psychosis, family members, advocates, providers, policy makers, researchers, and local, national, and international experts including leaders from SAMHSA and NIMH. Mass-STEP is updated to reflect advances and expand understanding of priorities.

DMH supports a number of strategies to raise awareness and to promote the use of EBPs for individuals with ESMI. MAPNET provides extensive training to area schools, colleges and universities, and to behavioral health and other health care providers to promote awareness of behavior associated with a psychotic episode and providing early and effective referral to services. All MA EP CSC providers are encouraged to engage in similar activities in their local communities as these presentations are important to build relationships with referral networks that feed the EP CSC program with appropriate referrals as well as to engage community partners for services.

In addition to EP-specific training in EBPs for the current BH workforce, DMH provides funding to nine psychology and psychiatry training programs to encourage the engagement of future behavioral health providers to work with people with SMI generally as well as ESMI specifically. Most of the MA EP CSC programs provide training to trainees of multiple behavioral health disciplines, e.g. psychiatry residents, psychology trainees across all stages (post-doctoral fellows, interns, practicum students, and college students), social work, nursing, and occupational therapy.

Massachusetts Psychosis Assessment and Triage Hub (M-PATH)
Repeatedly stakeholders have identified access to specialized EP services (e.g. comprehensive assessment and treatment) as an urgent need. The Massachusetts Psychosis Assessment and Triage Hub (M-PATH) at the Brookline Mental Health Center (BMHC) provides centralized screening, assessment, and admission for EP clinical programs.

DMH, MAPNET, and M-PATH work closely with the new Behavioral Health Help Line (BHHL) and the statewide network of Community Behavioral Health Centers (CBHC), to provide training in recognizing and responding to early signs and symptoms of psychosis and to establish workflows that facilitate warm handoffs and rapid access to specialized EP services. M-PATH also leverages BMHC's BRYT programs, a network of embedded mental health services in over 150 school systems (representing 40% of youth in Massachusetts) to more expeditiously identify and direct youth experiencing early signs and symptoms of psychosis and their families to EP specialized services. Staffed by knowledgeable clinicians, care coordinators, and peer specialists, M-PATH centralizes the referral and intake process for MA EP CSC programs, thereby eliminating duplicative screening and assessment processes at multiple EP CSCs and minimizing the burden on families and referring providers. M-PATH staff work closely with MAPNET to provide consultation, training, and support to behavioral health providers across the state so that treatment can be initiated immediately and to relieve some of the pressure on the early psychosis programs that lack capacity to currently treat all who need specialized care.

Navigate – EP CSC
The Navigate model of EP CSC provides both comprehensive individualized treatment and integrated mental and physical health services. Most MA EP CSC programs provide a comprehensive psycho-diagnostic assessment as an initial intervention for youth and their families and then offer treatment recommendations and consultation to youth, their families, and if applicable, a current provider, which may include enrollment in the EP CSC program. Health and wellness is a core tenet of the EP CSC model. DMH and the EP CSC programs work assertively to engage medical providers as partners to reduce the duration of untreated psychosis and to mitigate the physical health sequelae often observed in people with SMI.

Substance Abuse Services/Services for Persons with Co-Occurring Disorders

DMH is committed to including those with a dual diagnosis of serious mental illness and substance abuse in its programs and services and providing them with integrated treatment. The agency embraces co-occurring complexity as part of a universal approach to all individuals and families and delivers an integrated system that is welcoming, strength-based, and trauma informed. DMH expects all individuals served to have their needs identified, assessed, and treated in all services and programs.

Under the direction of the Medical Director for the Office of Inpatient Management, Facilities have implemented standardized protocols for Medication Assisted Therapy (MAT), and Medications for Opioid Use Disorder (MOUD). Approximately 80 DMH clinicians across the continuum of care have participated in training on the care and treatment of individuals with substance abuse and co-occurring disorders provided by the Yale institute. Training requirements for managing individuals with co-occurring disorders are included in the Department's Psychiatry Residency and Psychology Internship Training Program.

DMH incorporates program standards for the care and treatment of individuals with co-occurring disorders into its community service contracts. These requirements include the capacity to provide or arrange for interventions addressing engagement, relapse prevention, use of self-help groups and peer counseling. Within Adult Community Clinical Services (ACCS) and Program for Assertive Community Treatment (PACT), DMH requires a substance abuse clinician in the staffing models and includes program standards for assessment, treatment planning, and delivery of evidence-based interventions to address substance use.

To increase access and the quality of services, DMH has been an active member of an Interagency Work Group (IWG) established by the Department of Public Health in 2001 that meets monthly. Membership includes the Departments of Children and Families, Youth Services, Developmental Services and Transitional Assistance, the Massachusetts Behavioral Health Partnership, the Juvenile Court, the Parent Professional Advocacy League, and selected substance abuse providers as well as DMH. The IWG goals are to build common understanding

and vision across state systems; design and implement a community-centered system of comprehensive care for youth with behavioral health disorders that incorporates evidence-based practice; coordinate service delivery across systems; and simplify administrative processes and purchasing strategies to maximize federal and state dollars.

Since 2016 there has been an increase in the number of "dual diagnosis" community treatment beds available for individuals struggling with mental health and substance use disorders. These services provide a structured, 24-hour residential setting to assist in their recovery. The support will continue as individuals reintegrate into the community and return to work, school, and their social environments. The programs offer appropriate substance use and psychiatric treatment services, including coordination of medications for substance use and mental health. This includes evaluating the individual's need for medications, monitoring their medication, and introducing any of the three FDA-approved medications for treatment of opioid use disorder as clinically indicated: methadone, buprenorphine, and naltrexone. DMH is actively partnering with the DPH and MassHealth to facilitate an interagency approach to assist dually diagnosed persons to find care promptly. DMH is actively exploring to increase its community dual diagnosis program as an important system component to maintain individual care in the community post hospitalization discharge.

DMH addresses youth with dual diagnoses in a variety of manners, including taking steps to prepare the workforce. Through its Children's Behavioral Health Knowledge Center, the DMH Child, Youth, and Family (CYF) Division helps ensure that the workforce who provides services to youth and families are highly skilled and well-trained. The Center supports a range of training, workforce development and technical assistance opportunities. One training is a self-paced e-course – *Family Talk*. This evidence-based intervention is designed to help families identify the effects of parental depression, improve family communication about depression, and develop strategies to promote resilience in both parents and children. The e-course is publicly available at http://fampod.org/.

Other DMH activities for those with serious emotional disturbance and substance abuse include **Young Adult (YA) Access Centers**. Young Adult (YA) Access Centers are unique community spaces that allow young adults with mental health concerns to access services and supports in a timely and effective manner. The services are free and available to all young adult, and no diagnosis is required. Access Centers focus outreach and engagement efforts on those who may be facing challenges such as mental illness, substance misuse, economic insecurity, homelessness, pregnant/parenting, commercial/sexual exploitation, and those facing other challenges that have posed barriers to engagement in services. Peer support;

- Social activities;
- Linkages to healthcare, housing, employment, education, and other resources;
- Mental health and substance misuse supports;
- Individual support to identify and achieve goals in critical areas such as mental well-being, education, employment, and housing; and
- Amenities such as showers, laundry, kitchens, and computer/Wi-Fi access.

Furthermore, in order to best support youth and families with complex needs, DMH staff work closely with other child serving state agencies including child welfare, juvenile justice, substance addiction services, public health, developmental services, and the state's vocational rehabilitation agency. The agency engages in planning activities with state partners and other stakeholders to improve behavioral health care integration and the outcomes of residents of the Commonwealth. DMH staff members sit on (or chair) several Commissions, boards, and workgroups that promote and support children's behavioral health across the state. Examples include the following: the Interagency Workgroup on Substance Use; Infant and Early Childhood Mental Health Interagency workgroup; the Childhood Trauma Task Force; and the Unaccompanied Homeless Youth Commission. Finally, the DMH Commissioner also chairs a statewide Children's Behavioral Health Advisory Council which includes representatives from child-serving state agencies, providers, families, trade groups, and guilds. This group serves to inform the legislature and state leaders on critical issues and topics on children's behavioral health. .

Suicide Prevention

DMH has embraced Zero Suicide as the organizing structure for its suicide prevention work. Three of the Zero Suicide core components constitute the critical and necessary elements of any quality improvement initiative, e.g. leadership engagement, staff training, and the use of data to provide continuous feedback and impetus for returning the effort. DMH leadership, beginning with the Commissioner, emphasize the importance of addressing suicidality effectively throughout DMH operations, the MA behavioral health system, and the larger health care system across the Commonwealth. DMH's Learning and Development Office has instituted mandatory suicide prevention gatekeeper training in Question, Persuade, and Refer (QPR) for all DMH employees and supports the delivery of role-specific trainings in suicide prevention evidence-based practices, including the assessment of suicide risk, safety planning, counseling around access to lethal means, caring contacts, and treatment of suicidality. Regular monitoring of DMH data regarding adherence to DMH protocols and incidence of suicide attempts and suicide deaths is used to inform DMH internal operations and suicide prevention work. In addition to the focus on suicide prevention within DMH, DMH in its role as procurer or payer of services, has utilized the four services-focused components of Zero Suicide (Identify, Engage, Treat, Transition) as the framework to set expectations for contracted services, e.g. evidence-based screening, assessment, safety planning, transitions support, and treatment planning.

Even with this strong commitment to better address suicidality, the needs are great and there is a gap between the aspirational goal and the ongoing challenge of assuring the delivery of effective suicide prevention services. DMH staff are brilliant multi-taskers and passionate about instituting exemplary suicide prevention practices. The multi-disciplinary members of the DMH statewide Zero Suicide committee bring both the wisdom of many years in their roles across the DMH system (CYF, adult, inpatient, outpatient, community, forensic, peer, human rights, racial equity and inclusion, data, training, etc.) and the reality of the multitude of demands they each

manage and that the system as a whole manages. DMH has benefited in prior years from the opportunity to obtain SAMHSA Suicide Prevention grants to provide dedicated staffing on a short-term basis. DMH's efforts to instill effective suicide prevention strategies across the DMH and larger behavioral health system would be greatly advanced with dedicated resources, e.g. additional staff, to support the enormous amount of ongoing work to assure meaningful implementation of and fidelity to current best practices in suicide prevention.

Suicide prevention efforts in Massachusetts are funded largely through a separate line item in the state budget for the Massachusetts Suicide Prevention Program (MSPP) at the Department of Public Health. The MSPP funding supports suicide prevention services targeting veterans, older adults, college and university students, youth and young adults, mid-life adults, LGBQT youth, and transgender people. The MSPP oversees the analysis and publication of annual data on suicide and self-inflicted injuries and responds to requests for community/cohort specific data. Since 2012, the MSSP at DPH and DMH have forged a strong collaborative relationship, particularly around the dissemination of Zero Suicide to Massachusetts' health care systems.

The MSSP at DPH team spearheaded the successful multi-year implementation plan to prepare the Commonwealth's five suicide crisis lines for the launch of 988. DMH staff served on the MSPP 988 Implementation Team along with staff from each crisis center, 911, MBHP, and EOHHS. In addition to building crisis center capacity, the team focused on the interplay between 988 with 911, emergency service providers, and the Behavioral Health Help Line, as detailed earlier in this narrative, including protocols for bi-directional warm handoffs as needed. In 2022, the 988 Commission Statue (Chapter 177 of the Acts of 2022) established the 988 Commission to provide ongoing guidance regarding 988 service in Massachusetts. DMH holds a seat on the 988 Commission.

The Massachusetts Strategic Plan for Suicide Prevention (State Plan) is an initiative of the Massachusetts Coalition for Suicide Prevention (MCSP), working in close collaboration with the MSPP at DPH and DMH. The 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. DMH holds a permanent seat on the MCSP Executive Committee. From its inception, the MCSP has been a public/private partnership, involving government agencies including DPH and DMH working in partnership with community-based agencies, academic researchers, and people with lived experience of suicide loss and suicide attempts working together across a network of regional and local suicide prevention coalitions. The initial State Plan was released in 2009, modified in 2015, and currently undergoing review and revision. It provides the framework for identifying priorities, organizing efforts, and contributing to a statewide focus on suicide prevention. DMH staff work closely with the MSPP staff to advance the State Plan's goals, particularly around the importance of developing services informed by people with lived experience (e.g. survivors of suicide attempts, impacted friends and family, and suicide loss

survivors); the implementation of Zero Suicide among MA healthcare provider organizations; and the dissemination of suicide prevention evidence-based practices.

Additional MSPP and DMH collaborative initiatives as outlined in the State Plan include:

The Massachusetts Zero Suicide Training Initiative: Massachusetts has developed in-state expertise on how to support the effective dissemination and implementation of Zero Suicide in health and behavioral health care settings through efforts. To date, MSPP and DMH have led three Zero Suicide Learning Collaboratives (ZSLCs) statewide to provide training and implementation support for Zero Suicide and the associated suicide prevention evidence-based practices.

Massachusetts Annual Suicide Prevention Conference: MSPP, DMH, and MCSP co-sponsor and organize the annual Massachusetts Suicide Prevention Conference. The conference attracts hundreds of participants each year from across Massachusetts and neighboring states. In addition to national leaders in suicide prevention, conference sessions target a range of audiences including individuals with lived experience of suicidality; family and friends who've experienced suicide loss and/or loved ones' suicide attempts; first responders and community advocates; and health care providers.

Collaborative Assessment and Management of Suicidality (CAMS): Recognizing the need for competent clinicians to treat suicidality specifically, MSPP and DMH have invested heavily in the dissemination and implementation of CAMS, an EBP developed by Dr. David Jobes for the treatment of people experiencing suicidality that is recommended by SPRC and the ZS program. In addition to CAMS training for outpatient clinicians, DMH has sponsored CAMS training for inpatient facilities. Both MSPP and DMH disseminate CAMS 101, a training for administrators, supervisors, and other agency staff to provide orientation to the CAMS model of care and implications for agency operations. Most recently, CAMS4Teens launched in Massachusetts with a focus on adapting the model for youth and their families.

Regional Suicide Prevention Coalitions: In addition to the statewide coalition for suicide prevention, Massachusetts provides funding for eleven regional coalitions across the state, critical for engaging and organizing local resources for suicide prevention. DMH staff at the local level are active members of their regional coalitions.

Local Outreach to Suicide Survivor (LOSS) Teams: The MSPP funds four Local Outreach to Suicide Survivor (LOSS) teams across the Commonwealth with technical assistance provided by DMH staff to support their development and sustainability efforts. In prior years, DMH has provided extensive technical assistance, training, and resource mobilization toward the development of LOSS teams in the Southeast Area – one on Cape Cod (which is now funded by the MSPP) and the second in Plymouth County.

Mass Men: Massachusetts promotes a state-wide suicide prevention campaign targeting working age men who have the highest rates of suicide in the state.

Alternatives to Suicide: Integral to Massachusetts suicide prevention efforts is the inclusion of people directly affected by suicide, including loss survivors, attempt survivors, and their family members in all activities as leaders and participants in the work of the state and regional coalitions, statewide initiatives across the state and within DMH. MSPP and DMH have partnered to support the development, dissemination, and implementation of Alternatives to Suicide, a peer-to-peer support group for people contemplating suicide, which was developed by the Wildflower Alliance, formerly the DMH-funded Western Massachusetts Recovery Learning Community (WMRLC).

Governor's Challenge to Prevent Suicide Among SMVF: DMH is participating in the second cohort of the Governor's Challenge for Suicide Prevention of Service Members, Veterans, and their Families (SMVF) which launched in May 2025. (The first cohort launched in May 2021.) The Commonwealth's work under the auspices of the Governor's Challenge has blossomed into an inter-agency workgroup with over 35 individuals representing, MA National Guard, Department of Veterans Services (DVS), DPH, Riverside Trauma Center, HomeBase, Massachusetts Military Heroes, the School of Public Health at UMass (for evaluation support), the Veterans' Integrated Service Network (VISN 1), Jail Arrest Diversion Initiatives, Lowell VET Center, Air National Guard, Soldier On, New England Center for Veterans, the Massachusetts Suicide Prevention Coalition, Trial Court, Bedford VA Medical Center, and DMH. Together they have provided additional impetus to Inter-Agency Suicide Prevention work among EOHHS agencies: MassHealth's Office of Behavioral Health, DPH Division of Sexual and Domestic Violence Prevention and Services (DVSDVPS), DPH BSAS, Department of Veteran Services, Massachusetts Rehabilitation Commission, and the Office of Elder Affairs.

In the first cohort, four priority initiatives were identified: 1) Screening and Identification; 2) Promoting Connectedness and Care Transitions; 3) Increasing Lethal Means Safety and Safety Planning; and 4) Training (to disseminate trainings to support the work of the other three priority initiatives). Trainings developed include counseling around access to lethal means for gun safety instructors, as well as videos developed and produced to train healthcare providers how to "Ask the Question." Ongoing work to support these projects continues.

In the current cohort, Governor's Challenge team members decided to transition from the first cohort's structure to instead focus on three population-focused priority groups: 1) Clinicians; 2) Peers; and 3) Families. While focused on different populations, the work of each priority group will be intertwined as they develop their goals and implementation strategies for the next year. There will be an emphasis on promoting evidence-based practices in suicide prevention, intervention, and postvention while using a public health approach.

Suicide Mortality Review Board: DMH in partnership with the MSPP at DOH, the Office of the Chief Medical Examiner (OCME), and the Executive Office of Veterans Services (EOVS) are working toward creating a Suicide Mortality Review Board (SMRB) for adult suicides. Initially the SMRB will focus on suicides among veterans with the goal for it to expand to suicides across

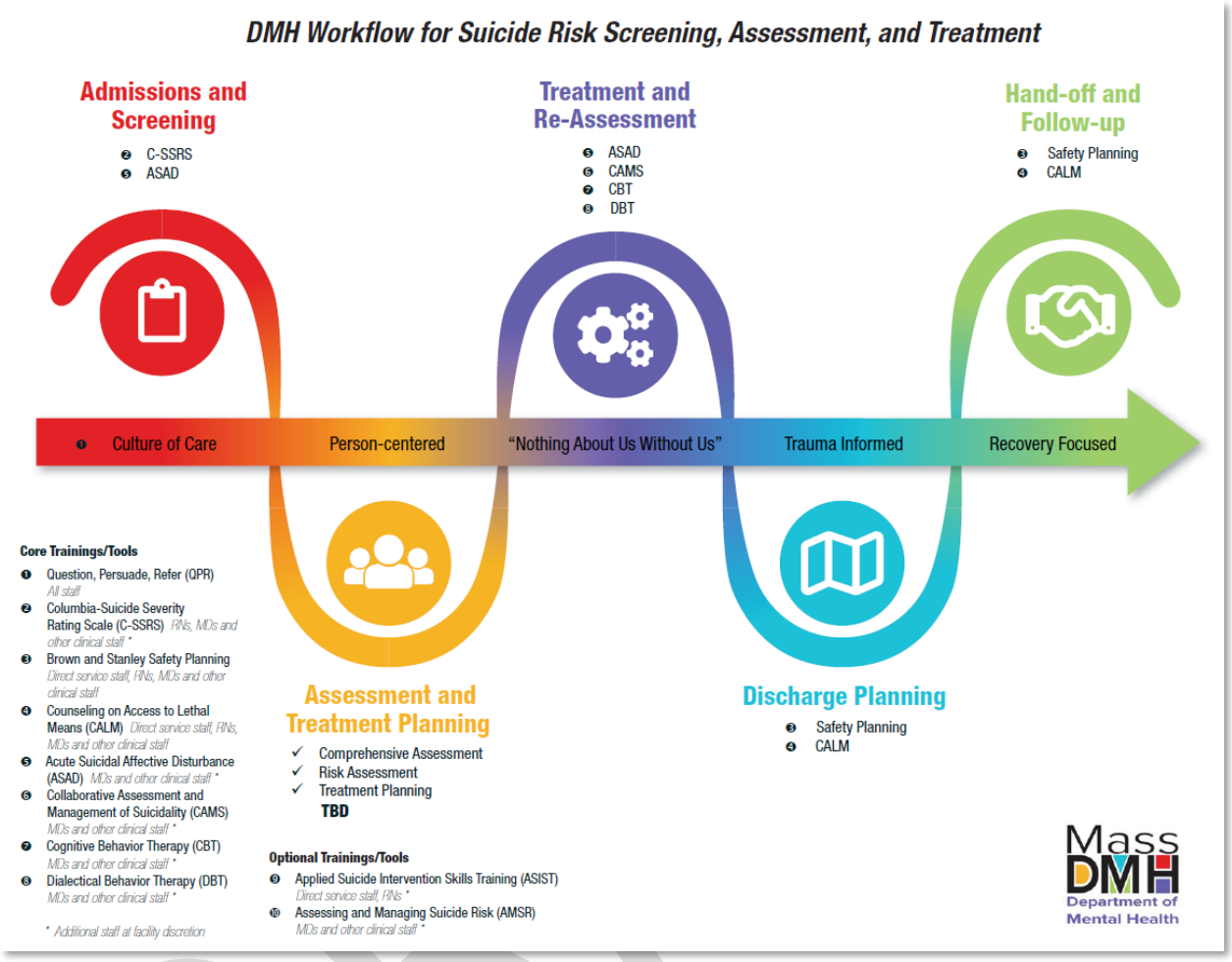
all adult populations. The SMR Committee is currently completing its landscape analysis and developing all necessary documentation processes, procedures, and policies. The SMRB will integrate with existing public health and behavioral health initiatives, using data-driven insights to enhance statewide strategies. By incorporating findings from mortality reviews into prevention planning, Massachusetts can strengthen its response to suicide risk factors and improve overall community well-being. The insights gained through the SMRB will drive targeted interventions, policy improvements, and systemic change.
DMH's internal suicide prevention efforts have been informed by the Zero Suicide method. DMH has incorporated the following strategies supportive of Zero Suicide:

DMH-wide: Across the entire DMH system, the DMH Suicide Prevention Steering Committee (DMH SPSC) and associated workgroups guide the Department's implementation of Zero Suicide across the continuum of DMH operated and DMH contracted services. The DMH SPSC is comprised of DMH staff from all five geographic services areas, child youth and family division, forensic services, inpatient, outpatient, and community services, recovery services, and quality management as well as community consultants with lived experience as attempt survivors. Informed by the recently updated Joint Commission standards, work has focused on the eight DMH inpatient facilities and implementing a standardized evidence-based approach to screening and assessing suicide risk, suicide specific treatment, discharge planning, and supporting transitions in care. The DMH Division of Clinical and Professional Services has responsibility for this task.

The DMH SPSC meets monthly to oversee the department's ZS efforts throughout DMH operations (adult; child, youth and family; forensic; inpatient, outpatient, and community services). DMH has instituted the requirement that all DMH staff participate in Question Persuade Refer, an evidence-based training recommended by the national Suicide Prevention Resource Center (SPRC) and the Zero Suicide program.

DMH has developed in-house training capacity in both QPR and the Columbia Suicide Severity Rating Scale Screener by sponsoring several Train the Trainer sessions and works closely with MSPP to develop in-state CAMS training capacity.

DMH has also been working closely with DMH IT/data and Quality Management to identify data tracking and reporting needs within DMH in order to assess adherence to current practices and monitor outcomes.



Adult inpatient: DMH has instituted a state-wide DMH inpatient suicide risk management protocol in conjunction with a review and update of DMH's overarching risk management policy and informed by Zero Suicide:

a. DMH instituted use of the Columbia Suicide Severity Rating Scale – Screener and an evidence-based assessment process for mitigating suicide risk in all DMH inpatient programs.
b. The DMH Safety Plan workgroup developed a comprehensive safety and wellness plan that incorporates elements from the Stanley Brown, the Copeland Wellness and Recovery Plan, and other person-centered coping and recovery strategies.
c. More than 80 staff across the DMH inpatient system have participated in CAMS training.

Adult Community/Outpatient: DMH piloted implementation of ZS EBPs across the DMH Southeast Area (SEA), primarily with DMH-operated adult services. DMH is working to standardize suicide screening and assessment and suicide risk mitigation efforts across DMH-

operated adult community and outpatient programs. DMH also instituted the requirement that vendor-operated programs that provide Adult Clinical Community Services (ACCS) must utilize the CSSRS-screener and an evidence-based assessment process for mitigating suicide risk

Child, Youth, and Family (CYF): DMH began piloting the implementation of Zero Suicide evidence-based practices with the Southeast Area's division of Child, Youth, and Family Services. That area has established a CYF SEA Zero Suicide Steering Committee who have arranged numerous training opportunities for SEA CYF staff and DMH providers around suicide prevention and the voices of lived experience, an introduction to the ZS framework, and the implementation of CAMS. This work has recently begun to expand to the other DMH Areas. CYF staff also serve on the Youth Suicide Prevention Interagency bi-monthly meeting hosted by the MSPP at DPH.

Suicide Prevention with Tribal Communities

DMH staff serve on the Executive Office of Health and Human Services (EOHHS) Statewide Inter-Agency Tribal Partners Work Group. Meeting every other month, the group brings together state agencies and other programs working with Tribes, as well as Tribal and Indigenous people serving organizations, to develop a cohesive and collaborative approach for partnering and supporting Tribal nations. DMH staff stay informed about potential opportunities for training, technical assistance, and grants available to Tribes and are able to more effectively coordinate collaborative efforts across state agencies.

DMH staff also informed the development of potential breakout sessions centered on SUD and suicide for the second annual Massachusetts Tribal and Indigenous Health Summit hosted by the DPH's Division of Community Engagement (DCE). Several DMH staff participated in the day-long summit focused on key issues impacting the health of Tribal and Indigenous People in Massachusetts including improving the collection and analysis of Tribal health data, improving communication between government health agencies and Tribal Nations, and ensuring more efficient and effective funding mechanisms to improve funding to support Tribal and Indigenous health.

DMH staff have fostered a connection with staff at Indian Health Services (IHS) and Health and Human Services (HHS) of the Mashpee Wampanoag Tribe since 2017 initially through the National Strategy for Suicide Prevention (NSSP) grant. Working in close collaboration with Massachusetts Suicide Prevention Program (MSPP) leadership, DMH staff provided technical assistance and support to IHS and HHS following a number of suicides and overdoses among Tribe members. DMH has facilitated linkages with IHS and HHS staff with several community-based organizations and health and behavioral health agencies on the Cape, including the DMH Pocasset site and Bay Cove, the region's ESP. IHS took part in the Cape and Islands Zero Suicide Learning Collaborative, and have incorporated evidence-based strategies for safer suicide care

into their clinic. Numerous IHS staff, HHS staff, and Mashpee Wampanoag Tribe Members have attended suicide prevention, intervention, and postvention training opportunities.

Prior to the pandemic, DMH and MSPP staff met with HHS staff monthly. The meetings provided a wonderful opportunity for relationship building between IHS, HHS, NSSP grant staff, and DPH and provided a comfortable forum for the teams to identify opportunities for support. Best practices regarding postvention, collecting resources from other Tribes across the country, suicide safe messaging practices, providing funding for suicide prevention activities within the Tribe, and onsite support at community events are among the activities completed.

At the onset of the pandemic the monthly meetings increased to weekly, and sometimes daily, virtual meetings with various HHS staff members. Very early in the pandemic, HHS staff identified that they, along with some of their colleagues, were experiencing difficulty providing virtual services to clients. Grant staff worked with HHS staff to secure seven paid annual zoom accounts for the tribe to virtually connect with clients, host cultural nights for community members, and facilitate support groups.

HHS also identified the increasing distress among Wampanoag Tribe members around social distancing, particularly after several community traumas where members would typically have been able to connect in person. HHS and NSSP grant staff, along with the Cape Samaritans, worked together to create mental wellness care packages for Wampanoag Tribe members and their families. NSSP grant funds purchased nearly 500 books among 27 different titles for Tribe members based on requests from HHS staff including *Meditations with Native American Elders: The Four Seasons* and *The Red Road to Wellbriety: In the Native American Way*.

In July 2024, the Mashpee Wampanoag Tribe was among 18 community organizations statewide to receive funding from the MA Suicide Prevention Program's procurement to provide suicide prevention, intervention, and postvention services. Funding is via state appropriations and continues until June 2035. The Mashpee Wampanoag Tribe also informed statewide strategic planning sessions for the MSPP. HHS staff shared their perspective on the strengths and weaknesses of the mental health and suicide prevention services available to Tribe members, and what they see as opportunities and challenges that may be arising.

Crisis Services

The Executive Office of Health and Human Services (EOHSS) through the MassHealth Program contracts with the Massachusetts Behavioral Health Partnership (MBHP) to maintain a 24/7/365 statewide system of Mobile Crisis Intervention (MCI) services for anyone in Massachusetts experiencing a mental health or substance use crisis. MCI services are provided by trained professionals who can travel to an individual's location or work with an individual at a Community Behavioral Health Center (CBHC) to assess an individual's needs, provide immediate assistance, and determine the best treatment options. Instead of going to the

Emergency Department, MCI services allow anyone going through a crisis to either walk into a CBHC or call for a team to come to their location and access immediate mental health care.

Community Crisis Stabilization (CCS) is a less restrictive alternative to inpatient hospitalization for people in need of short-term, overnight crisis care. CBHCs offer both Adult (18+) and Youth (18 and under) CCS programs with services including individual, group, and family therapy; medication management; crisis intervention; and future crisis prevention planning.

Additionally, the DMH offers mobile outreach services, and emergency department collaborations along with criminal justice system partnerships. DMH Forensic Services provides supports to law enforcement and administers grants to police departments to develop pre-arrest jail diversion programs (JDPs) including Crisis Intervention Teams and clinician/police co-responder programs.

Finally, in an effort to provide more timely access to short term stabilization services, DMH expanded its Respite service capacity using the 5% set aside over the last three years to provide diversion points from emergency departments, inpatient units, and homeless shelters and to facilitate safe transition plans for people with complex behavioral health needs. Respite Services deliver temporary, short-term, community-based clinical and rehabilitative services to assist individuals to maintain, enter, or return to permanent living situations. The services are delivered at site-based (24/7) locations and as a mobile service. The availability of community respite capacity increases the psychiatric inpatient providers' ability to discharge patients to the next treatment level, provides alternatives to hospitalization, and provides additional settings for clinical assessments. Over 60% of individuals accessing Respite Services are transitioning from a hospital or another institutional setting into a community living situation. DMH increased its Respite capacity to specifically address ED utilization and boarding with fourteen programs across the state, serving over 1,500 people in FY23 to date.

Inpatient Services

DMH currently operates 734 inpatient beds and oversees 30 contracted inpatient beds, totaling 764 beds. DMH has 702 adult continuing care beds including capacity for forensic admissions, 32 adult acute admission beds located within two community Mental Health Centers (CMHCs), and 30 adolescent continuing care beds. As reported in the FY22 URS tables, DMH served 1,415 adults and 24 children in its state operated and contracted psychiatric hospitals.

Children, adolescents, and most adults receive acute inpatient care in private or general hospitals. DMH has licensing authority over private inpatient psychiatric facilities, which provide acute care including short-term, intensive diagnostic, evaluation, treatment, and stabilization services to individuals experiencing an acute psychiatric episode. These services are provided almost entirely in private psychiatric facilities and general hospitals with psychiatric units. In

2021, DMH licensed 2,974 acute psychiatric beds within 65 facilities and licensed hospitals had 59,165 admissions. In 2022, DMH licensed 3,010 acute psychiatric beds within 65 facilities and licensed hospitals had 54,539 admissions. DMH is actively working to increase acute inpatient psychiatric beds and anticipates licensing approximately 72 new beds within the coming year.

DMH established program standards in ACCS for in-reach to facilities when a client is admitted to a hospital to collaborate with care coordination and the inpatient treatment team to support treatment and discharge planning activities and timely follow-up in the community. ACCS providers report all hospital admissions, discharges, and care transition contacts to DMH. ACCS performance measures include community tenure and timeliness of care transition follow-up.

DMH also provides Respite Services, which delivers temporary short-term, community-based clinical and rehabilitative services to assist individuals to maintain, enter, or return to permanent living situations. Respite Services are delivered in both site-based (24/7) locations and as a mobile service. The availability of community respite capacity increases the psychiatric inpatient providers' ability to discharge patients to the next treatment level, provides alternatives to hospitalization, and provides additional settings for clinical assessments. Over 60% of individuals accessing Respite are transitioning from a hospital or another institutional setting into a community living situation. DMH increased its Respite capacity to specifically address ED utilization and boarding with 14 programs across the state, serving over 1,500 people in FY23 to date.

In addition, DMH contracts for a Peer-Run Respite service in the Western Massachusetts Area. This service provides temporary peer support to individuals in emotional distress and/or emergent crisis. The service utilizes self-help strategies, trauma-informed peer support, and mutual learning to address the needs of people experiencing emotional distress. The service is intended to be a community-based alternative to a hospital psychiatric setting or other clinical setting for managing emotional distress or emergent crisis.

Another effort to reduce the hospitalizations is the Road Map for Behavioral Health Reform. As noted earlier in this application, DMH has worked in close collaboration with other Executive Office of Health and Human Services (EOHHS) agencies in the redesign of the behavioral health system across Massachusetts, including the examination of inpatient and community services. The multi-year plan – *Roadmap for Behavioral Health Reform: Ensuing the Right Treatment When and Where People Need It* – launched in February 2021 and was based on listening sessions and feedback from nearly 700 individuals, families, providers, and other stakeholders who identified the need for expanded access to more effective treatment and improved health equity.

A critical piece of the Roadmap is the creation of the Behavioral Health Help Line – a new, centralized service for people to call or text to find the right treatment for mental health and behavioral health when and where they need it. The 24/7 BHHL directly connects individuals

and families to the full range of treatment services for mental health and substance use offered in Massachusetts. Any Massachusetts residents can connect with qualified professionals for mental health assessments, crisis services, substance use treatment, referrals and more, with options in all communities via phone, web chat, and texts.

Further, the Roadmap provides more convenient community-based alternatives to the emergency department for urgent and crisis intervention services and more readily available outpatient services, including same-day evaluation and referral to treatment, and ensures residents can access integrated behavioral health care which serves the entire person. A network of Community Behavioral Health Centers (CBHCs) in communities across the state serves as an entryway to timely, high-quality, and accessible mental health and addiction treatment. CBHCs offer 24/7 mobile crisis services for anyone experiencing a potential mental health crisis, regardless of insurance or ability to pay. CBHCs also provide a wide range of outpatient services including individual and group therapy, recovery coaching, and prescribing for mental health and addiction treatment medication.

Mobile Crisis Intervention (MCI) services are available to anyone in Massachusetts experiencing a mental health or substance use crisis. MCI services are provided by trained professionals who can travel to an individual's location or work with an individual at a CBHC to assess an individual's needs, provide immediate assistance, and determine the best treatment options. Instead of going to the Emergency Department, MCI services allow anyone going through a crisis to either walk into a CBHC or call for a team to come to their location and access immediate mental health care.

Expedited Psychiatric Inpatient Admission

In January 2018, DMH implemented a new inter-agency initiative, Expedited Psychiatric Inpatient Admission (EPIA), which was designed to reduce the length of time that individuals requiring inpatient psychiatric hospitalization were waiting in hospital Emergency Departments (ED) for an inpatient bed ("boarding"). Under the direction and with the support of the EOHHS Secretary, DMH chairs a Task Force in partnership with MassHealth, the Department of Public Health, and the Division of Insurance which was charged with developing, implementing, and monitoring strategies to intervene and shorten ED boarding time. The task force membership includes government conveners, insurance carriers, psychiatric and medical hospital providers, hospital and carrier trade associations, professional associations, and state agency representatives. In August 2022, Chapter 177 of the Acts of 2022, An Act Addressing Barriers to Care for Mental Health ("Chapter 177") was signed. In addition to a number of other measures, Chapter 177 codified the EPIA program into law.

The EPIA procedures initially implemented in 2018 have been updated in response to the lessons learned and the exponential increase in demand for hospital level of care seen in recent years. During the early phase of the COVID-19 Pandemic, the time to escalate to DMH/EPIA

decreased from 96 hours of boarding to 48 hours with the goal of increasing throughput in EDs. In June 2020, it was evident that the behavioral health needs of the population were overwhelming Emergency Departments. The number of individual boarding ED's in June 2020 was 3 to 4 times the number seen in June 2019 when EPIA decreased the escalation time to 24 hours of boarding. In December 2020, escalation time to DMH was increased to 48 hours for youth and 60 hours for adults, so that EDs, Mobile Crisis Teams, and Insurance Carriers would have adequate time for their bed search and advocacy efforts prior to escalation. Additional efforts to reduce ED Boarding have included expanded authorization for the use of Special Services Billing Codes including services such as single rooms, one-to-one support, and extra staff.

Currently, the EPIA policy sets 24 hours as the maximum threshold for patient boarding in an ED to initiate escalation steps to obtain admission. The EPIA policy requires the hospital to alert health insurers governed by the Division of Insurance to start searching for an inpatient psychiatric bed at 24 hours post-emergency department admission and to go outside of the insurer's regular network of providers if necessary. At the 60-hour (adults) or 48-hour (youth) mark of an ED Boarding episode, DMH/EPIA will receive escalation referrals and begin advocacy efforts to procure a bed while respecting geographic considerations and family preferences.

The DMH EPIA team includes four admission advocates (three registered nurses and one program manager), and one administrative position to manage data collection. DMH engages in direct intervention with EDs, inpatient providers, and insurers to find appropriate placements. The team keeps inpatient facilities aware of who is boarding the longest and advocates for those individuals until they are admitted or a Change of Level of Care occurs. Advocacy entails twice daily email notifications of who is boarding for two weeks or longer (generally 25 – 40 individuals daily). Additionally, personalized efforts are made to better understand the barriers preventing admission and use creativity with insurers, State Agencies, and inpatient providers to decrease those barriers. At times, a case conference is organized by the State Medical Director with Insurers, hospitals, and state agency staff to discuss and conclude the best plan needed to secure treatment.

In 2021 there were 7,331 referrals to DMH to assist with inpatient placement from EDs (up from 4,304 in 2020) including 2,670 youth (36%) and 4,661 adult (64%). These high numbers persisted in 2022 with 7,938 referrals to DMH, though there was a slight reduction in total numbers and percentage of youth referred for DMH assistance (2,448 youth or 31%; 5,490 adults or 69%). Among these, 14.1% of referrals for DMH assistance were for individuals who were referred for assistance more than once in the year. (Individuals can be referred prior to the 60-hour mark especially in complex cases.) Approximately 40% of referrals to the EPIA team are successfully diverted to a different level of care

The pandemic magnified pre-pandemic ED Behavioral Health Boarding issues. The largest barrier to inpatient placement is consistently insufficient bed availability. Additional barriers

include the need for a continuum of outpatient, community-based services, and the widespread behavioral health (BH) workforce shortages.

DMH, in collaboration with the EOHHS and our sister state agencies, has taken a multivariate approach to this multiple causation problem. As noted throughout this application, the Behavioral Health Roadmap is the overarching strategic vision for the MA behavioral health system. The establishment of the 24/7 Behavioral Health Help Line is designed to help individuals access services with the hope of intervening early and averting emergencies. The network of CBHCs is accountable for fully integrated MH/SUD treatment that includes a coherent array of services that assures smooth, integrated services across levels of care including mobile crisis, new youth crisis stabilization beds, urgent behavioral health care, and ongoing substance use and mental health treatment. With the establishment of the CBHC network in January 2023, the Commonwealth has completely restructured 24/7 community-based crisis services to assure all residents have immediate access to mobile crisis independent of insurance status. The launch of CBHC has contributed to a decrease in EPIA referrals for children boarding longer than 48 hours and adults longer than 60 hours. In 2023, overall referrals decreased to 5420. Furthermore, there was a reduction in 2024 to 2,939.

Other efforts have included adjusting regulations around use of telemedicine and expanded scope of practice for some licensed staff to extend workforce response, prioritization of child and adolescent bed increases, and other specialty units (DD/ASD, geriatric). Further, DMH has worked with MassHealth to provide funding incentives to increase bed numbers over 2019 capacity.

In the state of Massachusetts, DMH has taken the lead with the Behavioral Health Treatment Referral Platform (BHTRP), where emergency departments are expected to upload individuals boarding for behavioral health care at 24 hours. All DMH licensed hospitals have access to the platform, allowing for efficiency and accessibility to care. The expectation of BH TRP is more efficient and effective communication, ultimately leading to a reduction in waiting times during the bed search process.

Emergency Department Diversion Program

DMH now provides an Emergency Department Diversion Program, partnering with hospitals and providers to offer alternative services where care can be provided at home. These services are also available through MassHealth.

DMH has implemented ED diversion programs aimed at reducing ED boarding by identifying and providing alternative services to youth and adults experiencing behavioral health crises who can be treated more appropriately in community-based settings or with in-home therapy services. Diversion is not appropriate for every patient; however, a significant percentage of individuals who arrive in the ED with behavioral health symptoms could be treated more

effectively in an outpatient setting if the services were available. The diversion programs connect EDs with community-based providers to determine their capacity to deliver the services outside the ED. Treatment is ultimately rendered more quickly and in a more appropriate and less expensive setting.

The DMH Emergency Department Diversion Program provide programs in 47 hospitals and have provided services to over 482 youth and 1,102 adults as of December 9, 2022. In addition to DMH funding, MassHealth expanded the intensive crisis intervention services and in-home therapy services in February 2022. Hospital ED diversion programs will relieve long-standing challenges with ED boarding, which as noted earlier escalated during the pandemic, while expediting behavioral health treatment for youth and support for their families.

Comprehensive Community-Based Mental Health Services

DMH directly provides and/or funds a range of services for 24,500 adult clients per year. These services include inpatient continuing care, case management, and other community clinical and rehabilitative services, including Adult Community Clinical Services (ACCS), Program for Assertive Community Treatment (PACT), Clubhouse, Respite, Homeless Support Services, and Recovery Learning Communities. Publicly funded acute-care services, including inpatient, crisis, and outpatient services are managed by MassHealth. However, DMH operates some acute-care inpatient and outpatient services in the Southeast and Metro Boston Areas.

In 2018 DMH completed a restructuring of adult community services in order to provide evidence-based interventions within the context of a standardized, clinically focused model. The Adult Community Clinical Services (ACCS) service is the cornerstone of the DMH adult community-based system and serves approximately three quarters of all adults receiving a DMH community-based service. The goal is to offer active and assertive engagement to improve health and behavioral health outcomes. ACCS offers clinical and rehabilitation services integrated with the health care system through care coordination functions delivered by the Behavioral Health Community Partners (BHCPs), DMH case management, and the One Care (Medicare-MassHealth eligible) Health Homes.

Beginning in FY24, DMH will engage in a significant expansion of ACCS services to address two gaps in the DMH system which are also impacting broader health care system. The first gap is that DMH's state operated inpatient continuing care and community-based capacity cannot meet the current need as demand for services, particularly inpatient and community residential beds, has steadily increased while capacity has not changed. The second gap is community care options, including integrated intensive medical support, for individual with serious mental illness who are transitioning or diverting from skilled nursing facilities. DMH is utilizing state and CMS Home and Community Based Services ARPA funds to expand ACCS capacity with 500 additional group living placements and 270 rental assistance and clinical outreach placements. The group living placements include a new model of care added to the ACCS model that will

provide nursing and hands-on care within the environment to meet and support the daily needs of individuals with chronic medical conditions, terminal illnesses, and/or disabilities which are impacted by their significant mental illness.

DMH is further supporting the transition of individuals with serious mental illness in nursing facilities through the creation of a DMH Nursing Facility Transition team that will be responsible for overseeing the screening and assessment of all nursing facility residents for serious mental illness and service coordination of behavioral health services for residents, as well as providing direct transition planning for individuals transitioning out of nursing facilities or who can be diverted from admission. DMH collaborated with EOHHS, MassHealth, and the Executive Office of Aging and Independence (AGE), to design this program and align it with the BH CP program, which will be providing the care coordination for nursing facility residents and the Community Transition Liaison Program, which leverages an existing AGE program to support all nursing facility residents who are 22 and older, regardless of diagnosis or insurance type, and are interested in transitioning to the community. These integrated programs will launch in July 2023.

Finally, DMH has expanded its Respite and PACT capacity. As described earlier, Respite services were expanded over the last three years to provide additional stabilization and diversion points from emergency departments, inpatient units, and homeless shelters and to facilitate safe transition plans for people with complex behavioral health needs. This expansion includes 14 new programs focusing on diversions from emergency departments which collectively served over 1,500 individuals in FY23. DMH also procured seven new PACT teams, including two new Forensic PACT teams that have the capacity to serve 410 additional individuals.

The following is a list of DMH Community-Based services for adults:

- Adult Community Clinical Services (ACCS): ACCS is a comprehensive, clinically focused service that provides clinical interventions and peer and family support to facilitate engagement, support functioning and maximize symptom stabilization and self-management of individuals residing in all housing settings. In addition, ACCS provides a range of provider-based housing options as treatment settings to assist individuals in developing skills, establishing natural supports and resources to live successfully in the community

- Respite Services: Respite Services provide temporary short-term, community-based clinical and rehabilitative services that enable a person to live in the community as fully and independently as possible;

- Program of Assertive Community Treatment (PACT): A multidisciplinary team approach providing acute and long-term support, community based psychiatric treatment, assertive outreach, and rehabilitation services to persons served;

- Clubhouses: Clubhouse Services provide skill development and employment services that help individuals to develop skills in social networking, independent living, budgeting, accessing transportation, self-care, maintaining educational goals, and securing and retaining employment;

- Recovery Learning Communities (RLCs): Consumer-operated networks of self-help/peer support, information and referral, advocacy, and training activities;

- DMH Case Management: State-operated service that provides assessment of needs, service planning development and monitoring, service referral and care coordination, and family/caregiver support;

- Homeless Support Services: Comprehensive screening, engagement, stabilization, needs assessment, and referral services for adults living in shelters, on the streets, and in other places not meant for human habitation; and

- Forensic Services: Provides court-based forensic mental health assessments and consultations for individuals facing criminal or delinquency charges and civil commitment proceedings; individual statutory and non-statutory evaluations; mental health liaisons to adult and juvenile justice court personnel.

During the pandemic, DMH shifted its approach to utilizing telehealth options to provide continuity of service delivery in the community and implemented a series of flexibility measures to reduce administrative activities and prioritize essential service delivery functions. All DMH community-based services continued to operate and provide in-person service delivery when clinically indicated with appropriate infection control precautions in place. DMH collaborated with providers and state-operated programs to respond to health and safety issues including meeting basic needs for food, medication, access to healthcare, and use of technology for telehealth and social connections. DMH worked extensively with EOHHS and sister agencies to provide access to vaccination for clients and staff and to develop and implement guidance addressing visitation, surveillance testing, and infection control practices in community settings. In anticipation of the Public Health Emergency ending, DMH continued to partner with EOHHS to ensure that infection control practices are integrated into community program operations. DMH programs continue to offer telehealth and in-person interventions, guided by client preference and clinical need.

Housing Services

DMH is committed to expanding access to affordable, integrated housing opportunities that support individuals as they progress through the DMH service system. These housing options are designed to foster independence, offer meaningful choice, uphold the rights and

responsibilities of tenancy, and ensure that service are tailored to each person's unique needs. DMH advances its mission through a strong partnership with state and local housing agencies, as well as with non-profit and for-profit housing organizations. Massachusetts is fortunate to have many affordable housing agencies and programs that directly and indirectly serve people with mental health conditions. Specific agencies include the Massachusetts Executive Office of Housing & Livable Communities (EOHLC), the MassHousing Finance Agency, and Community Economic Development Assistance Corp (CEDAC) in addition to the 200+ Local Housing Authorities.

DMH uses a broader definition of homelessness than the federal standard. It includes individuals currently residing in skilled nursing, rest homes, and other institutional settings who lack a permanent residence, as well as those temporarily staying with family or friends, without stable, long-term housing. Without access to subsidies, whether for market-rate units or existing subsidized housing, individuals receiving DMH services are at a greater risk of remaining in substandard living conditions or in transitional programs, hospitals, and other temporary settings for prolonged periods.

EOHLC is DMH's primary partner in providing affordable housing given the number and size of programs they administer. In their role as the state's primary housing oversight agency, EOHLC oversees state and federal housing resources including both federal and state rental assistance, public housing programs, Local Housing Authorities, state capital financing, federal and state tax credits, and homeless programs for individuals and families. DMH continues to participate in the Interagency Supportive Housing Initiative, led by EOHLC, to develop supportive housing, particularly for homeless persons and families, people with disabilities, and aging adults. This groundbreaking initiative pulls together over ten housing and service agencies to work toward securing the necessary housing funds along with their commitment to provide clinical and service supports which enable people to live in their own housing.

Through its collaboration with EOHLC, DMH has exclusive access to over 80 (ch. 689) developments, housing around 700 individuals served by DMH. These units are owned and managed by the Local Housing Authorities. EOHLC along with some 55 of its Local Housing Authorities and DMH together fund and manage the DMH Rental Subsidy Program (DMHRSP) that enables people to live in their own housing in communities throughout Massachusetts. The DMHRSP subsidy program in FY25 is budgeted at $37.5M and currently housing over 2,500 individuals. These rental subsidies are specifically designated for individuals served by DMH and cover up to 110% of the HUD Fair Market Rent (FMR). Participants can lease quality units in the private market while contributing 30% of their adjusted income toward rent, with the subsidy covering the remainder. Notably, the DMHRSP program does not require CORIs or credit checks, reducing common barriers to housing access. This program reflects a unique and collaborative partnership between a state housing agency and state mental health agency rooted in the recognition that people with mental health conditions often face significant challenges accessing mainstream housing resources.

On the capital investment side, EOHLC along with CEDAC helps DMH with securing new housing, mostly integrated into multi-family developments, specifically dedicated to individuals receiving DMH services. The Massachusetts Facilities Consolidation Fund (FCF) makes available loans or grants to non-profit and for-profit developers that covers up to 50% of the total development cost of the units dedicated to DMH. In a typical year, $11.5M is committed to projects funded through FCF. EOHLC also assists in securing project-based subsidies for units usually via the Housing Choice Vouchers or MA Rental Voucher Program (MRVP) to ensure long-term affordability. Units are high quality and integrated into multi-family developments that provide a normalized setting for individuals. FCF currently finances over 1,200 housing units. The majority of these units are either one-bedroom or studio sized.

Of particular note, under State Public Housing is the Chapter 689/167 Special Needs Housing Program managed by the Local Housing Authorities providing Group Living Environments (GLEs) in communities across the state at rents well below market. DMH leases over 80 developments, housing around 700 individuals. These buildings are generally designed to house four to eight people in either shared or individual apartments; no CORIs or credit checks are required.

MassHousing is a vital state housing partner of DMH, managing a portfolio of over 100,000 units of multi-family and elderly housing. Through a dedicated 3% Set-Aside program of their affordable units, Mass Housing reserves housing specifically for individuals served by DMH and the Department of Developmental Disabilities (DDS). These Set-Aside units provides approximately 400 high-quality, subsidized studios and one-bedroom units that are fully integrated into multi-unit developments. DMH and DDS have exclusive access to these units, allowing individuals to bypass traditional waitlists, which in some cases can take years before a unit is available.

With respect to housing for people experiencing homelessness, DMH has been very involved in accessing housing resources through participation in all eleven of Massachusetts HUD Continuums of Care (CoC) that manage HUD McKinney funds. The five DMH Areas all provide matching funds or leveraged services to CoC local grants that include Supportive Housing and Supportive Services Only. These programs are vital to the Department's ability to serve those who have difficulty accepting more traditional housing because of their mental health conditions.

Given DMH's focus on housing and with so many housing resources in play across the state, DMH has specific housing staff assigned to each of its five Areas dedicated to managing and monitoring the various housing assets in their Area. The DMH housing staff also play an active role in promoting housing development working with Local Housing Authorities, Community Development Corps, for-profit developers and others to expand DMH housing opportunities. They serve as the "boots on the ground" when it comes to local housing initiatives.

DMH Central Office helps to coordinate housing policy and programs across the five Areas, interfaces with State and Federal agencies, and links up the key state housing agencies with

local needs and activities. Central Office brings together the Area housing staff on a regular basis to discuss issues and incorporates into that discussion those personnel from various state agencies who can assist DMH with its housing goals and objectives.

Central Office actively participates in housing policy and work groups under the leadership of EOHLC and the Executive Office of Health and Human Services. These include the Olmstead Commission, the Interagency Supportive Housing Work Group, the Mental Health Planning Council Housing Committee, additional interagency activities include joint management of DMH Rental Subsidy Program with EOHLC, oversight of the MassHousing Set-Aside program, management of c689 Public Housing/EOHLC, and development activities with CEDAC and EOHLC.

DMH established a housing plan to give direction and support to the housing effort. The plan's goal is to create movement through the DMH system and support the Commonwealth's effort to end homelessness for individuals experiencing mental health and co-occurring conditions. The plan addresses the following key objectives:

- Expand DMH Rental Subsidy Program funding annually to enable more individuals to move from Group Living Environments into their own housing with supports, promoting greater independence and recovery;
- Increase utilization of the DMHRSP Tenant-Based subsidy for ACCS enrolled individuals and other DMH programs who are ready to transition to their own lease;
- Expand the number of Safe Havens programs across the state and resources for Program Staffing Support contracts to support the Commonwealth's efforts to end homelessness and promote movement within the DMH Homeless Support Services system.
- Leverage increased access to both State and Federal affordable housing resources (capital and operating funds) to serve the housing needs of individuals served by DMH
- Secure technical and data systems to enhance management of DMH housing resources and support for contract monitoring that incorporates the tracking of individual movement through the DMH system; and
- Identify and promote educational and learning opportunities specific to housing that are targeted to peers, service providers, and agency staff.

Service to Homeless Individuals

DMH is dedicated to meeting the needs of individuals with mental health conditions who are experiencing by offering comprehensive Supported Housing options. These services include Outreach and Engagement, Safe Havens programs, Supportive Housing, and long-term housing solutions designed to promote stability and recovery. The DMH/SAMHSA funded Projects for Assistance in Transition from Homelessness (PATH) program conducts statewide outreach on average to 2,100 individuals annually who are living on the streets or in shelters. This critical

statewide outreach effort is supported by an annual federal grant of $1.6 million from the Substance Abuse and Mental Health Services Administration (SAMHSA) and $1.85 million in state funding. The PATH program employs approximately 35 outreach staff, comprised of clinical social workers, peer support specialist, and experienced homeless outreach staff. These teams regularly visit more than 50 adult homeless shelters across the state. PATH serves individuals living with mental illness, including those with co-occurring psychiatric and substance use disorders, by offering a range of supports such as direct care, housing search, benefits navigation, advocacy, and referrals to health and behavioral health care services. Individuals who are assessed to meet DMH criteria are referred to for services, others may receive CSP-HI, a MassHealth service, or are referred to the local Continuum of Care. In the first 10 months of FY25, PATH reported enrolling 849 individuals, made 1,502 referrals (over half successful), and housed 127 of those discharged from PATH. DMH along with PATH continues to build on a very successful relationship with the Mass Library Association and Board of Library Commissioners, and most recently attended a Statewide in-person meeting with librarians on the subject of outreach and engagement and access to community resources.

DMH also supports homeless outreach and engagement through its own state-operated program in Boston, the Mobile Homeless Outreach Team (HOT). Comprised of 8 staff, HOT provides street outreach for adults 18 years or older that need mental health services. HOT works to connect individuals with appropriate supports and resources, with the goal of helping them transition off the streets and into stable care and housing. The team also provides psychiatric nurses to non-DMH Boston shelters to treat health problems and manage medication adherence. HOT further supports contracted homeless outreach services in Boston at the Pine Street Inn, Saint Francis House, and the Boston Public Health Commission. There is an additional outreach and engagement contract serving Cape Cod that provides street outreach and support to local shelters and police. The Cape Cod Outreach & Engagement Team hosts a weekly coffee house every Wednesday morning in partnership with Housing Assistance Corporation (HAC) and Duffy Health Center. The event is regularly attended by additional community partners, including Yarmouth CTC, the AIDS Support Group, the Community Justice Support Center, and others. This collaborative outreach effort provides support and services to approximately 20–30 individuals each week.

PATH received additional funding to enhance services for homeless individuals impacted by the pandemic. The funding allowed them to focus on people and locations for those living outdoors who need access to testing and supports, as the shelter system reduced overcrowding and saw significant numbers choose to remain outdoors. This work is extremely difficult with the rise in fentanyl available on the street.

DMH provides four transitional shelter residences in Boston with a capacity of 140 beds serving chronic homeless individuals with severe mental illness and often co-occurring disorders. These unique programs receive referrals from non-DMH shelters and other homeless programs and are oriented towards stabilization and placement within the DMH system. Each program is affiliated with a DMH Community Behavioral Health Centers (CBHC) and has clinically trained staff.

In addition, DMH contracts in Boston for outreach to homeless individuals with mental illness in transitional housing, on the streets, and in less populated areas of the state. Members of outreach teams do active street work, ride in medical vans, and visit emergency shelters. Physicians from affiliated agencies are available to provide medical care to homeless individuals who will not come into a center or shelter for treatment.

The Department has a long-standing permanent housing program for individuals that are homeless which is co-funded by DMH and the Department of Public Health and operates statewide. The Aggressive Treatment and Relapse Prevention program (ATARP) provides a "housing first" approach with necessary support services to a minimum of 55 individuals (50 single adults and 5 families) diagnosed with co-occurring psychiatric and substance use disorders.

DMH is an active partner is the Commonwealth's Tenancy Preservation Program (TPP), a Court-centered program operating across the state with mental health providers serving as the contracted clinical support. TPP operates in all five housing courts in Massachusetts and some District Courts, intervening with people who are about to be evicted from their housing. Four of the six providers serving TPP are mental health providers and bring critically important clinical and mediation skills to help avoid eviction or secure alterative housing. TPP has proven to be an extremely successful program either "saving" tenancies or providing for a "soft" landing in a more supported environment.

DMH works closely with the Executive Office of Health and Human Services (EHS) Office of Homeless Youth Services to identify the intersections between behavioral health challenges and housing instability among youth and young adults. Together, we develop strategies to address these challenges and coordinate efforts to support individuals who may be falling through the gaps between systems, with the goal of connecting them to resources that promote housing stability. DMH also partners with EOHLC to enhance mental health support and coordination for families placed in motels for shelter through EOHLC's emergency housing system. Massachusetts has a mandate for shelter for families that meet the eligibility criteria and when the family shelter network capacity has been reached, EOHLC purchases rooms in motels to temporarily shelter eligible families until a resource opens. DMH recognized this sheltering arrangement may be very challenging for any member of the family who may be experiencing a

mental health condition and works with its PATH provider to extend its reach into several high-volume motels serving homeless families.

DMH has built a flexible service model that adapts to the evolving needs of individuals, ensuring comprehensive support throughout their recovery. DMH's Transition Age Youth Initiative representative was also appointed to the EOHHS Unaccompanied Homeless Youth Commission to study and make recommendations relative to services for unaccompanied homeless youth age 24 and younger with the goal of ensuring a comprehensive and effective response to the unique needs of this population. Additionally, DMH requires providers to deliver services that are age and developmentally appropriate, including services for aging adults.

Rehabilitation, Support, and Recovery-based Services

As DMH is the primary provider and/or contractor of continuing care community-based services, rehabilitation, support and recovery are at the core of its programs. ACCS, the primary community-based service providing rehabilitation and support in the community, serves approximately three quarters of the people receiving a DMH community-based service. Other DMH state-operated and contracted services providing rehabilitation and support include case management and Program of Assertive Community Treatment (PACT).

In addition, DMH offers services focused on recovery and client empowerment, such as Clubhouses. In a shift towards consumer-directed care, DMH funds supports a variety of consumer initiatives, including peer and family support, peer mentoring, warm-lines and six Recovery Learning Communities (RLCs). These consumer-run RLCs initiate, sponsor, and provide technical assistance to a wide variety of supportive, educational, and advocacy activities spread out across their respective regions and continue to develop their capacity to support the growing peer workforce in Massachusetts. With the addition of the Director of the Office of Recovery and Empowerment at DMH during FY25, it has increased capacity to do the work in providing recovery support on the statewide level.

DMH is working with the contractor for Certified Peer Specialist training in the Commonwealth to include modules on Co-Occurring Disorders, and on Justice System involvement. The existing Wild Ivy Contract, which ensures the amplification of voices of those who are typically underserved by DMH. The Office of Recovery and Empowerment has been working with them to share contacts, and to help connect and collaborate with community groups across the state

Along with funding from MassHealth, DMH has increased the number of Certified Peer Specialist trainings to meet the increased demand for peers throughout the system. This includes the MassHealth-funded Community Behavioral Health Centers (CBHCs) which employs lived experience roles, including Certified Peer Specialists, in staffing patterns and

reimbursement design. The number of individuals with lived experience of mental illness who has been trained as Certified Peer Specialists (CPS) continues to increase. The Kiva Centers, a peer-run organization in Massachusetts, has been providing CPS training and certification since 2008. In January 2020, DMH awarded the Kiva Centers a new contract for Peer Specialist training and certification.

Since 2012 and in response to advocacy from the peer community, DMH sponsors a Peer-Run Respite in the Western MA division. This program, Afiya House, provides individuals experiencing emotional distress with short-term, overnight respite in a home-like environment. All staff members are peer supporters with intensive training in Intentional Peer Support and are employed by the Western Massachusetts Recovery Learning Community. Most are Certified Peer Specialists, and many have additional intensive training in Hearing Voices and/or Alternatives to Suicide. Afiya House is located in a residential area and has separate bedrooms for up to three individuals. This year, DMH funded three additional respites using our Model A Respite design but staffed by peer specialists. These respites are run by the Kiva Centers, who have a contract for the Central MA RLC and the MA Peer Training and Certification. DMH has worked with providers to document evidence-based peer supervision from our ACCS model and has encouraged our providers to develop career ladders for peers. Most of our larger providers have included a Senior Management-level peer position in their organization.

DMH, BSAS, and MassHealth have fostered the development of a trained peer workforce and incorporated peer positions into the aforementioned and other services. Additionally:

- BSAS supports training courses for recovery coaches and their supervisors. A total of 775 people have completed the Recovery Coaching training, and the MA Board of Substance Abuse Counselor Certification has begun certifying Addiction Recovery Coaches;

- BSAS supports Peer Recovery Support Centers, uses peers in SUD outpatient clinics and Access to Recovery services, and provides funding for several Learn to Cope sites that provide peer support for families with members who are struggling with addiction;

- MassHealth, in addition to providing children's Family Partners, includes peers as team members in ESPs for adults, enhanced outpatient programs, and Community Support Programs; places "peer bridgers" in some inpatient hospitals; and has peer positions in the One Care dual eligible demonstration; and

- DMH continues to infuse peer specialists into the mental health workforce and identify peer specialist needs within specific communities.

DMH requires providers to offer Peer Support services in all of its community services. Depending on the population served, providers may hire Substance Use Recovery Coaches in those roles. Many of the Certified Peer Specialists in the workforce are also pursuing Recovery Coach certification. Most of the DMH-funded Recovery Learning Communities run groups

around addiction. DMH Clubhouses continue to offer Dual Recovery Anonymous groups for members and others struggling with mental health and substance use disorders.

Massachusetts has included Older Adult Peer Support as part of its Home and Community Based Frail Elder Waiver. DMH worked closely with the Office of Aging and Independence (AGE), and MassHealth to ensure its implementation. DMH, along with AGE, is continuing to explore ways to dampen the workforce shortages in our older adult peer workforce by training home care aid workers who are aging out of heavy lifting duties to become older adult peer specialists so they may continue their work with older adults and remain in the workforce. During the pandemic, a training was developed for older adult peer specialists to learn how to offer virtual peer support given the necessary isolation of older adults during the pandemic.

Employment Services

DMH provides employment services through 35 Clubhouse programs, which offer members a range of career counseling, job search, training, support, and placement services for obtaining and maintaining permanent, supported, and transitional employment. Clubhouses also serve as multi-service centers for DMH clients and other persons with serious mental illness living in the community, assisting members with housing, health and wellness, and above all providing a community within which members are “wanted, needed, and expected.” DMH offices establish individualized or regional employment and education targets, which are monitored through an annual site visit, routine contract monitoring, and monthly outcome reports.
Clients also receive employment services through DMH's Program of Assertive Community Treatment (PACT), whose team includes a dedicated employment specialist among its mix of generalist and specialized community-based staff. DMH has revised reporting criteria for adult PACT programs to include person-level employment reporting, akin to clubhouses. Once implemented, this will bring DMH one step closer to its goal of unified reporting of employment outcomes across its services.

In 2018 DMH redesigned its principle community service to enhance the clinical focus and structurally integrate it in existing healthcare and employment delivery systems. As a result, it was decided that the new service, Adult Community Clinical Services (ACCS), instead of purchasing and integrating employment directly as was done in the previous service model, would leverage services from the existing employment service system. Using funding initially provided by DMH, MassAbility (then called the Massachusetts Rehabilitation Commission (MRC)) employs specialized vocational counselors dedicated to serving each ACCS contract as well as providing access to community-based employment-service providers . The program has cumulatively engaged 3,269 individuals since its inception in 2019, including 1,990 ACCS enrollees in SFY24 and 1944 ACCS enrollees in SFY25 by April 1. Of these enrollees, 1,482 individuals were placed in employment, inc. 370 (18.6%) in SFY24. The median hourly wage among those employed is $16.00 (and minimum wage is also $15.00) with an average hourly wage of $17.55. The median number of hours worked per week is 20; the average number of

hours worked per week is 21.4. The program continues to receive high marks for client satisfaction (over 90%).

DMH also continues to work with Massability and its staff to support employment and higher educational opportunities broadly. One example of this was the 2024 ReachHIRE forum, an event bringing together DMH, MassAbility, vendor staff, and persons-receiving services, to celebrate successes, promote best practices, and solicit input for future initiatives. 135 attendees participated in three "think tanks" focused on Long Term Supports, Increasing Referrals, and Data Collection and KPIs, as well as attending a panel discussion, reviewing data, networking, and suggesting new directions for future collaboration between the departments. Feedback from participants was collected and integrated with findings from DMH's Mental Health Planning Council Employment Subcommittee ACCS/MRC Focus groups and ultimately shared with Senior Leadership at both departments for approval and next steps.

As part of DMH's ongoing initiative to increase the availability of high-fidelity Coordinated Specialty Care (CSC) to youth and families experiencing a first episode of psychosis, DMH currently funds SEE (Supported Employment and Education) Specialists in eight early psychosis programs throughout the state. As part of this initiative, DMH provided training to new SEE staff, as well as an invitation to a monthly group supervision of SEE Specialists to collaboratively review cases, share resources, and celebrate successes. DMH's Senior Manager for Policy and Program Implementation, formerly DMH's Director of Employment, convened one monthly group, which continues to be supplemented by an additional monthly session hosted by DMH's SEE Consultant. Further, DMH and its technical assistance provider MAPNET (Massachusetts Psychosis Network for Early Treatment) have been conducting fidelity reviews of all early psychosis programs in the state, including a review of SEE Services, and has issued a Master Services Agreement (MSA) for high quality CSC care. The MSA prioritizes funding for SEE Staff in an effort to increase capacity for supported employment and education for youth in MA.

DMH also continues to have a close relationship with UMASS Medical School's Work Without Limits program, and specifically the Work Without Limits Benefits Counseling Program (WWL). WWL provides training for staff and one-on-one counseling to DMH clients and the members of the public who receive public benefits and are considering a return to competitive work. In 2023, WWL provided a comprehensive, multi-day "Nuts and Bolts of Social Security" training for 25 DMH and vendor staff, followed by two sessions of "Disability Benefits and Transition Age Youth" – one attended by 25 staff and the other attended by 60 youth and family members. In FY24, DMH contracted with WWL to re-offer "Disability Benefits and Transition Age Youth" for a Spanish speaking audience (n=24 attendees).

Beginning in March 2022, DMH issued an RFR for an expanded and enhanced Regional Employment Collaborative service. Regional Employment Collaboratives (REC) are formal, geographically-specific networks of staff and agencies committed to sharing ideas, resources, and practices with the goal of increasing the quantity and quality of competitive, integrated employment (CIE) opportunities available to persons with disabilities. RECs are by nature cross-

disability and are staffed by one-to-two Employer Liaisons, dedicated to sharing employment opportunities with the membership, and convening a job developer network for the free exchange of resources, ideas, job leads, and support. DMH had previously co-funded two RECs with the MA Department of Developmental Services, and with this procurement increased its commitment while expanding the territory of the Central MA Area REC and creating an entirely new REC serving the Southeast Area. As staffing shortages persist, RECs have proven to be an invaluable resource for Employment staff seeking efficiency, support, leads, resources, and training. As a result of REC outreach and support, 963 individuals statewide accepted offers of employment in SFY24, including 233 receiving DMH services. In the first two quarters of SFY25, 412 individuals secured competitive work with REC support, including 118 DMH clients.

Forensic Mental Health Services

DMH provides a variety of services, supports, grant programs, and state oversight functions to address the needs of the SMI population who are involved with the criminal justice and public safety systems. DMH Forensic Services is resourced and tasked to respond to and support the unique challenges this population presents at the intersection between the behavioral health system and at the various intercept points in the justice and public safety systems. The pertinent categories of DMH Forensic services are detailed below:

Court Evaluation Services: DMH provides forensic evaluation and treatment services to over 10,000 individuals each year who are referred to DMH by the Juvenile, District, Boston Municipal, and Superior Courts. These services are often “same day” and occur in court settings, but can also be provided in other community settings, correctional settings, and in forensic hospital settings in Massachusetts. The breadth and depth of DMH Court Evaluation service provided by DMH minimizes the exposure of the most acutely ill individuals to counter-therapeutic environments at a time when they are often most vulnerable and when their criminogenic risk may still be in question.

In SFY24, DMH court clinicians completed 10,000 evaluations of which 8,800 were for adults and 1,200 for juveniles. Additionally, 750 adults and 10 juveniles were admitted to DMH facilities for forensic evaluations. Furthermore, DMH provides step-down treatment in DMH facilities for individuals transferred from the Bridgewater State Hospital (BSH), a state correctional facility that operates as a specialty forensic hospital. In SFY24, 260 adult males stepped down to a DMH facility from BSH. DMH also provides community level re-entry supports for inmates with serious mental illness returning to the community. Evaluations that are court-ordered to DMH are accomplished in our state through a variety of programmatic approaches, as described below:

> **Court Clinics:** Court Clinics are responsible for providing all same-day and community based forensic and clinical evaluations performed in court houses, for the Juvenile, District, Municiap and Superior Courts in Massachusetts. Comprised mainly of

psychologists and social workers with specified forensic training, certified court clinicians evaluate individuals with suspected mental health difficulties who come to the attention of the justice system, often around issues of Competence to Stand Trial (CST) or Criminal Responsibility (CR), emergency civil commitments related to substance use and mental illness, and other types of concerns. Juvenile Court Clinic activities provided by DMH also include evaluations of youth regarding a number of matters ranging from delinquency to evaluations pertaining to Children Requiring Assistance (CRA) and Care and Protection petitions. Court clinics use both videoconferencing and in-person evaluations since the pandemic. In SFY24, there were a total of 8,800 adult court clinic evaluations and 1,200 juvenile court clinic evaluations completed.

Inpatient Forensic Evaluation Teams: DMH Forensic Services' Designated Forensic Professionals (DFP's) and Certified Juvenile Court Clinicians II (CJCC II's) who work on our facility-based forensic evaluation teams, conduct inpatient-based examinations of defendants on issues primarily pertaining to Competency to Stand Trial (CST), Criminal Responsibility (CR), and/or Aid-In-Sentencing. They coordinate their evaluative role with inpatient treatment teams and the courts. The inpatient evaluations ordered to DMH are conducted in DMH's Continuing Care facility settings. Though a proportionally smaller population than those who receive same-day evaluations in court, these individuals have been found to need hospital level of care for a psychiatric disorder or suspected psychiatric condition that may be interfering with their right to due process at the time of arraignment. Individuals sent to a Massachusetts forensic mental health hospital for evaluation may be committed for ongoing care and treatment beyond the evaluation period. Inpatient evaluators complete other forensic evaluations that include competence to stand trial updates and Independent Forensic Risk Assessments, which consist of risk assessment evaluations conducted by DFP's, set forth in DMH policy 10-01R.

Specialty Court Services: DMH Forensic Services partnered with the Massachusetts Trial Court's Specialty Court initiative in SFY24 by providing clinicians in a total of nine Mental Health Courts, five Veteran's Treatment Courts, thirty-two Drug Courts, and three other specialty courts in Massachusetts. A sexual exploitation session, with clinician, was added to the Dorchester court in SFY21. These clinicians provide assessment services, care coordination, and referral services to participants and clinical consultation to court personnel and to the Specialty Court multi-disciplinary teams. They are part of an integrated team of clinicians working in the District, Municipal, and Probate Court's specialty court programs, whose staff are supported by DMH and the Mass Trial Court.

Justice-Involved Veterans: DMH Forensic Services is involved with the administration and funding of programs and services for Justice Involved Veterans, including Veterans Treatment Courts, as an alternative to incarceration for veterans with co-occurring mental health and substance use challenges. DMH Forensic Services also provides a

portion of funding to the Department of Veterans Services (SAVE Team) to assist with peer support services for veterans who are court-involved.

Crisis Intervention Team (CIT) Development and Police-Based Jail Diversion Programs: Forensic Services provides supports to law enforcement and administers grants to police departments to develop pre-arrest jail diversion programs (JDPs) including Crisis Intervention Teams (CIT) and clinician/police co-responder programs. The Department of Mental Health and its Jail Diversion Program supports law enforcement agencies across the Commonwealth with grant funds as well as direct support and technical assistance. Through an open application process, departments and behavioral health providers offering services to support law enforcement for improving their responses to people in behavioral health crisis, can submit grant proposals. In SFY24, DMH funded a total of 120 such grant programs in local communities across the Commonwealth.

Also supported by DMH grants, CIT and Co-Response Training and Technical Assistance Centers (TTACs) provide behavioral health training for local law enforcement in Massachusetts. In SFY24, there were a total of 119 trainings and 41,564 hours of training provided by all of the TTAC's, resulting in 979 police officers receiving CIT training and/or Mental Health First Aid (MHFA).

Forensic Transition Team (FTT): Established by DMH in 1998, the Forensic Transition Team is a statewide workforce of community care coordinators that ensures DMH-service authorized individuals have an effective community reentry plan from state prisons and county houses of correction, as well as continuity of care when entering corrections from the community. The Forensic Transition team consists of over eleven personnel assigned specifically to this work in Massachusetts.

Certification and Training: The DMH Forensic Division oversees, through its regulations and administrative activities, the certification and training of Designated Forensic Professionals, (DFP's) Qualified Social Workers, (QSW's) and Certified Juvenile Court Clinicians (CJCC-I & CJCC-II). These certifications, in addition to state practitioner licenses for each discipline, furnish the courts with a widely accepted workforce of qualified forensic mental health professionals who can provide objective and neutral expert testimony in all necessary criminal and civil proceedings.

Correction Facility Audits and Other Interfaces: In order to fulfill its statutory obligation to supervise medical, dental, and psychiatric services in the segregated Department of Correction (DOC) prison units, a DMH multi-disciplinary team visits these DOC units on a regular basis to conduct audits. Health care audits ensure that inmates in restricted units receive appropriate medical, dental, and psychiatric care. Reports are generated for the Commissioner of Corrections to review, with occasional recommendations for corrective action. In addition, DMH provides annual reviews of specialized mental health units that operate in two of the county House of Corrections and coordinates care for persons transitioning out of Bridgewater

State Hospital (BSH), a strict security DOC facility that manages persons acquitted by reason of insanity or found incompetent to stand trial.

Prison Hospital Step-Downs: As part of the process of "stepping down" Bridgewater State Hospital (A Department of Correction facility) patients from a "strict security" environment to a DMH facility, some of these individuals may be identified as benefitting from an enhanced process. Enhanced step-down cases receive additional in-reach visits from DMH facility staff as well as increased care coordination meetings in order to ensure a successful transition between these two different environments of care.

Services for Special Forensic Populations: DMH Forensic Services provides specialized approaches and programming for persons with specific risk profiles, such as comprehensive risk assessments, evaluations, and expert consultation to various stakeholders.

MI/PSB Program: The MI/PSB Program is a resource for improving supports for individuals with mental illness and problematic sexual behaviors (MI/PSB). It provides clinical and risk management assessments, consultations, and treatment to assist inpatient treatment teams and community providers working with persons with these specific difficulties, some of whom have also been charged and/or convicted of sexual offenses. Additionally, Forensic Services is the DMH liaison for the Sexual Offender Registry Board (SORB) and the Criminal Justice Information System, the state entities that maintain Massachusetts arrest and court adjudication records. In this capacity DMH accesses SORB and criminal history records for risk management purposes for DMH inpatient units, supports the completion of court-ordered forensic evaluations, and assists in resolving SORB registration obligations in individual cases when challenges arise

IFRA Program: The Independent Forensic Risk Assessment (IFRA) program provides a policy-based specialized risk assessment and management consultation to our facility treatment teams, prior to contact with the community and/or discharge from the hospital for inpatients with significant histories of physical violence or a history of commitment in a strict security setting.

Community Risk Assessment Service: DMH has continued to provide technical assistance for the implementation of the systemic use of a structured risk assessment tool (HCR-20) and other evidence-based tools for use in our inpatient facilities and community programs.

Juvenile Forensic Services: DMH has a long history of providing forensic mental health services to the juvenile justice system and to DMH facilities, including DMH contracted intensive residential treatment units for youth. DMH Forensic Mental Health Services has assumed responsibility for procuring and managing all DMH clinical services for the statewide Juvenile Court system. Forensic specialists for the Juvenile population, sited in the juvenile courts, provide evaluation and consultation services for judges, attorneys, and probation officers on an as-needed basis, and they provide various other services including individual, group, and bridge treatment in some areas for court involved youth and case management services. Over the last

fifteen years, DMH's Juvenile Forensic Services has been a part of a statewide initiative, Juvenile Detention Alternative Initiative, focused on decreasing the number of youths being held in detention with clinicians participating on state and local committees and DMH representatives serving on the statewide Governance Committee. A Memorandum of Understanding (MOU) between the Department of Youth Services (DYS, the juvenile justice service system) and DMH has been developed to assure timely information sharing and thoughtful transition planning for youth with mental health needs in the DYS system. DMH provides clinical and psychiatric consultation for DYS youth upon request.

Child, Youth, and Family Services

For children, youth, or young adults who meet DMH's clinical criteria and do not have access to similar services from other state agencies, insurance, or their local education authority, DMH provides a comprehensive clinical assessment and works with the youth and family to develop a plan to best address the youth's mental health needs and support their healthy development and well-being. This includes working with and supporting the family as well. In order to meet the unique needs of each youth and family, DMH purchases a wide array of services and supports. These include:

- **Case management** which provides comprehensive mental health and family assessment as well as individual service planning, coordination of DMH-funded services and linkage to other community supports;

- **Flexible Support Services,** which are an individualized set of services and supports designed to prevent out-of-home placement, maintain the youth with his/her family, help the youth function successfully in the community, and assist families in supporting the growth and recovery of their child. Services include home-based family support, individual youth support and youth support groups;

- **Therapeutic day services** provide youth with an array of services including recreational and skill building activities as well as intensive clinical services in a structured program;

- **Intensive Community Services (ICS)** include clinically intensive home and community-based treatment, out-of-home treatment, and outreach support to youth, young adults, and families. ICS services help build, strengthen, and maintain connections to family, home, and community. Services are provided in a manner that is strengths-based, family-driven, youth guided, and culturally relevant. There are three models within the ICS array: Intensive Home Based Therapeutic Care; Therapeutic Group Care; and Young Adult Therapeutic Care;

- **Program for Assertive Community Treatment for Youth (PACT-Y)** is a comprehensive service for individuals under the age of 22 with serious emotional disturbance for whom traditional office- and/or community-based services and interventions have not been

helpful, and may benefit from intensive, coordinated, and comprehensive services that are provided by one integrated multi-disciplinary community-based team. The service is designed specifically for youth with the most challenging and persistent mental and behavioral health needs who are living in their communities but for whom other community-based behavioral health services have not resulted in sustained success for them to remain in their communities. This service is adapted from the evidence based adult model.

- **Intensive Residential Treatment Programs (IRTP) and Clinically Intensive Residential Treatment Program (CIRT) IRTPs** (for adolescents ages 13-18) and CIRT (for children ages 6-12) are designed for youth who are unable to live safely at home, in the community, or in a less intensive residential service. Both IRTP and CIRT program models provide 24-hour, clinically intensive treatment. Education is provided on site by the Department of Elementary and Secondary Education. The CIRT service is staff-secure but not locked. IRTPs are locked. Families have full access to their child while they are receiving treatment, unless prohibited by the court;

- **Continuing Care Inpatient Services** is the most intensive and restrictive treatment for adolescents aged 13-18 whose behavioral challenges pose a significant risk of harm to themselves or others. This service is located at Worcester Recovery Center and Hospital and includes an onsite school provided by the Department of Elementary and Secondary Education. Youth are referred to this service by acute psychiatric inpatient services when the youth needs exceed acute hospital care, or when the court orders a forensic evaluation (typically for competency to stand trial or criminal responsibility); and

- **Juvenile Court Clinic Services** provide clinical and forensic mental health evaluations and consultation to the Trial Court and Probation Department and helps families access community services.

DMH has been leading in the Commonwealth for Infant and Early Childhood Mental Health (IECHM) and School Based Mental Health. DMH's IECMH Coordinator has worked collaboratively to develop policy and service recommendations, deliver training and develop diagnostic criteria for infant and early childhood mental health. DMH's Director of Cross Agency Initiatives has collaborated with schools to provide technical assistance for mental health in schools, provided grants that support the **BRYT (Bridge for Resilient Youth in Transition) Program**, led by the Brookline Center. BRYT is an intensive, integrated academic, mental health, and family support model that has been replicated in over **200 schools** statewide. DMH has also collaborated with the Department of Early and Secondary Education to develop an Emergency Response Plan for schools to ensure they have clear protocols for responding to both medical and behavioral health emergencies.

Massachusetts' investment in a comprehensive array of community services has allowed our state the ability to successfully treat youth in their home environment and community settings.

Since 1992, DMH has closed five state hospitals, including the state-operated children's center, transferring responsibility for acute care from the public to the private sector. Children and adolescents receive acute inpatient care in private or general hospitals. This has enabled DMH to focus its expertise on providing home and community-based treatment.

In its role as the state mental health authority, DMH provides an array of mental health promotion and prevention services for the general population. This includes services such as family support, workforce training, mental health public awareness and stigma reduction campaigns, support for schools, and participation in various inter-agency initiatives and workgroups. Examples of these services include:

- DMH funds **Family Support Programs** in each of its five geographic areas. These programs aid with system navigation, community education and advocacy and provide group support meetings (in multiple languages), and some individual support for caregivers. Families do not need DMH service authorization to access these supports and are open to all families in the Commonwealth. DMH also supports the Parent/Professional Advocacy League (PPAL), a statewide, family-run organization dedicated to improving the mental health and well-being of youth and families through education, advocacy, and partnership.

- DMH also supports the **Massachusetts Child Psychiatry Access Program (MCPAP) and MCPAP for Moms**. The programs are free and available throughout Massachusetts regardless of health insurance type. MCPAP provides specialized psychiatric consultation to pediatricians and other primary care providers (PCPs) who serve children. The goal is to increase access to behavioral health treatment by making child psychiatry services available to PCPs across the Commonwealth. MCPAP is currently funded by DMH and through assessments on state regulated health insurance plans in Massachusetts. While MCPAP for Moms aims to promote maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to one year after delivery to effectively prevent, identify, and manage depression. MCPAP for Moms provides obstetricians, midwives, and PCPs with psychiatric consultation for behavioral health concerns and questions around medications when pregnant or breastfeeding. The program also supports connections with community-based services and support groups. Providers working with fathers and other caregivers experiencing postpartum depression can also access MCPAP for Moms

- Through its Children's Behavioral Health Knowledge Center, the DMH Child, Youth, and Family (CYF) Division helps ensure that the workforce who provides services to youth and families are highly skilled and well-trained. The Center supports a range of training, workforce development and technical assistance opportunities. Highlights include:

    - BIPOC Early Career Learning Community: The BIPOC Legacy Project is a professional mentorship and learning community designed specifically for Black,

Indigenous, and People of Color (BIPOC) Mental Health Practitioners who wish to deepen their clinical practice with youth and families, advance their professional development, and receive support from peers and seasoned professionals. Cohorts of 10 to 12 participants meet monthly for 9 months with Dr. Phillip Laidlaw, a psychologist with vast experience in community mental health, staff mentoring, and REI initiatives. Topics discussed include interventions to support BIPOC clients, best practices for working in community behavioral health settings, understanding and developing leadership within behavioral health organizations, skills for managing work stress and burnout, strategies to get the most out of supervision, strategies for addressing racism in the workplace, and Career development phases and processes; including credentialing, and becoming clinical supervisors.

- **First Episode Psychosis (FEP):** Enhances early access to treatment for individuals experiencing early psychosis by supporting dedicated staff to deliver evidence-based family interventions tailored to early psychosis and substance use.

- **CBT Training for Vendors Addressing Youth Violence:** Aimed at reducing violence among youth with serious mental illnesses or emotional disturbances. The project involves a series of training and fidelity testing phases for CBT with providers, interagency planning meetings, and detailed data reporting, with a goal to refine and expand violence prevention strategies among vulnerable youth populations.

- A self-paced e-course – *The School of Hard Talks Online: Lessons from Motivational Interviewing for Busy Families* – for parents of youth with mental illness or substance use disorders to help them learn how to engage in productive conversations with their children about difficult topics. The e-course is publicly available at www.handholdma.org.
- Training program for clinical and non-clinical staff to offer a preventive group-based behavioral intervention called Living In Families with our Emotions (LIFE) that aims to improve the mental health of adolescents and lessen the disability associated with having a mental health condition.
- A learning community of group- and residential-based psychiatric care providers who meets monthly to discuss clinical topics relevant to psychiatric care in group and residential treatment settings for youth.
- Training for young adult peer mentors
- Creation of technical assistance tools to support provider organizations, team members, and supervisors about the benefits of young adult peer mentoring and how to help peer mentors be successful in the workplace

- Family Partner Practice Profile and training resources for Family Partners
- Enhancing supervisor competency and organizational support for high-quality reflective supervision
- Strengthening supervisor and organizational competencies in supporting staff wellbeing by addressing secondary stress.
- Training and coaching for clinicians in family therapy, permanency practice and skills for facilitating effective treatment/family team meetings
- DC: 0-5 Clinical Trainings with follow up consultation and technical assistance to aid clinicians in implementation in practice
- Facilitating Attuned Interactions (FAN) Training (as well as a train the trainer session)
- Theraplay training

- DMH organized and implemented a **statewide restraint and seclusion prevention initiative** more than 20 years ago that was initially DMH-focused but soon became an Inter-agency effort with six other agencies participating (DCF, DYS, DDS, DESE, EEC, OCA) in a collaborative effort to address conflict, violence, and the situations that lead to restraint and seclusion of youth (and adults) in community, residential, school, hospital, and detention settings. This initiative supports training on trauma-informed care and convenes stakeholders from across the state to review data and share best practices on restraint and seclusion prevention and trauma-informed/trauma-responsive practices across care/service settings;

- **Young Adult (YA) Access Centers** are unique community spaces that allow young adults with mental health concerns to access services and supports in a timely and effective manner. The services are free and available to all young adults, and no diagnosis is required. Access Centers focus outreach and engagement efforts on those who may be facing challenges such as mental illness, substance misuse, economic insecurity, homelessness, pregnant/parenting, commercial/sexual exploitation, and those facing other challenges that have posed barriers to engagement in services. Centers provide opportunities to be part of community activities and receive individual support including:

  - Peer support;
  - Social activities;
  - Linkages to healthcare, housing, employment, education, and other resources;
  - Mental health and substance misuse supports;
  - Individual support to identify and achieve goals in critical areas such as mental well-being, education, employment, and housing; and
  - Amenities such as showers, laundry, kitchens, and computer/Wi-Fi access.

- **Insurance Resource Center for Autism and Behavioral Health (IRC)**, a program of the Eunice Kennedy Shriver Center at UMass Chan Medical School to assist state agency staff, families, and providers with navigating behavioral health commercial insurance benefits for children and adolescents.

DMH's Director of Young Adult Transitional Services ensures that transition processes are effective, identifies gaps in the system between youth and adult services, and develops strategies to address those gaps. Additionally, the Director of Cross-Agency Initiatives within the Child, Youth, and Family Division regularly works across systems to address key policy issues and service gaps.

DMH's Children's Behavioral Health Knowledge Center has worked with Dr. Daphne Holt and her team at the Department of Psychiatry at Massachusetts General Hospital to develop a training program for clinical and non-clinical staff to offer a group-based behavioral intervention called **Living In Families with our Emotions (LIFE)**. The program is for at-risk adolescents and their families and aims to improve resilience and long-term outcomes with the goal of improving the mental health of adolescents and lessen the disability associated with having a mental health condition.

Even before the onset of the pandemic, mental health challenges were the leading cause of disability and poor life outcomes in children and adolescents with up to one in five children ages 3 to 17 in the U.S. with a reported mental, emotional, developmental, or behavioral conditions (HHS, 2021). An analysis of the National Survey on Drug Use and Health by Substance Abuse Mental Health Services Administration (SAMHSA) showed that in 2019, 15.6 % of youth (ages 12 to 17 years old) in Massachusetts suffered from at least one major depressive episode in the past year (similar to the national rate of 13 %) (SAMHSA, 2019). In 2023, that rate increased to 18.7 % of youth in that same age range in Massachusetts (and 18.8 % nationally) (SAMHSA, 2023). In addition, rates of anxiety and depression increased in children during the pandemic. A report that used data from the National Survey of Children's Health (NSCH) showed that the percentage of children (ages 3 to 17 years old) in Massachusetts who had anxiety or depression increased by slightly over 50 % from 2016 to 2020 (from 12.2 % to 18.4 %) (The Annie E. Casey Foundation, 2022).

Concurrent with the increased need for behavioral health services, during the pandemic, recruitment and retention of mental health providers in Massachusetts has been challenging. Given this situation, training staff in non-clinical settings to provide preventive interventions such as LIFE is a strategy that could reduce the number of youths whose behavioral health concerns become serious and require therapeutic intervention.

Finally, treatment indices for the two (2) Continuing Care Inpatient Units and five (5) Intensive Residential Treatment Programs demonstrate ongoing "covid-recovery" and restoration of both operational and clinical capacity of these services. That is, compared to last fiscal year, the number of youths admitted, and the number of youths served is projected to increase almost

25%. Youth are also moving thru their course of care more effectively and we see a decrease in the number of youths who are unable to leave because of a lack of community resource. This change is reflected in a decrease of the total number of youths who are "stuck" and an approximate 20% decrease in 'administratively necessary days' (AND). AND designation occurs when youth are determined to be discharge-ready but are unable to transition out of the service due to a lack of a community resource. The Continuing Care Inpatient and Intensive Residential Treatment Programs also report a greater number of applicants for position postings (e.g. direct care, social work, and nursing), a greater number of newly hired staff who stay on the job, and a greater number of staff who have more experience in the role they are applying for. In short, the mental health service system appears to be gradually stabilizing from the significant untoward pandemic impact.

Through the state's MassHealth (Medicaid) program, youth up to age 21 with serious emotional disturbance who meet medical necessity criteria are eligible for Intensive Care Coordination (ICC). Care planning is driven by the needs of the youth and developed through a Wraparound planning process consistent with Systems of Care philosophy. ICC provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family and youth-driven, and ethnically, culturally, and linguistically relevant manner. ICC is designed to facilitate a collaborative relationship among a youth with SED and their family and involve child-serving systems to support the parent or caregiver in meeting their youth's needs. The ICC care planning process ensures that a care coordinator organizes and matches care across providers and child-serving systems to enable the youth to be served in their home community.

Staff members from DMH's Child, Youth, and Family Services Division participate in local systems of care committees that are facilitated by providers of ICC in the 32 geographic areas throughout the Commonwealth. These committees meet regularly and have representatives that participate from local school districts, child welfare, courts, juvenile justice, social services, and local treatment providers. DMH service integration specialists also serve as important points of contact for care coordinators to help ensure youth receiving ICC have access to supports that may be available from DMH such as camperships or therapeutic after-school programming.

For youth experiencing a behavioral health crisis, Mobile Crisis Intervention is available to all youth regardless of insurance. It provides a mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management and safety plan, if any. This service is provided 24 hours a day, 7 days a week and includes: crisis assessment; engagement in a crisis planning process that may result in the development or update of one or more Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family; up to 7 days

of crisis intervention and stabilization services including on-site face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

To help relieve longstanding challenges with Emergency Department (ED) boarding that were exacerbated during the pandemic, DMH also developed and implemented an ED Diversion program. DMH's ED Diversion Programs partner hospitals with community-based providers to deliver services to youth experiencing behavioral health crises who do not require treatment at an inpatient psychiatric facility and can be safely served in the community. These services provide immediate crisis stabilization to individuals and assistance with connection to behavioral health treatment services and other services and supports that promote community tenure. The goal is to help address issues that may have contributed to the ED visit and prevent future ED use while expediting access to behavioral health treatment for adults and youth and support for their family. The youth programs utilize mobile teams to deliver services to youth and families in their home and community which allows youth to remain connected to school, peers, and family. The average length of treatment in the youth ED Diversion program is four to five months. Eighty-two percent (82%) of youth served have not had an ED visit while participating in the programs.

In order to best support youth and families with complex needs, DMH staff work closely with other child serving state agencies including child welfare, juvenile justice, substance addiction services, public health, developmental services, and the state's vocational rehabilitation agency. The agency engages in planning activities with state partners and other stakeholders to improve behavioral health care integration and outcomes of residents of the Commonwealth. DMH staff members sit on (or chair) a number of Commissions, boards, and workgroups that promote and support children's behavioral health across the state. Examples include the Grandparents Raising Grandchildren Commission; the Interagency Workgroup on Substance Use; Infant and Early Childhood Mental Health Interagency workgroup; the Childhood Trauma Task Force; and the Unaccompanied Homeless Youth Commission. Finally, the DMH Commissioner also chairs a statewide Children's Behavioral Health Advisory Council which includes representatives from child-serving state agencies, providers, families, trade groups, and guilds. This group serves to inform the legislature and state leaders on critical issues and topics on children's behavioral health.

DMH's Coordinator of Infant and Early Childhood Mental Health (IECMH) convenes and staffs an interagency IECMH workgroup whose members include the Department of Public Health (DPH), Department of Transitional Assistance (DTA), Department of Early Education and Care (DEEC), and Department of Elementary and Secondary Education (DESE). This group works closely with external stakeholders to support the growth and development of IECMH promotion, prevention, and treatment.

DMH also closely coordinates with MassHealth, which funds comprehensive community-based behavioral health services for children and youth under the age of 21, through its Children's Behavioral Health Initiative (CBHI). Family voice, choice, and engagement are overarching principles guiding this transformation and to that end, families and youth with serious emotional disturbance (SED) are represented and active participants in these efforts. And DMH has been working closely with the Massachusetts Division of Insurance to support an expansion of intensive home- and community-based treatment similar to the CBHI for children and youth in state-regulated health insurance plans. Given the 5% prevalence of serious emotional disturbance among children and youth, there could be as many as 22,500 children and youth able to access these services.

The CYF division of DMH continues to provide ongoing training, program consultation, individual case consultation, and family education seminars/webinars on Trauma Informed Care to an array of services and local communities. The Department has contracted with Janina Fisher, PhD, to provide trainings up to four times per year on her Trauma Informed Stabilization and Treatment (TIST) model for all hospitals, child and adolescent treatment programs, community residential programs, and other programs as requested. Additionally, the Department is contracting with Dr. Jennifer Bogin and her team on developing a series of webinars to provide a basic behavioral orientation to recognizing the meaning of behavior, understanding patterns of behavior, and discerning what is "pathology" and what is not. In addition, DMH is planning additional training on the following: 1) the Six Core Strategies (an evidenced-based practice) to prevent conflict, violence and the use of restraint and seclusion, 2) recognizing violence with Andy Prisco, 3) the power of play with the Playmaker Project, 4) Trauma-Informed Yoga with Jennifer Turner, and 5) Behavior and Nutrition with the OWL Clinic at Children's Hospital in Boston. All of these trainings provide staff with CEUs, and are open across human service agencies, schools, community-based providers and families and advocates.

Finally, CYF is committed to being an anti-racist and socially just organization where all people are treated fairly, receive resources equitably, and feel valued and safe. The team's ongoing work to create meaningful and long-lasting change has included examination of policies, practices, and our contributions on an individual level to inequity. This shared commitment across the Division is a highlight of the work DMH's does on behalf of the youth and families we serve.

State Mental Health Planning Council

The State Mental Health Planning Council (SMHPC) is a standing committee of the Mental Health Advisory Council (MHAC) to the Department of Mental Health. Members of the Planning Council individuals with lived experience, family members of adults and children, legal and program advocates, providers, representatives from DMH and other state agencies, a

representative from the Mental Health Advisory Council (MHAC), mental health professionals, professional organizations, legislators, representatives from state employee unions, and members of racial, cultural, and linguistic minority groups. The Council's membership is reviewed regularly. Members who have not been active within the last year are contacted to confirm their commitment and new members are appointed to ensure a balanced and diverse membership. DMH provides staff to the Council.

In 2023, the Council updated its strategic plan that it initially drafted in 2018in order to reflect co-occurring conditions of mental health issues and substance use. The updated strategic plan provides an articulation vision and mission statement that supports the Council's work through FY29. The Council's vision statement is as follows:

- The Council shall ensure respect and dignity for all persons at risk for or living with behavioral health conditions. The Council shall promote access to prevention, early intervention, holistic health engagement and activation, housing, employment, and recovery support services. The Council promotes services that encourage individuals of all ages and their families/chosen families to develop resilience, fully recover and be productive members of their communities

- Its mission statement is to provide informed advice and perspective to the Massachusetts Department of Mental Health on key policy and program issues affecting individuals of all ages in the Commonwealth who are at risk for, or have, behavioral health conditions and their families/chosen families, and advocates for decision making and actions that protect and advance their health and well-being.

This advice and advocacy is aligned with the following guiding principles:

- Mental Health is a key part of overall health;

- Integration of mental health, substance use, and primary care services produces the best outcomes and proves the most effective approach to caring for people of all ages with behavioral health conditions and multiple healthcare needs;

- Promotion of Prevention, Early Intervention, Resiliency, and Recovery as well as fair and timely access to health care, income assistance, education, employment, housing, and engagement in meaningful social roles are important for the protection of and improvement in all aspects of health;

- It is important to foster the strengths of individuals of all ages with lived experience, their families, communities, and the organizations serving them;

- Innovative evidence-based programs and best practices should be regularly examined for applicability to, and replication in Massachusetts and promising models should be identified and pursued for implementation;

- It is important to foster an understanding of Social Determinants of Mental Health and incorporate that understanding in policy and program planning;

- Alignment of behavioral health policy across all state government agencies will promote better efficiency and effectiveness in providing individuals of all ages and their families with the health services and supports they need

In 2022, the SMHPC adopted bylaws to establish rules and policies around its purpose and charge, vision, mission, membership, Council chairs, standing committees, meetings, anti-discrimination, and amending and revising the bylaws. Documenting these processes has helped improve the structure and work of the SMHPC. Changes to the bylaws were made in 2024 to reflect changes in the Council's subcommittees.

The SMHPC has five subcommittees that cover specific special interests which consist of individuals with lived experience, family of those with lived experience, providers, advocates, and state agency staff. Subcommittees meet regularly to advocate for the needs of the individuals they represent, advise DMH on policy issues, and participate in the planning and implementation of new initiatives. These subcommittees are a principal means of involving individuals with lived experience and families in DMH.

The SMHPC also has a Steering Committee that was established in 2009 as a result of the Planning Council, recognizing the importance of the work of the subcommittee and the need to coordinate their work among themselves and with the Executive Committee. Currently, the Steering Committee comprises of Co-Chairs and/or liasion from each of the subcommittees and a chairperson who is also a member of the Council and sits on the Executive Committee as an ex officio, non-voting member. The Steering Committee meets twice a year and additionally as needed to review subcommittee activities, build cross-committee collaboration on shared concerns, discuss larger Block Grant-related activities, propose agenda items for Planning Council meetings, provide input to the Executive Committee, and address any other business that requires full Council membership review and feedback.

Finally, the SMHPC has an Executive Committee that currently consists of a Young Adult (aged between 18 and 30), two Older Adult Chairs (aged 31 and over), and the Steering Committee Chair. The Executive Committee aims to address suggestions, requests, and concerns from the respective subcommittees and full Council membership.
The SMHPC, its Steering Committee, its Executive Committee, and its subcommittees provide a strong and ongoing voice of recovery and resilience. The Council makes important contributions in identifying particular domains needing transformation in the mental health system and subcommittees have played an active role in planning and implementing many of these transformation efforts across the Commonwealth. Many members of the SMHPC are also involved in locally based participatory planning processes and with other advocacy groups.

The SMHPC subcommittees are as follows:

Housing Subcommittee Overview

The mission of the Housing Subcommittee is to promote decent, safe, and affordable housing for clients of the Massachusetts DMH, which will offer voluntary, flexible supports to foster recovery and are integrated into the broader community. This is accomplished through educational outreach to a wide range of stakeholders, along with research, planning, and advocacy that leads to increased access to existing housing resources and securing new resources to meet the growing need.

Housing is acknowledged as a basic human right in many circles. For individuals eligible for DMH services, it should be considered an essential component in the recovery process. Experience demonstrates that multiple factors influence a person's recovery and well-being. Some factors are less defined or understood than others, but housing is one factor that is primary and undeniable.

The Housing Subcommittee includes housing and clinical workers from mental health provider agencies, family members, peer supporters, state housing agencies, advocacy agencies, and DMH staff from across the state. All meetings have been held virtually with a significant number of participants. The ever-expanding contact list of well over 100 individuals has helped to promote meetings and resulted in attendance ranging between 30 – 50 during bi-monthly/quarterly meetings.

There are numerous highlights for the Housing Subcommittee in the past year alone including:

- **DMH Rental Subsidy Expansion**
  The Housing Subcommittee has diligently advocated for the DMH Rental Subsidy Program (DMHRSP) under the guidance and leadership of the Massachusetts Association of Mental Health (MAMH). The program is currently funded at $37.5M and houses almost 2,500. MAMH and other advocates are seeking a $5M funding increase in FY26. The Subcommittee is also helping to facilitate improvements to DMHRSP by offering a forum to providers and bringing together DHCD and housing agencies to examine changes to make it easier to lease up units.

- **Safe Havens**
  The Housing Subcommittee has also been advocating for more Safe Havens programs serving homeless individuals presenting with a mental health condition. Over the past two years, the number of Safe Havens funded has increased by six, representing a total of 42 beds. This brings a statewide total of 17 Safe Havens, representing a total of over 130 beds. MAMH is organizing support to annualize all the funding for the program in the state budget. expand in FY24 with four new programs of seven beds each.

- **Housing Access Collaboration Workgroup**
  The Housing Subcommittee merged 2 workgroups in March 2025 with similar goals. This single workgroup's goal is to focus on barriers and education regarding the DMHRSP for identified stakeholders across the state. The group has also focused on identifying paths for greater access to resources as a means to tenancy preservation. The first task established was to update the DMHRSP educational video on YouTube to reflect changes that have taken place since it was initially created. There's also been steps made towards collaborating with EOHLC to address challenges service providers come across when working with the subsidy to smooth the process. Other goals and actions are informing the creation of a comprehensive training module statewide for service providers, creating access points for dialogue with important stakeholders, and identifying creative ways to meet the housing needs of DMH clients in a rapidly changing landscape of resource accessibility. The workgroup has generated a lot of engagement and enthusiasm, which has created the ability to take concrete action steps in a short period of time.

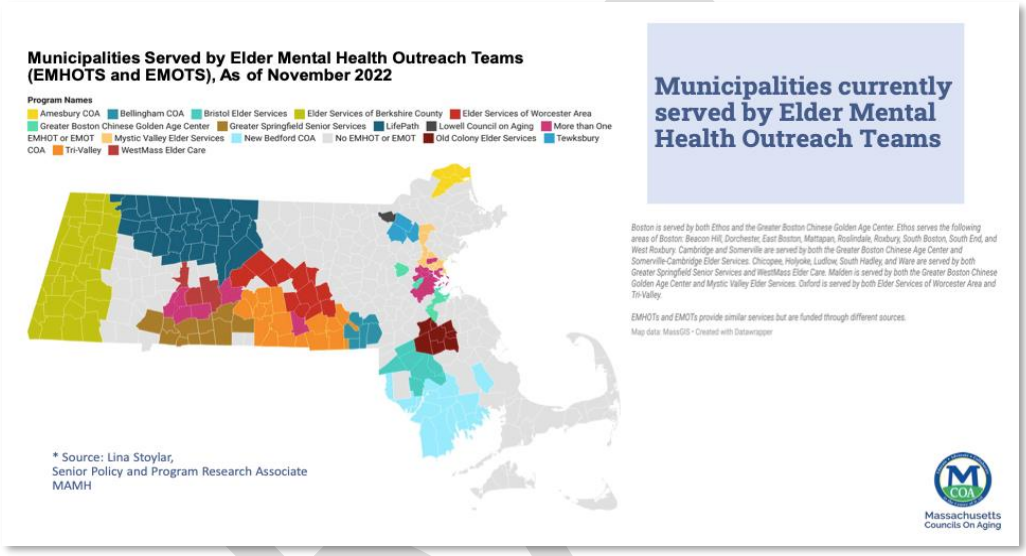
- **DMH Housing Plan**
  The Housing Subcommittee has reviewed and made recommendations to the Department's 2025-2029 Housing Plan. The plan includes goals related to housing production, managing housing assets, and education and networking opportunities for key stakeholders.

- **Information Access**
  The Housing Subcommittee also works to improve communications by utilizing the SMHPC website and implemented a housing subcommittee calendar which houses subcommittee meetings, workgroup meetings, and other related housing events of interest to subcommittee members**.**

Older Adult Behavioral Health Collaborative Subcommittee Overview

The Older Adult Behavioral Health Collaborative advocates for culturally and linguistically responsive behavioral health and wellness supports for older adults. Its membership includes senior leaders from DMH, the Executive Office of Aging and Independence (AGE), the Department of Public Health, providers, stakeholders, and statewide aging and mental health trade associations. Its open monthly meetings provide critical information and an opportunity for cross-pollination of aging and behavioral health providers. The Collaborative advocacy efforts are of critical importance given the majority of the Massachusetts population in the next twenty years will be over 60 and over half of older adults receive their mental health care from primary care.

The subcommittee has been working with DMH, the Executive Office of Aging and Independence (AGE), and other partners to advocate for statewide in-home behavioral health supports for older adults, better data collection on the population's needs, better planning for hospital and nursing home discharges, and a renewed commitment and interdepartmental collaboration from state and local leadership to support aging in place. The Collaborative worked with the State Legislature to secure funding for the Behavioral Health Outreach for Aging Populations program (BHOAP). Overseen by AGE, these outreach teams work with older adults who are not connected with services to provide crisis intervention and connection with behavioral health services.



The advocacy work of the Collaborative members has led to the expansion of BHOAPs to a total of thirteen teams. The Older Adult BH DEI subgroup was successful in requiring BHOAP grant applicants to demonstrate their ability to serve diverse older adults. As a result, there are new BHOAPs with increased linguistic capacity, such as the BHOAP launch at the Chinese Golden Age Living Center. Advocates also succeeded in funding older adult behavioral health innovation grants, including the expansion of a COAPS program to hire Latinx and Cambodian COAPS .

Statewide Young Adult Council Overview

The Statewide Young Adult Council (SYAC) subcommittee brings together youth, young adults, and providers to advise the Department of Mental Health and other young adult service organizations, ultimately creating a cohesive, supportive network of families, peers, and service providers throughout the Commonwealth. The SYAC seeks to inspire hope and recovery among the youth and young adults across the state, empowers their voices within DMH, and works together toward equity and advocacy on their behalf. It also encourages young people to

advocate for themselves and assists them in making their own decisions with transitional life skills, including education, employment, housing, and healthcare.

In FY25, the SYAC met monthly via Zoom with an average attendance of 15 people. SYAC advised the DMH and broader EOHHS agencies in numerous areas, including social media messaging, helpline services, and Young Adult Access Centers for young adults with mental health challenges. Currently, SYAC is developing goals and plans for FY26. Action steps in the near future include hosting in-person gatherings periodically for community-building and advocacy, broadening the statewide representation of young adults, identifying challenges and unmet needs in the mental health field, creating materials to aid public advocacy efforts, and planning a meeting with DMH leadership focused on the unique needs of young adults and transition age youth regarding mental health services, resources, and supports.

Employment Subcommittee Overview

The mission of Employment Subcommittee is to advocate for the full and equitable integration of employment and career services into the full array of DMH supports for the purpose of enabling individuals to work towards full recovery in the communities of their choice. Its vision is that all public and private agencies and partnerships serving people whose lives have been disrupted by trauma and serious mental health challenges value the importance of employment as a critical element of the recovery process and work collaboratively to create opportunities and reduce barriers to employment. Further, the subcommittee recognizes that employment is one of the essential elements of life in our society. All members of society should be given the opportunity to participate in employment without discrimination. This includes people whose lives have been disrupted by trauma and serious mental health challenges.

The Employment Subcommittee has broad representation from multiple stakeholders including persons with lived experience, advocates, employment services providers, senior staff from University of Massachusetts' Work Without Limits program, an Area Director representing the state vocational rehabilitation agency, and DMH Area and Central Office staff. Subcommittee members have significant experience and expertise in the provision of employment to individuals with mental health challenge, and a commitment to assessing and identifying any inequities related to race, ethnicity, or gender self-identification in regard to access to and outcomes from employment services.

The subcommittee utilizes the following strategies in its work:

- Advocates for DMH to focus on employment of individuals served as a critical and necessary component of recovery; and to ensure that funding is aligned with that priority;

- Determines and meets the specific vocational and educational needs and preferences of disenfranchised groups who experience mental health disruptions, often based on race, ethnicity, sexual orientation, gender identity, and age;
- Gathers information, data, and research on promising vocational rehabilitation, employment, and education practices for individuals with significant mental health conditions. Makes recommendations based on this information; monitors the implementation of these recommendations; and advocates for the resources to operationalize them;
- Ensures that applicable state agencies and employment providers have the necessary resources inclusive of staff training to assist individuals with lived experience to make informed employment-related decisions that include access to accurate and timely education around the impact of work on their public benefits and entitlements;
- Responds to emergent policy, fiscal, and legislative issues that may impact the availability of employment services for individuals with significant mental health conditions; and
- Advocates for greater education and collaboration amongst legislators, state agencies, employment providers, and private entities including employers to preserve, enhance and support integrated and coordinated employment services and opportunities for individuals with significant mental health conditions.

Finally, while gainful employment improves the long-term recovery for adults with serious mental health challenges, research suggests that young adults of color face significant systemic barriers that impede their vocational success. These barriers include a history of poverty, unstable housing, poor quality schools, disproportionate involvement with the criminal justice system, and common and everyday discrimination. Working to lessen the impact of these systemic barriers to employment for adults of color with serious mental health challenges is incumbent upon DMH, its providers, and this subcommittee.

Over several months in 2024, the Employment Subcommittee developed and executed a series of focus groups designed to capture best practices and emerging challenges from a variety of provider perspectives related to the current employment-service model used in ACCS. Forty-seven stakeholders participated across 3 sessions, including ACCS providers who themselves provide CIES (Competitive Integrated Employment Services) services; ACCS providers who do not provide CIES services; and CIES providers who do not provide ACCS. These discussions resulted in a final report providing recommended actions in the areas of: (1) Assertive Orientation; (2) Continuous Integrated Teamwork; (3) the referral process; (4) continuity of employment supports; and (5) cultural competency, particularly in respect to services for deaf/HH clients. These recommendations were in turn presented to MassAbility

representatives – the MA vocational rehabilitation agency and primary provider of ACCS employment services – to DMH's Assistant and Deputy Commissioners, and later incorporated into a complimentary MassAbility report similarly focused on quality improvement within the ACCS employment services sphere. Currently recommendations have been endorsed by DMH and are under review at MassAbility for an est. SFY26 start.

Peer Support Subcommittee Overview

The Peer Support Subcommittee has emerged to carry on its mission of Transcom following its two-year hiatus. With two new co-chairs now in place, the Peer Support Subcommittee has begun the work of forming a new group of stakeholders and thought leaders from the mental health and substance use fields who are committed to uplifting the vital role of peer support in behavioral health. The subcommittee is made up of senior peer workforce leaders representing DMH vendor agencies from across the Commonwealth. The mission of this subcommittee is to promote peer-driven initiatives, programs, and resources that empower individuals with lived experiences to connect, share, and thrive. The subcommittee strives to facilitate collaboration among diverse communities, ensuring that people with lived experiences inform policymaking, services, and strategies aimed at enhancing behavioral health services.

So far, the Peer Support subcommittee has completed its initial process of recruiting and convening leaders in the peer support workforce community in the Commonwealth and is now determining structure, vision, and priorities for elevating the recognition and value of peer support while advocating for equitable access to quality behavioral health services across the state.

Potential goal areas currently under discussion include the following:

- enhancing and expanding the training and skill building opportunities for the peer workforce
- creating a career ladder for peer professionals,
- furthering discussions between stakeholders to understand both uniqueness and commonalities found within the mental health and addiction peer communities,
- developing structures to amplify the voices of lived experience in service design and delivery, and
- developing recommendations to further the expansion of peer positions in a manner that promotes their full integration in behavioral health services while preserving the integrity of their roles.

There is a special interest on the systemic barriers faced by people with co-occurring mental health and addictions disorders. This is due to the separation of mental health and substance

use as opposed to independence between them. Adding in the Commonwealth of Massachusetts' unique positioning in having also separate state and provider agencies for mental health and substance use, the support systems that are developed under separate state and provider agencies have to navigate the differences in funding mechanisms, job classifications, criteria for credentials, and treatment systems. Consequently, people with co-occurring needs are often challenged with navigating these separate care systems in the state.

There is also an ongoing need to integrate peer roles and input into the planning of integrated care delivery systems for physical and behavioral health care. There is recognition within the state that access to recovery-based and peer services are a fundamental component of integrated care.

Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

DMH's priority population are adults with serious mental illness and children with serious emotional disturbance. Within these populations, DMH's role has been further defined to provide continuing care inpatient and community-based services. The majority of acute-care inpatient and outpatient services are funded through MassHealth and other third-party payers. While DMH does not directly provide or fund the majority of these acute-care services, DMH works collaboratively with MassHealth, the Executive Office of Health and Human Services (EOHHS), other third-party payers, acute-care inpatient and outpatient providers, and other stakeholders to identify and address the behavioral health needs of adults and children within the Commonwealth.

DMH has worked extensively with these partners over the last several years to achieve improved integration of behavioral health services, including mental health and substance use services, primary and specialty care, and other social supports. Structural challenges in access to mental health and addiction treatment remain, even after recent improvements made through legislation, policy reforms, and substantial public investment. These challenges include:

- Individuals and families often do not know what services are available or how to connect to them;
- Not enough behavioral health providers accept insurance (public or private) and those that do may have long waiting lists;
- People often turn to the emergency department during a behavioral health crisis because there is no effective system for immediate urgent care in the community;
- Individuals often cannot receive mental health and addiction treatment at the same location, even though mental health conditions and substance use disorder (SUD) often co-occur; and
- Culturally competent behavioral health care for racially, ethnically, and linguistically diverse communities is difficult to find.

To address these challenges, as discussed in Part 1, the Roadmap for Behavioral Health Reform aims to help people find the right treatment when and where they need it. Critical behavioral health system reforms through the Roadmap includes:

- A "front door" for people to get connected to the right treatment in real time;
- Readily available outpatient evaluation and treatment, including in primary care;
- Better, more convenient community-based alternatives to the emergency department for urgent and crisis intervention services; and
- Expanded inpatient psychiatric bed capacity.

The Roadmap has created a no-wrong door approach to treatment by encouraging multiple points of entry with same-day access, integrating addiction and mental health services, and providing community-based crisis response while upholding evidence-based practices. Further it will ensure parity between physical and behavioral health care; expand provider networks through MassHealth and private insurance; ensure treatment is based on goal-oriented, trauma-informed, evidence-based practices for individuals across the lifespan; support health equity by ensuring capacity to meet the diverse needs of all individuals in the Commonwealth; and require "no-reject" of individuals who need treatment, including returning patients.

DMH recognizes the unique position it serves as the State Mental Health Authority and will continue to be a strong partner for systems change via the Roadmap and by further identifying and addressing unmet needs and critical gaps within the DMH system itself. Many of these unmet needs, as well as additional highlights of the service system's strengths, are outlined below for adult services as well as child, youth, and family services.

Incorporating Race, Equity, and Inclusion Practices

Strengths: The Office for Human Rights advocates for individuals often marginalized by varying treatment systems. Because of the power inequities that cut across all social and economic dimensions, it is critical that individuals have a support system that not only advocates for them but teaches self-advocacy.

Needs: All identified gaps or unmet needs herein must be identified and then addressed in relation to race, equity, and inclusion concerns for Black, Indigenous, and People of Color (BIPOC) communities. Race, equity, and inclusion (REI) concerns, issues, and problems need to be intentionally spotlighted, data should be collected to gain understanding of the identified issues, and appropriate REI solutions recommended and implemented. Ongoing race, equity, and inclusion education should be provided throughout the system as needed.

Culturally Responsive Services

Strengths: State mental health authorities are poised to address issues in serving culturally and linguistically diverse populations. There are only a limited number of dedicated offices across the country that have taken a series of steps and strategies to implement cultural and linguistic competence with the goal of reducing mental health disparities in status and care. The Office of Race, Equity and Inclusion recently completed a review of interpreters in DMH's five Areas and is working to use technology to effectively and efficiently increase access and provide more culturally competent services.

Needs: All sectors of the service system are challenged by the ability to recruit and retain a qualified workforce, particularly for culturally and linguistically diverse populations. Access to

services can be challenging, particularly for people for whom English is not their primary language. As DMH redesigns its service system, particular attention needs to be paid to ensure that health care disparities among cultural and linguistic individuals and communities are reduced.

Furthermore, DMH serves approximately 109 people identified as Deaf or using American Sign Language as their preferred language and approximately 155 people who are Hard of Hearing. DMH also serves approximately 154 people with Limited English Proficiency (LEP) who need Spoken language interpreter services. It is difficult to estimate how many people should be served but typically, Deaf people and those with LEP are under-represented. The high frequency of trauma would indicate that people who are Deaf are at greater risk for mental health and substance abuse problems. Often people with LEP and who are Deaf re too often misdiagnosed and may not be referred to for services. People who are Deaf and with LEP are often not well served by the acute-care system due to cultural and linguistic barriers. There is also a lack of access to information to better understand mental illness and fear and stigma in culturally and linguistically diverse communities. Training efforts and other accommodations are being pursued to address the challenges of providing linguistic and culturally appropriate access and treatment within this setting -with the goal that those with LEP and those who are Deaf or Hard-of-Hearing, are able to participate equitably in all DMH programs and services.

Finally, given the clear need to use technology in order to optimize learning and communication, programs need to have substantial infrastructure to optimize technology, both for the workforce and those people served. There may be disparity among direct care staff and people served who lack access to devices such as phones and computers. The Department is assessing that need and a work group is developing a tool kit to support those with little experience using electronic devices to develop competence and confidence in these important tools for learning, documenting care, and participating in telehealth opportunities.

Behavioral Health Workforce

Strengths: DMH has made important investments in training Young Adult Peer Mentors and Family Partners as they are becoming an increasingly important part of the behavioral health workforce. DMH has also utilized funding to support reflective supervision training and coaching to help support the workforce, many of whom are new to the field and are working with some of the most severely ill individuals in the Commonwealth. DMH has made investments in stipends for internships to create an incentive to work in community behavioral health settings as well as loan repayment and other pipeline strategies.

Needs: Although the behavioral health workforce is beginning to show a bit more stability, it continues to struggle to keep up with the demand. The strain and stress the workforce is facing cannot be underestimated. All service needs continue to be difficult to meet given the workforce crisis. Waitlists continue to be longer than ever. Group care programs are struggling

to keep the milieus safely staffed. The pandemic created a situation in which even the helpers are dealing with their own mental health issues. There are also fewer people coming into these roles Pipeline creation coupled with strong support for the early career workforce is a critical need. The workforce also suffers from a lack of diversity which requires attention so that we can move the needle on treatment disparities.

Infrastructure Support to Track and Monitor Process and Performance

Strengths: DMH continues to make strides in building capacity for data driven decision making. Tableau data visualization software continues to serve as a key tool in monitoring the Adult Community Clinical Services (ACCS), Clubhouses, Respite, and Children Youth and Families programs as well as case management and service authorization. DMH is moving to a cloud-based system for Tableau which will allow greater use and enhanced security. DMH is also looking into widespread adoption of RedCap for various community based related data workflows and the respective infrastructure.

Needs: DMH continues to work on its IT infrastructure that does not easily support the collection, verification, and analysis of data for use in determining process and outcome performance. Despite these continued efforts, there is continued need to promote the use of data to inform the operational, policy, and programmatic improvements on services provided to DMH clients. These are critical in determining program progress and success. Data and quality work are heavily dependent on technology. DMH has contracted with a consulting group to develop a strategy and implementation roadmap for data and analytics.

Telehealth

Strengths: At the onset of the pandemic, behavioral health utilization dropped by about half. However, as providers pivoted to adopt telehealth, utilization quickly rebounded. MassHealth began covering telehealth for behavioral health services in February 2019, and during the pandemic expanded this coverage to include audio-only telehealth and reduced barriers for providers to adopt telehealth. DMH adopted flexibility measures with its providers to allow for telehealth and reduce administrative barriers.

Needs: There is a significant amount to learn about the effectiveness and best use application of telehealth and how telehealth can augment in-person service delivery. In addition, many individuals with behavioral health needs have limited access to equipment and data plans to engage in telehealth.

Implementation and Support for Evidence-Based and Emerging Practices

Strengths: DMH has engaged in significant efforts to implement evidence-based and emerging practices in a systemic manner, including the restraint and seclusion prevention/elimination initiatives in the child and adult systems, System of Care, trauma-informed care (child and adult systems), person-centered planning, supported employment, and Zero Suicide. DMH has partnered with providers, consumers, family members, academic institutions, and other experts to develop and implement these initiatives.

With the (re)procurement of its two Research Centers of Excellence (COE), DMH chose to establish a Center with a focus on implementation science to support the implementation of best practices in the treatment and services for people with SMI/SED and co-occurring SUD within DMH and across the Commonwealth. The efforts of the iSPARC COE over the past four years has been largely focused on DMH Adult Community Clinical Services (ACCS). ACCS providers are required to utilize standardized screening, evidence-based assessment procedures, and evidence-based practices for treatment and rehabilitation, including the C-SSRS screener for suicide risk, HCR-20 for risk of violence and SBIRT, and Motivational Interviewing. MGH COE faculty partner with DMH, MAPNET, and NAVIGATE trainers to provide training and consultation in the NAVIGATE EP CSC model with the goal of expanding MA capacity to implement this evidence-based practice in the community with fidelity. Both COEs are able to provide a review of the literature on requested topics (e.g. de-escalation strategies, differential diagnosis for ASD and SMI) in order to support DMH's effort to identify and implement appropriate EBPs.

Needs: State funding is limited, and DMH relies heavily on grants to support identification and initial implementation of promising and evidence-based practices. Grant funds are time limited and do not provide for the ongoing support and consultation necessary to achieve persistent fidelity and sustainability. Workforce development challenges contribute to the difficulty in sustaining adherence to evidence-based practices. Staff turnover undermines retention of trained staff, taxes training resources, and results in limited staff with significant experience and training in selected evidence-based practices.

Community Services Standards and Outcomes

Strengths: The redesign of adult community-based services intended to further strengthen DMH's ability to carry out its commitment to addressing the needs of specific populations. DMH is promoting a recovery system that is founded on the principles of person-centered care tailored to meet the individual needs of people served, including those whose needs are related to culture, language, sexual orientation, gender, age, and disability. Service standards in DMH contracts require that:

- Services are age and developmentally appropriate, including services for transitional age youth and elders;
- A trauma-informed approach to treatment planning and service delivery is utilized that includes an understanding of a client's symptoms in the context of the client's life experiences and history, social identity, and culture;
- Culturally and linguistically competent services are provided, including assessment and treatment planning that are sensitive to and responsive to cultural, ethnic, linguistic, sexual orientation, gender, parental status, and other individual needs of the clients; and
- Services are fully accessible regardless of physical disability, auditory, or visual impairment.

Needs: DMH recognizes that the presence of these service standards does not in itself address the challenges and obstacles in providing services that competently address these needs. Furthermore, data also suggests there are unique barriers for some populations in accessing behavioral health care, including DMH services. It is essential for DMH to measure and monitor the effectiveness of these services, including demonstrating that consumers, youth, and families are experiencing positive outcomes.

Behavioral Health Integration

Strengths: DMH is a leader in health care reform with its sister EOHHS agencies beginning with the passage of health care reform legislation in 2006 mandating universal health plan coverage. Approximately 98% of Massachusetts residents are insured. DMH works in close partnership with state partners, including the Bureau of Substance Addiction Services (BSAS) and MassHealth, to develop financing and service models in support of behavioral health and primary care integration.

Needs: DMH, BSAS, and MassHealth are each separate entities within EOHHS with distinct eligibility requirements, business process, and data systems. DMH administers continuing care community and inpatient services. Most public acute-care inpatient and outpatient services are funded and overseen by MassHealth and its managed care entities and more than half of DMH child and adolescent clients have at least part of their treatment paid for by their parent's private insurance. This separation in funding can make it difficult to integrate the clinical and fiscal components of service delivery that need to be in place for individuals with complex service needs. It impedes care coordination and is a barrier to early identification and delivery of timely follow up care. The agencies continue to work together to identify strategies to better integrate services as well as obtain a complete picture of the people who are accessing behavioral health and specialty care funded through each entity.

Suicide Prevention Services

Strengths: DMH, in strong partnership with the Massachusetts Suicide Prevention Program (MSPP) at DPH, is a leader in the dissemination of Zero Suicide across the Massachusetts health and behavioral health care systems. Furthermore, DMH has embraced Zero Suicide as the organizing structure for its suicide prevention, intervention, and postvention work. This crucial work has been made possible through strong support of DMH leadership, beginning with the Commissioner, with an emphasis on the importance of addressing suicidality effectively throughout DMH operations, the MA behavioral health system, and the larger health care system across the Commonwealth. In addition, DMH in its role as procurer or payer of services, has utilized Zero Suicide components as the framework to set expectations for contracted services (i.e. evidence-based screening, assessment, safety planning, transitions support, and treatment planning).

Needs: Even with this strong commitment to better address suicidality, the needs are great and there is a gap between the aspirational goal and the ongoing challenge of assuring the delivery of effective suicide prevention, intervention, and postvention services. DMH does not have its own dedicated budget to staff suicide prevention specialists. DMH's efforts to instill safer suicide care practices across the DMH and the larger MA health and behavioral health care systems would be greatly advanced with additional dedicated staff to support the enormous amount of ongoing work in partnership with the MSPP in order to assure meaningful implementation of and fidelity to current best practices with a goal toward reducing suicide attempts and deaths across the Commonwealth. DMH has also identified a gap in post-crisis workforce support, particularly in the aftermath of client suicide or other traumatic events. Programs such as The Hero's Journey and broader collective care initiatives are needed to help staff process grief, reduce burnout, and maintain resilience. There is also a growing need for wellness and safety planning training, not only for persons served, but as a support strategy for staff in crisis-stabilization roles.

Barriers to Housing Stability and Affordability

Strengths: DMH has a commitment in meeting the diverse housing needs of individuals living with mental health. DMH offers a wide array of housing resources tailored to various stages of recovery. There is a person-centered approach by identifying specific needs of each individual and thoughtfully matching them with the most appropriate housing option available. This individualized matching process helps to promote long-term housing stability and recovery.

Needs: Individuals experiencing homelessness face several critical gaps and unmet service needs that significantly impact their ability to achieve stability and recovery. One of the most pressing challenges is the shortage of affordable and supportive housing. While supportive housing models have proven effective, the demand for units that offer integrated mental health services far exceeds the supply, particularly for individuals with complex needs.

DMH recognizes that there can be delayed or inconsistent care due to a lack of integration between mental health services, housing providers, and the homelessness response system. One of the ways DMH has responded to the systematic barriers is through the recent procurement of our Homeless Support Network, providing an emphasis on integration between Mental Health service, Housing Providers and Homelessness response system by prioritizing collaboration during transition planning to support quality.

Given the rise in homelessness across Massachusetts, our Outreach and Engagement services would greatly benefit from additional resources. Currently, outreach teams are often under-resourced and lack the staffing and capacity needed to effectively respond to the increasing number of individuals experiencing homelessness. This strain limits their ability to provide consistent, meaningful engagement and support. In addition, there are significant gaps in transitional and step-down housing options, which makes it challenging for individuals to achieve stability following discharge from hospitals, shelters, or correctional facilities**.**

Affordable Housing and Coordinated Services for People Experiencing Homelessness

Strengths: DMH housing staff are committed to creating independent, community-based, and integrated housing opportunities for individuals receiving DMH services. By dedicating their time and expertise exclusively to managing housing resources, staff have significantly expanded DMH's own rental assistance program and cultivated strong partnerships with non-profit agencies and for-profit agencies, as well as municipalities working to increase affordable housing. Furthermore, through our PATH grant, DMH provides critical outreach and engagement to individuals experiencing homelessness who are living with mental health conditions and co-occurring substance use disorders. These individuals are often in shelters or on the streets, making it extremely difficult to support them through traditional service settings. The PATH program plays a vital role in reaching and serving this vulnerable population, offering care and connection that is often life-saving.

DMH is working with MassHealth and others to address the issue of discharges to shelter from private psychiatric hospitals. DMH Licensing established a tool for shelters to record and collect data on inappropriate discharges that come to their shelters. This data will inform the development and monitoring of policies and strategies addressing these discharges. DMH has participated in trainings with MassHealth to keep hospitals aware of the process of discharging and how to navigate challenging situations that may arise while discharging someone to a shelter or the streets.

The State Mental Health Planning Council Housing Subcommittee continues to work with DMH to update that DMH Housing Plan, with the goal to create movement through the DMH service system and support the Commonwealth's effort to end homelessness for individuals experiencing mental health and co-occurring conditions, including continued expansion of the

DMH Rental Subsidy Program (DMHRSP). In FY25 the program has grown to $37.5M housing over 2,500 individuals. Over the past three years, the Safe Havens programs have grown in funding adding six additional programs representing 42 beds. A smaller subgroup of the Subcommittee has formed a workgroup that is primary aimed to address barriers and increase awareness of the DMHRSP among key stakeholders statewide. The group is working on updating a DMHRSP educational video, enhancing collaboration with EOHLC to streamline provider processes, and developing a statewide training module for service providers.

Needs: At the same time, the quantitative demand for housing has not been fully measured. However, DMH providers, advocates, homeless shelters, and outreach programs continue to ask for more housing resources in the form of subsidies and capital investment. This demand is tied to the larger issue of the lack of affordable housing for low-income and working families, individuals with disabilities, those fleeing domestic violence, experiencing homelessness, and those with mental health and co-occurring conditions. DMH counts around 1900 individuals receiving services from the five DMH contracted and State-operated Homeless Outreach& Engagement programs, who need housing.

Peer and Family Member Involvement and Workforce

Strengths: Massachusetts benefits from a strong network of individuals with lived experience and family organizations that engage with DMH and other partners in a wide range of policy, program, advocacy, and other system-level efforts. Having built strong relationships statewide, these organizations effectively identify emerging consumer and family member leaders and provide training and mentoring to support their development as leaders. Further, Massachusetts is building a strong workforce of peers and family members. Additionally, Massachusetts has an adult peer specialist training and certification program as well as curricula specific to family support, transition age youth, older adult peer specialists, forensic peer specialists, and the Deaf and Hard of Hearing. Peer and family support positions are now required in multiple services, including ACCS.

Needs: There continues to be a need to recruit and train additional peers and family members to assume paid roles in the system, particularly those from cultural and linguistic minority populations. There is also a need for ongoing continuing education and support to people engaged in this work as well as training and other efforts to shift organizational culture to support recovery and acceptance in the workplace, including disclosure of mental health conditions and recovery experiences. In addition, opportunities for career advancement in the peer workforce are fickle despite increasing numbers of peer workers in direct care roles. Turnover of these roles will occur without an established career ladder in place.

Increase Access to Peer Support and Peer-run Services

Strengths: As noted previously, Massachusetts is furthering discussions between stakeholders to understand both uniqueness and commonalities found within the mental health and addiction peer communities. Of special interest are the systemic barriers faced by people with co-occurring mental health and addictions disorders. Because mental illness and addictions have historically been seen as very different conditions, mental health and substance abuse support systems have developed under separate state and provider agencies or divisions, each with its own funding mechanisms, job classifications, criteria for credentials, and treatment systems. Thus, people with co-occurring needs are often challenged with navigating these separate care systems.

Needs: There is an ongoing need to integrate peer roles and input into the planning of integrated care delivery systems for physical and behavioral health care. There is recognition within the state that access to recovery-based and peer services are a fundamental component of integrated care. There is a continued to pathways to increase clinical and adminstrative understanding of the importance of peer roles in these specialized settings to better inform best practices for peer supervision. The resulting friction and role drift further contributes to turnover and creates barriers to the full integration of this workforce in the behavioral health system.

Expand Available Employment Services

Strengths: Supporting employment for the people we serve requires cross-systems and "cross-silos" work. Because numerous challenges must be bridged, employment requires consistent messaging and coordination among various resources, including transportation, benefits counseling, clinical services, peer support, vocational rehabilitation, and inpatient facilities. Staff who are committed to employment must believe in the potential of people to surprise us, the dignity of risk, and possess more than a little creative thinking.

Needs: DMH has embedded employment support in all of its primary adult services (ACCS, Clubhouse, PACT) with the exception of Case Management and Homeless Services. Case Managed individuals or those served through homeless services (PATH) may access employment support at DMH through joining Clubhouses or enrolling in MassAbility (Massachusetts' vocational rehabilitation agency) but otherwise lack dedicated employment and education resources within their own services comparable to what is offered throughout DMH's other services.

While staff vacancies have impacted programs across mental health services, vacancies impact employment services in two ways: 1) through vacant employment specialist positions, and 2) by diverting attention from the remaining team members away from employment and towards crises or clinical priorities. Dedicated resources to hire, train, and retain staff, particularly

employment staff, are needed. While drafting said resources, assurance is needed to confirm alignment of education and employment definitions used in reporting across DMH services. Also, increasing availability of dedicated, evidence-based supported employment services for DMH case managed clients. Making linguistically accessible employment- and benefits-counseling services for non-English speaking clients are also needed.

Employment Data Analysis and Equity

Strengths: Following the reactivation of clubhouse data reporting, DMH produces a monthly employment and education data summary report, shared with clubhouse vendors, site offices, and DMH administrators. The report contains data at the clubhouse and statewide level, detailing employment rates, length of transitional employment, missing data, and education rates. Additional dashboards and visualizations are updated in real-time and applied to the twice-yearly clubhouse contract monitoring process, including data on demographics, dual-service enrollment, and trend-analysis. Also included in this data set is newly available data on clubhouse members Action Plan domain areas, giving DMH, and DMH vendors, for the first time a view into the goal-areas of the approximately 4,200 persons utilizing clubhouse services to find work, housing, education, reduce loneliness, and improve health.

Needs: While interest in employment remains consistent, persons served by DMH continue to struggle managing public benefits and continue to work at or marginally above minimum wage. Training programs, particularly skilled apprenticeships, acting as a gateway to higher levels of earnings, remain inaccessible, and complex social security rules continue to act as a deterrent for persons to increase their hours, accept raises, or seek higher paying positions. Reforms are needed to simultaneously remove barriers and equip individuals for higher paying careers.

Additionally, current data collection methods vary across DMH services. DMH would benefit from a simplified, consistent, timely system to receive information related to clients' paid employment. While data reporting improvements DMH can independently implement are under consideration, a simpler, faster, more reliable method for collecting this information would be a data-sharing agreement with the Department of Revenue, comparable to the system used in Maryland and other states, obviating the need for provider reporting at all.

DMH also continues to lack the ability to aggregate data across services to better understand the outcomes and effectiveness of employment services across the Department. Current data collection systems for PACT, ACCS, and Clubhouses rely on different measures, standards, and definitions, such that viewing data holistically across DMH is not yet feasible.

Forensic Services in the Commonwealth

Strengths: Massachusetts is able to provide court ordered competency evaluations, partially in non-correctional settings due to the DMH forensic mental health system in partnership with the

Trial Court. Furthermore, the highest degree of excellence and professionalism of the clinical personnel is maintained via our rigorous Forensic Professional certification process and quality surveillance system.

Needs: There continue to be numerous challenges for our system in the Commonwealth including the need for statewide expansion of the forensic evaluator workforce and the public psychiatric facility capacity to address the increasing rate of referral from forensic and civil commitments; housing resources and transition programs for persons with criminal justice involvement and behavioral health conditions; improved access to certain specialty services and community supports for forensic patients and for releasing inmates; and professional workforce personnel (forensically trained/certified clinicians) to recover depleted staffing levels related to the pandemic and to absorb the growth in need for forensic evaluations post-pandemic. There is also a growing need for the expansion of appropriate facility capacity to absorb the growing number of persons civilly committed for substance use treatment with both routine and complex treatment and care needs.

Connection with Schools

Strengths: DMH is firmly committed to supporting and strengthening linkages with schools and school-based services, and to developing a workforce knowledgeable about special education services, and student and parental rights under special education law. Each DMH Area funds community and school support contracts to offer support and consultation to parents on special education services and how to work with their local education authorities. DMH staff participate in a statewide special education advisory council to advise our state's single state education authority and also participate in IEP and school meetings at the local level for DMH-served youth. DMH knows that schools provide an important opportunity to identify children and youth at-risk for behavioral health conditions and to link them with needed services.

DMH aims to address challenges related to school based mental health while supporting and partnering with other state agencies on school based mental health initiatives. The University of Massachusetts BIRCh Project offers professional development to school professionals on the implementation of evidence-based school mental health interventions, social-emotional learning practices, strategies to create and sustain positive school climates, and conduct universal screening for early identification and intervention of student needs. DMH is actively seeking to expand and support BIRCh's reach statewide.

In consultation with DMH and DPH, the Department of Elementary and Secondary Education (DESE) is currently developing a cost-neutral model medical emergency response plan (MERP) that includes responding to behavioral health emergencies in order to promote best practices. DMH is providing support and clear guidelines for school behavioral and other health professionals, inclusive of school counselors, in order to develop a model that includes the use of the Behavioral Health Help Line (BHHL), Community Behavioral Health Centers (CBHC's), and

other community services. The MERP will assist school districts in their behavioral health response in order to reduce referrals to law enforcement interventions unless otherwise needed.

Needs: Due to the highly local nature of school funding and decision-making authority, it continues to be a challenge to determine the best way to support youth with behavioral health challenges in school settings.

Recognizing the Early Signs of a Behavioral Health Challenge

Strengths: DMH has invested in workforce development that enhances the capacity of professionals to do assessment and diagnosis in the early years by funding clinical training on the DC: 0-5 (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood). There has also been training of other professionals working with young children and families, like emergency shelter staff, on how to talk to families about behavioral concerns, social-emotional development screening, and follow-up with supportive resources.

DMH's Coordinator of Infant and Early Childhood Mental Health (IECMH) works with system partners and providers to support the growth and development of IECMH promotion, prevention, and treatment. This is an important gap area as there is a lack of awareness that infant and young children can experience mental health challenges.

Needs: Helping families and other system partners including schools and community organizations to recognize the early signs of a behavioral health condition is an ongoing challenge. By the time most families reach DMH they are often overwhelmed, exhausted, and the youth is far along in the course of their illness. To interrupt this trajectory, there needs to be a greater focus on preventing, diagnosing, and treating mental health problems in early childhood. There is also a need to increase the number of providers who are well trained in how to work with young families using dyadic treatment approaches.

Assisting Families Navigating the System

Strengths: As part of its reforms and improvements to the behavioral health system, DMH has contracted for a vendor to operate a 24/7 Behavioral Health Help Line (BHHL). The BHHL connects individuals and families to the full range of treatment services for mental health and substance use offered in Massachusetts, including outpatient, urgent, and immediate crisis care. Individuals and families can call, text, or chat with the BHHL to receive for real-time support, initial clinical assessment, and connection to the right evaluation and treatment.

Needs: Families often struggle to know where to start or who to turn to when their child needs behavioral health treatment. The current system is designed to follow the logic and flow of

funding and administration as opposed to the human experience. This is particularly true for communities who have not been well-served by the behavioral health system. Outreach and engagement strategies that draw upon the expertise of BIPOC and other groups that have been marginalized are necessary.

Providing Flexible Supports and Services for Young Adults

Strengths: DMH has already done some expansion of "low-barrier" access centers specifically designed to attract young adults between the ages of 16 and 25 who are not connected to formal services and, because of stigma, often avoid mental health services. The centers, open to anyone, are a welcoming place for young adults to get "back on track" with their life goals by connecting to resources for jobs, education, health care, and housing, as well as meeting peers with similar lived experience. Currently, there are seven Access Centers in Boston, Brockton, Springfield, Worcester, Framingham, Braintree, Lawrence, Lowell, New Bedford, and Gloucester.

Needs: Families need more flexibly designed supports and services that are available at convenient times and locations and do not require service authorization. These types of settings more successfully engage young adults of color and LGBTQ young adults than conventional clinical services. There is a need to continue to support and expand these types of services beyond discretionary grant funding.

Coordinated Care for Older Adults

Strengths: DMH services are flexibly designed to meet the needs of DMH clients throughout the lifespan; and DMH requires providers to deliver services that are age and developmentally appropriate, including services for elders. Over the last seven years, DMH and the Executive Office of Aging and Independence (AGE), the Massachusetts' State Unit on Aging, have taken a number of initiatives to improve services to older adults. The Department of Public Health has also been engaged as a key state partner and these agencies are working together to leverage resources to focus on suicide prevention in older adults.

Needs: DMH recognizes the need to coordinate care more closely for older adults with serious mental illness who need wrap around services from both home care agencies and behavioral health providers. The population of individuals with serious mental illness is getting older, and no one government agency is equipped to handle this need. Older adults with behavioral health conditions are the least likely to receive mental health treatment due to barriers such as lack of transportation, co-occurring cognitive conditions, isolation, higher rates of stigma and ageism among providers. Older adults who do not speak English and/or face additional cultural barriers are even less likely to receive treatment.

Expanding access to in-home culturally and linguistically responsive behavioral health support continues to be at the forefront of these needs. There is also a need for specialized substance use supports for older adults who face barriers such a lack of population specific treatment options and Medicare coverage issues.

Further, hoarding is estimated to impact 2.5% - 5% of adult population with higher rates for adults of 60. Hoarding is correlated with risks including homelessness, falls, isolation, and premature and unwanted nursing home admissions. There are a lack of availability of clinical and peer interventions, as well as homemakers/heavy chore providers trained in sorting and discarding. Increasing available and effective hoarding supports will help this population maintain independence in the community.

Strengthening Expedited Psychiatric Inpatient Admission Processes

Strengths: The Expedited Psychiatric Inpatient Admission (EPIA) initiative has been able to integrate into the fabric of mental health and substance use care in the Commonwealth of Massachusetts. The EPIA team utilizes clinical competencies/operational standards related to co-occurring substance use disorder (SUD) to ensure individuals suffering from substance abuse disorders and receive adequate access to care. Additionally, EPIA collaborates with various stakeholders involved in individual's holistic care. The EPIA team includes three registered nurses with extensive clinical backgrounds, allowing the team to assess clinical needs of individuals served and effectively strategize appropriate placements for these individuals. EPIA maintains consistent communication with stakeholders through attending multiple emergency department boarding meetings to discuss high risk patients and standard weekly calls with various hospital administration to address emergent issues. On February 2025. The Behavioral Health Treatment Referral Platform (BH TRP) was officially launched providing transparency for all individuals boarding within the emergency rooms throughout the Commonwealth.

Needs: Advocacy with the EPIA team advocacy revolves around individuals boarding in emergency rooms, specifically on securing consistent inpatient level of care to improve overall access to care. These individuals may need inpatient detox treatment and may need longer term care to address chronic substance use. This population can benefit from additional community supports to reduce relapses and recidivism.

Empowering Education Opportunities for Mental Health Workforce

Strengths: The Department of Mental Health's Learning & Development (L&D) teams across all regions have demonstrated strong, innovative, and collaborative approaches in advancing workforce development to better meet the complex and evolving needs of the individuals we serve. Across regions, there has been a focused effort to build a unified foundation in understanding the intersections of mental health, substance use disorders (SUD), and trauma-

informed care. Staff have been trained in motivational interviewing (MI), Columbia Suicide Severity Rating Scale (C-SSRS), and other tools like the Safety Wellness Action Plan, helping them engage more effectively and safely with at-risk individuals. The L&D teams have led powerful initiatives to strengthen the workforce's ability to support individuals who experience psychosis, hear voices, or face stigma and marginalization. Diversity, equity, and inclusion are woven throughout programming—evident in the intentional representation of diverse voices, speaker panels, and topics relevant to underrepresented communities.

Needs: While the Office of Learning and Development (L&D) at DMH initiatives have made meaningful strides, several critical gaps and unmet needs persist that impact on DMH's ability to fully support the workforce and the people we serve. These challenges span skill development, workforce support, and systemic equity.

There is an urgent and continued need for expanded Motivational Interviewing (MI) training and clinical supervision capacity across all areas. Additionally, more emphasis is needed on risk assessment and response, especially related to suicidality, violent behaviors, and early intervention for substance use among youth (e.g., marijuana exposure and its impact on brain development).

Direct care staff require more robust training in data analysis, data-informed decision making, and clinical formulation. This includes the ability to document and communicate individuals' needs in a way that guides responsive and person-centered service planning. Increased fluency in these areas is critical for delivering high-quality, accountable care.