Massachusetts

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 09/24/2017 10.06.53 AM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2018
End Year	2019

State DUNS Number

Number	878369362
Expiration Date	

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

Agency Name	Department of Mental Health
Organizational Unit	Management and Budget Division
Mailing Address	25 Staniford Street
City	Boston
Zip Code	02114-2503

II. Contact Person for the Grantee of the Block Grant

First Name	Joan
Last Name	Mikula
Agency Name	Massachusetts Department of Mental Health
Mailing Address	25 Staniford Street
City	Boston
Zip Code	02114-2503
Telephone	617-626-8123
Fax	617-626-8131
Email Address	Joan.Mikula@massmail.state.ma.us

III. Third Party Administrator of Mental Health Services

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date 8/31/2017 10:38:58 AM

Revision Date

VI. Contact Person Responsible for Application Submission

First Name David

Last Name Tringali

Telephone 617-626-8247

Fax 617-626-8330

Email Address david.tringali01@massmail.state.ma.us

Footnotes:

State Information

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

Fiscal Year 2018

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Joan Mikula

Signature of CEO or Designee[1]: _____

Title: Commissioner, Department of Mental Health

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction Programs and Certifications (Form 03)
Fiscal Year 2018/19

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
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State: MASS

Name of Chief Executive Officer (CEO) or Designee: Joan Mikula

Signature of CEO or Designee[1]: Joan Mikula

Title: Commissioner

Date Signed: 08/17/2017
mm/dd/yyyy

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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to

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

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

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

CHARLES D. BAKER
GOVERNOR

KARYN E. POLITO
LIEUTENANT GOVERNOR

Ms. Odessa F. Crocker
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 17th floor
Rockville, MD 20850

Dear Ms. Crocker:

As the Governor of the Commonwealth of Massachusetts, for the duration of my tenure, I delegate authority to Joan Mikula, Commissioner of the Massachusetts Department of Mental Health, or any one officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG).

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

Sincerely,

Charles D. Baker
Governor

cc: Marylou Sudders, Secretary, Executive Office of Health and Human Services

State Information

Disclosure of Lobbying Activities

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

Name

Title

Organization

Signature: Date:

Footnotes:

Planning Steps

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

Narrative Question:

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

Footnotes:

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Children and Families
600 Washington Street, 6th Floor
Boston, MA 02111
Tel.: 617-748-2000 Fax: 617-261-7435
www.mass.gov/dcf

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

LINDA S. SPEARS
Commissioner

June 16, 2017

Commissioner Joan Mikula
Department of Mental Health
25 Staniford Street
Boston, MA 02114

Dear Commissioner Mikula:

As the Commissioner of the Department of Children and Families, I am writing to indicate the support of this agency for the goals outlined in the Massachusetts Department of Mental Health (DMH) 2018-2019 Behavioral Health Assessment and Plan, for funding from the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Service Administration (SAMHSA), a division of the United States Department of Health and Human Services.

The Department of Children and Families (DCF) is charged with protecting children from abuse and neglect and strengthening families and in partnership with families and communities, ensuring children are able to grow and thrive in a safe and nurturing environment.

Currently, DCF is collaborating with DMH on multiple efforts to support youth with behavioral health needs and their families, enabling them to live, attend school, work and participate in their communities. Our cooperative and collaborative efforts include:

- Joint procurement of all residential services for clients/families served by each agency (Caring Together);
- DCF Statewide Advisory Council;
- Ongoing clinical collaboration to discuss trends, issues and complex situations related to client/family needs and young adults, ages 16-25;
- Parent Subcommittee of the State Mental Health Planning Council;
- Interagency Child and Adolescent Restraint Prevention Initiative; and
- Emergency Department Boarding Workgroup

We will endeavor to support the array of services being offered by DMH to support youth and families to live full and productive lives. Thank you for the opportunity to sustain these vital efforts.

Sincerely,

Linda S. Spears
Commissioner

Massachusetts Department of Elementary and Secondary Education

75 Pleasant Street, Malden, Massachusetts 02148-4906

Telephone: (781) 338-3000
TTY: N.E.T. Relay 1-800-439-2370

Mitchell D. Chester, Ed.D.
Commissioner

June 15, 2017

Joan Mikula
Commissioner, Department of Mental Health
25 Staniford Street
Boston, MA 02114

Dear Commissioner Mikula:

I am writing to indicate the support of this agency for the goals outlined in the Massachusetts Department of Mental Health (DMH) 2018-2109 Behavioral Health Assessment and Plan, for funding from the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Service Administration (SAMHSA), a division of the United States Department of Health and Human Services.

The Department of Elementary and Secondary Education (ESE) is committed to preparing all students for success in the world that awaits them after high school. Preparing all students for success (in school, the workplace, civic life, and more) includes attending to their social-emotional and health development. ESE is committed to building out supports and policies in partnership with practitioners in the field and other state agencies, notably DMH, to advance this work in the Commonwealth, both in and out of school. ESE is collaborating with DMH on multiple efforts to support youth with behavioral health needs and their families to achieve positive educational outcomes. Our cooperative and collaborative efforts include:

- State Special Education Advisory Council
- McKinney Vento Homeless Assistance Act Steering Committee
- Massachusetts Family Literacy Consortium
- Safe and Supportive Learning Environment Advisory Council
- Restraint and Seclusion Prevention Interagency Executive Team
- Interagency Workgroup on Services for Children and Youth with an Autism Spectrum Disorder
- Office of the Child Advocate's Residential Schools Group

We will endeavor to support the array of services being offered by DMH to support youth and families to live full and productive lives. Thank you for the opportunity to sustain these vital efforts.

Sincerely,

Mitchell D. Chester, Ed.D.
Commissioner of Elementary and Secondary Education

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

June 14, 2017

Joan Mikula
Commissioner, Department of Mental Health
25 Staniford Street
Boston, MA 02114

Dear Commissioner Mikula:

As the Commissioner of the Department of Public Health (DPH), I am writing to indicate DPH support for the goals outlined in the Massachusetts Department of Mental Health (DMH) 2018-2109 Behavioral Health Assessment and Plan. Funding is sought from the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Service Administration (SAMHSA), a division of the United States Department of Health and Human Services.

The DPH is dedicated to the mission of helping people lead healthier lives throughout the Commonwealth. DPH achieves its mission by:

- Operating four public health hospitals, the Hinton State Laboratory and the State Office of Pharmacy Services
- Collecting, maintaining and publishing vital records and health statistics
- Licensing, certifying and/or accrediting hospitals, clinics, laboratories and thousands of health professionals
- Interpreting and enforcing public health law
- Providing surveillance of chronic diseases, occupational hazards, injuries, and behavioral health risks
- Contracting with vendors and working with partners for prevention, intervention and treatment of public health issues
- Providing 24/7 coverage to detect, prevent and resolve infectious, environmental and bioterrorism threats to the health of the public

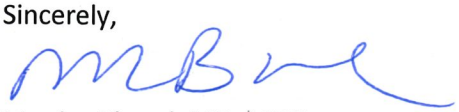
DPH collaborates with DMH on multiple efforts to meet the mental health needs of individuals of all ages, including people with substance use disorders, enabling them to live, work and participate in their communities. These activities include significant involvement between DMH and several DPH Bureaus, most notably the DPH Bureau of Substance Abuse Services (BSAS). Our inter-agency collaborative and cooperative efforts include:

- Youth Interagency Workgroup on Substance Abuse
- The Massachusetts Coalition for Suicide Prevention

- Aggressive Treatment and Relapse Prevention Program (ATARP)
- Emergency Department Boarding Workgroup
- Behavioral Risk Factor Surveillance System
- Women's Recovery from Addiction Program

We endeavor to support the array of services being offered by DMH which enable the residents of the Commonwealth with mental health conditions to live full and productive lives. Grant funding will afford DMH the opportunity to sustain these vital efforts.

Sincerely,



Monica Bharel, MD, MPH
Commissioner

The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Youth Services
600 Washington Street, 4th floor
Boston, MA 02111

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KARYN E. POLITO
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PETER J. FORBES
Commissioner

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June 19, 2017

Joan Mikula
Commissioner, Department of Mental Health
25 Staniford Street
Boston, MA 02114

Dear Commissioner Mikula:

As the Commissioner of the Department of Youth Services (DYS), I am writing to indicate the support of this agency for the goals outlined in the Massachusetts Department of Mental Health (DMH) 2018-2019 Behavioral Health Assessment and Plan, for funding from the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Services Administration (SAMHSA), a division of the United States Department of Health and Human Services.

The DYS is the principal Juvenile Justice agency in Massachusetts serving delinquent youth that are committed by the Juvenile Court. DYS promotes positive change in the youth in our care and custody. Our mission is to make communities safer by improving the life outcomes for youth in our care. Our goal is to change the developmental trajectory of the youth we serve from a negative one to a pro social one. To the extent we are successful, youth have better life outcomes, their families have an improved life quality and our communities are safer.

DYS is collaborating with DMH on multiple efforts to support youth with behavioral health needs and their families to live, attend school, work and participate in their communities. Our cooperative and collaborative efforts include:

- Development of consistent care coordination practices to ensure integration and coordination of service delivery for youth served by both DMH and DYS;
- Interagency Child and Adolescent Restraint Prevention Initiative;
- DYS Juvenile Detention Alternative Initiative;
- Inclusion of youth focus on DMH police-based jail diversion initiatives with DYS input;
- Periodic examination of youth who are court-involved and DYS-DMH Juvenile Court Clinic interface;
- Regular DYS, Department of Public Health (DPH), DMH, and academic interagency dialogue related to national and local trends focused on re-entry and other services for youth with co-occurring mental health and substance use conditions.

We will endeavor to support the array of services being offered by DMH to continue to support youth and families to live full and productive lives. Thank you for the opportunity to sustain these vital efforts.

Sincerely,

Peter J. Forbes
Commissioner

The Commonwealth of Massachusetts
Executive Office of Elder Affairs
One Ashburton Place, 5th Floor
Boston, Massachusetts 02108

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June 15, 2017

Joan Mikula
Commissioner, Department of Mental Health
25 Staniford Street
Boston, MA 02114

Dear Commissioner Mikula:

As Secretary of the Executive Office of Elder Affairs (EOEA), I am writing to indicate the support of this agency for the goals outlined in the Massachusetts Department of Mental Health (DMH) 2018-2109 Behavioral Health Assessment and Plan, for funding from the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Service Administration (SAMHSA), a division of the United States Department of Health and Human Services.

The mission at EOEA is to promote the independence, empowerment, and well-being of older adults, individuals with disabilities, and their caregivers. Our vision is that older adults and individuals with disabilities will have access to the resources they need to live well and thrive in every community of the Commonwealth.

Together, the EOEA and the DMH are working on multiple efforts to meet the mental health needs of older adults, including people with substance use disorders, enabling them to live, work, volunteer and participate in their communities. Specifically, the EOEA with DMH have collaborated to provide two rounds of Certified Older Adult Peer Specialists (COAPS) trainings in April 2015 and June 2016. Further, DMH provides the funding for 4 of the 38 COAPS in Massachusetts. Our collaborative and cooperative efforts include:

- An active Elder Mental Health Collaborative, a subcommittee of the State Mental Health Planning Council co-led by EOEA and DMH;
- Building local relationships to improve access for DMH older adults to community resources in the elder network;
- Work with the senior care organizations on potential evidence-based depression screening tools for older adults;
- Improvement in the PASRR process to promote diversions from nursing facility care; and
- Collaboration with DMH on Medicaid initiatives related to access to mental health care and the integration of primary care with behavioral health services for older adults including the Medicare/Medicaid Dual-Eligibles' Initiative.

Thank you for the opportunity to sustain these vital efforts.

Sincerely,

Alice F. Bonner
Secretary

CC: Terri Anderson, DMH Assistant Commissioner

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Massachusetts Rehabilitation Commission
600 Washington Street
Boston, MA 02111-1704

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July 13, 2017

Joan Mikula, Commissioner
Department of Mental Health
25 Staniford Street
Boston, MA 02114

Dear Commissioner Mikula:

As the Acting Commissioner of the Massachusetts Rehabilitation Commission (MRC), I am writing to indicate the support of this agency for the goals outlined in the Massachusetts Department of Mental Health (DMH) 2018-2109 Behavioral Health Assessment and Plan, for funding from the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Service Administration (SAMHSA), a division of the United States Department of Health and Human Services.

The MRC promotes equality, empowerment and independence of individuals with disabilities. MRC is responsible for Vocational Rehabilitation Services, Community Living Services, and eligibility determination for the Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) federal benefits programs.

Currently, MRC is collaborating with DMH on multiple efforts to meet the mental health needs of individuals of all ages, including people with substance use disorders, enabling them to live, work and participate in their communities. Our cooperative and collaborative efforts include:

- Collaboration with DMH and the Department of Developmental Services on the development of Regional Employment Collaboratives, funded by Work Without Limits;
- Collaboration with DMH and the Department of Developmental Services on Secretary Sudders' Autism Task Force;
- MRC Transition Works Advisory Board;
- Youth Development Committee of the State Mental Health Planning Council; and
- Three pilot projects with DMH/MRC field sites.

We will endeavor to support the array of services being offered by DMH to enable residents of the Commonwealth with mental health conditions to live full and productive lives. Thank you for the opportunity to sustain these vital efforts.

Sincerely,

Kasper M Goshgarian

Kasper M. Goshgarian
Acting Commissioner

The Commonwealth of Massachusetts
Executive Office of Public Safety & Security
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THOMAS A. TURCO III
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Chief of Staff

PAUL DIETL
BRUCE I. GELB
MICHAEL G. GRANT
CAROL A. MICI
Deputy Commissioners

June 16, 2017

Joan Mikula
Commissioner, Department of Mental Health
25 Staniford Street
Boston, MA 02114

Dear Commissioner Mikula:

As the Commissioner of the Department of Correction (DOC), I am writing to indicate the support of this agency for the goals outlined in the Massachusetts Department of Mental Health (DMH) 2018-2109 Behavioral Health Assessment and Plan, for funding from the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Service Administration (SAMHSA), a division of the United States Department of Health and Human Services.

The DOC's mission is to promote public safety by managing offenders while providing care and appropriate programming in preparation for successful reentry into the community. The DOC's vision is to effect positive behavioral change in order to eliminate violence, victimization and recidivism.

Currently, DOC is collaborating with DMH on multiple efforts to meet the mental health needs of individuals of all ages, including people with substance use disorders, enabling them to live, work and participate in their communities. Our cooperative and collaborative efforts include:

- DMH statewide Forensic Treatment Team (FTT);
- DMH coordinated multi-disciplinary team visits to the segregated units at DOC prisons to assist DOC in ensuring that inmates in those units receive appropriate medical, dental and psychiatric care;
- DMH/DOC committee to review issues that arise in the care and treatment of male inmate/patients at the Bridgewater State Hospital who may be stepping down to DMH facilities for further inpatient care;
- DMH Forensic Services review of mental health care DOC inmates receive through an examination of agreed upon outcomes that are tracked over time; and
- Collaboration and interagency planning related to statutorily mandated commitments for substance abuse treatment.

We will endeavor to support the array of services being offered by DMH to enable residents of the Commonwealth with mental health conditions to live full and productive lives. Thank you for the opportunity to sustain these vital efforts.

Sincerely,

Thomas A. Turco, III
Commissioner

Step 1: Assess the Strengths and Needs of the Service System

Overview of State's Mental Health System

Demographic Data

Massachusetts is a relatively small, industrial state with a net land area of 7,800 square miles and an average of 873.3 people per square mile. It had an estimated population of 6.811,779 as of July 1, 2016, with a population growth rate of 4% from April 1, 2010 to July 1, 2016. Among the states, MA ranks 5th in population density (https://www.census.gov/2010census/data/apportionment-dens-text.php) and 45th in total land area among the states. Most residents live within a 60 mile radius of Boston. Eastern Massachusetts is more urban than Western Massachusetts, which is primarily rural, save for four cities of which Springfield is largest and the Commonwealth's second major population area.. The state is 190 miles, east to west, and 110 miles, north to south, at its widest parts. The U.S. Census data shows a state population which is getting older, with persons under 18 representing 20.4% of the population, a drop from 21.7% in 2010, and those 65 years and over increasing from 13.8% in 2010 to 15.4% in 2015. An examination of race and Hispanic origin for the Commonwealth found that those reporting their race as white alone (not Hispanic or Latino) represented 73.5% of the population[1], with black or African American alone 8.4%, Hispanic or Latino 11.2%, Asian alone 6.6%, and 2.3% as multiracial.

In recent years, there have been significant increases in the numbers of immigrants and refugees from Africa, Southeast Asia, Central America, the Caribbean Islands and Eastern Europe with foreign born persons now representing 15.5% of the population.

Massachusetts' 2015 penetration rate for mental health services, as found in SAMHSA's 2015 Mental Health National outcome Measures, is 4.97 per 1,000 residents, with 33,556 clients served by the state mental health system[2]. SAMHSA reports a total of 21,652 adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) in Massachusetts for FY2015. Most of this population, 17,293 or 79.9%, are adults between the ages of 18 and 64 with SMI, with 2,991 (13.8%) children under 18 years of age with SED and 1,368 (6.3%) of older adults, age 65 and older, with SMI.

Examining Massachusetts data from the MMHS Uniform Reporting System tables found that the population of adults with SMI remained fairly stable from FY12 to FY15(17,558 to 17,293), while the children with SEDs increased nearly 70%(1,764 to 2,991) and older adults 12.4% over the same time period (1,217 to 1,368).

DMH - The State Mental Health Authority

The Department of Mental Health, as the State Mental Health Authority, 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,

[1] The previous report cited in the requested assignment indicates a white population of 83.2%. The US Census Bureau indicates that this category represents those reporting more than one race. A similar percentage (82.1%) was found but not reported in this exercise in favor of greater precision provided by the US Census.
[2] Massachusetts 2015 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System (URS) Output Tables (www.samhsa.gov/datareports-by-geography?tid=641&map=1).

regulation and policy the Department establishes standards to ensure effective and culturally competent care to promote recovery. The Department 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, providers and communities. DMH licenses acute psychiatric hospitals and acute psychiatric units in medical facilities. Further, DMH provides a system of person and family centered, trauma informed, recovery oriented care for a defined service population; adults with a qualifying mental disorder accompanied by functional impairments, and children with a 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 including the Department of Children and Families (DCF), and MassHealth, the Commonwealth's Medicaid agency.

Organization of the Department of Mental Health

Currently, DMH is organized into a Central Office and five geographic Areas; Central, Western, Northeast, Boston and Southeast Areas. The Central Office in Boston is organized into five divisions in addition to the Commissioner's office - Mental Health Services, Child, Youth and Family Services, Clinical and Professional Services, Management and Budget, and Legal. All Area Directors report to the Deputy Commissioner for Mental Health Services. 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 forensic mental health services, adolescent continuing care units, and adolescent intensive residential treatment programs. Within Central Office, there are offices of Human Rights, Recovery and Empowerment and Multicultural Affairs. Quality improvement activities, data analytics and liaison to the Executive Office of Health and Human Services (EOHHS) 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 Areas is managed by an Area Director and Area leadership teams, including medical directors, senior psychiatrists, child/adolescent psychiatrists, directors of community services, directors of child, youth and family services, and quality managers. The DMH Areas are subdivided into 27 local Service Site Offices located in 25 places across the Commonwealth. Each Service Site Office is overseen by a Site Director/Case Management Supervisor. The Sites authorize services for individuals, provide case management and oversee an integrated system of state and vendor-operated adult and child/adolescent 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 co-ordination.

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 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. Chapter 321 of the Acts of 2008 of the Massachusetts General Laws established and Children's Behavioral Health Advisory Committee, a body of no fewer than 24 members, appointed by the Secretary of Health and Human Services. The membership consists of a wide range of children's mental health stakeholders from state government, advocacy organizations, family and youth peer organizations, professional guilds, provider associations and academic training programs. The Advisory Council advises the Secretary of Health and Human Services, the Governor and the Legislature. Although not mandated by statute or regulation, there also is a Professional Advisory Committee on children's mental health, comprised of advocates, professionals, family members and state agency representatives and one advisory group to the Office of Multicultural Affairs.

All of the state hospitals, Community Mental Health Centers (CMHC), adolescent inpatient units, and Child, Youth, and Family intensive residential treatment programs are accredited by the Joint Commission and certified by the CMS (Center for Medicare and Medicaid Services). 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. DMH currently licenses a total of 2,776 inpatient beds located in 65 facilities statewide. 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. Of these beds, 2,661 are currently operational including 169 adolescent beds, 25 children's beds, 86 child/adolescent beds and 457 geriatric beds. In 2016, MA served 1,626 adults and 84 children in its state operated and contracted psychiatric hospitals.

Each of the 5 DMH Service Areas includes a major population center, and each local service site 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 thus DMH has collaborated with the State Office of Rural Health in its planning efforts.

Historical Perspective on Shift from Inpatient to Community Services

Massachusetts has been a national leader in caring for people with mental illnesses since it built the nation's first public asylum in America – Worcester State Hospital in 1833. This served as the model that other states soon followed.
A new era in mental health care emerged in the 1960s when President John F. Kennedy signed the Community Mental Health Centers Act of 1963, which espoused treating people with mental illnesses locally rather than in large isolated state hospitals and led to the construction of federally funded community mental health centers across the nation, including several in Massachusetts.

A community-based system of care has been evolving in Massachusetts since 1966 when the state Legislature enacted the Comprehensive Mental Health and Retardation Services Act. This measure decentralized the Department of Mental Health and established a robust network of services within each community so that people could receive treatment, services and support close to their homes. The federal Brewster Consent Decree in the western Massachusetts area, from 1978 to 1992, asserted the rights of individuals with mental illness to receive care in the least restrictive setting and increased the availability and quality of community programs.

In 1984, Executive Order 244 prohibited children under 19 from being treated on adult inpatient wards of state hospitals and led to the creation of new residential programs and a contracted vendor network for most services for children and their families. Executive Order 422 of June 2000 continues this prohibition but permits placement of certain forensically involved 17- or 18-year-olds on adult inpatient units in DMH facilities and permits youths under 19 to be admitted to certain specialty units in DMH facilities.

In 1986, Chapter 599 split DMH into separate departments of mental health and mental retardation (now developmental services) and created a new mission for DMH to "provide for services to citizens with long term or serious mental illnesses and research into the causes of mental illness." Between 1973 and 2010, DMH closed 10 of its public psychiatric hospitals, most of them built in the mid-1800s and early 1900s. This coincided with a significant effort to place clients who were ready to transition to appropriate community settings with the necessary supports.

Recognizing some individuals' continuing need for inpatient psychiatric care and after a seven-year planning, design and construction process, the Commonwealth invested $302 million to build and open in August, 2012 a new public psychiatric hospital, the Worcester Recovery Center and Hospital (WRCH). DMH currently operates or contracts for 671 continuing care beds in six facilities, including 260 beds at the WRCH.

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 and children with serious emotional disturbance. Clinical teams of DMH Clinical Service Authorization Specialists (CSASs) were identified and trained, and functional assessment instruments were selected for use with adults and children. The DMH service authorization process is currently engaged in a quality improvement process to ensure individuals who need DMH services promptly receive them.

Further, the DMH Child, Youth, and Family Services Division uses the Child, Youth, and Family Needs and Strengths (CANS) for service authorization. The CANS was inaugurated as part of the Rosie D lawsuit Remedy Services, and was already being used by the Department of

Children and Families, thus its use promotes standardization of assessment and assists cross-agency initiatives. Also, DMH clients receiving case management have the CANS completed as part of six month periodic reviews, and administered at discharge from residential and inpatient programs.

Regulations

The Department's enabling statute is M.G.L. Chapter 19 and its operating statute is M.G.L. Chapter 123. DMH is also governed by 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.

Under Governor Baker's direction to all agencies, DMH recently reviewed all of its regulations to identify those in need of revision. Through this recent effort, DMH continues to assure 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 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.

DMH's revised service planning regulations for adults incorporate the planning processes of its major community service model, Community Based Flexible Supports (CBFS). The regulations describe the Individual Action Plans (IAPs) that CBFS providers are required to develop and distinguishes them from Individual Service Plans (ISPs) developed by DMH case managers. The planning processes focus provider and consumer attention on consumer voice and choice, and are driven by a commitment to the principles of recovery. The regulations also shift the process away from categorical DMH eligibility to emphasize the matching of consumers who meet clinical criteria to specific services that DMH offers and has available. The CBFS model is currently under redesign into a "New Model", yet to be named, that aligns with MA new Section 1115 Waiver ACO model and Behavioral Health Community Partner Model. Through close collaboration, DMH and MassHealth assure patient centered care is delivered in a cost effective way that does not supplant funds.

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.

Research

To carry out its statutory research mission, DMH has operated two Research Centers of Excellence for more than twenty years through contracts with private contractors. DMH

currently funds one Center in Clinical Neuroscience and Neuropharmacology (Commonwealth Research Center at the Beth Israel Deaconess Medical Center, Harvard Medical School) and one Center in Behavioral and Forensic Sciences (Systems and Psychosocial Advances Research Center of the Department of Pscyhiatry at the University of Massachusetts Medical School). The Centers conduct research to advance the diagnoses, treatments, service programs, rehabilitation and recovery of adults with serious mental illness and children/adolescents with serious mental illness or severe emotional disturbance. The Centers' research activities are supported largely through external funding obtained by the contractors. DMH funding is used primarily to support the Centers' infrastructure costs. The Centers are also required to provide on-going research and evaluation consultation services to DMH. Their 2016 annual reports indicate a total of 20 new research awards and contracts.

In FY18, bids will open to applicants for a new 10 year contract period. For this period, DMH seeks a Research Center of Excellence for Systemic and Psychosocial Research as well as a Research Center of Excellence for Early Detection and Intervention in Psychosis. To be eligible, bidders must be either (1) a department of psychiatry of a medical school, or (2) an academic clinical health care system affiliated with a medical school having a distinct department of psychiatry and providing inpatient and outpatient services to adults with serious mental illness and children/adolescents with serious mental illness or severe emotional disturbance. Each Center has its distinct research focus. The Center of Excellence for Systemic and Psychosocial Research will focus on services research, including racial and ethnic disparities in healthcare utilization, forensic services and issues specific to child, adolescents, transition age youth and families. The Center of Excellence for Early Detection and Intervention in Psychosis will focus on identification, prevention, early intervention, and recovery for individuals at risk for psychosis or experiencing onset of psychosis and their families through the conduct of basic and clinical research, interventions science, and services research. DMH recognizes the value of collaboration in research and cultivation of early career scientists. It is expected that the Centers of Excellence will collaborate with community stakeholders including providers, consumer/family groups and with other research programs and will provide opportunities for graduate students, postdoctoral researchers, and new investigators to develop independent research projects.

Established by Chapter 321 of the Acts of 2008 in the Massachusetts General Laws, An Act Relative to Children's Mental Health, DMH funds and sponsors the Children's Behavioral Health Knowledge Center. At the heart of its mission is to focus on improving front-line practice through training, program design, organizational supports, and policy alignment. Within this broad mission, DMH has focused the Center's efforts on prevention and early intervention, across the developmental life stages of children and youth and across the levels of their behavioral health needs. The Knowledge Center partners with researchers and national experts to develop projects that fill important knowledge gaps and that the Center is uniquely positioned to support.

Finally, as required by federal law and state regulation, DMH's Central Office Research Review Committee (CORRC) reviews and must approve all requests by researchers who seek to work with DMH clients, past or present, in their research. Recently, the CORRC completed formal Institutional Review Board Certification and was renamed the DMH IRB. At any given time there are about 50 research studies taking place within DMH facilities, and about 20 new studies are reviewed and approved each year. The DMH IRB chair oversees the Research Centers of Excellence, and is part of the DMH Clinical and Professional Services Leadership team, tasked with setting clinical standards for DMH state operated and contracted services. The IRB chair also oversees the First Episode Psychosis and Suicide Prevention initiatives.

Human Rights

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, Youth and Family 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.

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. 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.

Forensic Mental Health Services

DMH Forensic Mental Health Services (Forensic Services) is involved at the intersection between mental health and the various intercept points in the justice system as described below:

- **Crisis Intervention Team 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 (JDP's) including Crisis Intervention Teams and clinician/police co-responder programs.
- **Court Clinics:** Court Clinics are responsible for providing all court-ordered forensic and clinical evaluations in the Juvenile, District, and Superior Courts in Massachusetts. Comprised mainly of psychologists, psychiatrists, social workers, and other licensed professionals, specified 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), civil commitment related to substance use and mental illness and other types of evaluations. Juvenile Court

Clinic activities also include evaluations of youth regarding a number of matters ranging from delinquency to evaluations pertaining to Children Requiring Assistance (CRA).

- **Inpatient Forensic Evaluations:** DMH Forensic Services Designated Forensic Professionals (DFP) and Certified Juvenile Court Clinicians II (CJCC II) conduct inpatient examinations of defendants on issues primarily pertaining to CST and CR or aid-in-sentencing and coordinates with inpatient treatment teams and the courts. Individuals sent 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 that set forth in DMH policy 10-01R.
- **Specialty Court Services:** DMH Forensic Services provides funding for clinical services at two Mental Health Courts in the Massachusetts District Court (Plymouth and Springfield), and provides support and assistance to Boston Municipal Court Mental Health Courts, supports Veterans Treatment Courts and Drug Courts with further plans for expansion in close partnership with the Trial Court.
- **Justice-Involved Veterans:** Forensic Services is involved with the administration and funding of programs and services for Justice Involved Veterans, including MISSION Implementation services for Veterans who are ordered to this service by the court post-adjudication as an alternative to incarceration for veterans with co-occurring mental health and substance use challenges. DMH Forensic Services also provides funding to the Department of Veterans Services to assist with peer support services for veterans who are court-involved.
- **Forensic Transition Team (FTT):** Established by the DMH in 1998, the Forensic Transition Team is a boundary spanning, statewide service that ensures DMH-service authorized individuals an effective community reentry plan from state prisons and county houses of correction.
- **Certification and Training:** DMH Forensic Services oversees, through its regulations, the certification and training of Designated Forensic Professionals, Qualified Social Workers, and Certified Juvenile Court Clinicians. Currently, DMH seeks SAMHSA technical assistance funds to train Forensic Peer Specialists.
- **Corrections:** 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 coordinated multi-disciplinary team visits these DOC units on a regular basis. Visits ensure that inmates in those units receive appropriate medical, dental and psychiatric care. Reports are generated for the Commissioner of Correction and his staff 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 served in the Bridgewater State Hospital, a strict security DOC facility that manages persons acquitted by reason of insanity or found incompetent to stand trial. Recently, nationally known treatment expert, Dr. Kevin Huckshorn, was contracted to provide BSH clinical oversight.
- **Services for Special Forensic Populations:** DMH Forensic Services provides a specialized program for persons with mental illness and problematic sexual behaviors (MIPSB). It includes clinical and risk management assessments, consultations, and

treatment to help inpatient treatment teams and community providers in working with persons with these specific difficulties, some of whom have also been charged and/or convicted of sexual offenses. The Independent Forensic Risk Assessment (IFRA) program, formerly known as Mandatory Forensic Review (MFR), provides a policy-based specialized risk assessment and management consultation 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. Additionally, Forensic Services is the DMH liaison for the Sexual Offender Registry Board (SORB) and the Criminal Justice Information System, the state entity that maintains 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 difficulties arise.

Office of Multicultural Affairs

The DMH Office of Multicultural Affairs (OMCA) has the structural and functional responsibility for implementing the Department of Mental Health's mission of providing culturally competent care. OMCA works collaboratively with DMH area leadership and staff including area diversity committees, divisions within DMH, and a group of mental health external stakeholders that comprise the Multicultural Advisory Committee 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.

OMCA is focusing on the following areas:

- Community Partnerships - Partner with mental health providers, community organizations, DMH area staff, and other 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) OMCA is in the process of piloting on-demand video remote interpreting services at two DMH-operated facilities.
- Training and Education - Integrate mental health disparities and cultural and linguistic competence into trainings and staff development for DMH employees.
- Data - Use of DMH client population census data, client satisfaction surveys, language access utilization reports, and Massachusetts population data to inform policy, program development, clinical practice, and recruitment/retention of diverse DMH workforce.

Please refer to the Health Disparities section for a description of these activities.

Training for Mental Health Providers

- DMH continues to maintain its commitment to increasing diversity in the workplace by ensuring that all staff attends Diversity training. More recently, DMH leaders reviewed staff demographics for the purpose of increasing diversity in the workforce. Annually, DMH holds the Stephanie Moulton Safety symposium and the Mentally Ill/Problematic Sexual Behavior conference. Regional training calendars are developed annually based on a needs assessment process that includes leadership prioritization of topics that support the mission and reflect Evidence Based Practices and other promising practices. Most recently, DMH's Person-Centered Planning Initiative trained all DMH staff and workforce members in the philosophy of Person-Centered Approaches to Treatment Planning.

MassHealth: Massachusetts' Medicaid Authority

Since 1992, the Commonwealth has operated its Medicaid program under a Section 1115 Demonstration waiver. The 1992 waiver authorized a behavioral health care carve-out program for MassHealth recipients, a group including about 4,000 DMH clients, enrolled in the Primary Care Clinician Program (PCCP). The Massachusetts Behavioral Health Partnership (MBHP) manages the network of the Primary Care Clinician Program, including a full array of Mental Health/Substance services. Together, MBHP, DMH, exercising its role as the State Mental Health Authority and MassHealth have ensured compliance on an array of program standards, clinical criteria and protocols, policies, performance incentives, and quality improvement goals that ensure the MassHealth Office of Behavioral Health Unit (OBH) and the vendor maintain a high quality of care. DMH provides funding to support the Massachusetts Child Psychiatry Access Program (MCPAP), a payer-blind, free pediatric psychiatry consultation service available to all pediatric practices in the state.

In order to ensure that the Department of Mental Health, as the mental health authority of the Commonwealth, maintained its critical role in the design of behavioral healthcare under the Medicaid State Plan, the mental health advocacy community secured passage of a law that requires all managed care organizations, including any specialty behavioral health managed care organizations contracting or delivering behavioral health services to persons receiving services under Medicaid, to obtain the approval of the Commissioner of the Department of Mental Health for all of the behavioral health benefits; including but not limited to policies, protocols, standards, contract specifications, utilization review and utilization management criteria and outcome measurements. (Section 113 of Chapter 58 of the Acts of 2006).

For the last decade, MA has led the U.S. 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 1.9 million residents, or 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. On November 4, 2016, EOHHS received approval from the Centers for Medicare and Medicaid Services (CMS) to amend and extend its MassHealth Section 1115 Demonstration. This extended waiver supports the restructuring of the MassHealth program to provide integrated, outcomes-based care.

This Waiver will allow Massachusetts to move from its current fee-based model to a system of Accountable Care Organization models (ACO) who work in close partnership with community-based organizations to better integrate care for behavioral health, long-term services

and supports and health-related social needs. The new waiver, which is effective July 2017, authorizes $1.8 billion over five years of new Delivery System Reform Incentive Program (DSRIP) funding to support the move to ACOs, invests in Community Partners for behavioral health (BHCPs) and long-term services and supports, and allows for innovative ways of addressing the social determinants of health. It also authorizes and sustains nearly $6 billion of additional safety net care payments over 5 years to hospitals and the health safety net for the uninsured and underinsured, and for subsidies to assist consumers in obtaining coverage on the Massachusetts Health Connector. As noted above, DMH is currently redesigning the CBFS program into a "New Model" which aligns with the BHCP services.

Substance Abuse Authority

The Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS) is the Single State Authority, overseeing the Commonwealth's substance abuse disorder, 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 a number of initiatives related to the planning of services for people with co-occurring substance use and mental health conditions with current emphasis on implementing Governor Baker's landmark legislation, Chapter 55 of the Acts of 2016, An Act relative to substance use, treatment, education and prevention, including recommendations from the Governor's Opioid Working Group.

Chapter 55 is most notably the first law in the nation to limit an opioid prescription to a 7-day supply for a first time adult prescriptions and a 7-day limit on every opiate prescription for minors, with certain exceptions. Other provisions from the Governor's recommendations include a requirement that information on opiate-use and misuse be disseminated at annual head injury safety programs for high school athletes, requirements for doctors to check the Prescription Monitoring Program (PMP) database before writing a prescription for a Schedule 2 or Schedule 3 narcotic and continuing education requirements for prescribers—ranging from training on effective pain management to the risks of abuse and addiction associated with opioid medications. As recently reported, MA has finally seen a slight reduction in opioid related overdoses and deaths. DMH has provided client level data to the DPH to assess the impact of opioid use on the DMH population. In August, 2017, DPH reported that less than 1% (.37%) of DMH clients served between 2012 and 2016 had an opioid related overdose death but represented 1.64% of all opioid related deaths during the 5 year period. Another 2.33% DMH clients experienced a non-fatal overdose during the period. DMH is currently reviewing and revising its substance use assessment tools and protocols.

Also, in late January, 2016 Governor Baker signed into law a bill to prohibit the civil commitment of women facing substance use disorders at MCI-Framingham and providing addiction treatment services at the state operated Lemuel Shattuck and Taunton State Hospitals. This reform was also a recommendation of the Governor's Opioid Working Group and ended the practice of sending women committed for treatment for a substance use disorder under section 35 of chapter 123 of the General Laws to MCI-Framingham. For the past 25 years, women committed under section 35 have been sent to this correctional institution instead of a detox center—preventing proper treatment options for women. Under this law, women can only be

committed to a facility approved by the Department of Public Health (DPH) or the Department of Mental Health (DMH). Subsequently, in February, 2016, the DMH operated 45 bed Women's Recovery from Addiction Program (WRAP) opened on the Taunton State Hospital Grounds.

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

Comprehensive Community-Based Mental Health Services - Adult

Available Services Narrative

DMH directly provides and/or funds a range of services for approximately 28,000 adult clients per year. These services include inpatient continuing care, emergency services, case management and other community and rehabilitative services, such as Community Based Flexible Supports (CBFS), Program for Assertive Community Treatment (PACT), Clubhouse and Respite. Although publicly funded acute-care services, including inpatient, emergency and outpatient services are managed by MassHealth, DMH operates some inpatient, outpatient and community services in the Southeast and Metro Boston Areas.

Since 2007, DMH has aligned its community based service system with the needs and preferences of consumers and families. This alignment, consistent with the vision of the Commonwealth's Community First initiative, ensures that individuals authorized for DMH services have access to services and supports to enable them to work, attend school, and live and participate as independently as possible in their communities.

DMH continued its redesign of the adult community mental health system with the re-procurement of respite services in SFY10. Subsequently, in SFY12, DMH procured a new service, Peer-Run Respite in the Western MA division. This service provides temporary peer support to individuals in emotional distress and/or emergent crisis. The service is described in further detail in the Crisis Services and Recovery sections. In SFY13, DMH issued Requests for Responses (RFRs) for Clubhouse services. The service model was enhanced to address unmet needs in the current community-based service system and focus on goals of employment and community integration. During SFY15, DMH worked with the Massachusetts Behavioral Health Partnership (MBHP), MassHealth's behavioral health coverage carve out, to expand peer resources for emergency services in two regions (Western Mass Area and Northeast Area).

For state fiscal 2018, DMH has worked intensely to re-bid its community services programs. New service contracts are currently in negotiation for PACT which is funded via the Block Grant, the Recovery Learning Centers, Homeless Support Services, Child/Adolescent Day Services, as well as adult and juvenile court clinics.

Housing Services

The Department seeks to promote access to affordable integrated housing opportunities that foster independence, provide choices, offer the rights and responsibilities of tenancy, and help individuals to receive services tailored to their specific needs. DMH accomplishes its housing mission through a close working relationship with state and local housing agencies and

organizations. The Department of Housing and Community Development (DHCD) is the critical partner in this work as they oversee a range of state and federal housing resources including both federal and state rental assistance, public housing programs, Local Housing Authorities, state capital financing, tax credits (federal & state) and homeless programs.

The Chapter 689/167 Special Needs Housing Program represents a long history of DMH working with DHCD and the Local Housing Authorities to provide Group Living Environments (GLEs) in communities across the state at below market rents; there are now some 85 development across the state housing nearly 700 clients. These buildings are generally designed to house eight people in either shared settings or individual apartments; no CORIs or credit checks required.

The DMH Rental Subsidy Program (DMH-RSP) is another strong collaboration between DHCD and DMH, housing over 1,400 clients. Funding is currently just under $8M annually and is exclusively targeted to DMH clients and their respective service providers. Clients lease quality units in the market and pay 30% of their adjusted income for rent, the subsidy pays the balance. This program is a unique partnership between a state housing agency and state mental health agency and recognizes the distinct housing needs of those with mental illness. In the DMH-RSP program there are no CORIs or credit checks making access much less complicated than the Sec. 8 Housing Choice Voucher Program.

DMH helps to build new housing using capital financing from DHCD specifically dedicated to assist DMH clients. This fund, known as the Facilities Consolidation Fund (FCF), makes available loans/grants to non-profit and for profit developers that covers up to 50% of the total development cost of the units. In a typical year, $11.5M is committed to projects funded through FCF. DHCD further assists in securing project-based subsidies for FCF units usually in the form of Sec.8 that ensure long-term affordability. These are high quality units integrated into multi-family developments that provide a normalized setting for clients. There are currently over 900 units of housing financed through the FCF Fund, most are one-bedroom or studio sized units.

Another critically important housing partner of DMH is MassHousing, the state housing finance agency with a portfolio of over 100,000 units of multi-family and elderly housing that provides a set-aside of 3% of their affordable units for use by DMH. The Set-Aside delivers to DMH clients some 400 high quality, subsidized units of either studios or one-bedrooms integrated into multi-unit developments. DMH has exclusive access to these units thereby avoiding long waitlists comprised of families and elders which can take years.

DMH has been very involved in accessing housing resources for homeless individuals through participation in HUD Continuums of Care (CoC), of which Massachusetts has 17. All five DMH Areas provide matching funds or leveraged services to CoC local grants that deliver rental assistance and leased housing. These programs are vital to the Department's ability to serve those who because of their illness have difficulty accepting more traditional housing.

With the many housing resources in play across the state DMH has specific housing staff in each of its five Areas dedicated to managing and monitoring the various housing assets assigned to their Area. In addition they plan 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 are the "boots on the ground" when it comes to local housing initiatives.

DMH Central Office helps to oversee the Area housing activities 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 in with its housing objectives.

Central Office actively participates in housing policy and work groups under the leadership of DHCD and the Executive Office of Health and Human Services (EOHHS). These include the DHCD Supported Housing Work Group and the EOHHS Housing Committee that brings together all human service agencies in an effort to coordinate activity and promote good communication. The State Mental Health Planning Council's Housing Subcommittee contributes actively to these efforts. Also, for many years the State, under the leadership of the Governor, has hosted the Interagency Council on Housing and Homeless.

Rehabilitative, Support and Recovery-based Services

As DMH is the primary provider/contractor of continuing care community-based services, rehabilitation, support and recovery are at the core of its programs. The primary community-based service providing rehabilitation and support in the community is currently CBFS, serving 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, including Clubhouse services. In a shift towards consumer-directed care, DMH funds and supports a variety of consumer initiatives, including peer and family support, peer mentoring, and Recovery Learning Communities (RLCs).

Employment Services

As noted above, DMH is r-procuring the service currently known as CBFS, with new contracts slated to begin July 1, 2018. The new model will focus on clinical and rehabilitative interventions to support all phases of individuals' pursuit of competitive work, while leveraging job development services from community partners. New Service Providers will be expected to integrate support for employment through all aspects of the service, as well as to coordinate closely with Massachusetts' state Vocational Rehabilitation Agency (MRC), clubhouses, and mainstream employment service providers. Further, the newly appointed Commissioner of the Massachusetts Rehabilitation Commission (MRC) served many years as chair of the State Mental Health Planning Council's Parenting Subcommittee. Under this new leadership and with the EOHHS Secretary's direction the MRC will redesign its service model to accommodate persons living with intellectual, developmental and behavioral disabilities as well as persons living with physical or co-occurring disabilities. DMH and other EOHHS agencies are instructed to 'bridge' their current employment services to MRC over the next 5 years but to continue community supports.

Currently, DMH continues to provide employment services through Clubhouses, which provide members with 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. Clubhouses pursue a variety of jobs for members including integrated, independent employment.

Clients also receive employment services through DMH's Program of Assertive Community Treatment (PACT), which are not employment programs per se but each PACT team does offer employment services within its mix of community-based client services.

Employment activities are further described in Step 2.

Educational Services

DMH community-based service providers are expected to develop effective working relationships with community organizations, including educational institutions and cultural and linguistic resources, to assist and support people served in accessing educational services. This is of significant priority for Transition Age Youth and is described further in Criterion 1: Child.

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 in providing them with integrated treatment. DMH incorporated 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.

Health and Mental Health Services Medical and Dental Services

DMH is seeking to improve the integration of the health care system in two broad areas. First, DMH aims to improve the integration of behavioral health, medical and specialty services provided directly to people who receive services as DMH clients. Second, DMH serves in its role as the State Mental Health Authority by engaging in a host of planning activities with state partners and other stakeholders to improve health care integration and outcomes of residents of the Commonwealth.

While the majority of health and mental health outpatient services for DMH clients are provided through MassHealth, DMH supports the health and wellness of individuals in a number of ways. The organizing structure for health and wellness is the DMH Healthy Changes Initiative. This project is designed to address the modifiable risk factors which result in chronic illness and early death in individuals with psychiatric disabilities. The DMH Healthy Changes Task Force is comprised of DMH leadership and staff and consumer representatives. It provides leadership, guidance, and coordination of resources and makes recommendations for trainings, which are grounded in evidence-based and other best practices. Each DMH Area is charged with the implementation and oversight of the Healthy Changes Initiative at the Area and facility level. The work of the Task Force informs development of program standards and data collection within DMH inpatient facilities and community-based services.

As noted earlier, DMH is currently revising its community services to align with MassHealth's new ACO health plan model. In so doing, DMH seeks to better coordinate community care for its clients across the life span, and coordinate services with child welfare, transitional assistance, housing, education, day care, long term supports, employment and criminal justice agencies.

Within DMH community-based adult services, contracted providers are required to provide rehabilitative and support services that enhance the physical health and well-being of people served through: 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. DMH's contract management activities emphasize quality care, using measures related to health and wellness as a priority and encourage providers to develop innovative

strategies to engage people served in wellness promotion activities. The DMH Healthy Changes Task Force, at statewide and Area levels, also engages with community providers to encourage and promote innovative health and wellness programming and serves as a vehicle for disseminating best practices and shared learning.

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 assure that they are enrolled for all benefits to which they are entitled, and case managers and provider staff advocate with insurers on questions of coverage.

Massachusetts behavioral health facilities have been addressing nicotine dependence with increasing emphasis over the last 20 years. The DMH Healthy Changes Task Force grew out of initial exploration in the early 2000's about the possibility of state mental hospital facilities going tobacco-free. In 2009, the Secretary of the Executive Office of Health and Human Services (EOHHS) issued a mandate that all EOHHS facilities—which include state mental hospitals and residential treatment programs, public health hospitals, programs for developmental disabilities and EOHHS administrative offices—become tobacco free. This initiative was prepared for by mandatory basic training of all behavioral health facility staff. Certain clinical staff at each of the large facilities was also trained as Tobacco Treatment Specialists in order to provide both group and individual smoking cessation treatment, and CO monitors were purchased for their use. Peer specialists in state mental health facilities have served as champions of wellness issues including physical activity, healthy eating and tobacco cessation.

Community mental health services in Massachusetts are now mostly provided by vendor agencies under contract to the Department of Mental Health. These contracts require reporting of quality measures. Providers have varied in their strategies for promoting tobacco cessation; strategies include smoking cessation classes and peer supports. Several providers with DMH contracts have established impressive wellness initiatives, including ones directed towards smoking cessation. Quit Helplines are likely underutilized, especially by inpatient facilities.

Reducing the Rate of Hospitalization

DMH has continued to work hard to shift its focus to community-based care as the state hospital census in Massachusetts has dropped drastically and the responsibility for acute care inpatient services was transferred from the public to the private sector. In addition to reducing the number of beds in the DMH system, this also has enabled DMH to focus its expertise on providing continuing and rehabilitative care in the community. The expansion of diversionary services and other community supports, and the entrance of behavioral managed care have substantially reduced the rate of hospitalization.

DMH currently operates or contracts for 733 inpatient beds. These are spread among two DMH-operated state psychiatric hospitals, two community mental health centers (CMHCs), two contracted adolescent units housed in a state psychiatric hospital, mental health units in two public health hospitals, and one contracted adult unit in a private hospital. The total inpatient capacity, which includes beds for forensic admissions, includes 671 adult continuing care beds, 32 adult acute admission beds and 30 adolescent beds. Children, adolescents and most adults receive acute inpatient care in private or general hospitals, with the exception of adult admissions to the CMHC acute units and some forensic admissions.

Since 2012, DMH has funded a Peer-Run Respite service in its Western MA service 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. Over time, DMH also expects that Peer-Run Respite Services will be an effective early intervention to prevent hospitalization and dependency on public mental health services through its focus on recovery and wellness values.

DMH Community-Based Services-Adult

Case Management: DMH case management is a service designed to assist persons served to gain access to continuing care and other community services, and to coordinate the provision of those services among various providers. To provide case management, DMH case managers must assess the person's service needs, create a service needs plan, and help to coordinate those services among providers in accordance with the plan.

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. Respite Services provide supports that assist persons to maintain, enter or return to permanent living situations. Respite Services are Site-Based and/or Mobile. Site-Based Respite Services provide temporary supportive services and short-term, community based living arrangements in a distinct location. Mobile Respite Services are mobile services, accessible to persons in variety of community settings such as: their current living situation, inpatient facilities, skilled nursing homes, and homeless shelters.

Clubhouse: The Clubhouse service is a psychosocial rehabilitation service that provides supports through a membership-based community center. Clubhouse Services assists people served to recognize their strengths, develop goals, and enhance the skills people determine are needed to live, work, learn, and participate fully in their communities. Components of Clubhouse Services includes: linkage to community resources, housing supports, employment services, education services, health and wellness services, social and recreational services, transportation services and empowerment and advocacy.

Program of Assertive Community Treatment (PACT): PACT is a multidisciplinary team approach providing acute- and long-term support, community based psychiatric treatment, assertive outreach, and rehabilitation services to persons served. The PACT Team provides assistance that promotes recovery and community integration, ensures person-centered goal setting, and assists persons in gaining hope and a sense of empowerment. The program provides services to persons served who often have co-occurring disorders such as substance abuse, homelessness or involvement with the judicial system. The team is the single point of clinical responsibility and assumes accountability for assisting persons served meet needs and achieve goals for recovery. The majority of services is provided directly by PACT team members in the natural environment of the person, and is available on a 24 hour, 7 day a week basis. Services are comprehensive, highly individualized and are modified as needed, through an ongoing assessment and treatment planning process. Individuals may access PACT as a diversion from

Continuing Care or as a first placement post Continuing Care or Acute Care discharge. As a service key to community placement, PACT is Block Grant funded.

The Recovery Learning Community (RLC): The RLC provides peer-to-peer support to individuals with serious mental illness. It is expected to serve as a "hub" in its respective DMH Area. The RLC Program is a resource and referral center that provides general information on topics of concern to peers. The information focuses on community resources and programs. Services may be offered in a variety of settings; at the RLC Program site, community mental health centers, inpatient hospitals, generic community settings, town hall, fairs, shopping mall, etc. Services include: providing and/or referring to a wide range of peer to peer support services; supporting the providers of peer-to-peer support through training, continuing education, and consultation; and linking together peer-operated services and supports for the purpose of creating a network. This network improves communication, facilitates the delivery of services, coordinates advocacy, and assists in responding to a person's needs, aspirations and goals as they evolve over time. The main goal of every RLC Program is to help persons achieve full community integration. Participation is not an end unto itself, but an additional step toward recovery. The services of a RLC Program are delivered primarily by Peers.

Comprehensive Community-Based Mental Health Services – Child

Available Services Narrative

DMH has an overall goal of promoting recovery and resiliency through partnership. This goal is fostered by the principles of: meaningful youth and family involvement; youth guided and family driven services; dignity and respect; culturally and linguistically competent care; elimination of disparities; use of evidence-based practices; and operational efficiencies. DMH provides services to youth with serious emotional disturbance and mental illness to facilitate and support their successful functioning in their communities and with their families. This is accomplished by providing services that are responsive to the preferences and needs of youth and their families and focused on resiliency and recovery.
DMH directly provides and/or funds a range of direct services for children and adolescents (ages 0 to 18) per year who have serious emotional disturbance. This figure represents annual service enrollment and does not include youth receiving emergency services, youth receiving evaluations through court clinics, or youth served through interagency projects to which DMH contributes funds but for which it is not the program administrator. In addition, this figure does not include youth who receive indirect services through school and community support programs, such as trauma counseling, nor does it include the parents across the Commonwealth who participate in an array of Family Support activities and groups. These latter: services are available to all parents in Massachusetts whose children experience mental health challenges and is not limited to parents of DMH youth clients.

Health and Mental Health Services with Medical and Dental Services

DMH is seeking to improve the integration of the health care system in two broad areas. First, DMH aims to improve the integration of behavioral health, medical and specialty services provided directly to people who receive services as DMH clients. Second, DMH serves in its role as the State Mental Health Authority by engaging in a host of planning activities with state

partners and other stakeholders to improve health care integration and outcomes of residents of the Commonwealth. The majority of dental and medical care services for DMH clients are provided through the state Medicaid authority, MassHealth or a third party plan. Part of the responsibility of case managers and program staff is to work with parents, children and youth to help them get connected and stay connected to appropriate services. Eligibility staff work with DMH applicants to assure that they are enrolled for all benefits to which they are entitled, and case managers and provider staff advocate with insurers on questions of coverage. With the introduction of the Accountable Care Organization model, care coordinators will also play a role in linking children and youth to medical and dental services.

DMH Community-Based Services – Child

Individual and Family Support Services ("Flex"): Flex Services include an array of interventions available to youth and their families in their homes and communities. Particular service interventions are based on the youth and family needs. Services offered may include, but are not limited to, the following: In-home family treatment interventions, individualized youth support, youth support groups, family support groups, therapeutic recreation and campership, respite (both in-home, community-based and facility-based), parent peer support specialists, youth peer support specialists, clinical collateral contacts, and specialized consultations.

Therapeutic Day Services: Therapeutic Day Services are voluntary, structured, therapeutic group modalities for children and adolescents who require interventions beyond what the school, family and traditional outpatient or recreational services can provide. A range of structured services are available from a Community Based Therapeutic Recreation Program and Therapeutic Psycho-educational and Recreation Program, to Therapeutic Milieu Programs and .Intensive Day Services
. All are designed to:

- provide services that enable youth to learn and practice skills related to social interaction, vocational/educational tasks, emotional regulation, and symptom management;
- engage youth in pro-social activities which harness youth's strengths and interests and which may expose them to previously unexplored talents and potential avocations;
- assist youth's transition to and engagement in other professional and non-professional supports and services in the community; and
- occur during: full day, partial day, afterschool, early evening, weekend and/or during school vacation.

All Therapeutic Day Services aim to achieve the following outcomes for the youth they serve:

- Increased use of social skills, coping skills and emotion regulation skills in school, home, and community settings.
- Increased positive social interactions with adults and peers.
- Increased school attendance and participation.
- Increase participation in pro-social activities of interest.
- Increase level of functioning in school, family and community settings.

SAMHSA Block Grant funding is directed to support the provision of these important community-based services for DMH enrolled youth.

DMH Community-Based Services for TAY

YOUForward is a Now Is The Time-Healthy Transitions (NITT-HT) grant focused on two communities in Massachusetts, Haverhill and Lawrence. Funded by SAMHSA, the goals are to: provide services and supports to transition age young adults with mental health concerns who have or are in danger of "falling through the cracks;" increase awareness and reduce stigma around mental health concerns; and in partnership with young adults, state agencies, providers, and the communities, build better policies and systems for transition age young adults. YOUForward offers drop-in centers, young adult peer mentors, high-fidelity Wraparound services (Achieve My Plan [AMP]), Transition to Independence Program (TIP), and Gathering and Inspiring Future Talent (GIFT) training.

DMH has received a new SAMHSA System of Care grant, to start in October, 2017, that will support the development of two new drop-in centers for TAY, one in Springfield, MA and Worcester, MA (the second largest city in the state). Like YOUForward, these sites are intended to be "low barrier" services for TAY, providing a developmentally appropriate setting for TAY with behavioral health needs to explore next steps for themselves, drawing on formal and informal supports and services.

Rehabilitation Services

As DMH is the primary provider/contractor of community-based services, the concepts of rehabilitation and support are at the core of its programs. However, resilience rather than rehabilitation is generally used for children and adolescents as the focus is on getting children on track for age-appropriate development, and acquiring the skills and strategies that will enable them to lead satisfying lives as adults.

Most community-based programs for children and youth promote resilience and supportive functions in a flexible manner to match the goals and needs of the individual client. These include case management, therapeutic day services, supported education and skills training, , individual and family flexible support, including in-home treatment, mentoring and respite care, and a range of residential services, provided in group care, apartment, or home settings.

- For children with severe needs, DMH provides a range of intensive services to meet these needs, including a residential level of care that can be provided in a child's home if clinically appropriate. These include the Caring Together (CT) services, a unique collaboration between DMH and Department of Children and Families (DCF), the Commonwealth's Child Welfare Agency. Caring Together, through joint procurement and contracting processes, established standardized program standards, rate structure, administrative processes, quality oversight, and evaluation for a variety of different service models. Caring Together services include:
- **Continuum:** For youth who meet clinical criteria for out-of-home placement, the Continuum provides intensive and comprehensive community-based services with out-of-home services available as needed and includes on-going support and education to families regardless of where the services are provided. The settings in which the services can be

delivered are group residential treatment programs; therapeutic foster homes; supervised apartments, and the child's own home.

- **Residential School Placements**: For youth who need a fully integrated educational and clinical treatment residential setting. DMH partners with the youth's Local Education Authority (LEA, i.e., the youth's local school district) to support the placement.
- **Group Home**: Congregate care residential settings that provide clinical services and supports to meet the mental health needs of the youth. Youth served in these programs leave grounds for school programming.
- **Short Term Assessment and Rapid Reintegration (**STARR) services provide short term assessment and rapid reunification with the family.
- **Family Partner Service:** This service is **p**rovided to parents and caregivers of youth receiving a Caring Together service by a trained professional who shares the experience of parenting a child/youth with significant mental/behavioral health needs. A Family Partner provides information and education to parents about the mental health system; assists parents in developing skills that help them successfully navigate the system and advocate on behalf of their and their child's needs; assists parents in navigating the system and accessing services and supports; and provides emotional support to the parent/caregiver.

In addition to community based services, DMH also contracts for continuing care inpatient services for adolescents, and for secure intensive residential treatment programs:

- **Statewide Programs:** The most intensive, 24-hour, locked facilities available in the Commonwealth for seriously emotionally disturbed youth. These programs include:
  - **Intensive Residential Treatment Programs (IRTP):** These services are for adolescents who meet the state's definition for commitment under the mental health statute but who do not need hospital level of care. These youth are typically involved with multiple state agencies. IRTPs are locked 24 hour programs for adolescents.
  - **Clinically Intensive Residential Treatment** (CIRT): This is staff-secure residential services with on-site schooling for children 6-12 ("latency age") who present a serious risk of harm to themselves or others.
- **Continuing Care Inpatient Services:** Hospital-based psychiatric care in locked units for children and adolescents who have completed a course of acute inpatient treatment or court-referred youth who require a court-ordered evaluation; and require continuing intensive medical and/or psychiatric stabilization. DMH has one contract for 2 units, total capacity of 30 beds at WRCH.

Juvenile Court Clinics: Funded by DMH in collaboration with the Juvenile Court Department of the Trial Court, juvenile court clinics operate across the state to provide assessments and referrals for children who come before the court, and that thereby promote diversion into treatment.

Each person receiving DMH funded direct services has an Individualized Action Plan (IAP) specifying the range of services and supports that will be provided to the child and or family by DMH service providers, and the outcomes these services are expected to achieve. If a youth is receiving DMH case management services, then s/he will also have an Individual Service Plan (ISP). Developed by the DMH Case Manager, the ISP is individualized, identifying

the client's goals, strengths, and needs, the DMH services and programs that address those needs, as well as the program specific treatment plans prepared by the service providers.

Support Services

Supports to children and their families are a critical element of the community-based services and are an integral part of the services described above. Support services for youth and families are available across the state and include but are not limited to respite services, family partners, youth mentors, therapeutic recreation, and assistance with transportation for families whose children are placed in a hospital or treatment facility at a distance from their home.

DMH funds Family Support Specialists in every DMH Area. Family Support Specialists are parents with lived experience caring for a child with serious emotional disturbance who assist other parents to navigate the system, access entitlements, and develop the skills that allow them to effectively advocate for the services and supports they and their child need. Family Support Specialists facilitate parent support groups that are open to all parents or caregivers of a child with emotional or behavioral needs and serve as an important resource in their communities to increase awareness about children's mental health. This includes providing training and consultation to local schools and/or local school systems regarding behavioral health needs of children, youth, and young adults; and providing information and resource referral to anyone in the community in need of information and/or assistance relating to children's mental health issues. In addition, DMH provides funding to the Parent Professional Advocacy League (PPAL), the statewide organization that supports and advocates on behalf of parents and families of children with behavioral health needs. PPAL, affiliated with the National Federation of Families for Children's Mental Health, works to promote parent participation in policy and program development so that behavioral health services are family-driven and reflect family voice and choice.

Employment Services

The increased national focus on transition age youth and young adults, ages 16-25, has increased the attention given to pre-vocational skill development, supported work and supported education activities. Residential providers and those providing intensive in-home interventions focus on arranging and supporting part-time work opportunities for youth that they can manage while still in school and during the summer. DMH trains Case Managers and Family Support Specialist to understand the requirements of the IDEA and WIOA (Workforce Innovation and Opportunity Act), how to access services for young adults served by DMH from the Massachusetts Rehabilitation Commission (MRC), and how to use the IEP process to promote vocational preparation.

DMH continues to work with the Massachusetts Rehabilitation Commission (MRC), the state's vocational rehabilitation agency, and its staff in supporting employment and higher educational opportunities for young adults served by DMH. The two agencies have (recently?) executed a Memorandum of Understanding (MOU) to create an "Implementation/Steering Committee", including young adult representative, to coordinate this work.

DMH also works closely with the Massachusetts Department of Labor and Workforce Development (DOLWD) and its Commonwealth Corporation (Commcorp) programs. DOLWD sponsors Workforce Investment Boards and oversees Career Centers that offer one-stop shopping for young adults.

In partnership with Commcorp and Employment Options (a DMH-funded Clubhouse), DMH secured a grant award of $162,780 to engage interagency partners in the design of a training curriculum and the allocation of employment positions for transition age youth. The "Gathering & Inspiring Future Talent (GIFT) Training" curriculum is the standardized training for young adults who are interested in exploring opportunities to become Peer Mentors/Peer Support Workers. It also supports young adults who are becoming active in youth advisory groups and other venues that seek to develop and promote the young adult voice. This training is expected to lead to further education, internships, participation in certified peer specialist training and employment.

DMH continues to develop the Transition Age Youth Peer Mentor workforce by increasing the use of TAY Peer Mentors in contracted programs and by sponsoring TAY Peer Mentor training programs. Through the support of a SAMHSA System of Care Grant and Cooperative Agreement, the Success for Transition Age Youth and Young Adults (**STAY**) initiative piloted the use of TAY Peer Mentors as Therapeutic Mentors within 12 MassHealth-funded Therapeutic Mentoring programs. Staff from DMH's Children's Behavioral Health Knowledge Center, MassHealth and the pilot provider agencies have developed a Young Adult Peer Mentor Practice Profile, a highly detailed practice standard for this service. The Practice Profile will be disseminated to all MassHealth-funded Therapeutic Mentoring programs in Massachusetts, facilitating their ability to effectively hire, train and supervise TAY Peer Mentors as Therapeutic Mentors.

Housing Services

Virtually all youth under the age of 18 served by DMH who are not in a residential treatment program live in the home of a family member or foster home, as do most youth who are age 18. DMH focuses on supports to youth and their families or caregivers in order to facilitate that kind of living arrangement, as is normative as well as economically realistic. Most youth, however, aim to eventually live independently. DMH supports this goal in several ways. Adolescent residential providers are required to use a formal curriculum to teach independent living skills, and teaching these skills can also be a focus of intervention for those receiving Community-Based Flexible Supports (CBFS). DMH currently funds a few supported housing slots specifically for older youth. As an agency, DMH has sponsored aggressive efforts to increase supported housing opportunities for the people it serves. DMH Central Office housing staff works with Area Housing Coordinators, DMH providers and state and local housing agencies to increase housing supply.

Central Office (CO) TAY policy staff are working with other CO staff developing standards for a re-procurement of the current Community-Based Flexible Support (CBFS) services program. Together, they are developing a plan for supportive housing for TAY within CBFS.

CO TAY staff represent DMH in an Executive Office of Health and Human Services (EOHHS) Secretariat-wide Unaccompanied Homeless Youth Commission to study and make recommendations for services for unaccompanied homeless youth age 24 and younger.

Members of the Youth Development Committee (YDC) have joined the State Mental Health Planning Council's Housing Subcommittee to represent and ensure the housing needs and concerns of young adults are addressed.

Educational Services

Children receiving community-based mental health services, including those living in residential programs, receive their educational services through their local educational authority, and are enrolled in public school programs or special education day programs either within or outside the school district. Most DMH clients receive special education services, while some receive Section 504 accommodations to address their mental health needs. In accordance with state law, the state Department of Elementary and Secondary Education (DESE), through its division of Special Education Services in Institutional Settings (SEIS) is responsible for delivery of educational services in DMH's inpatient and intensive residential programs, either directly or through provider contracts. DMH program staff work closely with the SEIS teachers assigned to them so that their work and approach with the child is complementary.

Each DMH Area funds Family Support Specialists through community and school support contracts with providers to offer training and consultation to local schools and/or local school systems regarding behavioral health needs of children, youth, and young adults. The focus of training is to help school staff understand the needs of children with serious emotional disturbance and other behavioral health needs, develop sensitive and effective classroom responses to children with SED, identify children at suicidal risk and implement suicide prevention strategies, respond to individual or community trauma, and facilitate referrals to mental health services.

Services Provided by Local School Systems under the Individuals with Disabilities Education Act (IDEA)

Local systems provide counseling within the school, usually contracting with local DMH providers for this and child specific consultation. Schools provide a variety of interventions, including but not limited to: aides; resource rooms; substantially separate classrooms, within district or out of district, or operated by educational collaboratives; home tutoring; or placement in residential school. Depending on circumstances, DMH may pay for the residential component of such a placement while the school system pays for the education only component. If a child is enrolled in a DMH after-school treatment program, schools may provide transportation to the program.

DMH provides training for case managers on accessing services under Individuals with Disabilities Education Act and under Section 504. PAL and Family Support Specialist provide similar trainings to parents in the community. Parents receive assistance with individual educational issues. Case managers attend IEP meetings at school, or provide information to the team, as requested by the parent, and with parental approval school staff participates in Individual Service Planning meetings. An attempt is made to have the IEP and ISP meetings held at the same time and place, to assure that the plans are complementary. As noted above under Educational Services, children in hospitals or intensive residential treatment programs have their special education services delivered through the Department of Elementary and Secondary Education in accordance with the local IEP.

The state director of special education participates on almost all interagency planning activities related to children's mental health, including the CBHI Advisory Committee and the Department of Elementary and Secondary Education (DESE) has been a payer in interagency blended funding initiatives.

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 in providing them with integrated treatment. DMH incorporated 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. Training requirements for managing individuals with co-occurring disorders are included in the Department's Psychiatry Residency and Psychology Internship Training Program.

To increase access and the quality of services for youth and young adults, 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 that maximize federal and state dollars.

The Department of Public Health/Bureau of Substance Abuse Services (BSAS) and DMH share the goal of finding solutions to those issues inherent in mental health and substance abusing clients who are serviced in both systems and to identify the emerging needs and resources necessary for a successful course of treatment. This past year, IWG has developed a strategic plan with input from all agencies; improved its continuum of substance abuse services from outpatient to residential; encouraged continued support from the interagency community insuring the referral of appropriate youth for services; reviewed the data and outcomes from residential and stabilization services developed by BSAS and identified additional needs, resources and collaborative projects.

The Children's Behavioral Health Knowledge Center funded implementation of the evidence-based Screening, Brief Intervention and Referral to Treatment (SBIRT) model in three outpatient mental health clinics serving children and youth in southeastern Massachusetts in State Fiscal Year 2017. Use of SBIRT by clinicians dramatically increased identification and treatment of SUD among youth served by the clinic.

Case Management Services

DMH remains committed to providing case management services to assist youth and their families access services available across the system of case that best meet their needs, and partner with youth and families in service planning and coordination, and assist them with securing entitlements. DMH Child, Youth, and Family Case Managers currently serve approximately 650 children and youth annually.

Reducing the Rate of Hospitalization

DMH has continued to work hard to shift its focus to community-based care. 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 continuing and rehabilitative care in the community.

The emphasis on prevention of seclusion and restraint has substantially reduced the need for continued care hospitalization, as high restraint use was a key indicator of the need for ongoing hospitalization. In 2007, DMH closed one of its three continuing care adolescent units, leaving a capacity of two units with 30 beds, and redeployed the funds into diversionary services and other community supports.

Criterion 4: Targeted services to rural, homeless and older adult populations

Outreach to Homeless – Adult and Child

DMH has a long history of addressing homelessness through outreach and engagement as well as housing programs. DMH Central Office, in collaboration with the five Areas and specifically the housing staff assigned to the Areas, work to oversee homeless activity including Continuums of Care, of which there are 17, covering the state funding about $65M in grants with a state match approaching $20M.

In addition there is the DMH/SAMHSA funded Projects for Assistance in Transition from Homelessness (PATH) program that outreaches to some 2,100 individuals living on the streets or in shelters. This statewide outreach is supported with $1.558 million annual federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and $660,600 in state DMH funds. PATH provides some 30 outreach staff comprised of clinical social workers and homeless practitioners who regularly visit more than 50 adult homeless shelters across the state serving persons with mental illness and co-occurring psychiatric and substance abuse disorders rendering assistance including direct care, housing search, benefits, advocacy and referrals to health care, substance abuse and mental health services. Adults and older adolescents determined to have a serious and persistent mental illness are referred to DMH for service authorization.

DMH also supports four transitional shelter residences with a capacity of 140 beds serving chronic homeless individuals with severe mental illness and co-occurring disorders in Boston. 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 mental health center (CMHC) and has clinically trained staff. DMH also sponsors in Boston the Mobile Homeless Outreach Team (HOT), comprised of 12 staff, focused on street outreach directed at adolescents and adults in need of mental health services and connects individuals with a range of services in an effort to bring them off the streets. The Team also provides psychiatric nurses to non-DMH Boston shelters to treat health problems and manage medication adherence.

In addition, DMH contributes funding 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.

Of particular note is a long-standing permanent housing program for homeless co-funded by DMH and the Department of Public Health (DPH) that operates statewide, referred to as the Aggressive Treatment and Relapse Prevention program (ATARP). ATARP provides a “housing first” approach with necessary support services to a minimum of 60 clients (55 single adults and 5 families) diagnosed with co-occurring psychiatric and substance abuse disorders.

DMH is an active partner is the Commonwealth's Tenancy Prevention 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. It has proven over the years to be an extremely successful program either "saving" tenancies or providing for a "soft" landing in a more supported environment.

DMH also participates on the McKinney Vento Homeless Assistance Act Steering Committee and as a member of this committee reviews the allocation of federal funds, makes recommendations for Homeless Liaisons and programming allocated throughout Massachusetts school systems and reviews reports on numbers of homeless children in Massachusetts preschool, elementary and high schools. Since SFY15, DMH has collaborated with the Department of Housing and Community Development (DHCD) to increase its mental health support and coordination for families assigned by DHCD to motels for shelter. Massachusetts has a mandate for shelter for families that meet the eligibility criteria and when the family shelter network capacity has been reached, DHCD purchases rooms in motels to temporarily shelter eligible families until a resource opens. DMH recognized that this sheltering arrangement may be very challenging for any member of the family who may be experiencing a mental health condition and worked with its PATH provider to extend its reach into several high volume motels serving homeless families.

DMH's Transition Age Youth Initiative 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.

Older Adults

DMH services are flexibly designed to meet the needs of DMH clients throughout the lifespan. DMH requires providers to deliver services that are age and developmentally appropriate, including services for elders. DMH strengthened its service standards in Community Based Flexible Supports (CBFS) to address health and wellness issues, including the early mortality of people with psychiatric disabilities. DMH community-based services, including CBFS, are described in Criterion I.

Over the last seven years, DMH and the Executive Office of Elder Affairs (EOEA), the Massachusetts' State Unit on Aging, have taken on a number of initiatives to improve services to older adults. The Department of Public Health (DPH) 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.

The Elder Collaborative is a Planning Council sub-committee made up of senior leaders from DMH, the Executive Office of Elder Affairs (EOEA), the Department of Public Health (DPH), representatives from local provider coalitions across the state, and statewide aging and mental health trade associations. The Collaborative has engaged in numerous projects over the last several years which include: publishing a guide of a range of community-based elder services; improving access to emergency services through provider trainings; and understanding the strengths and weaknesses of the nursing home screening system in an effort to divert admissions for those with a history of mental health; and promoting evidence-based practices. The Collaborative also worked on the revision of the Pre-Admission Screening and Resident

Review (PASRR) Level 2 tool to be more useable for diversion and discharge planning. These revisions were followed by trainings of almost 1,000 professionals from nursing homes, hospitals and local area agencies on aging.

Rural Area Services – Adult and Child

DMH does not have a separate division or special policies for adults, children or adolescents who reside in less populated areas of the state. 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 center of economic activity for the area. None of the Sites has a population density below 100 people per square mile.

The primary goal of DMH's local planning process is to address the issue of access to services for all DMH clients. 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. Geographic distribution of the population is not an issue. Poverty of clients and lack of insurance are more significant variables since the lack of financial resources to pay for transportation interferes with the client's physical ability to get to where services are located and the lack of insurance limits availability. At the Area level, many clients have identified this as a challenge. In Child, Youth, and Family service contracts, for example, support for transportation to assist family members in participating in their child's services is one of the flexible supports that can be provided.

Service System's Strengths and Needs

Massachusetts demonstrates a number of strengths which, woven together, represent the promise of a service delivery system organized around principles of recovery and resiliency, and consumer and family-directed care. At the heart of these strengths is a commitment to fostering partnerships with other state agencies, advocates, consumers, family members and other key stakeholders.

Peer and Family Member Involvement and Workforce

Strengths: Massachusetts benefits from a strong network of consumers 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 also building a strong workforce of peers and family members. The State Mental Health Planning Council has adopted the TransCom's Workforce Development Guidelines. Additionally, Massachusetts has an adult peer specialist training and certification program and is developing peer and family curricula specific to family support, transition age youth and the Deaf and hard of Hearing. Massachusetts has offered the Certified Older Adult Peer Specialist training in cooperation with the Executive Office of Elder Affairs, and has also jointly sponsored Buried in Treasures facilitator training, a peer-led program to reduce Hoarding, For the first time, we are training peers to work as Forensic Peer Specialists. The Office of Recovery and Empowerment is working on a project for Parent Peer Specialists, to support people with lived experience who are parents. Peer and family support positions are now required in multiple services, including our Homeless Outreach teams.

DMH funds "Gathering & Inspiring Future Talent (GIFT) Training" throughout the year. GIFT is the standardized training for young adults who are interested in exploring opportunities to become Peer Mentors/Peer Support Workers. It also supports young adults who are becoming active in youth advisory groups and other venues that seek to develop and promote the young adult voice. This training is expected to lead to further education, internships, participation in certified peer specialist training and employment.

DMH continues to develop the Transition Age Youth Peer Mentor workforce by increasing the use of TAY Peer Mentors in contracted programs and by sponsoring TAY Peer Mentor training programs. Through the support of a SAMHSA System of Care Grant and Cooperative Agreement, the Success for Transition Age Youth and Young Adults (***STAY***) initiative piloted the use of TAY Peer Mentors as Therapeutic Mentors within 12 MassHealth-funded Therapeutic Mentoring programs. Staff from DMH's Children's Behavioral Health Knowledge Center, MassHealth and the pilot provider agencies have developed a Young Adult Peer Mentor Practice Profile, a highly detailed practice standard for this service. The Practice Profile will be disseminated to all MassHealth-funded Therapeutic Mentoring programs in Massachusetts, facilitating their ability to effectively hire, train and supervise TAY Peer Mentors as Therapeutic Mentors.

Needs: There continues to be a need to recruit and train additional peers and family members to assume paid roles in 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 workplace, including disclosure of mental health conditions and recovery experiences.

Service System Planning for Transition Age Youth (TAY)

Strengths: The service system for Transition Age Youth has been developed and supported by both the child and the adult service systems with diverse programming being delivered through each sector. Guided by Youth Councils throughout the Areas, services are being designed that reflect the needs of young adults and support their progress toward positive outcomes and successful accomplishments. Innovative practices in housing, employment, education and treatment are working to better reflect the TAY population and engage them in their transition to adulthood. The Peer Mentoring Initiative has been strongly embraced by the provider community and resulted in a diverse and accomplished workforce that is able to articulate the needs of the population and offer suggestion and recommendations in the redesign of services, including DMH's new inpatient facility, Community Based Flexible Supports, Clubhouse, Individual and Family Flexible Supports, the DMH/DCF Caring Together joint residential procurement and the Children's Behavioral Health Initiative's Community Service Agency (CSA) services. Youth voice is now part of all planning and program development with priority being given to participatory research, education and training for underserved and stigmatized young adult populations.

Needs: The successful transition of young adults from the child system to the adult system and into the community continues to be a challenge. Since implementation of the Children's Behavioral Health Initiative (CBHI) behavioral health services available to adolescent MassHealth members under 21 in 2008, the disengagement of young adults from treatment has been highlighted. Inaugurated with 2012 SAMHSA funding, each DMH Area now has active

TAY teams, including a workgroup focused specifically on substance abuse service guidelines. . Last year a newly formed DMH TAY work group refocused the needs and approaches to serving this population by identifying existing best practices and exploring needed enhancements. The group is currently focused on the proposed regulation change that will raise the age of eligibility for CYF Service Authorization to 22 and allow youth to receive services from CYF, Adult Services or both, depending on their clinical and developmental needs.

Interagency Collaboration

Strengths: Interagency collaborations currently focus on persons living with homelessness, criminal and juvenile justice involvement, the needs of children and families, supporting positive educational outcomes and employment, and health care reform activities. Well established workgroups and councils are described throughout the State Plan.

Needs: Family members and consumers continue to identify the need for agencies to collaborate at both the system and program level to ensure that services are offered in a seamless and coordinated manner. A heightened emphasis on behavioral health integration with primary care and other social services and health care reform will require additional collaboration. There is also a need to implement mechanisms to allow data sharing between agencies to improve service delivery and system efficiencies. Problems in service access and coordination for children and adolescents are exacerbated by the differences in agency mandates, expected outcomes and staff expertise that make it challenging to deliver integrated services according to a single plan of care. Funding mechanisms present another challenge as reimbursement is tied to services specific to the identified client, as opposed to a family-focused intervention.

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 and supported employment. DMH has partnered with providers, consumers, family members, academic institutions and other experts to develop and implement these initiatives. During the 2016 Certification of Community Behavioral Health Clinics Planning Grant, DMH worked with members of the Association for Behavioral Health to identify EBPs considered essential to recovery. EBPs identified are Motivational Interviewing (MI); Cognitive Behavioral Therapy (combined with medication, where appropriate); Wellness Recovery Action Plan; Medication Assisted Treatment; Screening, Brief Intervention, and Referral to Treatment; harm reduction; and an array of psychosocial rehabilitation models, including Supported Employment and Permanent Supportive Housing.

Needs: While initial training and ongoing support and consultation require significant resources to achieve fidelity and sustainability, funding is limited. DMH continues to rely on grants to support these activities.

Community Services Redesign

Strengths: DMH engaged multiple partners over the course of several years to identify the strengths and weaknesses of the community service system. During SFY 17, MassHealth renegotiated a five year Section 1115 Waiver to implement an Accountable Care Organization (ACO) model with Delivery System Reform Incentive Payments (DSRIP) funding Behavioral

Health Community Partners (BHCPs). The BHCP role focuses on care coordination for MassHealth members enrolled in an ACO. DMH has worked closely with MassHealth to redesign its Community Based Flexible Supports (CBFS) Services to a "New Model" which will align, but not supplant funded services for MassHealth member DMH clients. Service details are being discussed currently.

The Division of DMH Child, Youth and Family Services' Therapeutic Day Services were just re-procured with a July 1, 2017 implementation of new service models and more robust performance management and outcome tracking and reporting capacity. Development is also underway to redesign and re-procure Individual and Family Flexible Supports, with a similar goal of implementing more robust performance management and outcome tracking and reporting capacity, and aligning the two services under a common performance management and outcome reporting structure. These changes are designed to enhance the system to be more flexible, recovery- and resiliency-oriented and family- and consumer- directed and to result in positive outcomes for consumers, youth and families.

Needs: As this system change continues to occur, 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 the passage of health care reform legislation in 2006. Approximately 98% of Massachusetts residents are insured. DMH is working with state partners, including the Bureau of Substance Abuse 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 Youth and Family 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 primary, and specialty care funded through each entity. DMH is actively engaged with MassHealth, BSAS and EOHHS which are described in detail in other sections of the Plan.

Culturally Competent Services

Recognizing that mental health is an essential part of healthcare, the Department of Mental Health (DMH) establishes standards to ensure effective and culturally competent care to promote recovery. The DMH Office of Multicultural Affairs (OMCA) is committed to reducing mental health disparities among diverse racial, ethnic, and linguistic populations in Massachusetts. OMCA ensures meaningful access to DMH services, programs, and activities for persons who have limited English proficiency. OMCA coordinates the scheduling of in-person interpreters

for clients in DMH-operated facilities/mental health units, persons seeking DMH services, and the family members who are involved in their care. Likewise, American Sign Language (ASL) interpreters and Communication Access Realtime Translation (CART) providers are utilized to help individuals who are deaf and hard of hearing. OMCA supports the provision of ASL interpreter and CART services by explaining to DMH staff how to request these services for their clients. Written materials are available in the client's preferred language. Examples of translated written materials include the *Right to An Interpreter* human rights poster, complaint forms, and service authorization application forms. Translations are done for individual client-specific matters on an as needed basis.

OMCA staffs the Multicultural Advisory Committee (MAC), noted above as a subcommittee of the State Mental Health Planning Council. MAC advises the Commissioner of DMH on the Department's commitment to equitable and quality mental health care for culturally and linguistically diverse communities. MAC members are mental health providers, community-based social services providers, representatives of city and state agencies, clients and family members, peer providers, people with lived experience of mental illness, educators, researchers, and other stakeholders who understand and advocate on behalf of diverse communities. MAC meetings occur every other month and serve as forums for MAC members to learn about mental health-related events so they can share this information with their communities.

OMCA coordinated the translation of the annual DMH consumer satisfaction surveys in order to increase participation by consumers and their family members whose primary language is not English. The satisfaction survey sent to adult clients enrolled in Community Based Flexible Support was translated into 6 languages. The family consumer satisfaction survey sent to parents/guardians of children enrolled in DMH services was translated into Spanish.

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.

Sample of culturally competent services:

- DMH LGBTQ workgroup: trainings for staff on providing quality care to people who are LGBTQ, developing departmental policy
- Preference for bilingual and multilingual candidates to fill job openings in order to better serve DMH's diverse client population
- Education and outreach to underserved communities by DMH areas (area offices, site offices, diversity committees) and Central Office
- YouForward grant: Drop-in centers for young adults located in cities with large Latino populations
- Bilingual/bicultural case managers, including case managers for deaf and hard of hearing clients
- Statewide interpreter and translation services program that provides language access for limited English proficient clients

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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 placed on ensuring that health care disparities among cultural and linguistic minorities are reduced and eliminated.

Planning Steps

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

Narrative Question:

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

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

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

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

Through the Healthy People Initiative[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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

Footnotes:

Step 2: Unmet Needs and Service Gaps

As defined by regulation and discussed in Step One, 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 continues to routinely engage multiple stakeholders in evaluating the strengths and needs of the current mental health system, including opportunities to respond to Requests for Information (RFIs) related to the redesign and re-procurements of adult and child community and child residential services; consumer and family involvement in procurement, policy development and quality improvement processes; work groups and task forces addressing issues such as behavioral health integration; and ongoing dialogue via established advisory and steering committees and workgroups. These groups, with diverse membership of consumers, family members, providers, advocates, state agency staff and others, are often the place where needs are first given voice as well as a place where information is exchanged, solutions are identified and successes are celebrated.

For DMH child, adolescent and family services, service planning is closely coordinated 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 SED are represented and active participants in these efforts.

Consistent through much of this feedback is the need for services that are individualized, flexible, person and family driven, and recovery and resiliency oriented. A related theme is also the need for integration with other behavioral, medical, and human services, as well as community resources and supports. The need for flexible and integrated services that focus on the strengths of the person and their family and result in positive outcomes is the common thread through the unmet needs and critical gaps identified below.

<u>Unmet Needs and Critical Gaps in the DMH Community-Based System for Adults (Population: Adults with serious mental illness)</u>

DMH has maintained its commitment to engage stakeholders in the service redesign process. Specifically, DMH has engaged stakeholders directly in designing the "New Model" to replace Community Based Flexible Services and to align with the BHCPs.

1. **Greater emphasis on services that directly impact on positive outcomes.**

As DMH continues to shift its services toward recovery-orientation, stakeholders, especially people with lived experience, have emphasized the need to provide services that result in positive outcomes for the people served, notably in health and wellness.

The DMH performance and contract management process provides DMH with the mechanisms to monitor and improve consumer outcomes. Current data, as presented below, highlights the need to focus on outcomes.

Health and Wellness

Data from Massachusetts and other states over the last decade show that those with psychiatric disabilities die from treatable medical illnesses at rates that are significantly higher than those in the general population, dying up to 25 years earlier from cardiovascular disease, respiratory illness, and lung cancer. (National Association of State Mental Health Program Directors: October 2006). Additional noteworthy data regarding individuals with serious mental illness include:

- 75% are tobacco-dependent compared to about 22% of the general population;
- 70% have a chronic health problem, most prevalent is pulmonary disease;
- 42% have a chronic health problem severe enough to limit functioning;
- Individuals with depression or bipolar disorder are twice as likely to be obese as the general population; with schizophrenia the likelihood is three times greater;
- 34% have hypertension; and
- 13% of schizophrenic adults in their 50s have also been diagnosed as diabetic as compared to 8% of 50 year olds in the general population.

DMH began collecting health and wellness data from CBFS providers in January 2011. CBFS providers report person-level data on several measures related to smoking cessation, physical activity and diet/nutrition, including the percentage of people with a current need in each of these areas, the percentage of people who "desire change now" (as reflected in the Individual Action Plan or IAP); and the percentage of people at each stage of change. In the first quarter of SFY17, the data include:

- 24% of people identify diet and nutrition as a current need; 62% of these people "desire change now"; and 36% are in pre-contemplative or contemplative stages of change.
- 18% of people are not engaging in any physical activity during the course of a week; 62% of people identify their level of physical activity as light; and 19% identify physical activity as a current need.
- 20% of people identified smoking cessation as a current need; 25% of these people "desire change now"; and 70% are in pre-contemplative or contemplative stages of change.

The organizing structure for health and wellness is the DMH Healthy Changes Initiative. This project is designed to address the modifiable risk factors which result in chronic illness and early death in individuals with psychiatric disabilities. The DMH Healthy Changes Task Force is comprised of DMH leadership and staff and consumer representatives. It provides leadership, guidance, and coordination of resources and makes recommendations for trainings, which are grounded in evidence-based and other best practices. Each DMH Area is charged with the implementation and oversight of the Healthy Changes Initiative at the Area and facility level. The work of the Task Force informs development of program standards and data collection within DMH inpatient facilities and community-based services.

The Healthy Changes Task Force has identified several needs which they are currently addressing. These include developing a system for collecting and managing population-based health status data for the DMH client population and to establish a process for integrating and coordinating health and wellness initiatives in the inpatient facilities. Other goals include building on the past DMH investment in peer specialist training by providing coordination and support for peer specialists to run Whole Health Action Management (WHAM) groups to the widest possible range of settings. DMH is working in collaboration with DPH and the Bureau of Substance Abuse Services in developing health-promoting interventions for DMH clients that will provide the linkages in tobacco, chronic disease prevention and control, and wellness for patients who have both behavioral diagnoses and chronic health diagnoses.

Service System's Strengths and Needs

Massachusetts demonstrates a number of strengths which, woven together, represent the promise of a service delivery system organized around principles of recovery oriented, consumer and family-directed care. At the heart of these strengths is a commitment to fostering partnerships with other state agencies, advocates, consumers, family members and other key stakeholders.

Peer and Family Member Involvement and Workforce

Strengths: Massachusetts benefits from a strong network of consumers 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 also building a strong workforce of peers and family members. The State Mental Health Planning Council has adopted the TransCom's Workforce Development Guidelines. Additionally, Massachusetts has an adult peer specialist training and certification program and is developing peer and family curricula specific to family support, transition age youth and the Deaf and hard of Hearing. Peer and family support positions are now required in multiple services.

Needs: There continues to be a need to recruit and train additional peers and family members to assume paid roles in 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 workplace, including disclosure of mental health conditions and recovery experiences.

Service System Planning for Transition Age Youth (TAY)

Strengths: The service system for Transition Age Youth has been developed and supported by both the child and the adult service systems with diverse programming being delivered through each sector. Guided by Youth Councils throughout the Areas, services are being designed that reflect the needs of young adults and support their progress toward positive outcomes and successful accomplishments. Innovative practices in housing, employment, education and treatment are working to better reflect the TAY population and engage them in their transition to adulthood. The Peer Mentoring Initiative has been strongly embraced by the provider community and resulted in a diverse and accomplished workforce that is able to articulate the needs of the population and offer suggestion and recommendations in the redesign of services, including DMH's new inpatient facility, Community Based Flexible Supports, Clubhouse, Individual and Family Flexible Supports, the DMH/DCF Caring Together joint

residential procurement and the Children's Behavioral Health Initiative's Community Service Agency (CSA) services. Youth voice is now part of all planning and program development with priority being given to participatory research, education and training for underserved and stigmatized young adult populations.

Needs: The successful transition of young adults from the child system to the adult system and into the community continues to be a challenge. Since implementation of the Children's Behavioral Health Initiative (CBHI) behavioral health services available to adolescent MassHealth members under 21 in 2008, the disengagement of young adults from treatment has been highlighted. Inaugurated with 2012 SAMHSA funding, each DMH Area now has active TAY teams, including a workgroup focused specifically on substance abuse service guidelines.

Interagency Collaboration

Strengths: Interagency collaborations currently focus on persons living with homelessness, criminal and juvenile justice involvement, the needs of children and families, supporting positive educational outcomes and employment, and health care reform activities. Well established workgroups and councils are described throughout the State Plan.

Needs: Family members and consumers continue to identify the need for agencies to collaborate at both the system and program level to ensure that services are offered in a seamless and coordinated manner. A heightened emphasis on behavioral health integration with primary care and other social services and health care reform will require additional collaboration. There is also a need to implement mechanisms to allow data sharing between agencies to improve service delivery and system efficiencies. Problems in service access and coordination for children and adolescents are exacerbated by the differences in agency mandates, expected outcomes and staff expertise that make it challenging to deliver integrated services according to a single plan of care. These are key issues for the Children's Behavioral Health Initiative. Funding mechanisms present another challenge as reimbursement is tied to services specific to the identified client, as opposed to a family-focused intervention.

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 and supported employment. DMH has partnered with providers, consumers, family members, academic institutions and other experts to develop and implement these initiatives. During the 2016 Certification of Community Behavioral Health Clinics Planning Grant, DMH worked with members of the Association for Behavioral Health to identify EBPs considered essential to recovery. EBPs identified are Motivational Interviewing (MI); Cognitive Behavioral Therapy (combined with medication, where appropriate); Wellness Recovery Action Plan; Medication Assisted Treatment; Screening, Brief Intervention, and Referral to Treatment; harm reduction; and an array of psychosocial rehabilitation models, including Supported Employment and Permanent Supportive Housing.

Needs: While initial training and ongoing support and consultation require significant resources to achieve fidelity and sustainability, funding is limited. DMH continues to rely on grants to support these activities.

Community Services Redesign

Strengths: DMH engaged multiple partners over the course of several years to identify the strengths and weaknesses of the community service system. During SFY 17, MassHealth

renegotiated a five year Section 1115 Waiver to implement an Accountable Care Organization (ACO) model with Delivery System Reform Incentive Payments (DSRIP) funding Behavioral Health Community Partners (BHCPs). The BHCP role focuses on care coordination for MassHealth members enrolled in an ACO. DMH has worked closely with MassHealth to redesign its Community Based Flexible Supports (CBFS) Services to a "New Model" which will align, but not supplant funded services for MassHealth member DMH clients. Service details are being discussed currently.

Behavioral Health Integration

Strengths: DMH is a leader in health care reform with the passage of health care reform legislation in 2006. Approximately 98% of Massachusetts residents are insured. DMH is working with state partners, including the Bureau of Substance Abuse 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 primary, and specialty care funded through each entity. DMH is actively engaged with MassHealth, BSAS and EOHHS which are described in detail in other sections of the Plan.

Culturally Competent 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 Multicultural Affairs recently completed a review of interpreters in its 5 Areas, and is working to use technology to effectively and efficiently increase access and provide more culturally competent services.

DMH has placed a significant focus on planning and monitoring efforts for underserved populations. DMH's Office of Multicultural Affairs, DMH's Statewide Cultural Competence Action Team and the Multicultural Advisory Committee continue their focus on the goals outlined in the multi-year Cultural Competence Action Plans. .

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 placed on ensuring that health care disparities among cultural and linguistic minorities are reduced and eliminated.

2. Addressing the needs of specific populations

The redesign of adult community-based services is 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 and gender differences, 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 and responsive to cultural, ethnic, linguistic, sexual orientation, gender differences, parental status, and other individual needs of the clients.
- Services are fully accessible regardless of physical disability, auditory or visual impairment.

However, 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 that there are unique barriers for some population in accessing behavioral health care, including DMH services.

Cultural and Linguistic Minorities

DMH has standardized the collection of clients' race, ethnicity, and preferred language information in the agency's Mental Health Information System (MHIS) basing the manner of collection on the Institute of Medicine's recommendations and Office of Management and Budget guidelines. DMH's Office of Multicultural Affairs (OMCA) 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. OMCA has worked closely with DMH's two Center 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. Further, DMH currently administers its adult client satisfaction survey in English and 6 additional languages: Spanish, Portuguese, Cape Verdean, Haitian Creole, Chinese, Vietnamese and Khmer.

Reviewing DMH data on the race and ethnicity of adults authorized to receive DMH services as compared Massachusetts census data reveal that that 65% of the adults (ages 19-64) served by DMH were White; 14% were Black/African American; 2% were Asian; 11% were Hispanic and 17% were non-Hispanic some other race. When compared to Massachusetts census, it is notable that while Blacks/African Americans (ages 19-64) represent 8.4% of the Massachusetts population, they represent 14% of the DMH population in this age group. Conversely, non-Hispanic, Whites (ages 19-64) represent 73.5% of the Massachusetts population, but 65% of the people served by DMH in this age group.

Elders

The Elder Mental Health Planning Collaborative, a subcommittee of the Planning Council, has been a strong advocate for the needs behavioral health needs of elders. The

subcommittee gave a presentation to the Planning with compelling data regarding the prevalence and needs of elders with behavioral health disorders, including:

- The majority of growth in the MA population in the next 20 years will be in 60+ age groups;
- Over half of older adults receive mental health care from primary care.
- In 2016, 1,829 persons age 65 or older received a DMH service, increased from 1,383 in 2009.

The subcommittee has been working with DMH, the Executive Office of Elder Affairs (EOEA), and other partners to advocate for: better data collection on the mental health needs of elders; better planning for hospital and nursing home discharges; and renewed commitment from state and local leadership to the needs of elders. The Collaborative has also been studying evidence-based practices and considering their potential application within Massachusetts. There are several key models (IMPACT, PEARLS, Healthy IDEAS, In-SHAPE) which appear to have great promise. The Collaborative supports the development of new initiatives to replicate such models. The Collaborative has also identified opportunities to address the needs of elders in models for integrating physical and behavioral healthcare, including the Senior Care Options (SCO) model as it combines Medicare and Medicaid funding in a way that encourages innovation and effective service delivery that can reduce negative health outcomes and manage costs.

LGBTQ Populations (Lesbian, Gay, Bisexual, Transgender, & Questioning)

DMH does not systematically collect data on sexual orientation (SO). Nor does it collect data on gender identify (GI) that align with national best practice; it only collects gender as male or female. The Department has convened an LGBTQ Committee to improve services to lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) populations. The Committee has worked with a consultant to implement a number of LGBTQ initiatives, specifically: a climate assessment involving key informant interviews with DMH Staff of varied positions and locales and focus groups with people receiving services; identification of best practices and other resources; development of a survey tool for all DMH staff to gather baseline information needed for a strategy for targeted training; and a presentation to DMH Senior Management/Executive Team. DMH is also investigating the feasibility of modifying its data collection systems to include SO/GI at the time of assessment for service authorization. This will allow the Department to better understand the needs of the LGBTQ population and address any revealed disparities in outcomes. Additionally, in an effort to begin capturing information on the needs of the DMH LGBTQ population, a question was added to the DMH annual consumer satisfaction survey. DMH recently completed revision of its LGBTQ policy and will issue the revisions in Fall, 2017.

Deaf/Hard of Hearing (HOH) Population

DMH serves approximately 90 people who are deaf and use American Sign Language and approximately 150 people who are hard of hearing who may use ASL but also use English as a primary language. It is difficult to estimate how many people should be served but typically, deaf people are under-represented. The high frequency of trauma would predict that people who are deaf are at greater risk for mental health and substance abuse problems. Often people who are Deaf are misdiagnosed and so not referred for services. Or, people who are deaf are not well

served by the acute-care system due to cultural and linguistic barriers and so drop out of that system and never make it to continuing care services. There is also a lack of access to information to understand mental illness and fear and stigma around the issue in the Deaf community.
The DMH Worcester Recovery Center and Hospital provides Deaf services within one its units. Training efforts and other accommodations are being pursued to address the challenges of providing linguistic and cultural access and treatment within this setting.
The quality and dependability of interpreters is varied. Workforce development is a major obstacle, including the recruitment and training of Deaf staff to be skilled staff in the delivery of behavioral health services. Staff training for Deaf staff is usually done through interpreters and not on the same level as hearing staff and the same applies for supervision. During the past year, DMH conducted DHH peer specialist training.

Veterans

In 2008, the Executive Office of Health and Human Services (EOHHS) was the recipient of an award to participate in the recent Returning Veteran's Policy Academy sponsored by SAMHSA and the Departments of Defense and Veteran's Affairs. Since 2008 and consistent with the goals of the Academy, Massachusetts created a vision statement and focused its planning efforts on improving veteran-related data; outreach to veterans and their families; access to and utilization of care; and employment access and retention. Key informants for the 2016 CCBHC planning grant identified high rates of post-traumatic stress disorder and co-occurring mental health and substance use disorders as problems for veterans. In Massachusetts, towns on the Cape and in the West and Southeast have veterans' populations exceeding 10% of the total population.
Left untreated these disorders may result in behaviors leading to involvement with the criminal justice system. To address veterans involved in the criminal justice system, DMH oversaw a SAMHSA funded grant (Jail Diversion and Trauma Recovery: Priority to Veterans) designed to provide peer support and structured case management services to veterans with co-occurring substance use and mental health disorders and trauma histories who present before the district court. The services augment usual treatment and provide an opportunity for diversion of the veterans from incarceration. This activity created a Memorandum of Agreement among over 18 agencies, stakeholder groups and provider partners.

People with Court Involvement and Forensic Histories

Nearly three in ten individuals in a cohort of mental health services recipients in Massachusetts experienced at least one arrest over a 10-year period and many experienced several (Fisher et al. 2007). Risks of arrest for misdemeanors and non-violent crimes were most significant, though many individuals also had histories of more serious offenses (Fisher et al. 2011). The risk factors for incarceration (unemployment, substance abuse, mental illness, poverty) are also risk factors for poor community outcomes. Individuals with mental health and substance abuse disorders have broad difficulties in the community leading to more specific problems including securing housing and appropriate healthcare, substance abuse, and subsequent criminality and related social costs post release (Baillargeon 2009).
At present there are several unique initiatives afoot in Massachusetts to "intercept" the multiple pathways to the criminal justice system for these individuals with co-occurring mental health and substance use disorders (CODs), based on the sequential intercept model (Munetz and Griffin 2006). Notably in the Boston Area, programs are initiated with the Boston Police Department to train police in jail diversion methods, and to engage with Forensic Peer Specialists.

DMH has a long history of providing forensic mental health services to the juvenile justice system and to DMH facilities, including DMH contracted adolescent residential units. The DMH Forensic Mental Health Services has assumed responsibility for procuring and managing all clinical services for the statewide Juvenile Court. Forensic specialists sited in the juvenile courts provide evaluation and consultation services for judges and probation officers on an as-needed basis, as well as treatment for children. Since juvenile court clinics began evaluating children under age 12, detention use for this population has significantly dropped. Protocols between the Department of Youth Services (DYS - the juvenile justice service system) and DMH have been developed to assure timely information sharing and thoughtful transition planning for youth with mental health needs in the DYS system. In a project jointly developed by DYS and DMH, the Capstone Project, a lead DMH clinician, based in Central Office, serves as the designated liaison to DYS regarding clinically challenging youth whose needs require sophisticated clinical and systems competencies.

3. Increased access to peer support and peer-run services.

The number of individuals with lived experience of mental illness who has been trained as Certified Peer Specialists (CPS) continues to increase. The Transformation Center, a peer-run organization in Massachusetts, has been providing CPS training and certification since 2008. In SFY15, DMH provided funding to Transformation Center to provide training to 180 individuals with a goal of achieving at least an 80% certification rate.

DMH and the peer and provider communities have also identified the need to expand the potential pool of CPS applicants and to provide culturally and linguistically competent peer services. The Transformation Center streamlined the application and interview process for the CPS training. This process includes a Self-Assessment and on-line preparation course. In addition, the Transformation Center provided four CPS preparation courses to support minority candidates and other underrepresented groups to develop a more diverse peer workforce. DMH regularly utilizes Block Grant technical assistance funds to sponsor population specific Peer Support Specialist Training sessions. Deaf, Hard of Hearing, and Deaf Blind individuals and Elders are specific examples

DMH funds six Recovery Learning Communities (RLCs). These consumer-run RLCs initiate, sponsor and provide technical assistance to a wide variety of support, education, and advocacy activities spread out across their respective regions of the state and continue to develop their capacity to support the growing peer workforce in Massachusetts. Massachusetts is taking a national lead in furthering the discussion between stakeholders to understand both uniqueness and commonalities found within the mental health and addiction peer communities. This project is a partnership between DMH, the Department of Public Health Bureau of Substance Abuse Services (BSAS), University of Massachusetts Medical School Department of Psychiatry, the Massachusetts Interagency Council on Substance Abuse Treatment and Prevention, the Massachusetts Organization for Addiction Recovery (MOAR), the Transformation Center, and the MassHealth Office of Behavioral Health and the Massachusetts Association for Behavioral Healthcare.

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.

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 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.

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. In 2016, the State Mental Health Planning Council focused two of its four sessions on Peer Services. Identified issues were the documentation required for health reimbursement and striking a balance between peer and professional service roles. 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 ten 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 Emergency Service Programs 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.
- Lead by Rob Walker, the DMH Director of Recovery and Empowerment, MA continues to infuse peer specialists into the mental health workforce.

4. Affordable housing and coordinated services for people who are homeless

Access to safe, affordable, high quality housing continues to be a key DMH objective in the delivery of mental health services. DMH works closely with the Department of Housing and Community Development (DHCD), the state's primary housing oversight agency, which is responsible for overseeing the Local Housing Authorities, managing federal and state rental assistance along with responsibility for policies and resources directed at homeless individuals and families. DMH clients who on average earn some $7,500 annually are at the very bottom of HUD's extremely low income category that targets those earning 30% of Area Median Income (AMI); DMH clients are at 15% of AMI).

DMH through its collaboration with DHCD has exclusive access to over 70 (ch. 689) developments, housing more than 650 clients. These units are owned and managed by the Local Housing Authorities. DHCD also manages the DMH-Rental Assistance program, currently funded at $7M housing that serves close to 1,300 clients. With respect to capital investment, DHCD funds the Facilities Consolidation Fund (FCF) that supports development of independent, integrated housing for DMH and now has in excess of 800 units across the state. Virtually all of

the units are owned by local Community Development Corps and other not for profit housing providers. The Department will continue to utilize FCF capital funds to expand integrated housing opportunities along with seeking to "re-purpose" state ch. 689 housing previously used by the Department of Developmental Disabilities.

HUD McKinney funds are critical to the mission of assisting those who are homeless and DMH is extremely active in all 20 HUD Continuums of Care across the state that in total manage some $65M in grant funds to house the homeless. DMH matches many of these grants that include Supportive Housing, Shelter Plus Care Safe Haven and Supportive Services Only.

DMH participated in the Interagency Supportive Housing Initiative, led by DHCD, to develop supportive housing, particularly for homeless persons and families, people with disabilities and elders. This groundbreaking initiative pulls together all the relevant housing and service agencies, 18 in all, to work toward securing the necessary housing funds along with their commitment to providing the clinical and service supports that would enable people to live in their own housing. This initiative was successful in creating 1,000 new units of Supportive Housing to serve homeless, disabled and elders exiting institutional care.

DMH case managers complete a housing assessment for each client receiving case management services twice a year. This assessment documents current housing status, history of homelessness and risk factors for homelessness. The DMH definition of homelessness is more expansive than the federal definition and includes clients who are currently residing in skilled nursing, rest homes and other institutional placements who do not have a permanent residence as well as those who are temporarily staying with family or friends and do not have a permanent residence. Without access to subsidies that enable people to find a unit in the market place or access units that are subsidized, people receiving DMH services are more likely to be living in substandard conditions or in transitional programs, hospitals and other temporary settings for extended periods of time.

5. Workforce development related to promoting recovery orientation, integrating peer workers and family partners into the service system, and implementing evidence-based practices

Workforce development has emerged as a major theme within the behavioral health system. As more is learned about effective engagement and treatment that promotes recovery and resiliency, there is a renewed urgency to ensure that staff are trained and demonstrate competencies in these practices. Providers frequently express frustration with high staff turnover rates that impede providers' ability to sustain best practices and a highly qualified workforce. The provision of training and ongoing supervision and support related to the practice is also resource intensive.

The Department of Mental Health's Person-Centered Planning Training initiative, which was initially funded by a SAMHSA Transformation Transfer Initiative (TTI) grant, occurred as a part of a Person-Centered Planning Implementation grant from the federal Centers for Medicare and Medicaid Services. DMH expanded on these efforts by developing its own curriculum. This overview training utilized a train the trainer model to provide training to all DMH staff. DMH launched a statewide effort to train all DMH workforce members in the philosophy of Person-Centered Approaches to Treatment Planning. 80 Trainers were trained to provide this training to the 3500 member workforce. In order to develop an infrastructure for full integration of these concepts into practice, DMH also retained the consultant to further develop the skills of PCA champions across the state as part of an effort to have subject matter experts working in most settings to mentor and coach other staff day-to-day. These individuals may also conduct quality

improvement activities and will communicate with local leadership to address challenges to implementation and inform future training needs. The training strategy also includes an informational segment for persons served about their role in PCP and what to expect. Peer specialist staff has been trained to lead discussion groups with this material.

Another area in which DMH recognizes a significant need is in providing evidence-based trauma-informed care. Multiple studies have highlighted the prevalence of trauma within mental health settings. They include the findings that 90% of public mental health clients have been exposed to trauma and that most have had multiple experiences of trauma (Meuser et al., 2004; Meuser et al., 1998). Additionally, 34-53% of people in other studies reported childhood sexual or physical abuse and 43-81% report some type of victimization. (Kessler et al., 1995; MHA NY & NYOMH, 1995).

The child/adolescent and adult restraint and seclusion prevention and elimination initiatives have both highlighted the need for culture change that reduce and eliminate the use of coercive practices and promote trauma-informed care. The Restraint and Seclusion Elimination subcommittee of the Planning Council was originally formed as a steering committee to DMH for the State Incentive Grant from the Substance Abuse and Mental Health Services Administration. The subcommittee has identified the need to improve understanding of trauma in the inpatient setting, to increase collaboration and communication at all levels of our system, provide training and ongoing workforce development, and offer alternatives to restraint and seclusion, such as comfort and sensory rooms. DMH recognized that these needs to understand trauma, increase collaboration and communication, and provide training and ongoing workforce development also exist in its community-based system.

DMH continues to collaborate with The Transformation Center, a peer-run, DMH funded agency to further expand and adapt training opportunities for peer support workers and certified peer specialists. DMH has also piloted the Gathering Inspiring Future Talent (GIFT) training for young adults. This is an intensive training program that prepares young adults with “lived experience” for the role of Peer Mentors and young adult advisory board members within the Community Service Agencies (CSAs) under the STAY Together grant. The training was also opened to other young adults with lived experience who are exploring the field of peer support work.

DMH also provided a number of trainings and educational tools that focus on the correlation between employment and recovery. A website (www.reachhirema.org) was created as a resource for young adults and those who work with them, focused on resources for pursuing employment, education, and financial management. In addition, several benefits intensive trainings were offered across the state to assist people in making informed decisions about employment options by better understanding their benefits.

6. Improve the safety of the service delivery system for people served and staff

Following the tragic death of a mental health worker in a group living environment in January of 2011, DMH led a review of DMH’s policies and practices pertaining to safety. To inform the process, the Commissioner appointed a task force comprised principally of individuals not employed by the Department and asked them to conduct an external review of DMH policies and procedures and develop some key recommendations regarding what they perceive to be priorities for improvement. The task force completed its report and recommendations, including a minority report, in June 2011. DMH then convened a Response Committee to evaluate the recommendations received from the internal and external review. From these recommendations

the Response Committee developed tangible work products and action steps. These work products and actions steps include:

- The agency revised the curriculum which addresses restraint prevention and personal safety for all. The revisions incorporate best practices, reflect SAMHSA's six core strategies, and integrate the principles of trauma informed care throughout the curriculum. National experts were consulted to review the draft revision and their recommendations were incorporated into a final version. DMH also developed a comparable curriculum that addresses trauma informed care and personal safety for all in community-based service settings.
- DMH revised standards for community services to require training around staff and consumer safety and to clarify Department expectations around documenting risk.
- DMH allocated additional funds for the expansion of its jail diversion program.
- The DMH Community Risk Mitigation Policy went into effect in July 2013. The policy establishes procedures for governing risk activities at DMH, including processes and tools to help identify and monitor public and personal safety related to individuals in the community. The policy was issued after much public input and discussion.
- In 2014, after receiving input from the peer community, DMH issued a revised Informed Consent policy that incorporates the principles of shared decision making and established clear procedures for obtaining and documenting informed consent.
- DMH designated a Safety Administrator in 2013 who has worked closely with EOHHS as EOHHS developed regulations to govern the procedures and criteria for workplace violence prevention and crisis response plans for the all EOHHS programs. DMH engaged its 13 Safety committees in completing a gap analysis related to OSHA standards, identifying needs and submitting requests for grant funding to purchase safety equipment. DMH is currently developing a Violence Prevention and Crisis Response Plan. In 2017, DMH began collecting data on all violent incidents occurring in its continuing care facilities by two categories; physical and/or sexual violence, as well as by the persons involved: staff and/or patients. Reports inform the Safety Committees work, and provide context for Workers Compensation statistics.
- In 2017 DMH retires its 'Incident Reporting' database developed in 1997 and implements a 'Safety Learning System" software product. The system will facilitate real time incident management.

<u>Unmet Needs and Critical Gaps in the DMH Community-Based System for Children/Adolescents (Population: Children with serious emotional disturbances and their families)</u>

1. **Greater emphasis on services that directly impact on positive outcomes.**
   The SAMHSA definition of youth with serious emotional disturbance (SED) is individuals younger than 18 years who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder resulting in functional impairment that substantially interferes with or limits the child's role in family, school, or community activities. Thus, these three primary life domains – home, school, and community - define the broad outcomes that DMH strives to impact through its Child, Youth, and Family Services. DMH Child, Youth, and Family services are also intricately tied to and aligned with the Commonwealth's interagency Children's Behavioral Health Interagency Initiative (CBHI). The goal of CBHI is to strengthen, expand and integrate Massachusetts state agency services

into a comprehensive, community-based system of care to ensure that families and their children with significant behavioral, emotional, and mental health needs obtain the services necessary for success at home and in their schools and community. Underlying the CBHI system transformation activities is a commitment to shifting the child and family system of care to promote positive outcomes for children and families. DMH shares this commitment and to holding itself and its providers accountable to those outcomes. Through its procurements, DMH emphasizes outcomes relating to child success at school, in the home, and in the community, by establishing explicit expectations of DMH service providers to demonstrate progress in school, home and community participation for youth receiving these services. The DMH performance and contract management process provides mechanisms for DMH to monitor child outcomes and to work with providers to modify services when needed to better support youth and families in achieving greater success in these areas.

2. Integration between adult and child systems for transition age youth and alignment between child service agencies for children and families with mental health issues, including parents of minor children.

Children with SED frequently require and receive services from a complex array of public and private providers and payers. Families, particularly those who receive services from multiple providers, often find it difficult to understand how the system might help them and how to access available services. When working with a family that is receiving services and supports from various parts of the system, service providers may also feel stymied by inefficient service planning, delivery, management, and financing processes. The result is less than optimal health, wellness, and life outcomes for the children, youth, and families receiving these services and inefficient use of system resources.

Parents and caregivers of youth with SED face a myriad of challenges associated with their children's care and may experience stigma relating to their children's behavioral health needs. Having a trusted ally who can provide structured and knowledgeable parent to parent support is often the critical link to successful access, engagement, and utilization of services. Parent to parent support, under a variety of titles, is currently offered in various places within the Massachusetts system of care: MassHealth Family Support and Training Service (FS&T, or "Family Partner"); MassHealth Mobile Crisis Service; Department of Mental Health Child, Youth, and Family Services (Family Support Specialists and Family Leaders); Department of Children and Families; Department of Youth Services; MassHealth Patient-Centered Medical Home Initiative; SAMHSA funded projects MYCHILD and Project LAUNCH; and individual providers, including residential schools.

The MassHealth FS&T (Family Partner) service is one of an array of Medicaid behavioral health benefits for eligible children with SED; and over 400 Family Partners currently provide support, education, coaching, and training to their parents and caregivers. Qualitative data collected in assessments of these services indicate that parents and caregivers highly value this service and it is integral to the success of the High Fidelity Wrap-around process that is the cornerstone of these MassHealth services. In focus group discussions with parents of children with SED, they consistently emphasize the importance of the Family Partner in helping them identify and access services, develop more effective strategies for advocating for appropriate services, managing their children's behaviors, and decreasing their own stress. A trusting relationship grounded in shared experience and mutual respect is key to the success of the service. It is one that requires time and nurturing to develop, particularly when a child moves

from one part of the service system to another. The continuity of this unique relationship is often disrupted as the Family Partner service provided in one part of the system ends when a child stops receiving services in that part of the system. Yet, stress and uncertainty can be most pronounced during transitions from one service to another and the need for the support and guidance of a Family Partner is often at its highest. Parents frequently state that they wish their Family Partner could stay with them as their child moves across the service system, particularly between residential and community-based services.

Since 2013, DMH and DCF Child, Youth, and Family residential services have been re-procured as a single residential system: *Caring Together: Strengthening Children and Families Through Community-Connected Residential Treatment*. The goals of the new residential services are two-fold: to better support youth to remain in their homes/community and/or successfully return to their home/community setting from a residential placement; and to better coordinate and integrate residential services purchased by the two agencies, based on consistent service standards and reimbursement rates. To further these goals, a new Family Partner service will be available to parents/caregivers of children receiving residential services. Responding to the profound message from parents and caregivers about the importance of the continuity of the Family Partner relationship as a child moves across service systems (see above), a key design element of this new service is to allow a Family Partner to continue working with a family as a child moves between the DMH/DCF residential system and the MassHealth community-based services. This will ensure the continuity of this important support and care for those youth who are publicly insured. As of June 2015, a pilot has been implemented in eight Community Service Agencies (CSAs) across the state.

Youth with behavioral health needs transitioning to adulthood require specific services to address the unique challenges they face as they move to greater independence from their family and from the child-serving to adult-serving service systems. Massachusetts has made great strides in developing services for Transition Age Youth (TAY) with diverse programming being offered across many areas of both the child and adult service systems.

3. Workforce development related to integrating peer workers and family partners into the service system and implementing evidence-based practices.

Parent to parent support, under a variety of titles, is currently offered in various places within the Massachusetts system of care: MassHealth Family Support and Training Service (FS&T, or "Family Partner"); MassHealth Mobile Crisis Service; Department of Mental Health Child, Youth, and Family Services (Family Support Specialists and Family Leaders); Department of Children and Families; Department of Youth Services; MassHealth Patient-Centered Medical Home Initiative; SAMHSA funded projects, MYCHILD and Project LAUNCH; and individual providers. The expansion of Family Partners through MassHealth and the DMH/DCF residential services poses opportunities and challenges regarding development of the Family Partner workforce across the Massachusetts system of care. These EOHHS agencies are working to develop consistent and cohesive training resources that respond to the needs of Family Partners across the system, including the potential development of a certification program.

DMH recognizes a significant need in providing evidence-based trauma-informed care across its service system. The child/adolescent and adult restraint and seclusion prevention and

elimination initiatives have both highlighted the need for culture change that reduce and eliminate the use of coercive practices and promote trauma-informed care.

As DMH completes re-procurement of its Child Youth and Family community-based services over the next two years, it will require that providers of these DMH services provide them in ways that are trauma-informed and reflect current evidence–based practices. DMH will support and promote the training needs of the provider workforce in trauma-informed care.

As more is learned about effective engagement and treatment that promotes recovery and resiliency, there is a renewed urgency to ensure that staff are trained and demonstrate competencies in these practices. Providers frequently express frustration with staff turnover rates affecting the ability to sustain best practices and a highly qualified workforce. Recognizing the high turnover rate in mental health service agencies, training emphasis has expanded to the supervisory level, where turnover rates are lower. It is expected that this will better ensure consistency in the quality and delivery of the service, consistent service specifications, rates, training, and quality management strategies are needed. DMH is working with MassHealth to align their respective services along these dimensions.

4. Improved linkages with schools

Children receiving community-based mental health services, including those living in residential programs, receive their educational services through their local educational authority, and are enrolled in public school programs or special education day programs either within or outside the school district. Children in hospitals or intensive residential treatment programs have their special education services delivered through the Department of Elementary and Secondary Education in accord with the local IEP. Most DMH clients receive special education services, while some receive Section 504 accommodations to address their mental health needs. In accordance with state law, the state Department of Elementary and Secondary Education (ESE), through its division of Special Education Services in Institutional Settings (SEIS), is responsible for delivery of educational services in DMH's inpatient and intensive residential programs, either directly or through provider contracts. DMH program staff work closely with the SEIS teachers assigned to them so that their work and approach with the child is complementary.

Local school systems provide counseling within the school. Schools provide a variety of interventions, including but not limited to: aides; resource rooms; separate classrooms, within district or out of district, or operated by educational collaboratives; home tutoring; or placement in residential school. Depending on circumstances, DMH may pay for the residential component of such a placement while the school system pays for the education only component. If a child is enrolled in a DMH after-school treatment program, schools may provide transportation to the program. Data on the total number of DMH youth receiving special education services is not available.

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 with providers to offer training and consultation to local schools and/or local school systems and thus support mainstreaming. The focus of training is usually to help school staff understand the needs of children with serious emotional disturbance, develop sensitive and effective classroom responses to children with SED, identify children at suicidal risk and implement suicide prevention strategies, respond to individual or community trauma, and facilitate referrals to mental health services.

Schools also provide an important opportunity to identify children and youth at risk for behavioral health conditions and to link them with needed services. DMH collaborated with the MA Child Psychiatry Access Project (MCPAP) in two pilot projects to provide child psychiatry consultations to school personnel in Western MA (2008) and in Southeastern MA (2014). The success of these projects provide a solid foundation for developing a model for statewide expansion, and DMH continues to work with MCPAP and other key stakeholders in seeking resources to support expansion of the MCPAP model into Massachusetts schools.

DMH provides training for case managers and other DMH staff on accessing services under Individuals with Disabilities Education Act and under Section 504. PAL and the DMH Family Support Specialists provide similar trainings to parents in the community. Parents receive assistance with individual educational issues. Case managers may attend IEP meetings at school, or provide information to the team, as requested by the parent, and with parental approval school staff participates in Individual Service Planning meetings. The state director of special education participates on most interagency planning activities related to children's mental health, including the CBHI Advisory Committee and the Department of Elementary and Secondary Education (DESE) has been a payer in interagency blended funding initiatives.

Additionally, DMH and the Department of Early Education and Care are partnering to expand services and supports for young children with behavioral challenges. Of particular interest is to address suspension and expulsion practices within early childhood care settings, a key indicator of long-term academic and other life challenges. Most recently, in June 2017 DMH supported an Early Childhood Mental Health Summit where a diverse group of key stakeholders that included policy makers, academics, insurers, early childhood providers, and families convened to identify key action steps for advancing the early childhood system of care.

Unmet Needs and Critical Gaps in the DMH Community-Based System Spanning Child and Adult Systems

1. Addressing the needs of specific populations, including:

Transition Age Youth and Adults

The Youth Development Committee (YDC) was organized in 2002 to focus on transition age programming (defined as those individuals between the ages of 16 and 25) and to create a voice for youth and young adults. Membership includes young adults as co-chairs, parents, providers, advocates, university representatives and interagency staff. This committee meets every other month and effectively oversees the DMH Statewide Transition Age Young Adult (TAY) Initiative. The Initiative has expanded its partnership through a concentrated focus on the development of young adult peer mentors and young adult peer leaders across the Commonwealth. The YDC represents and reports to the Planning Council on the various young adult activities occurring across the state and elicits feedback and input from the Area and Statewide Young Adult Councils. The two young adult co-chairs of the YDC are active members of the Planning Council and its steering committee. One of the YDC co-chairs is also one of three chairs for the State Mental Health Planning Council.

An Education Subcommittee of the YDC was created and established in SFY14. The subcommittee is currently working on raising awareness of mental health needs in educational settings by outreaching and engaging with community education partners to join in membership, and will also begin reviewing the educational resources listed on the ReachHire MA website for any missing components.

Starting in 2007, the Statewide Young Adult Council (SYAC) grew out of YDC because young adults wanted to create their own meeting to provide the young adult perspective and guidance on the Transition Age Youth (TAY) Initiative, share information on employment and educational opportunities, as well as provide feedback on policy and planning efforts ongoing in DMH. There are three young adult peer leaders co-chairing SYAC and the members comprised only of young adults and meets monthly in Westborough (Central MA). The SYAC continued to provide feedback to Work Without Limits, BenePlan, the Success for Transition Age Youth (STAY) and YOUForward grants, and the UMass Transitions Research & Training Center; and advise the Department on ReachHireMA (www.reachhirema.org) a young adult employment, education, and financial independence resource site, and Speaking of Hope (www.speakingofhope.org) a young adult recovery resource site. Most recently, SYAC was honored with a citation from Governor Baker for 10 years of providing young adult voice and produced a video that highlighted SYAC's formation, history, accomplishes, and personal impact on its members (https://www.youtube.com/watch?v=54sprGpUjHM).

In addition, SYAC has been instrumental in increasing youth voice into the mental health delivery system, and over the past year SYAC provided input into the EOHHS Transition Planning Process, and provided feedback on a young adult specific housing continuum. For SFY18-19 State Plan SYAC has identified infusing youth voice into the various re-procurements the Department has planned to ensure services are age and developmentally appropriate for transition age youth and young adults. SYAC has advised the Department into developing a weekly TAY email that highlights events and resources that young adults, providers, advocacy groups, and families will find useful. The purpose is to improve communication about available resources, and develop a greater sense of community across the Commonwealth for TAY.

Two young adult peer leaders co-chair the Statewide Young Adult Council (SYAC). The SYAC Council is comprised of young adults and meets monthly to provide the young adult perspective and guidance on the Transition Age Youth (TAY) Initiative, share information on employment and educational opportunities, as well as provide feedback on policy and planning efforts ongoing in DMH. These groups have identified several key needs related to employment, education, housing and provision of developmentally appropriate services, including peer mentoring. The needs for employment and education come together in two ways. The first is the need to provide pathways into the employment in the health and human service system by enlarging the young adult peer mentor workforce. The second opportunity to bridge education and employment is the need to engage in transition planning that occurs in special education and to continue to support transition to the Massachusetts Rehabilitation Commission (the state's vocational rehabilitation agency) and community colleges. There is a need for greater access to accommodation services at the college level and for tailored vocational supports at the post high school period. This past year, the SYAC was actively involved in the development, design and beta-testing of the ReachHire MA (www.reachhirema.org) website. This website contains information and resources for gaining employment, attending secondary and post-secondary education, and attaining financial independence targeted specifically for young adults.

The most important need within the delivery of developmentally appropriate services is to expand the peer mentor system so that young adults will have a support network as they move from the child to the adult service system. As described above, DMH is taking steps to provide additional training opportunities and career pathways for young adults. Young adult peer leaders have also created another website, Speaking of Hope (http://speakingofhope.org/), as a canvas

for expression and a toolbox of valuable resources. It was created by young adult with lived mental health experience for young adults as a place to share helpful tools, inspire confidence and connect with others.

In view of the changes that have been occurring in both the child and adult service systems, including the Children's Behavioral Health Initiative and CBFS, TAY is looking to position itself to be more strategically integrated into programming in the years ahead. Ongoing needs in the areas of housing, employment and education have emerged in this population with approximately 60% not completing high school and less than 5% employed full time. Housing and homelessness is also emerging as a need with 178 young adults or 26% of the young adults receiving case management identified as being at risk for homelessness in a housing assessment.

Young adults have participated on a number of advisory teams across the state and are continuously asked to join new boards and committees. These have included: the Children's Behavioral Health Advisory Council, Healthy Changes Task Force, DMH Safety Task Force, DMH New Facility Advisory Workgroup, Young Children's Council, DMH Council on Recovery and Empowerment (CORE), MBHP Consumer Council and EOHHS' Children, Youth & Families Advisory Council. In addition, young adults have been asked to participate on Review Committees for the DMH/DCF "Caring Together" joint procurement.

Research continues to be one of the strong components of the Young Adult Initiative, with partnerships ongoing at Boston University's Psychiatric Rehabilitation Center, Beth Israel, Deaconess Hospital's Cedar Clinic and the Prevention and Recovery in Early Psychosis (PREP) program and the University of Massachusetts (UMass) Medical Center's Learning and Working grant.

Parents with Mental Illness

Parenting is an extraordinary experience for all parents, including those living with a mental health condition. It is an experience that gives a parent's life meaning and focus, and a child's functioning and well-being has an impact on a parent's wellness. A majority of adults living with mental illness are parents and their role as parents can be a critical element of a meaningful recovery journey.

The State Mental Health Planning Council voted in 2009 to establish a Parent Support subcommittee. The Parent Support Sub-committee has made strides in increasing awareness among state agencies about the needs of parents living with SPMI. It has facilitated communication and collaboration among child and family-serving agencies to identify strategies for addressing parenting needs among adults with SPMI and the needs of children whose parents have SPMI. It is also working to identify existing promising practice models across the service system and promote broader adoption of these practices to improve supports for parents and children. DMH continues to provide the leadership in promoting these efforts with its sister health and human service agencies. In October 2014, the Parent Support Subcommittee focused the State Mental Health Planning Council meeting exclusively on this topic.

In spite of the high number of adults with SPMI who are parents, this dimension of a person's life is often not addressed when planning and providing mental health services. Most child and family mental health providers have no training or expertise in engaging parents or understanding and addressing the relevance of the parenting role in planning and providing services. There is also no systematic or structured cross-systems integration of adult mental health and substance abuse treatment with children's services. Child mental health providers frequently do not integrate services for parents with mental illness in the child's planning process. The significant gaps in our understanding of the relationship between mental illness

among parents and its impact on child outcomes and our ability to effectively address the parenting needs of adults with SPMI lead to diminished health and wellness outcomes for both parents and their children.

6. Addressing research priorities of consumers and families

The Massachusetts Department of Mental Health provides funding to two Centers of Excellence (COEs) that engage in research related to mental illnesses and mental health services. Although much of this research is intended to lead to improvements in the care that individuals with mental illnesses receive, there has traditionally been little communication between the researchers and other stakeholders, such as consumers, Massachusetts-based mental health community service providers, and advocates for persons with psychiatric disabilities.

In 2008, legislation was passed mandating that a Children's Behavioral Health Knowledge Center be established within the Department of Mental Health, subject to appropriation. Its primary mission is "to ensure that the workforce of clinicians and direct care staff providing children's behavioral health services are highly skilled and well trained, the services provided to children in the Commonwealth are cost-effective and evidence-based, and that the Commonwealth continues to develop and evaluate new methods of service delivery". DMH recognizes the research must inform practice improvement and that training supports diffusion of best and promising practices, and has solicited input from stakeholders across the CBHI service system to inform the development of an initial three-year strategic plan that outlines the Center's mission and goals, organizational structure, governance, and research agenda. The Center holds regular conferences and works collaboratively with MassHealth to provide trainings for direct care supervisors and staff.

The table on page 21 provides information on how the unmet need areas identified above are addressed in the priorities stablished by DMH.

Identified Need	Priority that Addresses Need
Greater emphasis on services that directly impact on and result in positive outcomes:	Enhance service system to promote recovery, resiliency and positive outcomes. Implement and promote use of evidence based
Addressing the needs of specific populations	Enhance service system to promote recovery, resiliency and positive outcomes. Implement and promote use of evidence based
Increased access to peer support and peer-run services.	Promote peer workers in all services to ensure that care is person and family centered. Continue Peer Specialist certification.
Affordable housing and coordinated services for people who are homeless	Enhance service system to promote recovery, resiliency and positive outcomes Promote community living and housing
Workforce development related to promoting recovery orientation, integrating peer workers and family partners into the service system,	Expand and integrate a peer workforce Ensure that all services are person and family centered
Improve the safety of the service delivery system for people served and staff	Enhance service system to promote recovery, resiliency and positive outcomes Implement and promote use of best practices
Addressing research priorities of consumers and families	Implement and promote use of best practices Ensure that all services are person and family centered
Funding and coordination of prevention related activities with other state agencies, academic institutions, and others	Implement and promote use of best practices
Improved access and integration between primary care and behavioral health, mental health and substance abuse services, and between mental health and acute and continuing care services.	Enhance service system to promote recovery, resiliency and positive outcomes. Implement and promote use of best practices Ensure that all services are person and family centered.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Implement and promote use of best practices

Priority Type:

Population(s):

Goal of the priority area:

Support the implementation of innovative and/or evidence-based practices that lead to meaningful outcomes – success in school for children and adolescents and employment for adults.

Objective:

Increase the percentage of children and adolescents who maintained or improved school attendance. Increase the percentage of adults who are employed, in the labor force or engaged in a work-related activity.

Strategies to attain the objective:

1. Increase collaboration and coordination across the DMH and mainstream employment service systems.
2. Continue person-level employment data collection in Clubhouse Services.
3. Coordinate statewide employment activities and resources to include dissemination of best practices and interagency collaboration.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the percentage of adults served in Clubhouses who are competitively employed.

Baseline Measurement: Baseline: 22%

First-year target/outcome measurement: SFY18: 22%;

Second-year target/outcome measurement: SFY19: 25%

Data Source:

Clubhouse data reporting

Description of Data:

Excel and XML files are submitted to the DMH DataWarehouse monthly reporting when a cllient achieves employment.

Data issues/caveats that affect outcome measures::

As the MRC amends its programs and assumes this responsibility from DMH the measure will be altered or eliminated.

Indicator #: 2

Indicator: Increase the percentage of children and adolescents who maintain or improve school attendance.

Baseline Measurement: Baseline: 63%

First-year target/outcome measurement: SFY16: 65%

Second-year target/outcome measurement: SFY17: 67%

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 2

Priority Area: Enhance service system to promote recovery, resiliency and positive outcomes

Priority Type:

Population(s):

Goal of the priority area:

Enhance adult and child and adolesent service system through ongoing planning and performance management activities so that services result in improved outcomes for individuals and families served.

Objective:

Increase the percentage of adults and family members of children/adolescents who report satisfaction with outcomes

Strategies to attain the objective:

1. Continue to develop performance and contract management structure for all DMH services.
2. Expand data collection and analysis capabilities to inform planning and continuous quality improvement.
3. Continue inclusive planning process, including engagement of multiple stakeholders, for CBFS rate development and service enhancements
4. Implement programs for Transition Age Youth and their Families by creating Transition Age Youth (TAY) Peer Mentor positions in Community Service Agencies (CSAs).
5. Continue and strengthen joint implementation of Caring Together Residential Services with the Department of Children and Families.
6. Implement “New Model” in alliance with MassHealth Behavioral Health Community Partners.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the percentage of adult clients who report positively about treatment outcomes.

Baseline Measurement: Baseline: 63%

First-year target/outcome measurement: SFY18: 65%

Second-year target/outcome measurement: SFY19: 68%

Data Source:

The DMH Consumer Satisfaction Survey administered annually

Description of Data:

The DMH instrument is a modified version of the Mental Health Statistical Information Project (MHSIP) tool.

Data issues/caveats that affect outcome measures::

During SFY 2019 DMH will coordinate sampling with the MassHealth program. No details are yet available.

Indicator #: 2

Indicator: Increase the percentage of family members of child/adolescent clients who report positively about treatment outcomes

Baseline Measurement: 69%

First-year target/outcome measurement: SFY18: 71%

Second-year target/outcome measurement: SFY19: 73%

Data Source:

The DMH Consumer Satisfaction Survey administered annually

Description of Data:

The DMH instrument is a modified version of the Mental Health Statistical Information Project (MHSIP) tool.

Data issues/caveats that affect outcome measures::

During SFY 2019 DMH will coordinate sampling with the MassHealth program. No details are yet available.

Priority #: 3

Priority Area: Increase access to treatment for early psychosis

Priority Type:

Population(s):

Goal of the priority area:

Provide evidence-based treatment for early psychosis in order to promote recovery, resiliency and positive outcomes

Objective:

Increase the number of individuals receiving evidence-based treatment for early psychosis

Strategies to attain the objective:

1. Implement PREP® program Technical Assistance Center .
2. Implement 2-4 new FEP service programs

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of young adults receiving evidence-based treatment for early psychosis.

Baseline Measurement: Baseline: 150 people

First-year target/outcome measurement: SFY18: 200

Second-year target/outcome measurement: SFY19: 250

Data Source:

Provider quarterly report

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Ensure that all services are person and family centered

Priority Type:

Population(s):

Goal of the priority area:

Ensure that all services are person and family centered by increasing peer and family roles; promoting integration of these roles into the delivery system; and implementing staff development resources for all staff

Objective:

Increase the percentage of adults who report positively about person-centered planning and family members of children/adolescents who report positively about family-centered planning.

Strategies to attain the objective:

1. Continue to provide certified peer specialist certification courses and trainings in Whole Health Action Management

2. Continue to provide specialized trainings to peer specialists who work with special populations.
3. Continue to develop resources for supervisors of peer roles
4. Create Transition Age Youth (TAY) Peer Mentor positions in Community Service Agencies (CSAs)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the percentage of adult clients who report positively about person-centered planning.

Baseline Measurement: Baseline: 80%

First-year target/outcome measurement: SFY18: 82%

Second-year target/outcome measurement: SFY19: 85%

Data Source:

The DMH Consumer Satisfaction Survey administered annually

Description of Data:

The DMH instrument is a modified version of the Mental Health Statistical Information Project (MHSIP) tool.

Data issues/caveats that affect outcome measures::

During SFY 2019 DMH will coordinate sampling with the MassHealth program. No details are yet available.

Indicator #: 2

Indicator: Increase the percentage of family members of child/adolescent clients who report positively family-centered planning.

Baseline Measurement: Baseline: 84%

First-year target/outcome measurement: SFY18: 85%

Second-year target/outcome measurement: SFY19: 86%

Data Source:

The DMH Consumer Satisfaction Survey administered annually

Description of Data:

The DMH instrument is a modified version of the Mental Health Statistical Information Project (MHSIP) tool.

Data issues/caveats that affect outcome measures::

During SFY 2019 DMH will coordinate sampling with the MassHealth program. No details are yet available.

Priority #: 5

Priority Area: Promote community living

Priority Type:

Population(s):

Goal of the priority area:

Align DMH inpatient and community systems to improve access and care coordination and promote community living.

Objective:

Increase the number of individuals maintaining community tenure

Strategies to attain the objective:

1. Continue the DMH Inpatient Strategic Planning and Community Expansion Initiatives.

2. Promote alternatives to hospitalization including respite and non-hospital based crisis services.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase the proportion of people discharged from DMH inpatient continuing care to the community within 180 days of admission.
Baseline Measurement:	Baseline: 70%
First-year target/outcome measurement:	SFY18: 75%
Second-year target/outcome measurement:	SFY19: 75%

Data Source:

Admission and Discharge records from Continuing Care faclities

Description of Data:

DMH state operated programs use two different Meditech software systems: the DMH Mental Health Information System (MHIS) and the DPH Meditech Hospitall System. The contracted Continuing Care vendor uses its own propriety system for admission and discharge records, which are reported on paper to the Western MA Area office and entered into the MHIS. Records are stored in the DMH Data Warehouse.

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention		$0	$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention							
b. Mental Health Primary*			$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		$2,098,692	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$0	$0	$167,245,230	$0	$2,359,198
7. Other 24 Hour Care		$0	$0	$0	$326,481,534	$0	$17,725,190
8. Ambulatory/Community Non-24 Hour Care		$18,861,068	$0	$10,152,012	$997,673,440	$0	$27,228,138
9. Administration (Excluding Program and Provider Level)		$40,240	$0	$16,000	$53,676,372	$0	$1,494,822
10. SubTotal (1,2,3,4,9)	$0	$40,240	$0	$16,000	$53,676,372	$0	$1,494,822
11. SubTotal (5,6,7,8)	$0	$20,959,760	$0	$10,152,012	$1,491,400,204	$0	$47,312,526
12. Total	$0	$21,000,000	$0	$10,168,012	$1,545,076,576	$0	$48,807,348

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMH or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems				
2. Infrastructure Support				
3. Partnerships, community outreach, and needs assessment				
4. Planning Council Activities (MHBG required, SABG optional)	$3,200			
5. Quality Assurance and Improvement				
6. Research and Evaluation				
7. Training and Education				
8. Total	$3,200	$0	$0	$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

   DMH is seeking to improve the integration of the health care system in two broad areas. First, DMH aims to improve the integration of behavioral health, medical and specialty services provided directly to people who receive services as DMH clients. Second, DMH serves in its role as the State Mental Health Authority by engaging in a host of planning activities with state partners and other stakeholders to improve health care integration and outcomes of residents of the Commonwealth.
   While the majority of health and mental health outpatient services for DMH clients are provided through MassHealth, DMH supports the health and wellness of individuals in a number of ways. The organizing structure for health and wellness is the DMH Healthy Changes Initiative. This project is designed to address the modifiable risk factors which result in chronic illness and early death in individuals with psychiatric disabilities. The DMH Healthy Changes Task Force is comprised of DMH leadership and staff and consumer representatives. It provides leadership, guidance, and coordination of resources and makes recommendations for trainings, which are grounded in evidence-based and other best practices. Each DMH Area is charged with the implementation and oversight of the Healthy Changes Initiative at the Area and facility level. The work of the Task Force informs development of program standards and data collection within DMH inpatient facilities and community-based services. The health and wellness of clients served in the community are monitored as part of contract management. For clients served in state operated services, tobacco use, physical activity, body mass index and substance use are monitored during care.
   As noted earlier, DMH is currently revising its community services to align with MassHealth's new ACO health plan model. In so doing, DMH seeks to better coordinate community care for its clients across the life span, and coordinate services with child welfare, transitional assistance, housing, education, day care, long term supports, employment and criminal justice agencies. DMH and MassHealth wlil be sharing data, and monitoring client care quality jointly using standard quality measures.
   Within DMH community-based adult services, contracted providers are required to provide rehabilitative and support services that enhance the physical health and well-being of people served through: 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. DMH's contract management activities emphasize quality care, using measures related to health and wellness as a priority and encourage providers to develop innovative strategies to engage people served in wellness promotion activities. The DMH Healthy Changes Task Force, at statewide and Area levels, also engages with community providers to encourage and promote innovative health and wellness programming and serves as a vehicle for disseminating best practices and shared learning.

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 assure that they are enrolled for all benefits to which they are entitled, and case managers and provider staff advocate with insurers on questions of coverage.

Massachusetts behavioral health facilities have been addressing nicotine dependence with increasing emphasis over the last 20 years. The DMH Healthy Changes Task Force grew out of initial exploration in the early 2000's about the possibility of state mental hospital facilities going tobacco-free. In 2009, the Secretary of the Executive Office of Health and Human Services (EOHHS) issued a mandate that all EOHHS facilities—which include state mental hospitals and residential treatment programs, public health hospitals, programs for developmental disabilities and EOHHS administrative offices—become tobacco free. This initiative was prepared for by mandatory basic training of all behavioral health facility staff. Certain clinical staff at each of the large facilities were also trained as Tobacco Treatment Specialists in order to provide both group and individual smoking cessation treatment, and CO monitors were purchased for their use. Peer specialists in state mental health facilities have served as champions of wellness issues including physical activity, healthy eating and tobacco cessation.

Community mental health services in Massachusetts are now mostly provided by vendor agencies under contract to the Department of Mental Health. These contracts require reporting of quality measures. Providers have varied in their strategies for promoting tobacco cessation; strategies include smoking cessation classes and peer supports. Several providers with DMH contracts have established impressive wellness initiatives, including ones directed towards smoking cessation. Quit Helplines are likely underutilized, especially by inpatient facilities.

Massachusetts further advanced its leadership in health care reform with the enactment of Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation". The intent of Chapter 224 is to tame health care growth and improve health care quality through the creation of new commissions and agencies to monitor the market and enforce the benchmark for health care cost growth; wide adoption of alternative payment methodologies for both public and private payers; focus on wellness and prevention; expansion of the primary care workforce; financing and supporting the expansion of electronic health records and the state health information marketplace; and numerous other provisions.

A key feature of Chapter 224 is to address accountability and transparency within the health care system through several mechanisms. One such mechanism is the Health Policy Commission (HPC), which was created under Chapter 224 to establish standards for certification of Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs). The Office of Patient Protection also resides within HPC. Chapter 224 also created the Center for Health Information and Analysis (CHIA) which is charged with compiling the state's annual cost trends reports, managing the state's All-Payer Claims Database (APCD), monitoring the performance and financial stability of hospitals and health plans, and analyzing total medical expenses in the Commonwealth. Finally, the Attorney General continues to monitor trends in the health care market and has new responsibility to investigate any provider organization referred by HPC through the Cost and Market Impact Review process.

All three of these offices are closely monitoring behavioral health trends in collaboration with DMH. The Health Policy Commission published the July 2014 Supplement to the 2013 Cost Trends Report, which includes a focus on behavioral health spending trends across payers. CHIA recently chaired a Task Force on Behavioral Health Data Policies and Long Term Stays. The Task Force filed its final report with the Legislature in June 2015. DMH was a member of this group. The Attorney General's (AG) office recently published a report on behavioral health as part of a series of reports examining health care costs. The AG's office also utilized funds from a pharmaceutical settlement to award two-year behavioral health grants that support and evaluate new projects that improve the delivery of mental health and/or substance abuse services in Massachusetts. DMH participated in the review of some of the grant applications.

Chapter 224 reaffirms Massachusetts' commitment to implementation of federal and state parity and to behavioral health. Although it does not delegate statutory responsibility for monitoring covered services or complaints to DMH, Chapter 224 provides multiple mechanisms for DMH's engagement and leadership with state partners on behavioral health integration. The law created a 19-member Behavioral Health Integration Task Force to study payment systems for behavioral and substance use disorders and integration with primary care. The scope of the Task Force was to review how to best include behavioral health services in the array of services provided by provider organizations; how current reimbursement methods may need to be modified; how payment should be included under alternative payment methodologies; how best to educate providers about recognition and referral for behavioral health conductions as well as cardiovascular disease, obesity and diabetes in patients with serious mental illness; and the unique privacy factors related to interoperable electronic health record. The Children's Behavioral Health Advisory Council provided input to the Task Force on issues specific to pediatric primary care integration and solicited input from CHIPRA Children's Health Quality Council and other key pediatric stakeholders in the development of its recommendations.

The Dual Eligibles Demonstration/One Care aims to provide integrated care to MassHealth's most vulnerable members. MassHealth completed a procurement of One Care Plans to provide medical, behavioral health and community-based services coordinated by an integrated team. By combining Medicare and Medicaid funding, MassHealth now offers a broader array of services that will better meet the needs of the population in the most cost effective way. The contracted entities will be evaluated based on a comprehensive set of quality metrics to assess performance. One Care continues within the new MassHealth 1115

Waiver.

DMH works closely with the Massachusetts Chapter of the American Academy of Pediatrics to promote children's behavioral health. The Academy, particularly through its Children's Behavioral Health Task Force, serves as a vital advocate for children's behavioral health in the Commonwealth. It has been at the forefront of efforts to seek and secure more comprehensive and integrated behavioral health services for children and youth in the Commonwealth from birth to adulthood. Several of its key efforts include: reimbursement for mental health screening for children and post-partum depression screening for new mothers, early childhood mental health, behavioral health supports in school settings through school nursing services, and integration of pediatric primary care and behavioral health.

DMH also funds the Massachusetts Child Psychiatry Access Project (MCPAP), administered by MBHP with DMH funding, that makes psychiatric consultation available to pediatric primary care practices to increase the capacity of primary care providers to respond to the mental and behavioral health needs of pediatric patients, including concerns about psychiatric medication and to assess the need for and assist in referrals to specialized mental health treatment. MCPAP is able to meet the psychiatric consultation needs of PCPs responsible for all 1.5 million children living in Massachusetts. This service is offered free of charge to the pediatrician and thus is available for all children regardless of their insurance status. Funding from two federal grants is supporting significant enhancements and expansions to the MCPAP service. A CMS State Innovation Model grant is restoring full-time coverage of the MCPAP clinical teams; expanding its capabilities regarding adolescent substance use; analyzing provider psychotropic medication prescribing patterns and practice and provider MCPAP utilization patterns to develop and implement targeted outreach strategies to increase appropriate utilization of the MCPAP service; and assessing MCPAP's role vis-à-vis emerging primary care-behavioral health integration models. A Department of Education Race To The Top grant, is funding DMH and MCPAP to implement an innovative, evidence-based early childhood parent support intervention in primary care settings.

Finally, the DMH Massachusetts Mental Health Center (MMHC) launched its Wellness and Recovery Medicine (WaRM) Center in May 2013, the start of the organization's transformation into a "Health Home." An estimated 60-80% of patients served by the Center have at least one chronic medical condition. The WaRM Center offers co-located and integrated wellness and primary care services to better address the significant unmet primary care needs of its patients. Services prioritize engagement and education of patients, allowing them to become informed and active partners in their healthcare. Patients have access to a full-service, on-site primary care clinic with two full-time primary care providers who work in close collaboration with each patient's mental health team. In-house phlebotomy is available, and vision and dental services and specialty medical care are available through local partnerships. The WaRM Center primary care clinic serves any MMHC patient who wants or need primary care services. The WaRM Center also focuses on center-wide wellness efforts, including general health screenings for modifiable cardiovascular disease risk factors, and group-based programming for the enhancement of nutrition and physical activity. To address highly prevalent rates of tobacco use, the WaRM Center Smoke Free Program offers an innovative, integrated, collaborative, and team-based service delivery model which leverages ongoing tobacco use assessment, personalized motivational enhancement and shared decision making tools, as well as a variety of evidence-based tobacco treatments to identify, engage, and support patients in becoming "Smoke Free at MMHC."

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS) is the Single State Authority, overseeing the Commonwealth's substance abuse, 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 a number of initiatives related to the planning of services for people with co-occurring substance use and mental health conditions with current emphasis on implementing Governor Baker's landmark legislation, Chapter 52 of the Acts of 2016, An Act relative to substance use, treatment, education and prevention, including recommendations from the Governor's Opioid Working Group.

Chapter 52 is most notably the first law in the nation to limit an opioid prescription to a 7-day supply for a first time adult prescriptions and a 7-day limit on every opiate prescription for minors, with certain exceptions. Other provisions from the Governor's recommendations include a requirement that information on opiate-use and misuse be disseminated at annual head injury safety programs for high school athletes, requirements for doctors to check the Prescription Monitoring Program (PMP) database before writing a prescription for a Schedule 2 or Schedule 3 narcotic and continuing education requirements for prescribers—ranging from training on effective pain management to the risks of abuse and addiction associated with opioid medications.

Also, in late January, 2016 Governor Baker signed into law a bill to prohibit the civil commitment of women facing substance use disorders at MCI-Framingham and providing addiction treatment services at the state operated Lemuel Shattuck and Taunton State Hospitals. This reform was also a recommendation of the Governor's Opioid Working Group and ended the practice of sending women committed for treatment for a substance use disorder under section 35 of chapter 123 of the General Laws to MCI -Framingham. For the past 25 years, women committed under section 35 have been sent to this correctional institution instead of a detox center—preventing proper treatment options for women. Under this law, women can only be committed to a facility approved by the Department of Public Health (DPH) or the Department of Mental Health (DMH).

Subsequently, in February, 2016, the DMH operated 45 bed Women's Recovery from Addiction Program (WRAP) opened on the Taunton State Hospital Grounds.

DMH funds five Recovery Learning Communities (RLCs). These consumer-run RLCs initiate, sponsor and provide technical assistance to a wide variety of support, education, and advocacy activities spread out across their respective regions of the state

and continue to develop their capacity to support the growing peer workforce in Massachusetts. Massachusetts is taking a national lead in furthering the discussion between stakeholders to understand both uniqueness and commonalities found within the mental health and addiction peer communities. This project is a partnership between DMH, the Department of Public Health Bureau of Substance Abuse Services (BSAS), University of Massachusetts Medical School Department of Psychiatry, the Massachusetts Interagency Council on Substance Abuse Treatment and Prevention, the Massachusetts Organization for Addiction Recovery (MOAR), the Transformation Center, the MassHealth Office of Behavioral Health and the Massachusetts Association for Behavioral Healthcare.

In 2016, the State Mental Health Planning Council focused two of its four sessions on Peer Services. Identified issues were the documentation required for health reimbursement and striking a balance between peer and professional service roles. 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 ten 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 Emergency Service Programs 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.

• Lead by Rob Walker, the DMH Director of Recovery and Empowerment, MA continues to infuse peer specialists into the mental health workforce.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ( ) Yes ( ) No

   and Medicaid? ( ) Yes ( ) No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

   The Division of Insurance (DOI), under Chapter 224 of Massachusetts law, with the Health Policy Commission (HPC) are responsible for monitoring access to M/SUD allowed by the Accountable Care Organizations and Health Plans. The Massachusetts Office of Medicaid submits an annual report on compliance with the Mental Health Parity and Addiction Equity Act.

   The DMH along with representatives from the DOI and HPC attended the SAMHSA Commercial Parity Policy Academy (CPPA) on April 17-18, 2017 to discuss the enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) and share best practices. The Massachusetts delegation benefited from discussions on national studies that compared insurance benefits, education and outreach to consumers, comparable analysis of medical services against behavioral health/substance use disorder services, and role of consumers and providers in enforcing efforts through reporting violations. Inter-agency co-ordination to assure parity is monitored at the Secretariat level with DMH actively participating.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ( ) Yes ( ) No

6. Do the behavioral health providers screen and refer for:

   a) Prevention and wellness education ( ) Yes ( ) No

   b) Health risks such as

      i) heart disease ( ) Yes ( ) No

      ii) hypertension ( ) Yes ( ) No

      viii) high cholesterol ( ) Yes ( ) No

      ix) diabetes ( ) Yes ( ) No

   c) Recovery supports ( ) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ( ) Yes ( ) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ( ) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

   THe DMH is involved as an advisory member to the Division of Insurance. One commonly noted issue is insured persons lack of awareness of the coverage provided for them. Another involves providers' knowledge of available community resources. Active steps are underway to educate consumers and link providers to community resources via websites.

10. Does the state have any activities related to this section that you would like to highlight?

None yet completed.

Please indicate areas of technical assistance needed related to this section

Footnotes:

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities[45], Healthy People, 2020[46], National Stakeholder Strategy for Achieving Health Equity[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

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

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

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

[48] http://www.thinkculturalhealth.hhs.gov

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

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

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

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

    a) Race — Yes / No

    b) Ethnicity — Yes / No

    c) Gender — Yes / No

    d) Sexual orientation — Yes / No

    e) Gender identity — Yes / No

    f) Age — Yes / No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? — Yes / No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? — Yes / No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? — Yes / No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? — Yes / No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? — Yes / No

7. Does the state have any activities related to this section that you would like to highlight?

    Please indicate areas of technical assistance needed related to this section

Footnotes:

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (TIPS)[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

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

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

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

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

[56] http://psychiatryonline.org/

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

[58] http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☐ Yes ☐ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

   a) ☐ Leadership support, including investment of human and financial resources.

   b) ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

   c) ☐ Use of financial and non-financial incentives for providers or consumers.

   d) ☐ Provider involvement in planning value-based purchasing.

   e) ☐ Use of accurate and reliable measures of quality in payment arrangements.

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

   g) ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

   h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

   Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ( ) Yes ( ) No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? ( ) Yes ( ) No

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   DMH is promoting use of the NAVIGATE model, one of SAMHSA's options for implementing Coordinated Specialty Care (CSC) for early psychosis. DMH further promotes use of several EBPs for 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), Motivational Interviewing (MI), Cognitive Enhancement Treatment (CET), and MacFarlane Multi-family groups.

   During FY'17 DMH funded Vinfen as its PREP® East provider and ServiceNet as its PREP® West provider. PREP® East provides training to psychiatry residents, psychology trainees across all stages (post-doctoral fellows, interns, practicum students, and college students), social work, nursing, and occupational therapy. PREP® West demonstrated relationships with academic programs and a commitment to providing training to psychiatry, psychology, social work, and trainees of other health care disciplines. Healthcare providers aside from an educational setting may refer a young adult for a psycho-diagnostic assessment and treatment consultation.
   Also during FY17, the emphasis for the two existing programs went towards adopting standards in implementation strategies, performance indicators and baseline measures. DMH aligned program data collection and reporting processes across PREP® East and PREP® West via bi-monthly (twice per month) meetings with PREP® East, PREP® West, and their respective data/IT staff to define necessary data elements, methods for data collection and reporting.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

The Commonwealth of Massachusetts has a strong history of advancing the evidence-base for treatment of early psychosis. The Massachusetts Department of Mental Health (DMH) and one of its two Research Centers of Excellence – the Commonwealth Research Center at the Beth Israel Deaconess Medical Center, Harvard Medical School (CRC) identified prevention and early treatment of psychosis as a research priority in the mid-1990s. This focus led to the development of the Prevention and Recovery in Early Psychosis (PREP®) program in 2003 and has evolved since its inception into a multi-disciplinary, person-centered and evidence-based approach to the treatment of early psychosis in young adults. The program, operated within a state-operated outpatient mental health clinic, is supported primarily through DMH funds with some third-party billing.
PREP® is a comprehensive intervention comprised of the same components as the NAVIGATE approach with the addition of several other components including a peer group program for both young adults and their families and Cognitive Enhancement Therapy (CET). The PREP® model is an intensive outpatient clinical service comprised of the core components of Coordinated Specialty Care (CSC) combined with a therapeutic peer group program, cognitive remediation services, and family treatment and support. PREP® utilizes several EBPs for 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), Motivational Interviewing (MI), Cognitive Enhancement Treatment (CET), and MacFarlane Multi-family groups.

The PREP® program staffing model includes the following disciplines and supports: psychiatry, social work, psychology, advanced -practice nursing, milieu staff and administrative support. The program components include: a thorough diagnostic assessment and ongoing re-assessment; group treatment focusing on developmentally appropriate skill building such as education, employment, relationships and wellness; individualized case management and psychotherapy; cognitive remediation; and family treatment. In addition, these core services are enhanced by the peer community and a storefront location, providing a normalizing and positive environment. Through the peer community, clients and their families support and learn from each other. This is aided by facilitation from specially trained staff with expertise in working with young adults who are living with psychosis and their families. Peer group treatment modalities include multi-family therapy, an intensive peer group program, and Cognitive Enhancement Treatment. Also included are community outreach to area schools, colleges and universities and to health care providers and community education promoting awareness of behavior associated with a psychotic episode.
The PREP® programs must be Department of Public Health licensed outpatient clinics and maintain Medicaid and Medicare certification for all populations. Further, the PREP® must be part of an organization with a treatment philosophy and operating history of being committed to serving persons with severe and persistent mental illness, have staff whose competencies meet the full range of needs of the Young Adults and their families, deliver a responsive clinical and rehabilitative program in an attractive and safe setting and have a strong community presence.

The core program components consist of a multi-disciplinary team consisting of a minimum of 4 core roles:team leader, prescriber, individual/family coach, and employment/education specialist. Team meetings must occur weekly at a dedicated time. Persons served are assigned a primary clinician, from whom they receive care coordination and individual psychotherapy. Care coordination can range from helping an individual secure supported housing or disability insurance to advocating for accommodations at school. Psychotherapy is recovery oriented and includes supportive counseling and individually tailored CTP, targeting delusional beliefs and catastrophic appraisals of hallucinations in order to help members to get back on track in their lives. Family engagement is expected throughout treatment with the proper authorization of the Young Adult. Staff support the Young Adult in negotiating his/her relationship with the family. All family involvement is consistent with HIPAA and Massachusetts privacy laws. Typically, a primary clinician meets with the whole family about once per month to help the Young Adult share progress, to provide support and psychoeducation, and to augment intra-family communication and problem-solving skills. Family members can equally find comfort and support in information that helps put their experience with psychosis into perspective. Families needing further assistance are encouraged to join the evidence-based McFarlane-model multifamily group (MFG). MFG include 3-5 families and their affected relatives. The treatment involves an introductory, day-long psychoeducational workshop followed by a bi-weekly, structured group that helps family members and Young Adults discuss solutions to problems and work toward specific goals. When families require more individualized treatment (e.g., divorced parents who will not sit together in the same room, relatives with significant psychopathology or mistrust of treatment and medications), a clinician works individually with the family until they are ready to join one of the multifamily groups.

Further, pharmacotherapy is a core component. As many Young Adults with early psychosis are reluctant to start or stay on medication, FEP staff work to develop trusting relationships and provide education about medication options and best practices for medication treatment for early psychosis so that Young Adults are willing to adhere to medication recommendations. To build rapport and pre-emptively address concerns, psychopharmacology providers (medical director or psychiatry resident) meet frequently with Young Adults (often weekly or biweekly for first few months) to assess adherence and address questions raised by the Young Adult and/or the Young Adult's family.

Psycho-pharmacologists also prescribe healthy lifestyle behaviors (i.e., healthy diet and exercise) to prevent side effects associated with treatment. The goal is to find and administer the lowest doses that are effective, to minimize the larger side effects of higher doses. The use of medication involves complex decision making and requires an active partnership between the Young Adult and the prescriber. Shared decision making offers a framework for addressing the complexities of these choices with an emphasis on the unique concerns, values and life circumstances of the person served and the treatment advantages and disadvantages of medications based on empirical evidence.

As work and education are also rehabilitative and contribute to one's quality of life and standard of living, support services assist FEP members to find and maintain employment. Also, educational supports help individuals pursue educational programs

necessary for securing a desired vocation.

Further, the FEP milieu provides opportunities for informal exchanges before, in-between and after FEP groups among FEP members and staff that mirror everyday contacts outside the program, but often feel safer to FEP members. When new members join FEP, “veteran” members in the program are often called upon to serve as a “buddy” to the new member and to help that person get to know the program routines and peers. Special outings provide opportunities to practice social interaction and other recovery-relevant skills. As members grow more comfortable with each other, they may attempt greater social connection, first with between-group trips to the corner store and eventually through gatherings apart from FEP. Having staff and FEP members share a milieu encourages therapeutic connections and incidental interventions.

The FEP program offers presentations for local high schools, college counseling centers, outpatient clinics, emergency rooms, etc. on recognizing early psychosis and providing early and effective referral to services. These presentations are important to build relationships with referral networks to feed the program with appropriate referrals as well as to engage community partners for services.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? Yes No

5. Does the state collect data specifically related to ESMI? Yes No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? Yes No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

1. NAVIGATE identifies a number of EBPs which MA is also promoting. These EBPs are Cognitive Therapy for Psychosis (CTP), Dialectical Behavioral Therapy skills training (DBT), Acceptance and Commitment Therapy (ACT), Motivational Interviewing (MI), Cognitive Enhancement Treatment (CET), and MacFarlane Multi-family groups.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

In FY 18 and 19 DMH will expand its Early Intervention capacity in three ways: (1) support 6 Multi-Component First Episode (FEP) treatment programs throughout the Commonwealth now including Cambridge Health Alliance, Beth Israel Deaconess Medical Center, Community Health Link and Advocates for Human Potential; (2) support Beth Israel Deaconess Medical Center as the First Episode Psychosis (FEP) Technical Assistance Center to provide training and support in FEP best practices to the Massachusetts behavioral health workforce; and (3) sponsor FEP Learning Collaboratives to support dissemination and implementation of FEP evidence-supported practices.

The Learning Collaboratives will bring together teams from FEP Programs to work on improving their processes, practices, or systems by enabling participants to share and learn from their collective experiences and challenges. The Learning Collaborative will be comprised of up to three in-person training sessions with follow-up consultation activities (through phone and Internet), feedback loops, and resources to support sustained learning.

During SFY17, the emphasis for Vinfen and ServiceNet programs went towards adopting standards in implementation strategies, performance indicators and baseline measures. DMH aligned program data collection and reporting processes via bi-monthly (twice per month) meetings with their respective data/IT staff. During 18 and 19, this effort will be expanded to all 6 programs. Further, DMH will collect a minimum data set from all 6. This data will be used for URS reporting, contract monitoring and for performance and quality measurement. DMH is requesting technical assistance in this area.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

DMH has required a core set of assessment and outcome measures in development for all DMH supported FEP programs. This battery is consistent with the Westat external evaluation protocol and the PHEN-X measures. Data is collected in FEP programs at six month intervals.
During FY 18 DMH in partnership with EHS IT will adopt and reconfigure a software application enabling its FEP vendors to submit individual record data. This data will be used to monitor vendor quality and peformance as well as for URS submissions.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Diagnostic categories include any psychosis including affective disorders with psychotic features. These may include schizophrenia, schizoaffective disorder, schizophreniform disorder, psychosis NOS, depression with psychotic features, bipolar disorder with psychotic features, etc.

Does the state have any activities related to this section that you would like to highlight?

All funded FEP programs are using the funds to support employment services which are not third party reimbursable in MA. Under Secretary Sudders' direction the Massachusetts Rehabilitation Commission (MRC) is redesigning its employment service model to adopt best practices that assist persons living with developmental and behavioral disabilities to find and secure employment.

These new models will expand MRC's legacy approach which evolved from service to those living with physical disabilities. Further, the DMH and its sister agencies will 'bridge' employment services to the MRC over the coming 5 year planning period.

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

1. Approaches to evaluating model fidelity through the technical assistance center and in contract monitoring
2. Any client data standards required for future URS submissions.
3. Performance measures for DUP as suggested in the August 22nd webinar and the August 25th working session with Westat for the MHBG 10% set-aside study.

Footnotes:

In regards to the data specifically related to ESMI, DMH currently requires providers to use the
Global Functioning: Social Scale
Global Functioning: Role Scale
Dimensions of Psychopathology: Symptom Severity
Recovery Assessment Scale (self-report)
Lehman Quality of Life Scale (self-report)
Colorado Symptom Index (self-report)

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? ( ) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

DMH, as the State Mental Health Authority, 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. DMH establishes standards to ensure effective and culturally competent care to promote recovery. DMH sets policy, 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, providers and communities.
Through administrative processes, staff assignment, and procurement, DMH continues to address key concerns raised by families and people receiving services, to the extent that resources allow. Family members and consumers are represented on various councils and advisory boards that provide significant input and direction into the development of DMH policies, procedures, program development and service evaluation, including:
• Commissioner's Statewide Advisory Council;
• Family member participation in the Caring Together Family Advisory Council, the Caring Together Provider Advisory Council and a committee of stakeholders to develop quality and outcome indicators for Caring Together services;
• State Mental Health Planning Council and its subcommittees, including the Professional Advisory Committee on Children's Mental Health (PAC), Youth Development Committee, TransCom, Restraint/Seclusion Elimination Committee, Multicultural Advisory Committee, Employment Subcommittee, Housing Subcommittee and Parent Support Committee. . Parents and consumers also assume leadership roles on these subcommittees;
• The Children's Behavioral Health Advisory Council, established in 2009 in response to Chapter 321 of the Acts of 2008, the Children's Mental Health Law, which has parent and youth representation as Council members;
• Young adult representation on the following committees and workgroups: Children's Behavioral Health Advisory Council, MBHP Consumer Council, Youth Development Committee, Statewide Young Adult Advisory Council, Employment Subcommittee, Housing Subcommittee and Education Subcommittee, and Multicultural Advisory Committee;
• Site and Area Boards that advise on local program development, regulations, statutes and policies;
• Two parents with lived experience that are contracted consultants for Central Office Child, Youth and Family Services. These consultants are integral in service development and implementation;
• Service procurement process through community forums, Requests for Information (RFIs) and membership on proposal review committees that make recommendations to the Department about contract awards. Family members serve on design teams, are represented on Selection Review Teams, and co-present with state agency staff at provider forums and meetings with state agency staff as an orientation to new service models being procured.
• Contract management meetings and other local committees that work on the details of refining and improving the quality of DMH services; and

DMH also contracts with the Parent/Professional Advocacy League (PPAL), the state chapter of the National Federation of Families for Children's Mental Health. This is the statewide organization responsible for making sure that the voices of parents and family members of children with mental health needs are represented in all policy and program development forums both within DMH and in other state agency and interagency forums. PPAL efforts to promote family empowerment include:
• On-going support, through networking, information-sharing, and training, for the network of forty-three DMH Family Support Specialists to enhance their advocacy skills.
• Regular communication with the local support groups facilitated by DMH Family Support Specialists. This communication is used to solicit input on proposed changes to state and federal laws, regulations, and program designs that affect children with mental

health challenges.
• Feedback from PPAL to DMH staff about problems that parents are experiencing in regard to service access and quality based on information from support groups, surveys that it conducts, and calls to the office. PPAL members have also been frank about the fact that, beyond the child identified as the client, family members often have their own needs, and PPAL has advocated for service provision that is built on an understanding of the needs and strengths of both the child and the family.
• Collaboration with DMH to solicit ad hoc input from parents, youth, and family members regarding specific issues that impact DMH service design, practice, and policy formulation.
• DMH currently contracts with PPAL to conduct topical surveys of parents and families on current and emerging issues and challenges that families face in getting needed services and supports for their children with behavioral health needs. These findings are used to inform DMH's work, as well as MassHealth and the broader children's behavioral health service system.
• To ensure that DMH provides services that are culturally competent to lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) persons and their families, the Department has launched an LGBTQ initiative. As an initial first step, DMH held interviews with key informants, as well as focus groups with DMH clients who self-identify as LGBTQ. Recently, the Department 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 in FY '18.
• The State Mental Health Planning Council subcommittees provide significant input into policy and program development.
o The Professional Advisory Committee on Children's Mental Health (PAC) continues to be unique in its broad approach to children's mental health. It has a unique function and role, as the only non-state chaired advisory, entity to the Department of Mental Health focusing on needs and services to children, youth and parents. The PAC's priorities include the Children's Behavioral Health Initiative and opportunities for promoting integrated service delivery across child and family serving agencies. Recently, the PAC has focused discussion and provided input to DMH to ensure that children's behavioral health care, in the re-engineering of integrated primary care payment systems, will maintain a high quality and provide effective access. Further, the PAC supports the development of coordinated care for infants' and young children's mental health. Finally the PAC collaborates with the Parent Support Subcommittee of the State Mental Health Planning Council to enhance care for parents with mental illness.
o The Youth Development Committee (YDC) was organized in 2002 to focus on transition age programming (defined as those individuals between the ages of 16 and 25) and to create a voice for youth and young adults. Membership includes young adults as co-chairs, parents, providers, advocates, university representatives and interagency staff. This committee meets monthly and effectively oversees the DMH Statewide Transition Age Young Adult (TAY) Initiative. The Initiative has expanded its partnership through a concentrated focus on the development of young adult peer mentors and young adult peer leaders across the Commonwealth. The YDC represents and reports to the Planning Council on the various young adult activities occurring across the state and elicits feedback and input from the Area and Statewide Young Adult Councils. The two young adult co-chairs of the YDC are active members of the Planning Council and its steering committee. One of the YDC co-chairs has now also become one of three chairs for the State Mental Health Planning Council.
o The Multicultural Advisory Committee (MAC) advises the Commissioner of the Department of Mental Health (DMH), the Director of the DMH Office of Multicultural Affairs, and the State Mental Health Planning Council on the Department's commitment to equitable and quality mental health care for culturally and linguistically diverse communities. The MAC consists of representatives from mental health providers, community-based social services providers, peer providers, city and state government agencies, consumers, family members, educators, and researchers. The committee has expanded its advisory role to other groups within DMH. MAC has been a subcommittee of the State Mental Health Planning Council since April 2007. The diverse MAC membership provides a collective voice, linkages, and advice to DMH on addressing the complex bio-psychosocial, mental health, recovery, and support needs of children, adolescents, adults, and elderly in Massachusetts' culturally and linguistically diverse populations, especially communities that are marginalized, underserved, or unserved. MAC's goals include:
? Serving as the Department's ambassadors to culturally and linguistically diverse communities by sharing communities' perspectives with DMH and helping DMH outreach to communities;
? Strengthening communication and connections among culturally and linguistically diverse communities, civic organizations, mental health and human services providers, and DMH, including with DMH area operations; and sharing knowledge to increase clients' access to quality care for the reduction of health and mental health disparities and improvement in outcomes.
o Parent Support Committee: This subcommittee works with the DMH Children's Behavioral Health Knowledge Center and numerous stakeholders to review the fit and feasibility of adaption the evidence-based Let's Talk intervention for adult mental health providers working with clients who are parents. Using the resources from the National Implementation Research Network, the team drafted a practice profile for the intervention adaptation; reviewing available training materials with a plan to adapt/develop materials relevant to the Massachusetts service context.
• On-going psycho-educational training for parents and caregivers: In partnership with PPAL, the project developed and published a training curriculum for parents of transitioning youth called Transition Planning: Empowering Families. This publication addresses the changing roles of families, provides an overview of benefits, health care and advocacy, discusses legal options, and addresses communication with one's child and with the child's provider.

DMH trains its clinical staff to assure a standard approach to consumer and caregiver engagement. The Department of Mental Health's Person-Centered Planning Training initiative, which was initially funded by a SAMHSA Transformation Transfer Initiative (TTI) grant, originated as a part of a Person-Centered Planning Implementation grant from the federal Centers for Medicare and Medicaid Services. DMH expanded on these efforts by developing its own curriculum. This overview training utilizes a train the trainer model to provide training to all DMH staff. DMH launched a statewide effort to train all DMH workforce members in the philosophy of Person-Centered Approaches (PCA) to Treatment Planning. 80 Trainers were trained to provide this training to the 3500 member workforce. In order to develop an infrastructure for full integration of these concepts into practice, DMH also retained the consultant to further develop the skills of PCA champions across the state as part of an effort to have subject matter

experts working in most settings to mentor and coach other staff day-to-day. These individuals may also conduct quality improvement activities and will communicate with local leadership to address challenges to implementation and inform future training needs. The training strategy also includes an informational segment for persons served about their role in PCP and what to expect. Peer specialist staff have been trained to lead discussion groups with this material.

Also, DMH's revised service planning regulations incorporate "Individual Action Plans (IAPs)" that providers are required to develop and distinguishes them from Individual Service Plans (ISPs) developed by DMH case managers. The planning processes focus provider and consumer attention on incorporating the consumer's voice and choice, and are driven by a commitment to the principles of recovery. The regulations emphasize the matching of consumers who meet clinical criteria to specific services. It is intended that the IAP will serve as the Person's Served treatment plan. To further assure person-centered planning in its contracted services DMH made organizational and procedural changes in a number of its traditional services to better incorporate the principles of person-centered and recovery oriented care. These changes make services more responsive to clients and include roles for peer service providers. They are supported by training and continuous quality improvement efforts. Expectations both for training and quality improvement initiatives are written into service contracts and monitored twice yearly for compliance. Further, DMH allows providers to offer flexible supports and to maintain service continuity when a consumer moves from a residential setting to independent living.

Specific processes used in Block Grant funded services are described in item #4 below.

4. Describe the person-centered planning process in your state.

Through staff training, supervision and coaching as well as through contract requirements and monitoring, DMH assures use of a person-centered planning process. This section contains two specific examples demonstrating the process standards applied department and statewide.

The person-centered planning process is evident in the program requirements for the Block Grant funded DMH Program of Assertive Community Treatment (PACT) programs. The program provides services to persons served who often have co-occurring disorders such as substance abuse, homelessness or involvement with the judicial system. The PACT team is the single point of clinical responsibility and assumes accountability for assisting the persons served to meet their needs and to achieve their personal goals for recovery. PACT emphasizes an in-depth process of assessment and service delivery which is based on a person-centered plan developed through listening to and learning about each person's subjective experiences. Through a collaborative effort between the person served and the PACT team psychiatrist, treatment options are explored, including symptom self-management and shared/supported decision making strategies.

Specifically, a comprehensive assessment must be completed within 7 days of an individual being enrolled into PACT. Comprehensive assessments are approached as a process of engaging the person served and establishing trust and rapport. It is a way to understand and respect the person's served views of the ways mental illness impacts his/her life and how he/she wants to be supported in his/her personal process of Recovery. Each area of the assessment is completed by the team member who has the skill and knowledge of the area being assessed. No one team member is responsible for the entire assessment. The assessment shall include, but not be limited to, the person's living situation, family history, social supports, legal status and criminal justice system involvement history, education, employment and meaningful daily activities, income or financial supports, military service, substance abuse history and substance use disorder treatment history, physical health and mental status. If it is determined that medication can be helpful in assisting a Person Served to meet his or her goals, then a medication treatment is chosen, prescribed and evaluated towards the goal of self-medication management.
The IAP is then collaboratively constructed, using National Program Standards for ACT Teams, to address the person's served strengths, abilities and resiliencies; activities of daily living; mental health/illness management-behavior management; risk mitigation; treatment history, including the individual's experience of past treatment and his/her perception of its benefits/limitations; the personal impact of the individual's mental health diagnosis and their medical and dental health and wellness. The IAP will identify the action step(s) necessary to address the needs, including making referrals where indicated, who is responsible to coordinate the plan, who will assist the Person Served with the action steps, and when the needs will be addressed shall be modified when needs are addressed, new needs arise and/or the individual's circumstances change. At the time of the initial IAP, using the goals of the person served the PACT provider in partnership with the persons served and any legally authorized representative (LAR) must develop discharge criteria. Discharge criteria are to be reviewed with the IAP review and modified as necessary. As the recovery process unfolds, rehabilitative, recovery and clinical services are constantly adapted to utilize the individual's strengths and to encourage and support individuals to achieve desired life roles (e.g., spouse, friend, parent, student, and employee). At a minimum, IAPs must be reviewed and revised as necessary every six months.

In FY 2016, 84% consumers of community services surveyed indicated satisfaction with the person centered planning processes.

Similarly, individual and family centered service planning is required for the Block Grant funded Child, Adolescent and Family Day Treatment Services. In its work with children, youth and families, DMH recognizes that parents/guardians, youth, and providers are partners and work collaboratively in the treatment of youth with mental health conditions. Because parents/guardians are essential sources of support for their children throughout their lives, they need to be actively involved with their children and have timely and accurate information about their children's conditions and the range of available interventions and services. Youth also need every opportunity to be involved with and stay connected to their parents/guardians and family members. While

parents/guardians, youth, and professionals bring different perspectives, each benefits from understanding the other's vantage point. Policies, services and supports must be designed and evaluated collaboratively and be family-driven, youth-guided, strength-based, culturally and linguistically competent, individualized, informed by best practices and evidence, and consistent with the research on sustained positive outcomes.
The provider, a masters' level clinician where one is on staff, engages the parent/caregiver/LAR (and other family members as applicable and authorization permitting) as part of the youth's team in designing the Individualized Action Plan (IAP) and participates in the ongoing review of the youth's progress in achieving IAP goals. Provider must facilitate obtaining the necessary authorizations. Further, the provider must engage in regular communication with the caregivers/parents/LAR about the youth's progress in groups as well as any challenges or successes the youth is experiencing at home. The provider offers and encourages families to participate in relevant family oriented activities offered by the Provider organization and other organizations in their community and invites family members as appropriate to participate in community based and agency based Day Services activities as appropriate.

Thus, each person receiving DMH funded direct services has an Individualized Action Plan (IAP) specifying the range of services and supports that will be provided to the child and or family by DMH service providers, and the outcomes these services are expected to achieve. If a youth is receiving DMH case management services, then s/he will also have an Individual Service Plan (ISP). Developed by the DMH Case Manager, the ISP is individualized, identifying the client's goals, strengths, and needs, the DMH services and programs that address those needs, as well as the program specific treatment plans prepared by the service providers. Further, DMH funds parent support coordinators in every DMH Area. These coordinators, or "Family Support Specialists", assist other parents to navigate the system, access entitlements, and develop the skills that allow them to effectively advocate for the services and supports they and their child need. Family Support Specialists also facilitate parent support groups that are open to all parents or caregivers of a child with emotional or behavioral needs.

Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ( ) Yes ( ) No

2. Are there any concretely planned initiatives in our state specific to self-direction? ( ) Yes ( ) No

   If yes, describe the currently planned initiatives. In particular, please answer the following questions:

   a) How is this initiative financed:

   b) What are the eligibility criteria?

   c) How are budgets set, and what is the scope of the budget?

   d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

   e) What, if any, research and evaluation activities are connected to the initiative?

   f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ( ) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ( ) Yes ( ) No

Does the state have any activites related to this section that you would like to highlight?

DMH's core functions include setting service delivery standards; promoting practices that support recovery, resiliency and person/family centered planning; providing contractual and service delivery oversight; and ensuring that delivery of quality services is consistent for everyone who needs them. To achieve these functions, DMH continues to strengthen its statewide structure for performance and contract management. This system utilizes an integrated, systematic and consistent approach to the management of individual contracts in order to evaluate statewide effectiveness of services, inform ongoing program development, ensure program integrity and compliance and promote quality improvement efforts. Included in this approach are methods to review service utilization, budgets, compliance with standards and client and family outcome data to ensure that services are being delivered in an effective and efficient manner.

In SFY17, DMH re-allocated its block grant award to fund three activities services: Program for Assertive Community Treatment, Child/Adolescent Family Systems Intervention, a component of Individual and Family Flexible Support Services, and the 10% Set-Aside for Treatment of Early Psychosis.

DMH adheres to the policies and procedures issued by the Massachusetts Office of the Comptroller (OSC), which are compliant with the Single State Audit. All sub-recipients are informed that they are receiving federal dollars, the funding amount, and the Catalog of Federal Domestic Assistance (CFDA) number of the grant. The sub-recipients, based on funding threshold, are also instructed of their A-133 audit requirements. If a sub recipients funding level is less than the A-133 threshold, Massachusetts purchase of service policies will still require that the sub recipient file audited financial statements with the Commonwealth. As required by Massachusetts General Laws (MGL), DMH adheres to all applicable purchasing and contracting laws of the State's

Purchase of Service system (POS) in the management of contracts, regardless of the presence or absence of block grant funds. DMH performance and contract management structure ensures compliance with contract standards and federal requirements, informs ongoing program development, and promotes quality improvement. Through this structure, DMH continues to build consistent business practices and an integrated information system to ensure effective fiscal, programmatic and quality management.

DMH collects client-level service, utilization and outcome data for the majority of its community-based services and continues to expand data collection efforts. These data are used for service authorization, contract oversight and quality improvement activities. DMH conducts periodic contract management meetings with each vendor in which fiscal and programmatic information is integrated and reviewed to ensure compliance, identify opportunities for improvement and recognize high performance. In addition, DMH's contract compliance office, in conjunction with the Massachusetts Executive Office of Health and Human Services, the Executive Office of Administration and Finance and the Division of Purchased Service, conducts an annual review of the administrative and financial management systems of sub recipient vendors. This review ensures that the agencies are fiscally sound and compliant with GAAP/A-133 reporting, and if needed, corrective action plans are issued in order to correct any audit/quality assurance finding. This helps ensure that the sub-recipient vendors are capable of both providing and maintaining a sound service delivery system to clients of the Commonwealth.

The majority of DMH's contracts are currently paid for using various payment methodologies, including cost reimbursement, accommodation, and unit rate pricing. These payment methodologies are not based on an individual-based encounter or claims-based approach to payment, but rather on costs that make up the program being purchased. However, the method in which DMH procures and purchases services is changing in response to legislation passed in August, 2008: Chapter 257 of the Acts of 2008, "An Act Relative to Rates for Human and Social Service Programs." This law, as enacted, provides that the Secretary of Health and Human Services shall have the sole responsibility for establishing rates of payment for social service programs purchased by governmental units. EOHHS began implementing this law in SFY10, and developed an implementation schedule for each of the Departments under its Office. DMH is working with EOHHS on the implementation of Chapter 257. As new service contracts are awarded, Chapter 257 rates are in place for most service types.

The DMH performance and contract management structure (structure) for community based adult and child and adolescent services is aligned with the Executive Office of Health and Human Services strategic plan, and the Governor's Executive Order No. 540, "Improving the Performance of State Government by Implementing a Comprehensive Strategic Planning and Performance Management Framework in the Executive Departments." The DMH structure reflects seven strategic goals:

1. The system of care is recovery oriented, person centered, and supports consumer and family choice, community living, and health and safety.
2. The service system is effectively measured and monitored to promote state and contractor accountability for results.
3. Consumers and families are active participants in all policy and program development and improvement activities.
4. Individuals and families have access to high quality services throughout the DMH continuum of care that support recovery, promote resiliency, and meet their needs.
5. DMH and providers retain quality staff and support their continued development by promoting continuous learning, ensuring cultural competency, and expanding a peer workforce
6. The DMH service system promotes physical health and well-being in partnership with the individuals being served.
7. DMH effectively carries out its role as the state mental health authority to prevent illness, promote healthy and safe communities, and support the recovery and resiliency of individuals in the Commonwealth.

The structure for adult services employs a chartered Performance and Contract Management Team, composed of Site Directors, Area Directors of Community Service, Area Quality Managers, Central Office and EOHHS Information Technology managers. Similarly, the child and adolescent (C/A) services staff teams include Area Case Managers, C/A Clinical Managers, C/A Area Directors and most recently, with Department of Children and Families representation, Caring Together Regional Teams.

The DMH performance and contract management process (process) encourages providers to continuously assess and improve their own performance. DMH implements the process primarily through its site offices (Sites). DMH Sites routinely schedule provider meetings to monitor contract, organizational and/or client specific clinical and administrative issues. Additionally, Area Offices (Areas) coordinate the sites' process by convening regular meetings to monitor provider specific, and/or client specific contracts. These meeting agenda cover topics such as fiscal, programmatic, and organizational performance, clients' clinical progress and contract specification compliance. Further, the DMH Central Office provides process oversight, informs program development, identifies systemic quality improvement efforts, and coordinates data collection, reporting and analysis used in the Site and Area level activities. The process incorporates multiple data and reporting tools (inventory below), follows the fiscal year calendar (example below), and a uniform Contract Management Agenda.

During the 2018-2019 period, the Director for Quality Improvement is leading the Performance Review Group, a sub-committee of the Performance and Contract Management Team, composed of quality managers from each of the 5 Areas and the Directors of Community Service and Evaluation. This team develops standard measures and protocols for the New Model as well as for the newly contracted services, including PACT.

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

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

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

   Does the state have any activites related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

   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 including the Department of Children and Families (DCF), MassHealth, the Commonwealth's Medicaid agency.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

a)	Physical Health	Yes No
b)	Mental Health	Yes No
c)	Rehabilitation services	Yes No
d)	Employment services	Yes No
e)	Housing services	Yes No
f)	Educational Services	Yes No
g)	Substance misuse prevention and SUD treatment services	Yes No
h)	Medical and dental services	Yes No
i)	Support services	Yes No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	Yes No
k)	Services for persons with co-occuring M/SUDs	Yes No

   Please describe as needed (for example, best practices, service needs, concerns, etc)

   Under direction from Secretary Sudders, the Massachusetts Rehabilitation Commission is now charged with updating and amending its practices to be inclusive of behavioral health, intellectual and developmental disabilities in addition to its legacy focus on physical disabilities. Other EOHHS agencies, including DMH, are instructed to 'bridge' to the MRC all direct employment related services and instead focus on the clinical and support services needed to prepare a person for employment.

3. Describe your state's case management services

   DMH case management is a service designed to assist persons served gain access to continuing care and other community services, and to coordinate the provision of those services among various providers. To provide case management, DMH case managers must assess the person's service needs, create a service needs plan, and help to coordinate those services among providers in accordance with the plan.

   DMH remains committed to providing case management and its case management workforce, and currently serves approximately

1,000 children and youth annually. Principally, clients in need of service coordination amongst various providers are assigned to case management.

Using housing as one example of case management services, DMH case managers complete a housing assessment for each client receiving case management services twice a year. This assessment documents current housing status, history of homelessness and risk factors for homelessness. The DMH definition of homelessness is more expansive than the federal definition and includes clients who are currently residing in skilled nursing, rest homes and other institutional placements who do not have a permanent residence as well as those who are temporarily staying with family or friends and do not have a permanent residence. Without access to subsidies that enable people to find a unit in the market place or access units that are subsidized, people receiving DMH services are more likely to be living in substandard conditions or in transitional programs, hospitals and other temporary settings for extended periods of time.

4. Describe activities intended to reduce hospitalizations and hospital stays.

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 including the Department of Children and Families (DCF), MassHealth, the Commonwealth's Medicaid agency.

DMH has continued to work hard to shift its focus to community-based care. 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 continuing and rehabilitative care in the community.

The emphasis on prevention of seclusion and restraint has substantially reduced the need for continued care hospitalization, as high restraint use was a key indicator of the need for ongoing hospitalization. In 2007, DMH closed one of its three continuing care adolescent units, leaving a capacity of two units with 30 beds, and redeployed the funds into diversionary services and other community supports.

DMH has continued to work hard to shift its focus to community-based care as the state hospital census in Massachusetts has dropped drastically and the responsibility for acute care inpatient services was transferred from the public to the private sector. In addition to reducing the number of beds in the DMH system, this also has enabled DMH to focus its expertise on providing continuing and rehabilitative care in the community. The expansion of diversionary services and other community supports, and the entrance of behavioral managed care have substantially reduced the rate of hospitalization.

DMH currently operates or contracts for 733 inpatient beds. These are spread among two DMH-operated state psychiatric hospitals, two community mental health centers (CMHCs), two contracted adolescent units housed in a state psychiatric hospital, mental health units in two public health hospitals, and one contracted adult unit in a private hospital. The total inpatient capacity, which includes beds for forensic admissions, includes 671 adult continuing care beds, 32 adult acute admission beds and 30 adolescent beds. Children, adolescents and most adults receive acute inpatient care in private or general hospitals, with the exception of adult admissions to the CMHC acute units and some forensic admissions.

DMH procured a Peer-Run Respite service during SFY12 in the Western MA 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. Over time, DMH also expects that Peer-Run Respite Services will be an effective early intervention to prevent hospitalization and dependency on public mental health services through its focus on recovery and wellness values.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	5.4%	3.47/1000 penetration rate
2.Children with SED	11%	1.94/1000 penetration rate

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Prevalence rates for this submission are obtained from the MMHS Uniform Reporting System and reflect 2015 data. They reflect data from the adult SMI and child SED prevalence table. The child prevalence rate reflects the population from the level of functioning score of 60 upper limit.

DMH uses penetration rate instead of incidence rate. Penetration rate calculations reflect 2016 data obtained from the MMHIS Uniform Reporting System and the US Census.

Narratve Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	Yes No
b)	Educational services, including services provided under IDE	Yes No
c)	Juvenile justice services	Yes No
d)	Substance misuse preventiion and SUD treatment services	Yes No
e)	Health and mental health services	Yes No
f)	Establishes defined geographic area for the provision of services of such system	Yes No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

Outreach to Homeless – Adult and Child

DMH has a long history of addressing homelessness through outreach and engagement as well as housing programs. DMH Central Office, in collaboration with the five Areas and specifically the housing staff assigned to the Areas, work to oversee homeless activity including Continuums of Care, of which there are 17, covering the state funding about $65M in grants with a state match approaching $20M.
In addition there is the DMH/SAMHSA funded Projects for Assistance in Transition from Homelessness (PATH) program that outreaches to some 2,100 individuals living on the streets or in shelters. This statewide outreach is supported with $1.558 million annual federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and $660,600 in state DMH funds. PATH provides some 30 outreach staff comprised of clinical social workers and homeless practitioners who regularly visit more than 50 adult homeless shelters across the state serving persons with mental illness and co-occurring psychiatric and substance abuse disorders rendering assistance including direct care, housing search, benefits, advocacy and referrals to health care, substance abuse and mental health services. Adults and older adolescents determined to have a serious and persistent mental illness are referred to DMH for service authorization.

DMH also supports four transitional shelter residences with a capacity of 140 beds serving chronic homeless individuals with severe mental illness and co-occurring disorders in Boston. 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 mental health center (CMHC) and has clinically trained staff. DMH also sponsors in Boston the Mobile Homeless Outreach Team (HOT), comprised of 12 staff, focused on street outreach directed at adolescents and adults in need of mental health services and connects individuals with a range of services in an effort to bring them off the streets. The Team also provides psychiatric nurses to non-DMH Boston shelters to treat health problems and manage medication adherence.

In addition, DMH contributes funding 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.

Of particular note is a long-standing permanent housing program for homeless co-funded by DMH and the Department of Public Health (DPH) that operates statewide referred to as the Aggressive Treatment and Relapse Prevention program (ATARP). ATARP provides a “housing first” approach with necessary support services to a minimum of 60 clients (55 single adults and 5 families) diagnosed with co-occurring psychiatric and substance abuse disorders.

DMH is an active partner is the Commonwealth’s Tenancy Prevention 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. It has proven over the years to be an extremely successful program either “saving” tenancies or providing for a “soft” landing in a more supported environment.

DMH also participates on the McKinney Vento Homeless Assistance Act Steering Committee and as a member of this committee reviews the allocation of federal funds, makes recommendations for Homeless Liaisons and programming allocated throughout Massachusetts school systems and reviews reports on numbers of homeless children in Massachusetts preschool, elementary and high schools. Since SFY15, DMH has collaborated with the Department of Housing and Community Development (DHCD) to increase its mental health support and coordination for families assigned by DHCD to motels for shelter. Massachusetts has a mandate for shelter for families that meet the eligibility criteria and when the family shelter network capacity has been reached, DHCD purchases rooms in motels to temporarily shelter eligible families until a resource opens. DMH recognized that this sheltering arrangement may be very challenging for any member of the family who may be experiencing a mental health condition and worked with its PATH provider to extend its reach into several high volume motels serving homeless families.

DMH’s Transition Age Youth Initiative 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.

Older Adults

DMH services are flexibly designed to meet the needs of DMH clients throughout the lifespan. DMH requires providers to deliver services that are age and developmentally appropriate, including services for elders. DMH strengthened its service standards in Community Based Flexible Supports (CBFS) to address health and wellness issues, including the early mortality of people with psychiatric disabilities. DMH community-based services, including CBFS, are described in Criterion I.

Over the last seven years, DMH and the Executive Office of Elder Affairs (EOEA), the Massachusetts' State Unit on Aging, have taken on a number of initiatives to improve services to older adults. The Department of Public Health (DPH) 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.

The Elder Collaborative is a Planning Council sub-committee made up of senior leaders from DMH, the Executive Office of Elder Affairs (EOEA), the Department of Public Health (DPH), representatives from local provider coalitions across the state, and statewide aging and mental health trade associations. The Collaborative has engaged in numerous projects over the last several years which include: publishing a guide of a range of community-based elder services; improving access to emergency services through provider trainings; and understanding the strengths and weaknesses of the nursing home screening system in an effort to divert admissions for those with a history of mental health; and promoting evidence-based practices. The Collaborative also worked on the revision of the Pre-Admission Screening and Resident Review (PASRR) Level 2 tool to be more useable for diversion and discharge planning. These revisions were followed by trainings of almost 1,000 professionals from nursing homes, hospitals and local area agencies on aging.

Rural Area Services – Adult and Child

DMH does not have a separate division or special policies for adults, children or adolescents who reside in less populated areas of the state. 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 center of economic activity for the area. None of the Sites has a population density below 100 people per square mile.
The primary goal of DMH's local planning process is to address the issue of access to services for all DMH clients. 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. Geographic distribution of the population is not an issue. Poverty of clients and lack of insurance are more significant variables since the lack of financial resources to pay for transportation interferes with the client's physical ability to get to where services are located and the lack of insurance limits availability. A particular focus relevant to rural populations continues to be access to transportation. At the Area level, many clients have identified this as a challenge. In child and adolescent service contracts, for example, transportation is one of the flexible supports often provided.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

Financial Resources:

Aside from its MHBG award, the DMH budget for SFY 2018 totals $800, 152,446 of which $773,199,000 is derived directly from the Commonwealth's operating budget. The remainder is derived from trust accounts, and federal discretionary grant awards.

How the state intends to expend this grant for the fiscal years involved

The MH block grant funds are targeted to (1) the Program for Assertive Community Treatment (PACT for adults with serious mental illness; (2) therapeutic day services for children, adolescents with serious emotional disturbance and their families; (3) First Episode Psychosis programs (10% set aside); and (4) administrative support for the State Mental Health Planning Council. Services supported by the block grant are an integral part of the community mental health service delivery system and an important means of developing a comprehensive service system for all individuals in need of publicly funded care.
DMH's Program of Assertive Community Treatment (PACT) is the only DMH service that monitors fidelity toward evidence-based standards. There are currently 15 PACT programs in operation across the state and contracts will be awarded in the near further for October, 2017 implementation. DMH conducts site visits which include a fidelity assessment. DMH is moving towards a system of self-assessment of fidelity as a part of DMH's overall contract management approach. DMH also views PACT as a vehicle for the use of other evidence-based practices, including trauma-informed care, motivational interviewing, peer support and treatment of co-occurring mental health and substance abuse disorders. DMH utilizes its contract management structure to support the use of EBPs within the PACT model. Under MassHealth's ACO model, DMH clients enrolled in PACT who are members of the One Care or Massachusetts Behavioral Health Provider plans will have their care reimbursed by the ACO. Thus PACT providers' close monitoring of DMH clients' health plan membership and appropriate billing practices have become part of DMH contract management practice. During FY 18 any MHBG funds allocated for PACT but not likely to utilized will be redirected for information system development after consultation with our Project Officer.
Child and Adolescent Therapeutic Day Services is a community based service designed to support youth with serious emotional disturbances develop the skills needed to maintain successful functioning in the home and community. Therapeutic Day services may also provide a bridge for transition between more acute or long term services to other less intensive community services and support. The service provides a therapeutic group modality that supports engagement in prosocial activities, problem solving, communication and relationship building for youth whose stabilization is fragile, and whose symptoms and skill deficits interfere with their ability to integrate into family, school and community activities.
The MA FEP programs and the SMHPC are described elsewhere in this application.

Staffing, and training for mental health services providers necessary for the plan

DMH is committed to the delivery of quality care that supports persons served and their families in achieving independence and a meaningful life in their community. This is built on the premise that the services offered are effective and the best match for the person's served goals. All MHBG funded services are provided by contract. Imbedded in each contract are requirements for staffing levels and training. This section describes how DMH monitors its vendors. Through DMH's procurement, contract management, workforce development and research activities, DMH is promoting knowledge and use of evidence-based practices (EBPs) and promising practices.

DMH's core functions include setting service delivery standards; promoting practices that support recovery, resiliency and person/family centered planning; providing contractual and service delivery oversight; and ensuring that delivery of quality services is consistent for everyone who needs them. To achieve these functions, DMH is constantly strengthening its statewide structure for performance and quality monitoring and contract management. This system requires an integrated, systematic approach with consistent management of individual contracts in order to evaluate statewide effectiveness of services, inform ongoing program development, ensure program integrity and compliance and promote quality improvement efforts. Included in this approach are methods to review service utilization and client and family outcome data to ensure that services are being delivered in an effective and efficient manner.
DMH is able to track specific services and providers that receive block grant funding and reports these annually in the implementation report and URS tables. DMH, in contracting with community providers, no longer blends block grant funds with state appropriated dollars. DMH maintains the same programmatic standards and contract management methods for its services, regardless of the presence or absence of block grant funds, and therefore does not distinguish between contracts receiving block grant funds and those that do not in the data collected.
DMH, through its service authorization and re-authorization process, routinely determines that the individual seeking services does not have other means to receive the service, including coverage by Medicaid or private insurance. Through this same process, DMH assesses the individual's insurance status and works with him or her to address insurance issues, including lapses in

coverage. As DMH has the highest rate of insurance in the nation (currently 97% of residents in the Commonwealth), most people seeking DMH services are insured. As DMH and MassHealth continue to more closely integrate
The majority of DMH's contracts are currently paid for using various payment methodologies, including units of service, cost reimbursement, and accommodation unit base. Chapter 257 of the Acts of 2008, "An Act Relative to Rates for Human and Social Service Programs" provides that the Secretary of Health and Human Services shall have the sole responsibility for establishing rates of payment for social service programs purchased by governmental units. EOHHS began implementing this law in SFY10, and has developed an implementation schedule for each of the Departments under its Office and is striving to have Chapter 257 fully implemented by the close of SFY18. In order to effectively implement Chapter 257, DMH will require an integrated system and process for the management of service enrollments, provider billing, and utilization management to ensure that services are provided and billed as authorized by DMH. These processes must also be integrated with performance management functions to monitor that the services provided are of high quality and result in positive outcomes for youth, adults and families. DMH is envisioning a continuous quality improvement approach to increase its capacity to monitor individual and family outcomes, service quality, and provider performance. DMH is aligning its Area specific business practices into departmental standards. .
The DMH performance and contract management structure (structure) for community based adult and child and adolescent services is aligned with the Executive Office of Health and Human Services strategic plan, and the Governor's Executive Order No. 540, "Improving the Performance of State Government by Implementing a Comprehensive Strategic Planning and Performance Management Framework in the Executive Departments." The DMH structure reflects seven strategic goals:

1. The system of care is recovery oriented; person centered, and supports consumer and family choice, community living, and health and safety.
2. The service system is effectively measured and monitored to promote state and contractor accountability for results.
3. Consumers and families are active participants in all policy and program development and improvement activities.
4. Individuals and families have access to high quality services throughout the DMH continuum of care that support recovery, promote resiliency, and meet their needs.
5. DMH and providers retain quality staff and support their continued development by promoting continuous learning, ensuring cultural competency, and expanding a peer workforce
6. The DMH service system promotes physical health and well-being in partnership with the individuals being served.
7. DMH effectively carries out its role as the state mental health authority to prevent illness, promote healthy and safe communities, and support the recovery and resiliency of individuals in the Commonwealth.

The structure for adult services employs a chartered Performance and Contract Management Team, composed of Site Directors, Area Directors of Community Service, Area Quality Managers, Central Office and EOHHS Information Technology managers. Similarly, the child and adolescent (C/A) services staff teams include Area Case Managers, C/A Clinical Managers, C/A Area Directors and with Department of Children and Families representation, Caring Together Regional Teams.

The DMH performance and contract management process (process) encourages providers to continuously assess and improve their own performance. DMH implements the process primarily through its site offices (Sites). DMH Sites routinely schedule provider meetings to monitor contract, organizational and/or client specific clinical and administrative issues. Additionally, Area Offices (Areas) coordinate the sites' process by convening regular meetings to monitor provider specific, and/or client specific contracts. These meeting agenda cover topics such as fiscal, programmatic, and organizational performance, clients' clinical progress and contract specification compliance. Further, the DMH Central Office provides process oversight, informs program development, identifies systemic quality improvement efforts, and coordinates data collection, reporting and analysis used in the Site and Area level activities. The process incorporates multiple data and reporting tools, follows the fiscal year calendar and a uniform Contract Management Agenda. Client outcomes, monitored via the structure and process, are organized in six domains: Community Tenure and Integration; Engagement in school and/or employment; Patient Experience of Care; Health and Wellness; Housing controlled by the individual/family; and skills needed to support family efficacy and/or maintain recovery.
Recent DMH steps towards improvement of its contract and performance management structure include:
• Participation in EOHHS Statewide Quality Measurement workgroups to align DMH and MassHealth's use of quality measures for behavioral health services.
• Expansion of the annual DMH consumer satisfaction survey in order to differentially evaluate the experience of persons served in the community. Beginning in SFY '19, the DMH survey will be coordinated with MassHealth and the Health Policy Commission survey projects to minimize people's receipt of duplicate instruments and to assure that persons associate their survey responses with the appropriate agency service.

Providers of emergency health services regarding SMI and SED;

Massachusetts provides a statewide network of Emergency Service Programs (ESPs) that provide a comprehensive, integrated program of crisis behavioral health services. ESPs are funded by MassHealth. The Massachusetts Behavioral Health Partnership (MBHP) manages the ESP network. Services are provided through locally based providers in 21 catchment areas covering every city and town in Massachusetts. There are four components to the ESP model:
• Crisis assessment, intervention and stabilization services are delivered in community-based locations. These "hubs" coordinate the operations of the ESP and provide an alternative to hospital emergency departments.
• Mobile crisis intervention to youth provides a short-term face-to-face therapeutic response to youth experiencing a behavioral health crisis. It is one of the new CBHI remedy services. The service utilizes the Wraparound principles and mobilizes to the home or other site where the youth is located.

• Adult mobile crisis intervention services are also provided to adults in their private homes or other community locations.
• Adult Community Crisis Stabilization (CSS) provides a staff-secure, safe and structured crisis treatment service in a community-based program that serves as a less restrictive alternative to inpatient care.

The ESP model is based on a recovery-promoting approach that incorporates Certified Peer Specialists and Family Partners. It emphasizes mobile and community-based responses to reduce the likelihood of the use of restrictive dispositions, such as inpatient admissions and to increase self-direction and resolution of the crisis in the least restrictive setting. In SFY15, DMH funded two ESPs to provide peer-enhanced services. These ESPs are located in Western MA and in Eastern MA. The ESPs utilized funds to enhance peer specialist staffing and provide peer enhanced crisis intervention. The goal is to reduce utilization of emergency departments as well as voluntary and involuntary hospitalizations.
In addition, MBHP manages the statewide Massachusetts Behavioral Health Access System. This web-based system is utilized by ESPs to locate available beds for 24-hour levels of care. ESPs performance indicators include: response time, service location (mobile, community-based location, emergency department), emergency department diversions and disposition (use of community -based services, use of adult CSS as diversion and inpatient diversion).
DMH also funds Respite Services that 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. Respite Services provide supports that assist persons to maintain, enter or return to permanent living situations. Services are both site-based and mobile.
Further, DMH funds six Recovery Learning Communities (RLCs). These consumer-run RLCs initiate, sponsor and provide technical assistance to a wide variety of support, education, and advocacy activities spread out across their respective regions of the state and continue to develop their capacity to support the growing peer workforce in Massachusetts. RLCs, including expansion of supports and the development of a peer-run respite program are described in the Recovery section.
In Western Mass DMH funds the Western Mass Recovery Learning Community to operate a peer-run respite program in Northampton, MA. Established in August, 2012, Afiya House provides individuals experiencing emotional distress with short-term, overnight respite in a home-like environment. All staff 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.

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? Yes No

   Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

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

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ( ) Yes ( ) No
2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ( ) Yes ( ) No
3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ( ) Yes ( ) No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ( ) Yes ( ) No
5. Does the state have any activities related to this section that you would like to highlight.

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

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

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

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

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

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

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? ( ) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ( ) Yes ( ) No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? ( ) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? ( ) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ( ) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? ( ) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes ( ) No

   a) é Methadone

   b) é Buprenophine, Buprenorphine/naloxone

   c) é Disulfiram

   d) é Acamprosate

   e) é Naltexone (oral, IM)

   f) é Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? ( ) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section.

   **Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[65],

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

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

[64] http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

[65] Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please respond to the following items:

1. Crisis Prevention and Early Intervention
   - a) é Wellness Recovery Action Plan (WRAP) Crisis Planning
   - b) é Psychiatric Advance Directives
   - c) é Family Engagement
   - d) é Safety Planning
   - e) é Peer-Operated Warm Lines
   - f) é Peer-Run Crisis Respite Programs
   - g) é Suicide Prevention
2. Crisis Intervention/Stabilization
   - a) é Assessment/Triage (Living Room Model)
   - b) é Open Dialogue
   - c) é Crisis Residential/Respite
   - d) é Crisis Intervention Team/Law Enforcement
   - e) é Mobile Crisis Outreach
   - f) é Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Support
   - a) é WRAP Post-Crisis
   - b) é Peer Support/Peer Bridges

c) é Follow-up Outreach and Support

d) é Family to Family Engagement

e) é Connection to care coordination and follow-up clinical care for individuals in crisis

f) é Follow-up crisis engagement with families and involved community members

g) é Recovery community coaches/peer recovery coaches

h) é Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Footnotes:

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.
States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ( ) Yes ( ) No

b) Required peer accreditation or certification? ( ) Yes ( ) No

c) Block grant funding of recovery support services. ( ) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

DMH is committed to the meaningful and sustained involvement of individuals and families in all aspects of the planning and delivery of DMH services. Massachusetts benefits from a strong network of consumers and family organizations that engage with DMH and other partners in a wide range of policy, program, advocacy, and other system-level efforts. These organizations have built strong working relationships across the state. They also effectively identify emerging consumer and family member leaders and provide training and mentoring to support their development as leaders. Parents, family members, and consumers are involved in both the design and implementation phases of DMH services, initiatives, and policies.

A principal means of involving consumers and families is through the State Mental Health Planning Council and its subcommittees. The Planning Council and its subcommittees provide a strong and ongoing voice for recovery and resiliency. The Council has made significant 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 occurring in the Commonwealth. The State Behavioral Health Advisory Council section of the Plan contains detailed information about the contributions of the Council and subcommittees. Family members and consumers are also represented on the Commissioner's Statewide Advisory Council (of which the Planning Council is a standing committee) and on Site and Area Boards that advise on local program development, regulations, statutes and policies. During the last several years, DMH strengthened the infrastructure and supports for consumer, youth and family involvement in policy and program development with the goal that all policy and program development is guided by consumer and family voice.

For children and adolescents, DMH service system planning is intertwined with planning and implementation of the Children's Behavioral Health Initiative (CBHI), the first phase of which was implementation of the remedy for the Rosie D lawsuit. The population directly affected by the remedy (MassHealth members from birth to 21 with SED) includes many families who are also part of the DMH service population. Therefore, as the CBHI implementation progresses, DMH continues to assess how it purchases and delivers services so that its services align with the Commonwealth's overarching goal of a service system for families of children with serious emotional disturbance that addresses child and family needs regardless of the family's insurance status or particular agency involvement. The input from families of youth up to age 21 and from young adults is critical in guiding thinking about the DMH child-adolescent system and is solicited through targeted meetings of parents and young adults, as well as the active participation and engagement of parents who sit as members of CBHI executive and advisory committees and other DMH policy committees. More specific input is also solicited from families and young adults as part of each DMH procurement of child-adolescent services. Family members serve on design teams and co-present with state agency staff at provider forums and meetings with state agency staff as an orientation to new service models being procured.

The DMH Child, Youth and Family Services Division has established several mechanisms for soliciting on-going input from parents and youth to ensure that the Department's procurements, policies, and other activities reflect parent and youth perspectives and experiences. This is particularly evident for Caring Together, the joint DMH-Department of Children and Families program. These mechanisms include:

o Caring Together Family Advisory Committee: comprised entirely of parents and other family members to inform implementation of Caring Together services.

o Caring Together Implementation Committee: comprised of Caring Together providers, state agency staff, and two parents.

o Caring Together Coordinators of Family Driven Practice: Staff who are parents with lived experience raising a child with significant behavioral health needs and have extensive professional experience as a Family Partner, Senior Family Partner, or other Parent Support Provider within the children's behavioral health service system. Their role is to advance family engagement practices and family-driven care within the Caring Together system and lead practice improvement efforts

throughout the Caring Together system.

DMH also contracts with the Parent/Professional Advocacy League (PPAL), the state chapter of the National Federation of Families for Children's Mental Health and statewide organization responsible for making sure that the voices of parents and family members of children with mental health needs are represented in all policy and program development forums both within DMH and in other state agency and interagency forums. PPAL provides training to a network of forty-three family support specialists to enhance their advocacy skills. PPAL maintains regular communication with the local support groups facilitated by family support specialists, and, through them, solicits input on proposed changes to state and federal laws, regulations, and program designs that affect children with mental health challenges. PPAL provides feedback to DMH staff about problems that parents are experiencing in regard to service access and quality based on information from support groups, surveys that it conducts, and calls to the office. PPAL members have also been frank about the fact that, beyond the child identified as the client, family members often have their own needs, and PPAL has advocated for service provision that is built on an understanding of the needs and strengths of both the child and the family. DMH staff maintains regular communication with PPAL and with representatives of other parent organizations serving families whose children have mental health needs.

DMH has paid particular attention to promoting the voices of youth and young adults. The Young Adult (YA) Policy Team, created through a partnership with the TransComr, is comprised of young adults who receive leadership training and coaching as they participate on the subcommittees of the Children's Behavioral Health Advisory Council.

DMH contracts with TransCom, Massachusetts' statewide consumer technical assistance center, to provide leadership, support and training within the peer community. TransCom has taken a lead role in the state in training consumers for leadership roles, conducting annual peer specialist (CPS) trainings and the Massachusetts Leadership Academy. TransCom participates on training teams with DMH and several leading national consultants to provide training on person centered planning and trauma informed care. As a direct result, the number of individuals with lived experience of mental illness who have been trained as Certified Peer Specialists (CPS) and work in the care system continues to increase.

DMH and the peer and provider communities have also identified the need to expand the potential pool of CPS applicants and to provide culturally and linguistically competent peer services. TransCom streamlined the application and interview process for the CPS training to accommodate this applicant pool. The revised process includes a Self-Assessment and on-line preparation course. In addition, Transcom provided four CPS preparation courses to support minority candidates and other underrepresented groups to develop a more diverse peer workforce. Working with Transcom, DMH regularly utilizes Block Grant technical assistance funds to sponsor population specific Peer Support Specialist Training sessions. Deaf, Hard of Hearing, and Deaf Blind individuals and Elders are specific examples.

DMH funds five Recovery Learning Communities (RLCs) described in detail in #3 below. These consumer-run RLCs initiate, sponsor and provide technical assistance to a wide variety of support, education, and advocacy activities spread out across their respective regions of the state and continue to develop their capacity to support the growing peer workforce in Massachusetts.

2. Does the state measure the impact of your consumer and recovery community outreach activity? Yes No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Individual and Family Support is imbedded in the Department of Mental Health's (DMH) mission statement. As the State Mental Health Authority, 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. Its critical mission is accomplished by working in partnership with other state agencies, individuals, families, providers and communities. This ongoing collaboration supports clients, their families, the communities where they live and our sister state agencies.

DMH funds Recovery Learning Communities (RLCs) in each DMH Area to provide peer-to-peer support to individuals living with serious mental illness. . A Recovery Learning Community is a recovery oriented service, addressing one or more of the following four major recovery dimensions: health, home, purpose and community. RLC operations are recovery-based, implementing SAMHSA's principles of recovery into the community-based mental health care system. The services of the RLC are to be delivered primarily by Persons with Lived Experience. The RLC program director and staff who provide direct services must be persons with lived experience and the program director and a majority of full-time staff must have completed a peer certification program and been awarded a certificate by a recognized certified peer specialist program.

RLCs must gather input from community members, DMH and others to determine the types and/or frequency of activities and/or trainings needed in the Area and may choose to have an advisory group or council as a structure to gain input and perform on-going needs assessment responsibilities. These consumer-run RLCs initiate, sponsor and provide technical assistance to a wide variety of support, education, and advocacy activities spread out across their respective regions of the state and continue to develop their capacity to support the growing peer workforce in Massachusetts.

The RLC is expected to serve as a "hub" in its respective DMH Area. The RLC Program is a resource and referral center that provides general information on topics of concern to peers. The information focuses on community resources and programs. Services may be offered in a variety of settings; at the RLC Program site, community mental health centers, inpatient hospitals, generic community settings, town hall, fairs, shopping mall, etc. Services include: providing and/or referring to a wide range of peer to peer support services; supporting the providers of peer-to-peer support through training, continuing education, and consultation; and linking together peer-operated services and supports for the purpose of creating a network. This network improves communication, facilitates the delivery of services, coordinates advocacy, and assists in responding to a person's needs.

aspirations and goals in their valued life roles such as learning, working, social and family relationships, citizenship, and parenting, as they evolve over time. The main goal of every RLC Program is to help persons achieve full community integration. Participation is not an end unto itself, but an additional step toward recovery.

Also for adults living with a serious mental illness DMH funds Afiya House, a peer-run respite provideing individuals experiencing emotional distress with short-term, overnight respite in a home-like environment initiated in 2012. Afiya is further discussed in Planning Step 1.

DMH contracts with TransCom, Massachusetts' statewide consumer technical assistance center, to provide leadership, support and training within the peer community. TransCom has taken a lead role in the state in training consumers for leadership roles, conducting annual peer specialist (CPS) trainings. Transcom was instrumental in the 2016 July and October State Mental Health Planning Council meetings which were devoted to the topic of Certified Peer Specialist and Recovery Coach roles. The SMHP Council supports parallel credentialing processes for both Recovery Coach and Certified Peer Specialist with support of BSAS and DMH respectively. A policy document for circulation statewide was presented, and is included as an attachment here.

DMH continues Gathering Inspiring Future Talent (GIFT) training for young adults. This is an intensive training program that prepares young adults with "lived experience" for the role of Peer Mentors and young adult advisory board members within the Community Service Agencies (CSAs). The training is also open to other young adults with lived experience who are exploring the field of peer support work.

DMH provided a number of trainings and educational tools that focus on the correlation between employment and recovery. A website (www.reachhirema.org) was created as a resource for young adults and those who work with them, focused on resources for pursuing employment, education, and financial management. In addition, several benefits intensive trainings were offered across the state to assist people in making informed decisions about employment options by better understanding their benefits.

For DMH, the term recovery 'support' includes all activities that assist individuals in their recovery and families to promote the growth, resiliency, recovery and rehabilitation of their affected family member. In providing family support, DMH uses the broad definition of family, which may include adults and children, parents and guardians, spouses and partners, other relatives, and non-related individuals whom the client defines as family and who play a significant role in the client's life. In addition, DMH includes support that is provided to the person themselves in order to facilitate his or her recovery process as these activities are central to the mission and values of the Department.

Supports to children and their families are a critical element of the continuing care community-based services and are an integral part of the services described above. Support services for youth and families, including parents and care givers in recovery, are available across the state and include but are not limited to respite services, parent mentors, parent partners, youth mentors, therapeutic recreation, and transportation, including transportation and lodging for families whose children are placed in a hospital or treatment facility at a distance from their home. Further, DMH funds parent support coordinators in every DMH Area. These coordinators, or "Family Support Specialists", assist other parents to navigate the system, access entitlements, and develop the skills that allow them to effectively advocate for the services and supports they and their child need. Family Support Specialists also facilitate parent support groups that are open to all parents or caregivers of a child with emotional or behavioral needs. In addition, DMH provides funding to the Parent Professional Advocacy League (PPAL), the statewide organization that supports and advocates on behalf of parents and families of children with behavioral health needs. This organization works to promote parent participation in policy and program development so that behavioral health services are family-driven and reflect family voice and choice. DMH recognizes that adults with psychiatric conditions are quite likely to be parents themselves and is adapting recovery and support services to meet the unique needs of parents and care givers with mental health conditions.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

BSAS, DMH, and MassHealth have fostered the development of a trained peer workforce and incorporated peer positions into mental health and substance use disorder treatment programs. Specifically:

• 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 ten 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.

• The RLCs provide a range of recovery support services responding to Community Members' needs, aspirations and goals as they evolve over time.

The Massachusetts Organization for Addiction and Recovery is an active participant in the State Mental Health Planning Council, aligning its peer-support efforts with Transcom. These organizations recognize the ongoing need to coordinate and align the mental health and substance use disorder communities. Further, DMH and BSAS provide full support towards screening, assessment and treatment planning for persons living with a dual diagnosis.

DMH is committed to including those with a dual diagnosis of serious mental illness and substance abuse in its programs and services and in providing them with integrated treatment. DMH incorporated program standards for the care and treatment of individuals with co-occurring disorders into its CBFS contracts. These requirements include the capacity to provide or arrange for interventions addressing engagement, relapse prevention, use of self-help groups and peer counseling. Training requirements for managing individuals with co-occurring disorders are included in the Department's Psychiatry Residency and Psychology Internship Training Program.

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 that maximize federal and state dollars. The Department of Public Health/Bureau of Substance Abuse Services (BSAS) and DMH share the goal of finding solutions to those issues inherent in mental health and substance abusing clients who are serviced in both systems and to identify the emerging needs and resources necessary for a successful course of treatment. This past year, IWG has developed a strategic plan with input from all agencies; improved its continuum of substance abuse services from outpatient to residential; encouraged continued support from the interagency community insuring the referral of appropriate youth for services; reviewed the data and outcomes from residential and stabilization services developed by BSAS and identified additional needs, resources and collaborative projects.

5. Does the state have any activities that it would like to highlight?

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

Measuring the impact of consumer and recovery community outreach activities.

Footnotes:

Under item #1 C the Block Grant funded recovery support services are those described within the PACT and Child and Adolescent Day Services programs. Both include recovery support components. Other recovery support components are state funded or funded via MassHealth, the state Medicaid Authority.

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

   - housing services provided. ( ) Yes ( ) No
   - home and community based services. ( ) Yes ( ) No
   - peer support services. ( ) Yes ( ) No
   - employment services. ( ) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? ( ) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

   Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[70]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010

[71] http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

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Please respond to the following items:

1. Does the state utilize a system of care approach to support:

   a) The recovery and resilience of children and youth with SED? ( ) Yes ( ) No

   b) The recovery and resilience of children and youth with SUD? ( ) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

   a) Child welfare? ( ) Yes ( ) No

   b) Juvenile justice? ( ) Yes ( ) No

   c) Education? ( ) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

   a) Service utilization? ( ) Yes ( ) No

   b) Costs? ( ) Yes ( ) No

   c) Outcomes for children and youth services? ( ) Yes ( ) No

4. Does the state provide training in evidence-based:

   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ( ) Yes ( ) No

   b) Mental health treatment and recovery services for children/adolescents and their families? ( ) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

   a) to the adult behavioral health system? ( ) Yes ( ) No

   b) for youth in foster care? ( ) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

   DMH is seeking to improve the integration of the health care system in two broad areas. First, DMH aims to improve the integration of behavioral health, medical and specialty services provided directly to people who receive services as DMH clients. Second, DMH serves in its role as the State Mental Health Authority by engaging in a host of planning activities with state partners and other stakeholders to improve health care integration and outcomes of residents of the Commonwealth. The majority of dental and medical care services for DMH clients are provided through the state Medicaid authority, MassHealth or a third party plan. Part of the responsibility of case managers and program staff is to work with parents, children and youth to help them get connected and stay connected to appropriate services. Eligibility staff work with DMH applicants to assure that they are enrolled for all benefits to which they are entitled, and case managers and provider staff advocate with insurers on questions of coverage. With the introduction of the Accountable Care Organization model, care coordinators will also play a role in linking children and youth to medical and dental services.

   Health and Mental Health Services with Medical and Dental Services

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DMH Community-Based Services – Child

Individual and Family Support Services ("Flex"): Flex Services include an array of interventions available to youth and their families in their homes and communities. Particular service interventions are based on the youth and family needs. Services offered may include, but are not limited to, the following: In-home family treatment interventions, individualized youth support, youth support groups, family support groups, therapeutic recreation and camperships, respite (both in-home, community-based and facility-based), parent peer support specialists, youth peer support specialists, clinical collateral contacts, and specialized consultations.

Therapeutic Day Services: Therapeutic Day Services are voluntary, structured, therapeutic group modalities for children and adolescents who require interventions beyond what the school, family and traditional outpatient or recreational services can provide. A range of structured services are available from a Community Based Therapeutic Recreation Program and Therapeutic Psycho-educational and Recreation Program, to Therapeutic Milieu Programs and .Intensive Day Services.
All are designed to:
• provide services that enable youth to learn and practice skills related to social interaction, vocational/educational tasks, emotional regulation, and symptom management;
• engage youth in pro-social activities which harness youth's strengths and interests and which may expose them to previously unexplored talents and potential avocations;
• assist youth's transition to and engagement in other professional and non-professional supports and services in the community; and
• occur during: full day, partial day, afterschool, early evening, weekend and/or during school vacation.

All Therapeutic Day Services aim to achieve the following outcomes for the youth they serve:
• Increased use of social skills, coping skills and emotion regulation skills in school, home, and community settings.
• Increased positive social interactions with adults and peers.
• Increased school attendance and participation.
• Increase participation in pro-social activities of interest.
• Increase level of functioning in school, family and community settings.

SAMHSA Block Grant funding is directed to support the provision of these important community-based services for DMH enrolled youth.

DMH Community-Based Services for TAY

YOUForward is a Now Is The Time-Health Transitions (NITT-HT) grant focused on two communities in Massachusetts, Haverhill and Lawrence. Funded by SAMHSA, the goals are to: provide services and supports to transition age young adults with mental health concerns who have or are in danger of "falling through the cracks;" increase awareness and reduce stigma around mental health concerns; and in partnership with young adults, state agencies, providers, and the communities, build better policies and systems for transition age young adults. YOUForward offers drop-in centers, young adult peer mentors, high-fidelity Wraparound services (Achieve My Plan [AMP]), Transition to Independence Program (TIP), and Gathering and Inspiring Future Talent (GIFT) training.

DMH has received a new SAMHSA System of Care grant, to start in October, 2017, that will support the development of two new drop-in centers for TAY, one in Springfield, MA (the second largest city in Mass.) and Worcester, MA. Like YOUForward, these sites are intended to be "low barrier" services for TAY, providing a developmentally appropriate setting for TAY with behavioral health needs to explore next steps for themselves, drawing on formal and informal supports and services.

Rehabilitation Services
As DMH is the primary provider/contractor of community-based services, the concepts of rehabilitation and support are at the core of its programs. However, resilience rather than rehabilitation is generally used for children and adolescents as the focus is on getting children on track for age-appropriate development, and acquiring the skills and strategies that will enable them to lead satisfying lives as adults.
Most community-based programs for children and youth promote resilience and supportive functions in a flexible manner to match the goals and needs of the individual client. These include case management, therapeutic day services, supported education and skills training, , individual and family flexible support, including in-home treatment, mentoring and respite care, and a range of residential services, provided in group care, apartment, or home settings.

• For children with severe needs, DMH provides a range of intensive services to meet these needs, including a residential level of care that can be provided in a child's home if clinically appropriate. These include the Caring Together (CT) services, a unique collaboration between DMH and Department of Children and Families (DCF), the Commonwealth's Child Welfare Agency. Caring Together, through joint procurement and contracting processes, established standardized program standards, rate structure, administrative processes, quality oversight, and evaluation for a variety of different service models. Caring Together services include:
• Continuum: For youth who meet clinical criteria for out-of-home placement, the Continuum provides intensive and comprehensive community-based services with out-of-home services available as needed and includes on-going support and education to families regardless of where the services are provided. The settings in which the services can be delivered are group residential treatment programs; therapeutic foster homes; supervised apartments, and the child's own home.
• Residential School Placements: For youth who need a fully integrated educational and clinical treatment residential setting. DMH partners with the youth's Local Education Authority (LEA, i.e., the youth's local school district) to support the placement.
• Group Home: Congregate care residential settings that provide clinical services and supports to meet the mental health needs of the youth. Youth served in these programs leave grounds for school programming.
• Short Term Assessment and Rapid Reintegration (STARR) services provide short term assessment and rapid reunification with the family.
• Family Partner Service: This service is provided to parents and caregivers of youth receiving a Caring Together service by a trained professional who shares the experience of parenting a child/youth with significant mental/behavioral health needs. A Family Partner provides information and education to parents about the mental health system; assists parents in developing skills that help them successfully navigate the system and advocate on behalf of their and their child's needs; assists parents in navigating the system and accessing services and supports; and provides emotional support to the parent/caregiver.

In addition to community based services, DMH also contracts for continuing care inpatient services for adolescents, and for secure intensive residential treatment programs:

• Statewide Programs: The most intensive, 24-hour, locked facilities available in the Commonwealth for seriously emotionally disturbed youth. These programs include:
• Intensive Residential Treatment Programs (IRTP): These services are for adolescents who meet the state's definition for commitment under the mental health statute but who do not need hospital level of care. These youth are typically involved with multiple state agencies. IRTPs are locked 24 hour programs for adolescents.
• Clinically Intensive Residential Treatment (CIRT): This is staff-secure residential services with on-site schooling for children 6-12 ("latency age") who present a serious risk of harm to themselves or others.
• Continuing Care Inpatient Services: Hospital-based psychiatric care in locked units for children and adolescents who have completed a course of acute inpatient treatment or court-referred youth who require a court-ordered evaluation; and require continuing intensive medical and/or psychiatric stabilization. DMH has one contract for 2 units, total capacity of 30 beds at WRCH.

Juvenile Court Clinics: Funded by DMH in collaboration with the Juvenile Court Department of the Trial Court, juvenile court clinics operate across the state to provide assessments and referrals for children who come before the court, and that thereby promote diversion into treatment.
Each person receiving DMH funded direct services has an Individualized Action Plan (IAP) specifying the range of services and supports that will be provided to the child and or family by DMH service providers, and the outcomes these services are expected to achieve. If a youth is receiving DMH case management services, then s/he will also have an Individual Service Plan (ISP). Developed by the DMH Case Manager, the ISP is individualized, identifying the client's goals, strengths, and needs, the DMH services and programs that address those needs, as well as the program specific treatment plans prepared by the service providers.

Support Services
Supports to children and their families are a critical element of the community-based services and are an integral part of the services described above. Support services for youth and families are available across the state and include but are not limited to respite services, family partners, youth mentors, therapeutic recreation, and assistance with transportation for families whose children are placed in a hospital or treatment facility at a distance from their home.
DMH funds Family Support Specialists in every DMH Area. Family Support Specialists are parents with lived experience caring for a child with serious emotional disturbance who assist other parents to navigate the system, access entitlements, and develop the skills that allow them to effectively advocate for the services and supports they and their child need. Family Support Specialists facilitate parent support groups that are open to all parents or caregivers of a child with emotional or behavioral needs and serve as an important resource in their communities to increase awareness about children's mental health. This includes providing training and consultation to local schools and/or local school systems regarding behavioral health needs of children, youth, and young adults; and providing information and resource referral to anyone in the community in need of information and/or assistance relating to children's mental health issues. In addition, DMH provides funding to the Parent Professional Advocacy League (PPAL), the statewide organization that supports and advocates on behalf of parents and families of children with behavioral health needs. PPAL, affiliated with the National Federation of Families for Children's Mental Health, works to promote parent participation in policy and program development so that behavioral health services are family-driven and reflect family voice and choice.

Employment Services
The increased national focus on transition age youth and young adults, ages 16-25, has increased the attention given to pre-

vocational skill development, supported work and supported education activities. Residential providers and those providing intensive in-home interventions focus on arranging and supporting part-time work opportunities for youth that they can manage while still in school and during the summer. DMH trains Case Managers and Family Support Specialist to understand the requirements of the IDEA and WIOA (Workforce Innovation and Opportunity Act), how to access services for young adults served by DMH from the Massachusetts Rehabilitation Commission (MRC), and how to use the IEP process to promote vocational preparation.

DMH continues to work with the Massachusetts Rehabilitation Commission (MRC), the state's vocational rehabilitation agency, and its staff in supporting employment and higher educational opportunities for young adults served by DMH. The two agencies have (recently?) executed a Memorandum of Understanding (MOU) to create an "Implementation/Steering Committee", including young adult representative, to coordinate this work.

DMH also works closely with the Massachusetts Department of Labor and Workforce Development (DOLWD) and its Commonwealth Corporation (Commcorp) programs. DOLWD sponsors Workforce Investment Boards and oversees Career Centers that offer one-stop shopping for young adults.

In partnership with Commcorp and Employment Options (a DMH-funded Clubhouse), DMH secured a grant award of $162,780 to engage interagency partners in the design of a training curriculum and the allocation of employment positions for transition age youth. The "Gathering & Inspiring Future Talent (GIFT) Training" curriculum is the standardized training for young adults who are interested in exploring opportunities to become Peer Mentors/Peer Support Workers. It also supports young adults who are becoming active in youth advisory groups and other venues that seek to develop and promote the young adult voice. This training is expected to lead to further education, internships, participation in certified peer specialist training and employment.

DMH continues to develop the Transition Age Youth Peer Mentor workforce by increasing the use of TAY Peer Mentors in contracted programs and by sponsoring TAY Peer Mentor training programs. Through the support of a SAMHSA System of Care Grant and Cooperative Agreement, the Success for Transition Age Youth and Young Adults (STAY) initiative piloted the use of TAY Peer Mentors as Therapeutic Mentors within 12 MassHealth-funded Therapeutic Mentoring programs. Staff from DMH's Children's Behavioral Health Knowledge Center, MassHealth and the pilot provider agencies have developed a Young Adult Peer Mentor Practice Profile, a highly detailed practice standard for this service. The Practice Profile will be disseminated to all MassHealth-funded Therapeutic Mentoring programs in Massachusetts, facilitating their ability to effectively hire, train and supervise TAY Peer Mentors as Therapeutic Mentors.

Housing Services

Virtually all youth under the age of 18 served by DMH who are not in a residential treatment program live in the home of a family member or foster home, as do most youth who are age 18. DMH focuses on supports to youth and their families or caregivers in order to facilitate that kind of living arrangement, as is normative as well as economically realistic. Most youth, however, aim to eventually live independently. DMH supports this goal in several ways. Adolescent residential providers are required to use a formal curriculum to teach independent living skills, and teaching these skills can also be a focus of intervention for those receiving Community-Based Flexible Supports (CBFS). DMH currently funds a few supported housing slots specifically for older youth. As an agency, DMH has sponsored aggressive efforts to increase supported housing opportunities for the people it serves. DMH Central Office housing staff works with Area Housing Coordinators, DMH providers and state and local housing agencies to increase housing supply.

Central Office (CO) TAY policy staff are working with other CO staff developing standards for a reprocurement of the current Community-Based Flexible Support (CBFS) services program. Together, they are developing a plan for supportive housing for TAY within CBFS.

CO TAY staff represent DMH in an Executive Office of Health and Human Services (EOHHS) Secretariat-wide Unaccompanied Homeless Youth Commission to study and make recommendations for services for unaccompanied homeless youth age 24 and younger.

Members of the Youth Development Committee (YDC) have joined the State Mental Health Planning Council's Housing Subcommittee to represent and ensure the housing needs and concerns of young adults are addressed.

Educational Services

Children receiving community-based mental health services, including those living in residential programs, receive their educational services through their local educational authority, and are enrolled in public school programs or special education day programs either within or outside the school district. Most DMH clients receive special education services, while some receive Section 504 accommodations to address their mental health needs. In accordance with state law, the state Department of Elementary and Secondary Education (DESE), through its division of Special Education Services in Institutional Settings (SEIS) is responsible for delivery of educational services in DMH's inpatient and intensive residential programs, either directly or through provider contracts. DMH program staff work closely with the SEIS teachers assigned to them so that their work and approach with the child is complementary.

Each DMH Area funds Family Support Specialists through community and school support contracts with providers to offer training and consultation to local schools and/or local school systems regarding behavioral health needs of children, youth, and young adults. The focus of training is to help school staff understand the needs of children with serious emotional disturbance and other behavioral health needs, develop sensitive and effective classroom responses to children with SED, identify children at suicidal risk and implement suicide prevention strategies, respond to individual or community trauma, and facilitate referrals to mental health services.

Services Provided by Local School Systems under the Individuals with Disabilities Education Act (IDEA)

Local systems provide counseling within the school, usually contracting with local DMH providers for this and child specific

consultation. Schools provide a variety of interventions, including but not limited to: aides; resource rooms; substantially separate classrooms, within district or out of district, or operated by educational collaboratives; home tutoring; or placement in residential school. Depending on circumstances, DMH may pay for the residential component of such a placement while the school system pays for the education only component. If a child is enrolled in a DMH after-school treatment program, schools may provide transportation to the program.

DMH provides training for case managers on accessing services under Individuals with Disabilities Education Act and under Section 504. PAL and Family Support Specialist provide similar trainings to parents in the community. Parents receive assistance with individual educational issues. Case managers attend IEP meetings at school, or provide information to the team, as requested by the parent, and with parental approval school staff participates in Individual Service Planning meetings. An attempt is made to have the IEP and ISP meetings held at the same time and place, to assure that the plans are complementary. As noted above under Educational Services, children in hospitals or intensive residential treatment programs have their special education services delivered through the Department of Elementary and Secondary Education in accordance with the local IEP.

The state director of special education participates on almost all interagency planning activities related to children's mental health, including the CBHI Advisory Committee and the Department of Elementary and Secondary Education (DESE) has been a payer in interagency blended funding initiatives.

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 in providing them with integrated treatment. DMH incorporated 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. Training requirements for managing individuals with co-occurring disorders are included in the Department's Psychiatry Residency and Psychology Internship Training Program.

To increase access and the quality of services for youth and young adults, 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 that maximize federal and state dollars.

The Department of Public Health/Bureau of Substance Abuse Services (BSAS) and DMH share the goal of finding solutions to those issues inherent in mental health and substance abusing clients who are serviced in both systems and to identify the emerging needs and resources necessary for a successful course of treatment. This past year, IWG has developed a strategic plan with input from all agencies; improved its continuum of substance abuse services from outpatient to residential; encouraged continued support from the interagency community insuring the referral of appropriate youth for services; reviewed the data and outcomes from residential and stabilization services developed by BSAS and identified additional needs, resources and collaborative projects.

The Children's Behavioral Health Knowledge Center funded implementation of the evidence-based Screening, Brief Intervention and Referral to Treatment (SBIRT) model in three outpatient mental health clinics serving children and youth in southeastern Massachusetts in State Fiscal Year 2017. Use of SBIRT by clinicians dramatically increased identification and treatment of SUD among youth served by the clinic.

Case Management Services

DMH remains committed to providing case management services to assist youth and their families access services available across the system of case that best meet their needs, and partner with youth and families in service planning and coordination, and assist them with securing entitlements. DMH Child, Youth, and Family Case Managers currently serve approximately 650 children and youth annually.

Reducing the Rate of Hospitalization

DMH has continued to work hard to shift its focus to community-based care. 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 continuing and rehabilitative care in the community.

The emphasis on prevention of seclusion and restraint has substantially reduced the need for continued care hospitalization, as high restraint use was a key indicator of the need for ongoing hospitalization. In 2007, DMH closed one of its three continuing care adolescent units, leaving a capacity of two units with 30 beds, and redeployed the funds into diversionary services and other community supports.

7. Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ( ) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

The Massachusetts Strategic Plan for Suicide Prevention (State Plan) is an initiative of the Massachusetts Coalition for Suicide Prevention, working in collaboration with the Department of Public Health (DPH) and DMH. The Massachusetts Coalition for Suicide Prevention (MCSP) is a broad-based inclusive alliance of suicide prevention advocates, including public and private agency representatives, policy makers, suicide survivors, mental health and public health consumers and providers and concerned citizens committed to working together to reduce the incidence of self-harm and suicide in the Commonwealth. From its inception, the Coalition has been a public/private partnership, involving government agencies including DPH and DMH working in partnership with community-based agencies and interested individuals. The attached Massachusetts Strategic Plan for Suicide Prevention, initially released in 2009 and modified in 2015, still provides the framework for identifying priorities, organizing efforts, and contributing to a statewide focus on suicide prevention. The plan's development was guided by a seven-member Steering Committee convened by MCSP, with DPH as the lead agency and the Department of Mental Health's (DMH) support. The 2017 DMH submission for Zero Suicide grant funding reflects the state's continued commitment to adopt and promote Zero Suicide for its defined patient population.

DPH, DMH and the Coalition collaborate on a number of the initiatives outlined in the plan, including:

• The Zero Suicide Learning Collaborative to promote and support the implementation of Zero Suicide in state agencies, health care systems, and community provider organizations across the state which will be co-chaired by the DMH and DPH Suicide Prevention leaders. Members of the Collaborative will include other state agencies, e.g. DYS and DCF, and Massachusetts Behavioral Health Partnership, the Medicaid payor for 1200+ providers.

• Nine 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.

• The state-wide suicide prevention campaign targeting middle aged men who have the highest rates of suicide in the state, MassMen (http://massmen.org/).

• The integration of attempt survivors, in addition to loss survivors, into the membership and leadership voice of the state and regional coalitions.

• State funding for the development, dissemination and implementation of Alternatives to Suicide, a peer to peer support group for people contemplating suicide.

• State funding support for suicide prevention services targeting veterans, older adults, college and university students, youth and young adults, mid-life adults, GLBT youth, and transgender people. DPH publications of annual data on suicide and self-inflicted injuries, and provision of targeted data to communities

• Provision of education and training for Recovery Learning Centers and promotion of suicide prevention through Trauma Informed Care education.

• Collaboration between DPH, DMH and the Coalition to co-sponsor the annual Massachusetts Suicide Prevention Conference, attracting hundreds of participants each year.

• DMH and DPH have partnered with MBHP (the primary behavioral MCO in MA) to promote Zero Suicide throughout the entire health care system.

• DMH and DPH have co-sponsored a Zero Suicide (ZS) Learning Collaborative with four hospitals and four community mental health providers.

• DMH, DPH and MBHP are working with our statewide system of 24-hour psychiatric service providers and our state suicide prevention suicide call-centers (Lifeline) to institute follow-up support following a ED or inpatient admission for suicide.

In FY 2017, DMH Commissioner Mikula convened a Suicide Prevention Steering Committee to examine how DMH can better address suicide prevention across the continuum of services which DMH provides. The Suicide Prevention Steering Committee is comprised of DMH staff from all five areas, child and adolescent services, forensic services, inpatient, outpatient, and community services, recovery services, quality management, etc. as well as two consultants from the Riverside Trauma Center. The committee is

utilizing the Zero Suicide model of quality improvement to organize this effort. An initial focus area is adopting standard tools for suicide-focused screening, assessment and treatment planning. The DMH Division of Clinical and Professional Services has responsibility for this task,has convened a Suicide Assessment Working Group.

3. Have you incorporated any strategies supportive of Zero Suicide? Yes No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? Yes No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? Yes No

If so, please describe the population targeted.

DMH is targeting people living with SMI and has prioritized Zero Suicide implementation within the nine DMH operated and contracted inpatient facilities.

Does the state have any activities related to this section that you would like to highlight?

The Massachusetts Department of Mental Health proposes a Zero Suicide Initiative (ZSI) that will 1) embed ZS components in DMH's nine inpatient facilities. To ensure patients have a safe transition after discharge, the ZSI will 2) engage a ZS Resource Development Coalition (RDC) to enhance community based suicide informed clinical and support resources in each DMH Area, and 3) design and implement Engagement and Follow-up Services (E&F), to provide a caring connection and support. The population of focus is the very vulnerable population of adults over age 25 with Serious Mental Illness served in DMH continuing care and acute inpatient facilities. The rate of suicide is among all DMH clients is ten times higher than the state's, and is rising (MDMH, 2017c). The risk is even higher for those who have had a psychiatric hospitalization, especially in the first three months after discharge (Chung et al., 2017). Demographically, DMH clients are slightly more than half male, and 3% Veterans. Two-thirds identify as Cauca-sian; 13.7% as African American 6.4% as Hispanic and 2.7% as Asian Twelve percent prefer to speak another language, primarily Spanish (3.4%) (MA DMH, 2017a).
In Y1, DMH ZSI will conduct ZS self-studies at the state and facility level to guide implementa-tion of all ZS components within each inpatient facility. A statewide ZS Steering Committee, and facility based Leadership and Implementation Teams, each with attempt and loss survivor mem-bers, will: during Y1, develop and implement consistent statewide policies and protocols incor-porating ZS standards of care; train 90% of DMH inpatient facility staff in suicide awareness and gatekeeper skills; and train direct care and clinical staff in suicide-relevant EBPs. During Y2, these strategies should result in: comprehensive EHR documentation of suicide screening, as-sessment, a standardized patient centered discharge planning process for 90% of admissions; and suicide specific treatment, a standardized patient centered discharge planning process, and tele-phone follow-up within 48 hours will be provided for 90% of inpatient admissions at risk for sui-cide. An unduplicated 9,475 inpatient admissions will be screened for suicide, and 1706 will get suicide specific treatment.
Each year, one DMH Area will engage community treatment, services and suicide prevention providers in a ZS RDC committed to provide rapid access and coordinated care. Each RDC will develop service pathways that, by the end of the RDC's first year, achieves a clinical visit within 1 week of discharge for 85% of discharged patients at risk of suicide. The ZSI team will expand access to suicide specific treatment by training 150 community clinicians across the state, and support RDC members in partners in developing suicide safer environments. A total of 3425 people will receive suicide training through the ZSI.
To provide support for safe transitions, the ZSI will design and implement E&F Services provid-ed by trained Crisis Call Center volunteers who make a caring telephonic connection with 987 people at risk of suicide within 24 hours of discharge, and offer ongoing emotional support and reinforcement of their comprehensive discharge plan until they are engaged in community care.
The DMH Zero Suicide initiative is beginning with our inpatient units but includes our community and outpatient providers so that we are addressing the full continuum of care from the beginning. The Implementation team is comprised of people with lived experience as well as staff representative of all departments and functions. Our training director is working closely with DPH Suicide Prevention Committee to identify training priorities to assure a workforce competent in ZS best practices.

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

Approaches to tracking suicide attempts for the general state population would be useful.

Footnotes:

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ( ) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes ( ) No

If yes, with whom?

DMH is now engaged in a significant redesign of its community-based service system, with the development of a new service model replacing the Community Based Flexible Supports (CBFS) model and integrating with MassHealth's ACO/Behavioral Health Community Partners. Thus, the DMH partnership with MassHealth has taken on a new aspect, including service model planning and data sharing. The DMH "New Model" requires that providers integrate evidence-based and best practices into the service delivery structure. Specifically, providers are required to utilize trauma-informed practices and to adhere to the principles of IPS model of Supported Employment. MassHealth and DMH encourage providers to develop and maintain housing options that are consistent with the Supported Housing model. Statewide and regional DMH housing staff provide technical assistance and support to CBFS providers. The DMH Director of Employment continues to monitor, evaluate, and coordinate the Department's various employment services and staff.

Further, to monitor the extent of opioid related fatal and nonfatal overdoses both in the Commonwealth DMH has entered into a new data sharing partnership with the DPH under Chapter 55. Through a data exchange, DPH examined the experience of 22,704 DMH clients served in the community between 2011-2015. DPH determined that the rate of overdose deaths and nonfatal overdoses found among DMH clients was much higher than that found for the state's population, about 6 times higher on an annual basis. There was also a higher rate of multiple overdoses seen in DMH clients, but he did not include that ratio. The specific results sent are as follows:

1. 85/22,704 DMH clients (0.37%) had an opioid related overdose death.

2. 85/5,170 opioid related overdose deaths (1.64%) were in the DMH population.

3. 734/22,704 DMH clients (3.23%) had at least 1 Non -Fatal Overdose (NFO) and these 734 people had a total of 1,096 NFOs.

4. 734/31,469 people who had an NFO (2.33%) were in the DMH population.

5. 800/22,704 DMH clients (3.52%) had an NFO and/or a fatal overdose.

6. 800/35,791 people who had an NFO and/or a fatal overdose (2.24%) where in the DMH population.
DMH and DPH will continue to monitor overdose prevalence through this partnership.

Also, DMH has greatly strengthened its alliance with the Executive Office of Health and Human Services Information Technology Services Division and the new Executive Office of Technology Services and Security. An important project nearing completion with these partners is implementation of the DMH Safety Learning System, a web application through which DMH will manage reported incidents of harm to staff or to clients. This new application represents a first use of a SaaS, software as a service solution, with the vendor providing both an application lease with hosting. Other projects underway include a server upgrade, and a data quality initiative.
Historically, EOHHS IT has delegated to one Assistant Chief Information Officer responsibility for the technology and data systems of DMH, the DPH hospitals and the Department of Developmental Services (developmental and intellectual disabilities). During this time, the DMH was under-served, Through a new 2017 partnership, the DMH now has an Assistant Chief Information Officer devoted entirely to the agency, who works closely with the DMH Assistant Commissioner for Quality, Utilization and Analysis and the DMH Security Liaison. An early product of this new partnership is an initial Information Technology Capital Improvement award dedicated to completing an assessment of the agency's technology and data needs, a 5 year technology road map for improvement and a strategy for new systems adoption.
Another new partnership involves the Center for Health Information and Analysis (CHIA), an agency created under Chapter 224 operating within the Executive Office of Health and Human Services. CHIA invited the DMH analytics team to join its 3 part "Data Science" institute, which will address advanced analyses using Excel, analyses of claims data and an assessment of an analytic tool kit. CHIA is also currently partnering iwth DMH on a 'case mix' project, which will lead to a greater understanding of clients served in DMH continuing care as compared with clients served in acute facilities.
With the Health Policy Commission, DMH is working with its EOHHS partners and the Blue Cross Blue Shield foundation to assess and align multiple Community Resource Directory projects. Under EOHHS leadership, the goal is to understand how to best support web-based community resource directories that can best guide providers in coordinating care and services for clients.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

DMH is actively engaged with it state partners on numerous initiatives aimed to improve service delivery and outcomes for individuals and families served by multiple agencies and the broader behavioral health care system. The table below identifies the state agencies with which DMH is partnering, and lists the activities. Many of these activities are listed throughout the submission.

Executive Office of Health and Human Services (EOHHS)/ MassHealth
• Joint management of the Massachusetts Behavioral Health Partnership (MBHP) contract
• Coordination of the One Care Implementation Council; expansion of Family Partners; implementation of the Family Support Plan
• Behavioral Health Community Partners
• Positive Behavioral Interventions and Supports in schools initiative

Department of Housing and Community Development (DHCD)
• Chapter 679/167 Special Needs Housing Program, DMH Rental Subsidy Program, Facilities Consolidation Fund, DHCD Interagency Supported Housing Initiative; mental health support and coordination for families assigned by DHCD to motels for shelter

MassHousing
• Set-Aside of affordable units for use by DMH

Department of Children and Families
• DMH/DCF Caring Together Services
• Expansion of Family Partners (within Caring Together Services)
• Ongoing cross-training, DMH consultations to DCF regarding service planning and other planning activities

Massachusetts Rehabilitation Commission
• Memorandum of Understanding, including designation of local liaisons and MOU Implementation Committee

Department of Elementary and Secondary Education (DESE)

• Educational services in inpatient and intensive residential settings
• Positive Behavioral Interventions and Supports in schools initiative

Department of Public Health
• Interagency Work Group, addressing substance abuse and mental health service needs; Aggressive Treatment and Relapse Prevention Program (ATARP); Family Substance Abuse Shelters; Elder Collaborative; Summit on Older Adults
• Joint sponsorship of the Massachusetts State Leadership Academy on Tobacco-free Recovery and ongoing subcommittee work; Massachusetts Coalition for Suicide Prevention
• Elder Mental Health Planning Collaborative, Summit on Older Adults

Courts
• Court Clinics, Mental Health Courts, Tenancy Prevention Program (TPP)

Police Department
• Jail Diversion Programs

Department of Veterans Services
• MISSION Implementation Services, Peer Support

Prisons and Houses of Correction
• Forensic Transition Team

Department of Correction
• Joint committees on care and treatment of inmates and persons served at Bridgewater State Hospital
• Department of Justice, Second Chance Act

Executive Office of Elder Affairs
• Elder Mental Health Planning Collaborative, Summit on Older Adults; participation on the Elder Mental Health Planning Collaborative

Department of Developmental Services
• Co-funding of two Regional Employment Collaboratives

Department of Youth Services
• Interagency protocols addressing information sharing and transition planning

Department of Early Education and Care (DEEC)
• DESE Statewide Advisory Committee on Special Education

Historically, great barriers to data sharing across state agencies existed. Under the Baker administration, with leadership from Secretary Sudders and Commissioner Mikula, DMH has been able to plan and execute a greater variety of data sharing projects in particular for development, implementation and monitoring of the Behavioral Health Community Parnters-DMH New Model alignment described above.

Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[72]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[72] http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   The Planning Council reviews the Department's State Plan, monitors its implementation and advocates regarding mental health system issues. The Council met on July 14, 2016 to begin a two meeting focus on the current state of Peer services and Funding Mechanisms, and to assess accomplishments along with concerns and barriers peers face. Panelists including a Peer Mentor, the Transformation Center's Executive Director, the Massachusetts Organization for Addiction Recovery, and DMH leads for the STAY initiatives and Elder Health. Topics discussed included Medicaid support, Recovery Coach Credentialing, as well as MA accomplishments in support for the peer community and workforce. At the October 13, 2016 meeting the focus turned to funding for peer services. It was noted that the MA CCBHC planning grant had included funded peer positions as part of its Prospective Payment System proposal. Further discussion noted a geographically based difference of opinion on funding documentation among Peer specialists. At the core was the need to distinguish between a 'peer role' and a 'professional role' with the latter more focused on documentation. The January 12, 2017 meeting focused on subcommittee reports but also included important reminders of compliance with the Commonwealth's Open meeting law. The Council meeting on April 13, 2017 to hear from the Deputy Commissioner for Child, Youth and Family Services, the Housing Sub-Committee and results of the community Consumer Satisfaction Survey. The Council met again on July 13, 2017 to review the draft of the Plan and prepare the Planning Council letter. As is customary at Planning Council meetings, the Commissioner and other members of DMH senior leadership are in attendance.

   The Planning Council and its subcommittees provide a strong and ongoing voice for recovery and resiliency. The Council has made significant contributions in identifying particular domains needing transformation in the mental health system in Massachusetts. As described above and in the Unmet Service Needs and Critical Gaps section, many of the subcommittees contributed data and information that is used to describe and define these needs. In addition, the Council and subcommittees have played an active role in planning many of the transformation efforts occurring in the Commonwealth.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i — ( ) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)? — ( ) Yes ( ) No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery,

families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Many members of the Planning Council are also involved in locally based participatory planning processes and with other advocacy groups. As issues arise, smaller groups function as subcommittees of the Council, with membership that includes individuals on the Planning Council as well as other interested persons. These issues include the mental health needs of elders, children and adolescents, young adults, parents, cultural/linguistic minorities, and topics on consumer-directed activities and restraint/seclusion elimination. These 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.

Does the state have any activities related to this section that you would like to highlight?

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

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

August 28, 2017

Joan Mikula, Commissioner
Department of Mental Health
25 Staniford Street
Boston, Ma. 02114

Dear Commissioner Mikula,

The State Mental Health Planning Council (Council), a subcommittee of the Mental Health Advisory Council, met on July 13th to review the State 2018-19 Fiscal Year, State Mental Health Plan (Plan), as part of the Commonwealth's Community Mental Health Services Block Grant application.

We are grateful to you and others at the Department for your transparency and effective planning process that engages a wide stakeholder group to address service needs and policy recommendations. As the Chair of the Housing Subcommittee, I have seen firsthand that through this process, services and policies for consumers in mental health recovery are continually being reviewed, and when fiscally sound, service gaps and policies are implemented to better address the needs of the people we serve.

As a result of this thoughtful planning process, we want you to know the Council unanimously voted to approve the Plan, in its entirety.

Overall Comments from Council
Council members expressed appreciation for the extensive information provided in the Plan. This has been a year of planning and changes within the Department, with several services set for re-procurement. The Committee recognizes the work that is being done to ensure all stakeholders have a voice in changes and redesigns of the current programs for adult, child, adolescent and family services.

Specific Comments from Committees and Stakeholders

The Youth Development Committee appreciates the Department's work in developing employment and educational opportunities. The promotion of having young adult peer advocates in state, licensed and contracted programs has helped to ensure that their voices are heard.

The Housing Sub Committee acknowledges the need for increased housing capacity. Housing vouchers and set-asides are in constant demand and, while the number of

individuals requesting housing assistance has increased, supply had not kept up with demand.

The Employment Subcommittee of the Council has been a strong advocate for increasing access to employment services and improving employment outcomes. They appreciate the work the Department has done in strengthening ties with the Massachusetts Rehabilitation Commission and with Work Without Limits.

Parent Subcommittee acknowledges the work of the Department in the integration between adult and child systems for parents and families affected by mental illness, yet agrees there is more that needs to be accomplished. Key thought leaders will need to be involved to continue to shift systems and reduce "silos: between agencies and departments within agencies to ensure comprehensive planning, resources and expertise sharing resulting in empowering and strengthening families."

The Restraint and Seclusion Elimination Subcommittee has undergone numerous member changes and additions. Several key people from state facilities have now joined the Subcommittee and are providing needed information and feedback.

TransCom acknowledged the key points and challenges Peer Specialist/Workers are experiencing in the workforce as identified in the Plan. Training and workforce resources are needed across the provider network to establish guidelines for the successful integration of peer workers in the mental health care delivery system.

Finally, the Council wishes to recognize the work the Department has done with the opening of the Women's Recovery from Addictions Program (WRAP.) This is a positive step in the treatment of co-occuring mental health and substance abuse disorders.

Yours truly,

Anne Whitman
Co Chair

Jonathan Bowen-Leopold
Co Chair

Danna Mauch
Co Chair

Joseph Finn
Housing Sub-committee Chair

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Steve Aalto	Providers	Work, Inc	1419 Hancock Street Quincy MA, 02171 PH: 617-691-1702	saalto@workinc.org
Chantell Albert	Parents of children with SED		45 Bromfield Street Boston MA, 02108 PH: 617-542-7860	
Jonathan Bowen-Leopold	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Young Adult consumer	76 Union Street Randolph MA, 02368 PH: 774-286-9172	
Tom Brigham	Others (Not State employees or providers)	Massachusetts Housing & Shelter Alliance	PO Box 120070 Boston MA, 02112 PH: 617-367-6447	
Rep. F.D. Antonio Cabral	State Employees	Massachusetts House of Representatives	State House Boston MA, 02133 PH: 617-722-2140	
James Callahan	Others (Not State employees or providers)	Hawthorne Services	78 Main Street Chicopee MA, 01020-1838 PH: 413-592-5199	
Bernard J. Carey	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Massachusetts Association for Mental Health	130 Bowdoin Street Boston MA, 02108 PH: 617-742-7452	berncarey@aol.com
Valeria Chambers	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Consumers of Color Peer Networking Project-M*Power	70 St. Botolph Street Boston MA, 02116 PH: 617-424-9665	
Theodore Chelmow	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Consumer Quality Initiatives, Inc.	98 Magazine Street Roxbury MA, 02119 PH: 617-427-0505	
Brenda Correia	State Employees	Executive Office of Elder Affairs	One Ashburton Place Boston MA, 02108 PH: 617-222-7482	
Deborah Daitch	Family Members of Individuals in Recovery (to include family members of adults with SMI)		87 Pine Stret Norton MA, 02766	
Deborah Delman	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	The Transformation Center	98 Magazine Street Roxbury MA, 02119 PH: 617-442-4111	

Jon Delman	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Technical Assistance Center	12 Summer Street Stoneham MA, 02180	
Vic DiGravio	Others (Not State employees or providers)	Mental Health & Substance Abuse Corporations of Massachusetts, Inc.	251 West Central Street Natick MA, 01760 PH: 508-647-8385	
Elena Eisman, Ed.D	Others (Not State employees or providers)	Massachusetts Psychological Association	195 Worcester Street Wellesley MA, 02481 PH: 781-263-0080	
Dana Farley	Parents of children with SED	Wayside Youth & Family Support Network	118 Central Street Waltham MA, 02453 PH: 781-891-0556	
Robert Fleischner	Others (Not State employees or providers)	Center for Public Representation	22 Green Street Northampton MA, 01060 PH: 413-586-6024	
Lawrence Gottlieb	Providers	Eliot Community Services	186 Bedford Street Lexington MA, 02420 PH: 781-734-2025	
Mary Gregorio	Providers	U.S. Psychosocial Rehab Association/Center House, Inc.	31 Bowker Street Boston MA, 02114 PH: 617-788-1002	
Lisa Gurland	State Employees	Other	Department of Public Health Boston MA, 02108 PH: 617-624-5294	
Phil Hadley	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI-Mass	400 West Cummings Park Woburn MA, 01810 PH: 781-938-4048	
Marjorie Harvey	Others (Not State employees or providers)	Statewide Advisory Committee	80 Park Street Brookline MA, 02446 PH: 617-735-9477	
Don Hughes	Providers	Riverside Community Care	450 Washington Street Dedham MA, 02026 PH: 781-329-0909	
Susan Keiley	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Eliot Community Human Services, Inc.	75 Pleasant Street Arlington MA, 02476 PH: 781-643-5093	
Robert Kinscherff	State Employees	Criminal Justice	Administrative Office of Juvenile Court Boston MA, 02124 PH: 603-391-4418	
Chrystal Kornegay	State Employees	Housing	Department of Housing and Community Development Boston MA, 02114 PH: 617-573-1101	

Lisa Lambert	Parents of children with SED	Parent/Professional Advocacy League	59 Temple Place Boston MA, 02111 PH: 617-542-7860	
Frank Laski	Others (Not State employees or providers)	Mental Health Legal Advisors Committee	399 Washington Street Boston MA, 02108 PH: 617-338-2345	
Pat Lawrence	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI-Mass	8 Elliot Road Lynnfield MA, 01940 PH: 781-334-5756	
Nancy Blake Lewis	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Refuah	15 Hemlock Terrace Randolph MA, 02368 PH: 781-961-2815	
Laurie Markoff, Ph.D.	Providers	Institute for Health and Recovery	349 Broadway Cambridge MA, 02139 PH: 617-661-3991	
Laurie Martinelli	Others (Not State employees or providers)	NAMI-Mass	400 West Cummings Park Woburn MA, 01801 PH: 781-938-4048	
David Matteodo	Leading State Experts	Massachusetts Association of Behavioral Health Systems	115 Mill Street Belmont MA, 02478 PH: 617-855-3520	
Danna Mauch	Leading State Experts	Massachusetts Association for Mental Health	130 Bowdoin Street Boston MA, 02108 PH: 617-680-8200	
Dennis McCrory, M.D.	Others (Not State employees or providers)	Friends of the Psychiatrically Disabled	6 Ridge Avenue Newton Center MA, 02459 PH: 617-471-9990	
Lauri Medeiros	Parents of children with SED	Mass Families Organizing for Change	94 Edward Street Medford MA, 02155 PH: 617-605-7404	
Joan Mikula	State Employees	Mental Health	25 Staniford Street Boston MA, 02114 PH: 617-626-8086	
Marcia Mittnacht	State Employees	Education	350 Main Street Malden MA, 02148 PH: 781-338-3388	
Kate Nemens	Others (Not State employees or providers)	Mental Health Legal Advisors Committee	399 Washington Street Boston MA, 02108 PH: 617-338-2345	
Adelaide Osborne	State Employees	Vocational Rehabilitation	600 Washington Street Boston MA, 02111 PH: 617-204-3620	
Ruth Rose-Jacobs	Parents of children with SED	Boston University School of Medicine & Boston Medical Center	91 East Concord Street Boston MA, 02118 PH: 617-414-5480	
			47 Harold Street	

Darcy Rubino	Parents of children with SED		North Andover MA, 01845 PH: 978-201-1196	
Sarah Ruiz	State Employees	Other	Department of Public Health Boston MA, 02108 PH: 617-624-5136	
Beverly Sheehan	Others (Not State employees or providers)	Massachusetts Psychiatric Society	40 Washington Street Wellesley MA, 02181 PH: 781-237-8100	
Linda Spears	State Employees	Child Welfare	Department of Children and Families Boston MA, 02210 PH: 617-748-2325	Linda.Spears@MassMail.State.MA.US
Reva Stein	Others (Not State employees or providers)	Massachusetts Clubhouse Coalition	15 Vernon Street Waltham MA, 02453 PH: 781-788-8803	
Scott Taberner	State Employees	Medicaid	600 Washington Street Boston MA, 02111 PH: 617-573-1715	
Howard Trachtman	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Boston Resource Center	c/o Solomon Carter Fuller Boston MA, 02118 PH: 617-305-9976	
Sara Trillo-Adams	Others (Not State employees or providers)	Central MA Area Health Education Center/Latino Mental Healh Program	35 Harvard Street Worcester MA, 01609 PH: 508-756-6676	
Carol Trust	Others (Not State employees or providers)	Massachusetts Association of Social Workers	14 Beacon Street Boston MA, 02105 PH: 617-227-9635	
Stephanie Ward	Others (Not State employees or providers)	Massachusetts Council of Human Service Providers, Inc.	JRI Meadowridge Swansea MA, 02777 PH: 508-207-8504	
Chuck Weinstein	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		85 E. Newton Street Boston MA, 02118 PH: 617-305-9989	
Anne Whitman, Ph.D.	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Cole Resource Center/McLean Hospital	4 Dana Place Cambridge MA, 02138 PH: 617-855-3298	
John D. Willett	Family Members of Individuals in Recovery (to include family members of adults with SMI)		14 Cottage Street Pepperell MA, 01463 PH: 978-858-4462	
Toni Wolf	Providers	Employment Options	82 Brigham Street Marlboro MA, 01752 PH: 508-485-5051	

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	53	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	9	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	6	
Parents of children with SED*	6	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	15	
Total Individuals in Recovery, Family Members & Others	36	67.92%
State Employees	11	
Providers	6	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	17	32.08%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Persons in recovery from or providing treatment for or advocating for substance abuse services	36	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Planning Council subcommittees gave initial input to development of the plan during the January, 2017 meeting and completed at the April, 2017 meeting. Their input was incorporated into a draft circulated to the Council members. The draft was reviewed and approved at the July, 2017 meeting. This draft was posted for public comment on July 31, 2017.

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

   a) Public meetings or hearings? ( ) Yes ( ) No

   b) Posting of the plan on the web for public comment? ( ) Yes ( ) No

   c) Other (e.g. public service announcements, print media) ( ) Yes ( ) No

   If yes, provide URL:

Footnotes:

Massachusetts FEP Program Self-Assessment Tool

1. **Program Name:**
   Site Address:

   Contact Person:
   Mailing address
   email address:
   phone number:

2. **Program Overview**

   2.1 How long have you had a formal First Episode Psychosis (FEP) program (years)?

   2.2 Program Facilities
   Please describe what 'space' is available to the FEP program, e.g. dedicated milieu space, group room, etc.

   2.3 What ages do you currently serve?

Age Range	FEP program currently
Under age 15	
15-18	
19-25	
26+	
Total:	

   2.4 Describe the people you serve currently with regard to gender, race, ethnicity.

   2.5 What are the eligibility criteria for participation in your program (include any criteria related to age, diagnosis, or duration of illness, etc.)

   2.6 What are the geographic areas that comprise the communities that you serve?

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2.7 What are the cultural, linguistic and other needs of the communities that you serve?

2.8 Referral sources
Please identify your most common referral sources:

2.9 Where and what community-based recruitment activities do you offer (e.g. PCP practices, college health centers, high schools, etc.)?

2.10 What collaborations/community partnerships have you developed?

3. Team Operations

3.1 Core FEP team roles
For each role listed below, please indicate how this role is currently fulfilled:

	Current staff member (name, credentials, FTE allocated to the role)	**Liaison with community resources***	**Unavailable at this time**
Team Leader			
Prescriber			
Psychologist (assessment and program evaluation)			
Individual Therapist			
Family Therapist			
Peer specialist			
Nurse			
Substance Abuse Specialist			
Employment specialist			

Education specialist			

*Please describe how you liaison with community resources to fulfil the roles above.

3.2 FEP Team Services offered

Please indicate what **Multi-Component FEP services you have currently implemented and to what degree you offer them** through the FEP team or in collaboration with other community resources.

	Fully available through your FEP program	**Partially available through your FEP program***	**Available through collaborations with other service providers***	**Not currently available**
Individual Psychotherapy				
Care coordination				
Group Psychotherapy				
Supported Employment				
Supported Education				
Psychoeducation (young adult focused)				
Psychoeducation (family focused)				
Family Therapy – Individual Families				
Family Therapy – Multi-family Group				

Peer Support				
Health and Wellness				
Psychopharmacology				
Substance Use				
Assessment (cognitive, functioning, psychosocial)				
Community Outreach				

*Please describe what you are able to partially offer through your FEP program and how you collaborate with community resources to deliver the services above:

*Please describe any plans that you have to enhance your ability to deliver these services through partnerships, contracts, or other funding sources:

3.3 Multidisciplinary Treatment team meetings
Please indicate the frequency with which the Multi-disciplinary team meets regularly to conduct case review

More than once a week	Weekly	Every other week	Monthly	No regular schedule	No team meetings

3.4 Staff supervision

Please indicate the frequency with which individual team members receive regular supervision for their FEP team work.

More than once a week	Weekly	Every other week	Monthly	No regular schedule	No team meetings

3.5 Staff Training

Please indicate what are your current training priorities:

	Current Training priority 1=now; 2=next 1-2 yrs; 3=2+ years 4=Already addressed	Proportion of Staff with some exposure 1=none, 2=some, 3=most; 4=all
Core Principles in First Episode Psychosis **(**Recovery-oriented, trauma-informed, person-centered, shared decision making, developmentally informed, phase-specific)		
Addressing vulnerability to Substance Abuse among young adults with psychosis		
Suicide Risk assessment and prevention for young adults with psychosis		
Psychopharmacology for young adults with psychosis		
Individual treatment for young adults with psychosis		
Family treatment for young adults with psychosis		

Please describe what areas your program has expertise that you can share with the learning community:

3.6 **Evidence Based Practices**

For each EBP listed below, please indicate whether this EBP is currently offered through your FEP team and/or agency and what opportunities staff have had to learn about the EBP. Use the scale defined here and indicate all that apply for each EBP.

0 = Not currently available
1 = Staff have had a one-time training;
2 = Staff participated in on-going training and supervision/consultation;
3 = There are on-site, certified trainers in this EBP;
4 = Practitioners of the EBP participate in fidelity monitoring

NOTE: You are welcome to list additional EBPs provided through your FEP team as well.

	FEP team offers	Agency offers
1. Motivational Interviewing		
2. CBT for Psychosis		
3. MacFarlane Multi-family groups		
4. Open Dialogues		
5. Individual Resiliency Training		
6. Individual Placement and Support		
7. Cognitive Enhancement Treatment		
8. Acceptance and Commitment Therapy		
9. Dialectical Behavior Therapy		

3.7 Describe whether and how you currently monitor and assess fidelity to EBPs

4. FEP team Continuous Quality Improvement

4.1 Please describe how you currently evaluate the effectiveness of your program. List all assessment measures you utilize and how often they are administered, e.g. at admission, every 6 months, annually, at discharge.

4.2 Describe how you currently obtain and incorporate feedback from young adults and their families.

5. FEP Program Development Planning

5.1 Summarize the strengths and needs of your program.

5.2 Describe your FEP Program development goals and plan for the next 2 years

5.3 Identify the goal(s) for which you are seeking DMH support and describe how you will utilize DMH funds to support these goals.

MASSACHUSETTS STRATEGIC PLAN FOR SUICIDE PREVENTION

"It is the hope that the plan will bring attention to the public health problem of suicide and the reality that there is a great deal that we can do to prevent it."

Timothy P. Murray,
Lieutenant Governor
September, 2009

"Suicide remains the sorrow that still struggles to speak its name."

Eileen McNamara
Boston Globe
December, 2007

MASSACHUSETTS COALITION FOR SUICIDE PREVENTION
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH

INTRODUCTORY LETTERS

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I. INTRODUCTION

It is our goal that suicide and suicidal behavior be prevented and reduced in Massachusetts. With prevention strategies grounded in the best evidence available, the support and involvement of all stakeholders, and the guidance offered by this plan, we are confident we can make significant progress toward this goal over the next several years.

In Massachusetts:

- In 2007, there were 504 suicides in Massachusetts —more than deaths from homicide (183) and HIV/AIDS (143) combined[1].
- Most Massachusetts ' suicides occur in the middle age population; 43.8% of all suicides in 2007 were among those ages 35-54 years (N=221, 11.3 per 100,000)[2].
- Male suicides exceeded female suicides by more than 3 to 1 (in MA)[3].
- Both nationwide and in Massachusetts, youth suicide is the third leading cause of death for young people ages 15 – 24[4].
- Although the highest number of suicides among males occurred in mid-life ages 35-44 years (N=92, 19.2 per 100,000), the highest rate of suicide occurred among males 85 and older (N=16, 38.9 per 100,000)[5].
- The highest number and rate of suicides among females were among those ages 55-64 years (N=25, 6.6 per 100,000)[6].
- Nonfatal self-injury also burdens the Commonwealth's health care system— there were 4,305 hospital stays[7] (66.7 per 100,000) and 6,720 emergency department discharges[8] (104.2 per 100,000) for nonfatal self-inflicted injury in FY2007[9].

Experts agree that most suicides can be prevented. Suicide is less about death and more about the need to overcome unbearable psychological pain.

There is also general agreement that suicide and suicide attempts are under-reported at present, due to lack of data standards, pressure from some survivors, and stigma. Similar to other previously under-recognized problems (e.g. intimate partner violence, child abuse), as awareness of the scope of the problem rises and more people feel comfortable with reporting the event, rates may increase for a time. We anticipate that the same thing may happen with suicide; that is, as suicide and suicidal behavior become more recognized and is reported more frequently, rates will actually increase for a time.

The Massachusetts Strategic Plan for Suicide Prevention (State Plan) is an initiative of the Massachusetts Coalition for Suicide Prevention, working in collaboration with the Department of

[1] Registry of Vital Records and Statistics, Massachusetts Department of Public Health
[2] *Op. cit*.
[3] *Op. cit*.
[4] WISQARS, National Center for Health Statistics (NCHS), National Vital Statistics System
[5] Registry of Vital Records and Statistics, Massachusetts Department of Public Health
[6] *Op. cit*.
[7] Massachusetts Inpatient Hospital Discharge Database, Division of Health Care Finance and Policy
[8] Massachusetts Outpatient Emergency Department Database, Division of Health Care Finance and Policy
[9] Massachusetts Observation Stay Database, Division of Health Care Finance and Policy

Public Health (DPH) and the Department of Mental Health (DMH). As the recipient of legislative funding for suicide prevention, the Department of Public Health also provided financial support and resources for the development of the plan.

The field of suicidology uses common words that have specific definitions relevant to the diagnosis, intervention and prevention of suicide; such words used in this document are defined in the Glossary in Appendix B.

The Massachusetts Coalition for Suicide Prevention

The Massachusetts Coalition for Suicide Prevention (MCSP) is a broad-based inclusive alliance of suicide prevention advocates, including public and private agency representatives, policy makers, suicide survivors, mental health and public health consumers and providers and concerned citizens committed to working together to reduce the incidence of self-harm and suicide in the Commonwealth. From its inception, the Coalition has been a public/private partnership, involving government agencies including the Department of Public Health and Department of Mental Health working in partnership with community-based agencies and interested individuals.

The MCSP's mission is to support and develop effective suicide prevention initiatives by providing leadership and advocacy, promoting collaborations among organizations, developing and recommending policy and promoting research and program development.

Massachusetts Department of Public Health Suicide Prevention Program

The Massachusetts Suicide Prevention Program, in the Division of Violence and Injury Prevention, provides support, education, and outreach to all Massachusetts residents, especially those who may be at increased risk, have attempted suicide, or have lost a loved one to suicide. Through education and outreach efforts, this program develops and disseminates materials designed to increase awareness and knowledge, provides community grants, and develops and evaluates training modules for populations at increased risk for suicide or suicidal behavior. This initiative educates professionals and the general public on the scope of suicide, self-inflicted injuries, and suicide prevention. Staff also can provide data, resources and support to communities and agencies which are either working to prevent suicide or coping in the aftermath of a suicide. The program has received state funding for implementation since FY2002.

The Suicide Prevention Program provides training to a broad array of individuals, including public health and mental health professionals, social workers, nurses, public safety officials, first responders, law enforcement officers, emergency medical technicians, corrections personnel, community leaders and advocates, survivors, counselors, clergy and faith community leaders, educators and school administrators, elder service staff, persons working with youth programs, advocates for the gay, lesbian, bisexual, and transgender communities and allies, and anyone interested in preventing self-harm and suicide in the Commonwealth of Massachusetts.

II. THE STRATEGIC PLANNING PROCESS

Massachusetts' first state plan for suicide prevention was completed and issued in 2002. Modeled on the National Strategy for Suicide Prevention, the State Plan offered a blueprint for the Commonwealth and collaborating partners for establishing priorities and implementing new, coordinated programming and services.

When the first State Plan was completed, there were no state funds for suicide prevention. However, the legislature appropriated $500,000 in funding for suicide prevention in FY 2002, and the line-item has grown, reaching a $4.75 million appropriation for FY09.

In 2007, recognizing that it was time to update and enhance the plan, the MCSP convened a seven-member Steering Committee to guide development of a new State Plan. Utilizing funding from legislatively appropriated resources for suicide prevention, the Department of Public Health provided financial support and resources to the development process.

Information Gathering

The Steering Committee committed to an extensive data-gathering process to assure inclusive information collection. Methods included a survey, an Electronic Town Meeting, stakeholder interviews, and focus groups. In addition, members of the MCSP were given the opportunity to offer feedback at several points in the plan's development. Over 500 individuals contributed their comments; this number accounts for the fact that any one person may have participated in multiple methods (for example, responded to the survey, participated in the electronic town meeting, and participated in a focus group).

Survey

As a key step in the planning process, a survey was developed to learn more about constituents' thoughts, suggestions, priorities, and vision on this public health issue.

The survey was conducted during May and June, 2007. Surveys were distributed at the DPH/DMH/MCSP Statewide Suicide Prevention Conference in May and the survey was publicized through the MCSP website and listserv. An online survey link was provided through the MCSP website.

There were a total of 189 responses to the survey: 102 paper surveys were completed at the conference and entered into the results database, 87 surveys were completed online.

Electronic Town Meeting

On June 6, 2007, the MCSP hosted an Electronic Town Meeting to solicit broad input on strategic planning priorities. The E-Town meeting attracted 280 participants, including 110 on-site at the meeting and 170 online.

Participants engaged in an interactive panel discussion and answered questions on key aspects of the previous State Plan, including:

- Reducing access to lethal means and methods of self-harm

- Improving access to and community linkages with mental health and substance abuse services
- Developing and implementing community-based suicide prevention programs
- Strategies to reduce the stigma associated with suicide and with being a consumer of mental health, substance abuse, and suicide prevention services

Interviews

Twenty individuals were interviewed in person or by telephone, including representatives from state agencies, MCSP leadership, members of the legislature, and survivors.

Focus Groups

Seventy-two individuals participated in eight focus groups:

- Consumers (individuals currently utilizing mental health services or who have received such services in the past)
- Survivors
- MCSP Members (Eastern Massachusetts)
- MCSP Members (Western Massachusetts)
- Elder Services Providers
- Veterans Services Providers
- Staff of the Massachusetts Department of Public Health
- Staff of the Garrett Lee Smith Project Grant (a federally-funded suicide prevention project focused on youth in state custody)

Both the interviews and focus groups asked for feedback on a number of questions, including:

1. What are the needs of you and or / your constituency around suicide prevention?
2. Do you have the data you need?
3. What are the challenges and barriers to suicide prevention?
4. What are the top three things that would need to happen for more forward movement on this issue?
5. In what areas are current efforts working well? Not working well?
6. Are you familiar with the current state plan? If so, how does it address your needs?
7. What has been the impact of the work coming out of the most recent state plan?
8. What are your suggestions for how the future strategic plan might best be circulated and used?

III. KEY FINDINGS FROM THE INFORMATION GATHERING

The comments, suggestions, and other information gathered during this outreach process were synthesized and integrated. They yielded a wealth of information and numerous suggestions about what might be included in the plan. Given the breadth of comments, it is not possible to highlight every single one. However, a number of **common themes** emerged that merited reflection and consideration for inclusion in the new state plan.

1. People don't think of suicide as a preventable public health problem.

2. There is a need for culturally competent, community-based training on suicide prevention that reaches broadly across the state to address the needs of survivors, consumers, caregivers, and targeted populations.

3. Stigma associated with suicide (either discussing feelings of suicide, loss to suicide, or experience with suicide) and/or with mental illness/substance abuse is a significant barrier to prevention and help-seeking.

4. Stigma may be associated with long and complex histories of oppression in some communities that take specific cultural forms, e.g. racial/ethnic communities, GLBT communities, etc.

5. Poor linkages exist at the state and community level between mental health, substance abuse, and community health services as well as with schools, faith-based organizations, and first responders.

6. There are barriers to accessing appropriate mental health care due to numerous obstacles including:
   - Lack of transportation, particularly in suburban and rural areas;
   - Interrupted or inconsistent care due to lack of standardized assessment protocols, problems with the Emergency Service Program (ESP) system, a shortage of trained mental health clinicians, HIPAA[10] rules restricting sharing of information, and complicated insurance and reimbursement regulations that often limit access to care, especially mental health treatment.
   - Inability or reluctance of many primary care physicians to address mental health issues with patients.
   - Cost.
   - Lack of culturally and linguistically appropriate mental health resources for racial, ethnic minority and GLBT consumers.

7. There is limited awareness about the effectiveness of reducing access to lethal means and methods of self-harm.

[10] P.L. 104-191, Health Insurance Portability and Accountability Act (HIPAA), 1996. The law includes protection of confidentiality and security of health data through setting and enforcing standards among other provisions.

At the same time, participants in the information gathering want the **infrastructure** to support undertaking these priorities to include:

1. Increased public awareness of suicide and suicide prevention
2. Stronger collaboration among state agencies
3. Consumer and survivor engagement at all levels of decision-making
4. Ongoing, coordinated advocacy for resources to support plan implementation, including alternative options to state funding
5. Commitment to addressing specific needs of higher risk populations and the creation of appropriate services and strategies
6. Continued investment in surveillance along with improved and expanded data collection
7. Regular evaluation of progress in plan implementation
8. Increased presence of additional regional and local suicide prevention coalitions and strengthening the state-wide coalition

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IV. USING THE STRATEGIC PLAN, AND MONITORING, EVALUATING, AND REPORTING PROGRESS

Using the Strategic Plan

The purpose of the Massachusetts Strategic Plan for Suicide Prevention is to provide a framework for identifying priorities, organizing efforts, and contributing to a state-wide focus on suicide prevention, over the next several years.

The State Plan is designed to be accessible to all stakeholders in the Commonwealth; stakeholders include individuals, groups, communities, organizations, institutions, and all levels of government. Understandably, this is a very broad and diverse group. And, by necessity, preventing suicide must be a very broad effort with diverse approaches. The MCSP hopes that all of those involved with suicide prevention will assume collective ownership of the Plan and use it to guide their efforts. With a variety of stakeholders acting together and using the state plan as a common point of reference, there is a vastly increased likelihood of achieving the Vision of Success (see Section V) for suicide prevention in Massachusetts.

Data-gathering and outreach during the strategic planning process helped identify a range of issues, and the Plan establishes a framework for specific goals related to suicide prevention. While the MCSP initiated efforts to begin development of the Plan, along with the Department of Public Health as the lead state agency and the Department of Mental Health, it does not assume that a specific agency or organization has the overall responsibility or capacity to address all, or even the majority, of these goals. Rather, this State Plan holds many opportunities for individuals, groups of people, communities, institutions, and organizations to make contributions toward achieving goals, individually and collectively. Collaborating and partnering with others can result in significantly greater impact. Likewise, this Plan does not assume that current state government funding will be the only resource for realizing these goals. Therefore, to ensure sustainability of all efforts, organizations must advocate for and pursue diversification of funding.

For those actively involved in suicide prevention, the Massachusetts Strategic Plan for Suicide Prevention can provide guidance and a framework as you proceed with your work. The State Plan can assist in identifying priorities as you develop an organizational strategic plan, an annual work plan, or specific action plans for your organization's efforts in suicide prevention. In this way, you can chart your organization's progress as well as measure your contributions against the overall goals of the statewide strategic plan. In addition, you are encouraged to coordinate with other organizations state-wide that may be working toward the same and/or complementary goals as presented in the State Plan.

Monitoring, Evaluating, and Reporting Progress

While the collective ownership and inclusive nature of the Massachusetts Strategic Plan for Suicide Prevention is a great strength, it also presents challenges because of the dispersed nature of the effort. For this reason the MCSP will take the lead in monitoring, evaluating, and reporting on the progress and implementation of the Plan.

MCSP will connect with stakeholders to track progress on implementation of the Plan, the status and success of specific goals and actions, and to solicit feedback on the strengths and weaknesses of the Plan itself. As with other organizations which must stay accountable to supporters and funders on an annual basis, MCSP will develop an annual progress report on the State Plan; this will be shared with the state legislature, appropriate state agencies and other stakeholders. The Plan and progress reports will serve as valuable resources to track and communicate progress and outcomes.

What This Plan Does Not Address and Next Steps

The scope of this plan is limited to statewide suicide prevention efforts across Massachusetts. We did not attempt to do an inventory of the significant suicide prevention activities already in place at various stages of implementation. Furthermore, because the Department of Public Health publishes 'Suicide and Self-Inflicted Injuries in Massachusetts' annually, we did not include a data report as part of the Plan.

This State Plan includes broad strategies appropriate to the statewide population. Examples of possible actions are general and not meant to be exhaustive. We recognize that some populations are at higher risk of suicide than others, including (but not limited to) consumers of mental health services, veterans, gay/lesbian/bisexual and transgender youth, survivors of trauma, and others.

Targeted population-based strategies are necessary and appropriate. While the Plan acknowledges that implementation will involve development of culturally specific and appropriate strategies and models for those at higher risk, the Plan does not identify targeted needs of populations known to be at increased risk of suicide, nor of specific geographic regions or communities. As part of implementing this Plan, it is our hope groups associated with both populations at increased risk of suicide, and coalitions addressing suicide prevention for regions, or cities and towns will use this Plan as a starting point to develop their own population-specific, more tailored plans.

Representatives of populations at increased risk have participated throughout the process of development the State Plan. As groups work to develop their own more targeted plans, the MCSP and the Department of Public Health will provide technical assistance to address suicide prevention for those groups at increased risk of suicide.

V. VISION OF SUCCESS AND GUIDING PRINCIPLES FOR SUICIDE PREVENTION PLANNING

A Vision Statement is a description of the desired future; it describes what success will look like at some future time. A Vision is an expression of possibility, based in reality yet far enough of a "stretch" that people are inspired to help make it happen despite the challenge and uncertain prospects for success.

The Vision gives a sense of direction. It presents a realistic, credible and attractive future.

Provided below are the components of the Vision of Success for Suicide Prevention.

Vision of Success

- Suicide is viewed as a preventable public health problem.
- Individuals experiencing mental illness, substance abuse, or feelings of suicide feel comfortable asking for help, and have access to culturally appropriate services in their communities.
- Suicide prevention services are provided in an integrated manner so that people receive the comprehensive coverage and support best suited for their individual needs.
- Suicide prevention activities incorporate elements of resiliency and protective factors as well as risk factors.
- Prevention strategies grounded in the best evidence available are used in cities and towns across the Commonwealth.
- There is a strong, diverse, state-wide suicide prevention coalition with regional coalitions in every part of the state, as well as local community coalitions.
- Institutions and organizations include mental health, suicide prevention, and risk and resiliency efforts as part of their health and wellness benefits, policies, curricula, and other initiatives.
- Suicide prevention is supported by public and private funding sources.
- There is a general public awareness of suicide prevention efforts in the Commonwealth and willingness to assist those who may be in need of help.

GUIDING PRINCIPLES

The guiding principles listed below reflect the beliefs of those who have contributed to the development of this State Plan. We hope these principles will continue to be reflected in the implementation of the plan.

We believe:

- Suicide affects people of all ages and must be addressed across the lifespan.
- Stigma and discrimination prevents open acknowledgment of mental illness and suicidal behavior, and this inhibits successful prevention, intervention, and recovery.
- Some populations are at higher risk of suicide than others; therefore, targeted population-based strategies and models are necessary and appropriate.
- Every person should have a safe, caring, and healthy relationship with at least one other person.
- Prevention should take into account both risk and resiliency of individuals and populations.
- All suicide prevention materials, resources, and services should be culturally and linguistically competent, and developmentally and age appropriate.
- Consumers and target groups should have input and participate in all levels of suicide prevention planning and decision-making.
- Information-sharing and collaboration must occur between all stakeholders in suicide prevention.
- The best evidence available should be used, to the extent possible, when planning, designing, and implementing suicide prevention efforts.
- More research and evaluation of suicide and suicide prevention programs, including innovative approaches and best evidence available, should be undertaken.
- To ensure sustainability of suicide prevention efforts, there should be advocacy for diverse funding and other resources.
- Comprehensive coverage, accessibility, and continuity of physical and mental health care services should be ensured.

VI. FRAMEWORK

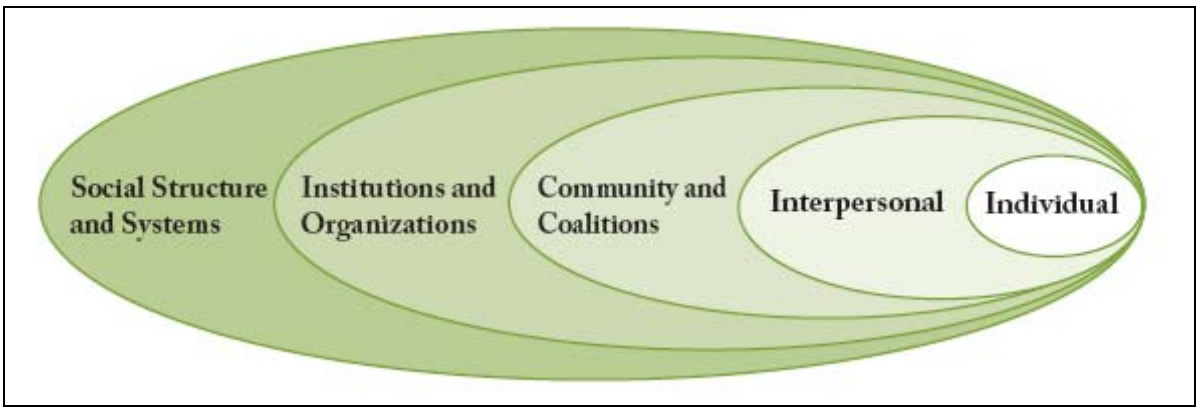
The Massachusetts Strategic Plan for Suicide Prevention recognizes the complex interplay between the various stakeholders (individuals, groups, communities, government, organizations, and institutions) in society that are involved with and, indeed, required for successful suicide prevention efforts. The Plan acknowledges this interdependency; it encourages and requires a connected and common effort among all stakeholders.

The framework for planning provides a basic structure for defining, organizing, and supporting the Massachusetts Strategic Plan for Suicide Prevention. This framework was derived primarily from two well-known public health models: the Spectrum of Prevention and the Social-Ecological model.

The Massachusetts Strategic Plan for Suicide Prevention is organized around five dynamic and interactive Levels, designed to include and represent all stakeholders:

I. Individual
II. Interpersonal
III. Community and Coalitions
IV. Institutions and Organizations
V. Social Structure and Systems

These Levels represent a continuum from a specific individual (Level I) to the society in which that individual lives (Level V). The graphic below illustrates this continuum.



For the Plan to be successful, significant activity is required in each of the five Levels. The synergy of the Levels will result in increased awareness, momentum, and integration of suicide prevention efforts. The framework for the Plan is based on the assumption that action must occur within each of the five Levels. The Plan encourages information-sharing and collaboration between and among stakeholders. With a variety of stakeholders acting together in a concerted effort, there is an increased likelihood of success.

Each of the five Levels includes several components:

- **Theme:** A description of the overall purpose of the Level.

- **Audience:** The stakeholders at whom the Theme is aimed; those who will be affected by and those who will be involved with implementing the Goals. The Audience list for each Area is not intended to be exhaustive; it is presented to provide examples of possible stakeholders.

- **Goals:** Major long-term aims, and an articulation of the desired achievements for each Theme. The Goals for each Theme are not presented in any particular order. It is understood that many of the Goals, due to the structural and systemic complexity of the issues and the many stakeholders involved, will take more than five years to attain. In addition, some Goals may be on-going and never fully completed.

- **Examples of Possible Actions:** Actions are specific acts or activities that can be used to make progress toward a Goal. In this plan, the Actions presented are examples only; they are not meant to be prescriptive. Each stakeholder should make decisions about Actions to take and how to approach implementation based on their unique and specific situation. Creativity, innovation, and finding the best "fit" is encouraged.

Beyond presenting an overall Vision of Success for suicide prevention in Massachusetts (Section V), this Plan does not articulate specific outcomes desired and measures of success for each Goal and Possible Action. To identify specific measures of success for Goals and Actions was beyond the scope and time of this effort, and complicated by the multiplicity of stakeholders and decentralized nature of the work to be done. However, measuring progress and outcomes of specific Goals and Actions will be a key part of evaluating and reporting on the implementation of the Plan. As noted in Section IV, MCSP will take the lead in this effort and develop appropriate documentation.

The Goals, Strategies, and Actions in the Massachusetts Strategic Plan for Suicide Prevention have been developed based on suggestions from outreach and information gathering. To the extent possible, they were compared against the current growing knowledge base on suicide and suicide prevention and have met the criteria of being evidence-based; that is, they represent approaches to suicide prevention that have been developed and evaluated using scientific processes and have been found to be credible and sustainable.

Some of the Actions listed are already in various stages of implementation – some just beginning and others have been used for several years. Other Actions are examples that have not yet begun to be implemented. Still other Actions may be currently implemented by some stakeholders with others looking to replicate them.

The above components for each of the five Levels are presented in matrices on the following pages.

VII. MATRIX

LEVEL I: INDIVIDUAL

Theme

Promote the well-being, safety, and resiliency of individuals who may be at higher risk of suicide, and those whose lives have been touched by suicide

Audience (including, but not limited to): Suicide attempt survivors, survivors, people at higher risk, populations at higher risk

Goals	Examples Of Possible Actions
1A. Increase self-awareness of risk and protective factors and encourage help-seeking and support during a crisis and over the long-term	1. Promote public testimony from credible spokespeople, including those well-known, who have received help 2. Promote crisis plans for individuals who need them, their providers and support system 3. Develop plans/protocols for survivors: immediately following a suicide (e.g. a survivor contacts a survivor); in-person and on-line support groups, other specialized services 4. Disseminate appropriate materials and resources to individuals 5. Encourage evidence-based therapeutic treatment
1B. Educate providers and private and public funders on suicide risk and protective factors, warning signs, and available resources	1. Target education and training at professionals serving those at increased risk (primary care providers, mental health clinicians, caseworkers, nurses, and others) 2. Promote information on mental health and emergency resources available to assist individuals at risk of suicide and providers who serve them 3. Promote awareness of the differences between ongoing mental illness and situational stress, e.g. divorce, bereavement, academic problems, financial or professional loss, or other circumstantial stressors
1C. Support resiliency for those at risk through sustainable, skill-building efforts and resources	1. Conduct resiliency training across the life-span, including good decision-making, values clarification, coping mechanisms, impulse control, role models and mentors 2. Build individual help seeking and self-help skills 3. Increase awareness of how / where to get help

Goals	Examples Of Possible Actions
1D. Address ongoing needs of those at higher risk of suicide	1. Promote support groups, peer-to-peer training and outreach, and other avenues of peer education and support 2. Identify best venues for education to reach those most in need, e.g. home-based programs for elders, at the time of demobilization for members of the US military, safe schools programs for youth 3. Address environmental factors that contribute to suicidal behavior, such as discrimination, limited understanding of coping with those with mental illness, and lack of access to support and services 4. Educate individuals at higher risk on resources and help available including warm lines and hot lines

LEVEL II: INTERPERSONAL

Theme
Support and educate people to cultivate helping relationships and address suicide risks with awareness and sensitivity **Audience** (including, but not limited to): mental health consumers, survivors, suicide attempt survivors, families, including foster parents; friends; partners; peer groups; health care providers (nurses, doctors, therapists, counselors; emergency personnel (fire, police, EMTs); all personnel in health care, clinical, social and human service settings; HELP lines; clergy; school personnel; funeral directors; human resource staff

Goals	Examples Of Possible Actions
2A. Promote and develop systems of care that utilize the best evidence available to identify and help those at risk	1. Develop comprehensive protocols for service providers (health care, public safety, social service, educational institutions) in recognizing and treating suicidal behavior 2. Recognize those at risk through best available assessment tools; screening/checklist approaches (depression, behavioral health) 3. Incorporate "Lethal means counseling" into the existing suicide prevention protocols of gatekeepers and health/mental health providers
2B. Promote access to and continuity of care for individuals at risk through sustainable service linkages at the local, regional, and state level with all relevant providers	1. Support transitions and postvention services: re-entry plans for students and adults; step down from in-patient care; ensure a connection with a professional service provider is made 2. Identify needs and provide services to people in non-clinical environments, including caregivers 3. Increase face-to-face contact with those at risk through mentoring, visiting, volunteer advocates, and peer support groups 4. Identify and access approaches and avenues (that respect privacy and build trust) that increase the likelihood that those who are in need will ask for help
2C. Implement sustainable, replicable, and evidence-based training programs in recognizing and treating suicidal behavior	1. Encourage consistency of trainings where possible and appropriate 2. Conduct " gatekeeper" awareness and training programs for the lay and professional population

Goals	Examples Of Possible Actions
2D. Recognize and address the commonalities and the barriers (language, approaches, stigma, goals, training) that exist between professionals in different disciplines who are working with those at risk, so they can better connect and integrate prevention services	1. Increase opportunities for professionals serving higher risk populations to work more collaboratively 2. Provide training opportunities on collaborating and connecting suicide prevention to mental health, substance abuse prevention, and other related health issues 3. Create connections between community-based organizations and mental health professionals in providing a spectrum of appropriate and affordable services 4. Address the shortage of service providers who reflect characteristics of the populations served
2E. Design and implement multi-disciplinary protocols for all personnel and institutions who respond to individuals in crisis	1. Encourage appropriate and sensitive treatment of people with mental illness, in all settings 2. Ensure continuity of care for each individual in crisis and/or for people in treatment, by linking the individual with a service professional for a follow-up visit 3. Maintain, disseminate, and publicize resource directories (hard copy and web-based) for suicide prevention providers and others 4. Increase crisis intervention training; recognizing the fragility of people in crisis

LEVEL III: COMMUNITY AND COALITIONS

Theme
Create collaborations and foster networks to achieve broad impact through common goals in suicide prevention **Audience** (including, but not limited to): families, including foster parents; friends; partners; peer groups; survivors; consumers; neighborhoods; workplaces; faith communities and places of worship; sports teams; social and cultural clubs; professional networks, associations, and labor unions; local, regional, and statewide coalitions and networks; philanthropic organizations and funders; local government; local and county elected and appointed officials

Goals	Examples Of Possible Actions
3A. Advance and sustain local, community-based, and regional coalitions for suicide prevention, with connections to the state-wide coalition (MCSP)	1. Increase the number of community and regional suicide prevention coalitions while strengthening the statewide coalition; offer technical assistance and resources while affirming that each coalition is unique 2. Provide information about the availability of local grants for community-based efforts via community and regional coalitions 3. Build relationships and connections with existing networks to further efforts, e.g. Community Health Network Areas (CHNAs) and Regional Centers for Healthy Communities 4. Educate local government, elected and appointed officials and engage in community planning and prevention activities 5. Educate public and private funders and engage them in community planning and prevention activities
3B. Promote suicide prevention education and training for groups, communities and coalitions, and potential funders	1. Publicize trainings on the MCSP website and other websites 2. Create an MCSP listserv, and encourage regional and local coalitions to develop listserves or other communication systems 3. Develop, disseminate and share materials, technical assistance, and programs as needed, e.g., local resource guides, wellness campaigns, web-based tools 4. Facilitate networking and referrals through conferences and other convening approaches 5. Conduct education and outreach to local elected and appointed officials and potential funders

Goals	Examples Of Possible Actions
3C. Strengthen access to and collaboration among suicide prevention, mental health and health, substance abuse, crisis lines, and other prevention and advocacy services	1. Identify services available and service gaps in communities 2. Improve communication among service providers to support access and collaboration 3. Create and support avenues for open, multi-directional communication among Coalition members, including listservs and other venues 4. Integrate suicide prevention planning with planning for prevention and intervention of other health issues that share similar risk and protective factors, including mental health, substance abuse, and interpersonal violence, among others 5. Document successful community-wide approaches
3D. Support local data collection as part of suicide surveillance systems, and align with statewide efforts	1. Increase community awareness of available data 2. Train community members on how to locate and analyze available data, as needed
3E. Promote and support suicide prevention planning	1. Educate community and regional coalitions about the Massachusetts Strategic Plan for Suicide Prevention 2. Involve regional and local coalitions in implementing the Massachusetts Strategic Plan for Suicide Prevention 3. Increase engagement in suicide prevention activities through outreach to groups and constituencies at risk 4. Guide coalitions in developing suicide prevention plans tailored to their own specific needs 5. Encourage all communities to have a crisis plan and protocol, a review process/system for when a suicide occurs
3F. Develop additional primary prevention strategies	1. Increase awareness of the impact of violence and oppression on mental health 2. Collaborate with those developing trauma-informed care strategies within health and human service systems

LEVEL IV: INSTITUTIONS AND ORGANIZATIONS

Theme
Implement policies, procedures, initiatives, programs, and services in support of suicide prevention **Audience** (including, but not limited to): public, private, and non-profit organizations and institutions including educational institutions; health care providers; businesses, service-specific systems of providers (e.g., child care agencies, domestic violence shelters, elder care, homeless shelters); state and federal agencies and personnel (e.g. correctional facilities, veterans facilities), elected and appointed officials

Goals	Examples Of Possible Actions
4A. Address comprehensive continuity of physical and mental health care services	1. Promote case management and smooth referral systems to facilitate treatment access and treatment maintenance 2. Promote transportation services to providers, specifically for veterans, elders, homeless, people in rural areas 3. Address resource shortages (e.g., rural isolation and limited services, outpatient day programs, adolescent psychiatric beds, etc.) 4. Create incentives for treatment of patients with dual diagnosis issues (e.g. substance abuse and mental health) 5. Develop comprehensive protocols for service providers (health care, public safety, social service) in recognizing and treating suicidal behavior 6. Ensure statewide access to crisis support hot lines

Goals	Examples Of Possible Actions
4B. Support inclusion of mental health, suicide prevention, and resiliency efforts, and other initiatives into health and wellness benefits, policies, and curricula	1. Promote multiple mechanisms for delivering suicide prevention services; use schools and workplaces as access and referral points for services 2. Promote collaboration and integration among health issues in recognition of how experiences of violence and suicide can intersect. 3. Provide and improve prevention, intervention, and postvention services in the workplace and in workforce development and training programs 4. Promote state-wide K – 12 and college/university prevention, intervention, and postvention support and educational programs 5. Train employees in recognizing the warning signs and getting help for themselves and others
4C. Increase cultural competence among institutions and organizations and promote culturally diverse services	1. Connect with outreach efforts to community-based, racially, culturally and ethnically diverse groups and organizations 2. Equip organizations to provide culturally competent services 3. Increase the number of culturally competent mental health providers through workforce development, particularly those with expertise in adolescent and older adult mental health issues, and target geographically underserved areas 4. Provide suicide prevention training for medical interpreters
4D. Reduce access to and implement restrictions for methods of self-harm	1. Increase awareness of the effectiveness of means restriction as a suicide prevention strategy 2. Continue Massachusetts' successful gun safety regulations 3. Review train crossings where there have been suicides to assess safety features 4. Review major bridges and overpasses to assess safety features 5. Train health and mental health professionals to discuss risks of access to lethal means with their clients

Goals	Examples Of Possible Actions
4E. Support and focus the Massachusetts data-collection and suicide surveillance system at the state and local levels	1. Explore data on: passive suicide as an unrecognized cause of death; linkages between suicide and substance abuse overdoses 2. Improve documentation of race, ethnicity and language; secure data on certain populations (refugees); and distinguish rural, suburban, and urban data 3. Address under-reporting and nomenclature issues 4. Develop and share data on effectiveness and success of prevention programs and services; including costs of prevention vs. cost of crisis care 5. Explore approaches to make information sharing under HIPAA less difficult to ensure that services and resources are available for individuals in need 6. Include questions on suicidal behaviors, related risk factors and exposure to suicide on data collection instruments 7. Assess implementation of suicide prevention efforts in other states for possible application within the Commonwealth 8. Evaluate the impact and effectiveness of the Massachusetts Strategic Plan for Suicide Prevention in reducing suicide morbidity and mortality
4F. Promote the adoption of "zero suicide" as an aspirational goal by health care and community support systems that provide services and support the defined patient populations	1. Educate health care systems on the concept and dimensions of "zero suicide" 2. Establish a suicide prevention task force among state agencies to address the goal of reducing suicides and suicide attempts 3. Work with community support systems including state agencies that serve high risk populations to adopt a "zero suicide" policy

LEVEL V: SOCIAL STRUCTURE AND SYSTEMS

Theme

Reduce the stigma and discrimination associated with suicide, and promote healthy and help-seeking behaviors in society, with supportive policy, regulation, and law.

Audience (including, but not limited to): any individual of any age; society at-large; the media; philanthropic organizations and funders; state elected and appointed officials

Goals	Examples Of Possible Actions
5A. Maintain and promote political will and ongoing support for suicide prevention and resiliency building	1. Create a joint legislative, executive, and private sector commission to study and implement strategies to prevent suicide and self-harm 2. Implement mental health parity through federal and state legislation 3. Assess and address policies, programs, and procedures of public and private health insurance regarding suicide prevention and mental health services 4. Educate philanthropic organizations and funders about suicide and related prevention and engage them in policy and planning activities
5B. Reduce stigma associated with mental illness, substance abuse, violence and suicide	1. Promote help-seeking as a healthy behavior 2. Promote awareness that suicide is a preventable public health problem and that mental illness is treatable 3. Raise awareness and understanding of the mental health consequences of oppression and violence 4. Promote a multi-media public information campaign to dispel myths and increase awareness 5. Identify and develop credible advocates, prominent people, speakers bureau 6. Foster partnerships with and involve news media in public awareness efforts 7. Promote appropriate media reporting on and portrayals of suicide and mental illness and collaborate with the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) stigma reduction campaign 8. Develop, implement, monitor and update guidelines on the safety of online content for new and emerging communication technologies and applications

Goals	Examples Of Possible Actions
5C. Increase broad based support for suicide prevention	1. Conduct education and outreach on suicide and related prevention to elected and appointed officials at all levels of government 2. Increase outreach to cities and towns through the statewide coalition and the development of regional and local suicide prevention coalitions 3. Raise awareness of suicide as a public health problem among philanthropic organizations and funders and engage their support for suicide prevention activities 4. Disseminate the national suicide prevention research agenda 5. Foster sharing of research and data within the state
5D. Strengthen suicide prevention efforts at all state agencies, and ensure collaboration among and coordination within state agencies	1. Increase the numbers of people on state commissions and councils with suicide prevention expertise and include perspective representing youth, suicide loss survivors and suicide attempt survivors 2. Promote cross-agency dialogue within EOHHS 3. Implement recommendations of the January 2007 report to prevent suicide in Massachusetts prisons[11] 4. Align suicide prevention planning and implementation with Federal and State health and human services initiatives

[11] Hayes, Lindsay M. *Technical Assistance Report on Suicide Prevention Practices within the Massachusetts Department of Correction.* National Center on Institutions and Alternatives, January 31, 2007.

VIII. LOGIC MODEL

We are incorporating a logic model as part of the Massachusetts Strategic Plan for Suicide Prevention. A logic model communicates the logic or rationale behind a plan or program. It illustrates the relationship between inputs, processes, and outcomes—showing the chain of "logic", or what causes what toward the desired goal or outcome. Logic models are presented as a visual schematic, although there is no proscribed formula.

Included in this section of the State Plan are three sets of Logic Models, each based on the "Theory of Change Logic Model:"

A.) A model for the overall plan captures how implementing this planning framework of Levels/Themes will lead to the reduced incidence of suicide and self harm through short-term, then intermediate, and then finally, long-term outcomes.

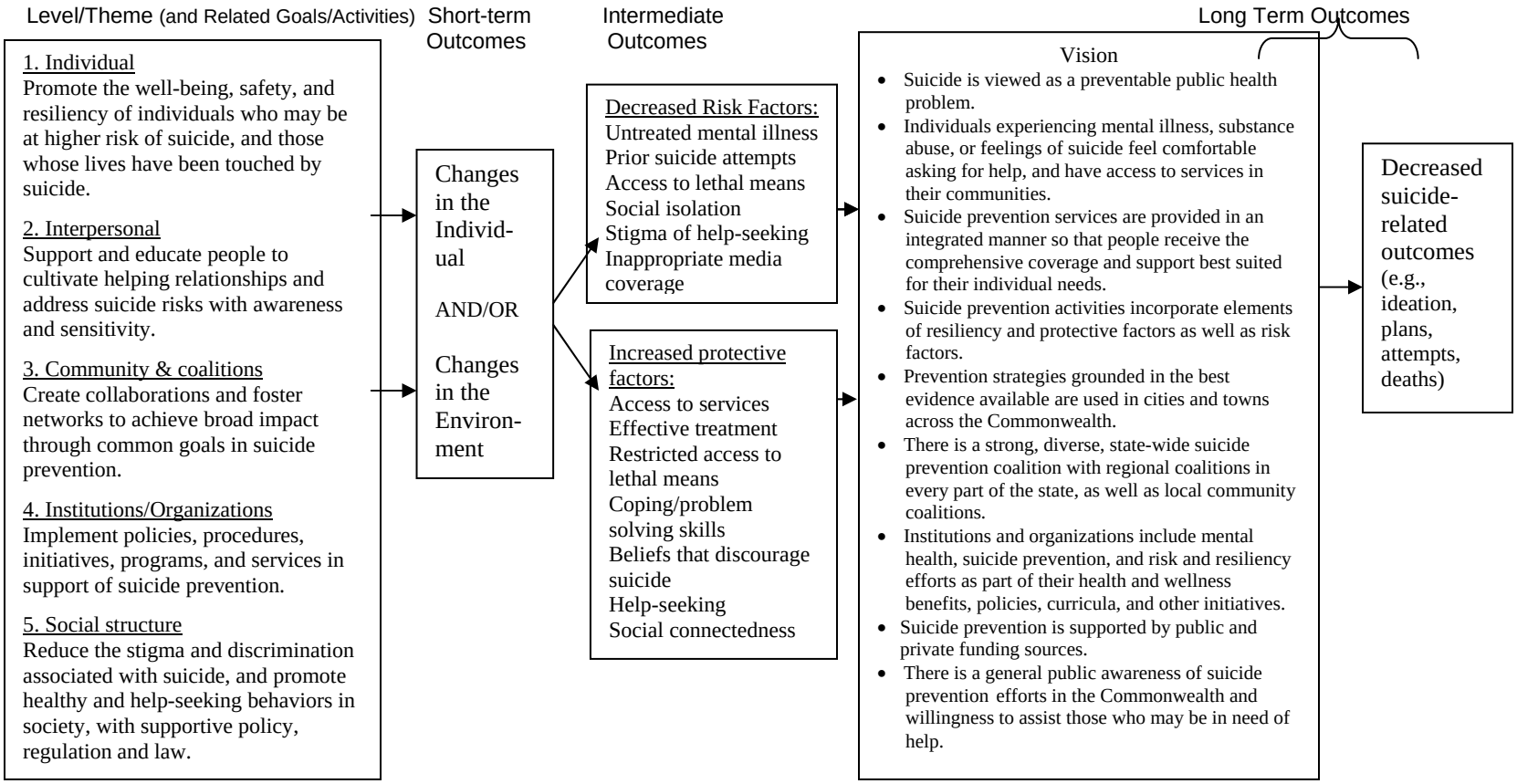
B.) There are logic models for each of the five Levels of the framework—individual, interpersonal, community and coalitions, institutions and organizations, and social structures and systems. These illustrate how implementation of Possible Actions will result in the realization of each Level/Theme.

C.) A final set of logic models will be developed in the future to address Possible Actions. A sample Action logic model is included here, for Level III, Goal 3A, Action 1. Other models will be developed in collaboration with MCSP members as we begin to implement the plan.

For more information on logic models, see 'Everything You Wanted To Know About Logic Models But Were Afraid to Ask' (Schmitz and Parsons,) at http://www.insites.org/documents/logmod.pdf

If you'd like more detailed information about logic models and other ways to evaluate suicide prevention programs, visit the website of the National Center for Suicide Prevention Training at http://training.sprc.org/. The workshop entitled 'Planning & Evaluation for Youth Suicide Prevention' includes a section on 'Using Logic Models for Plan Implementation'. Their online courses are free and self-guided, though electronic registration is required.

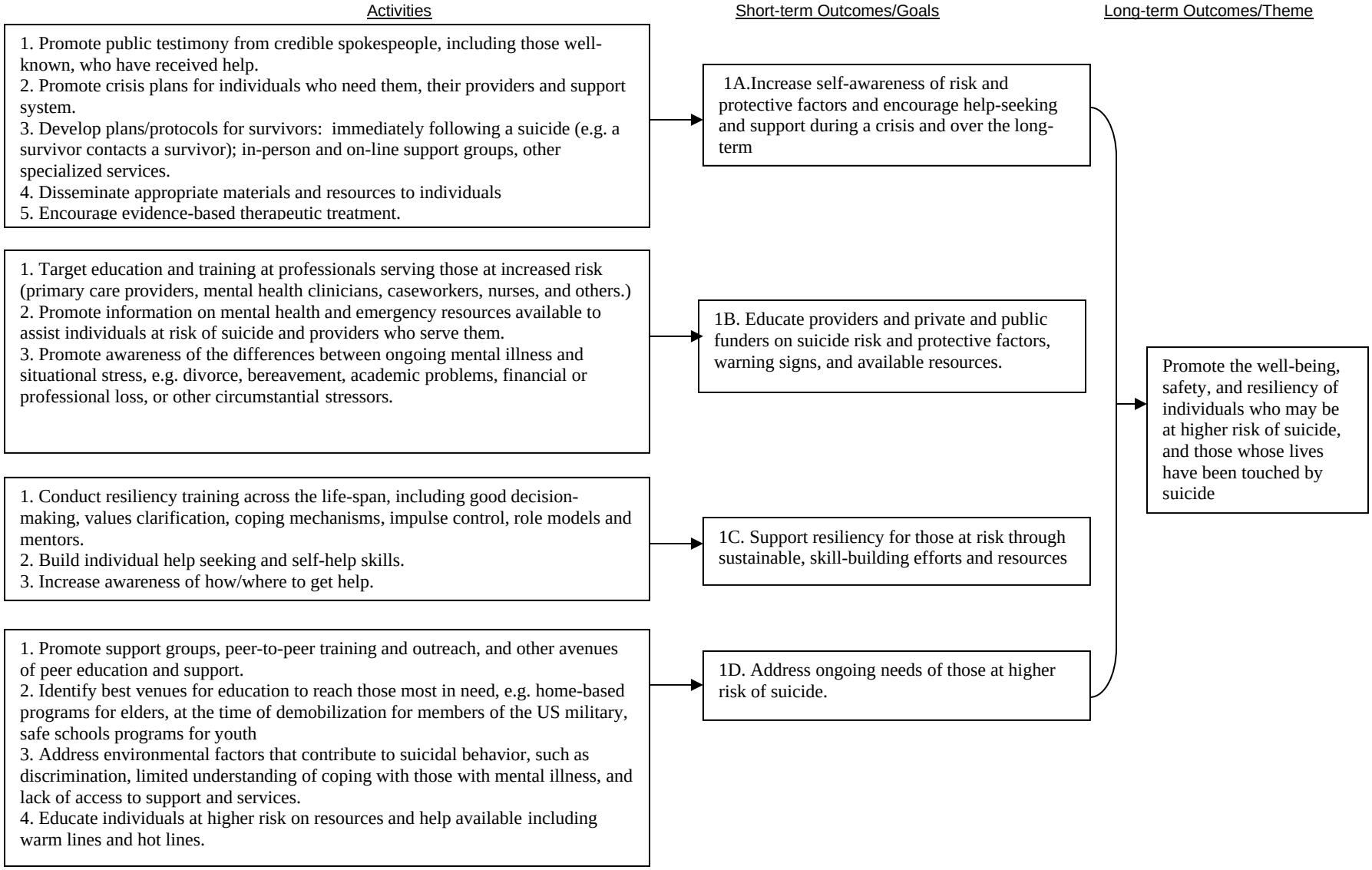
A. Logic Model for Overall Plan



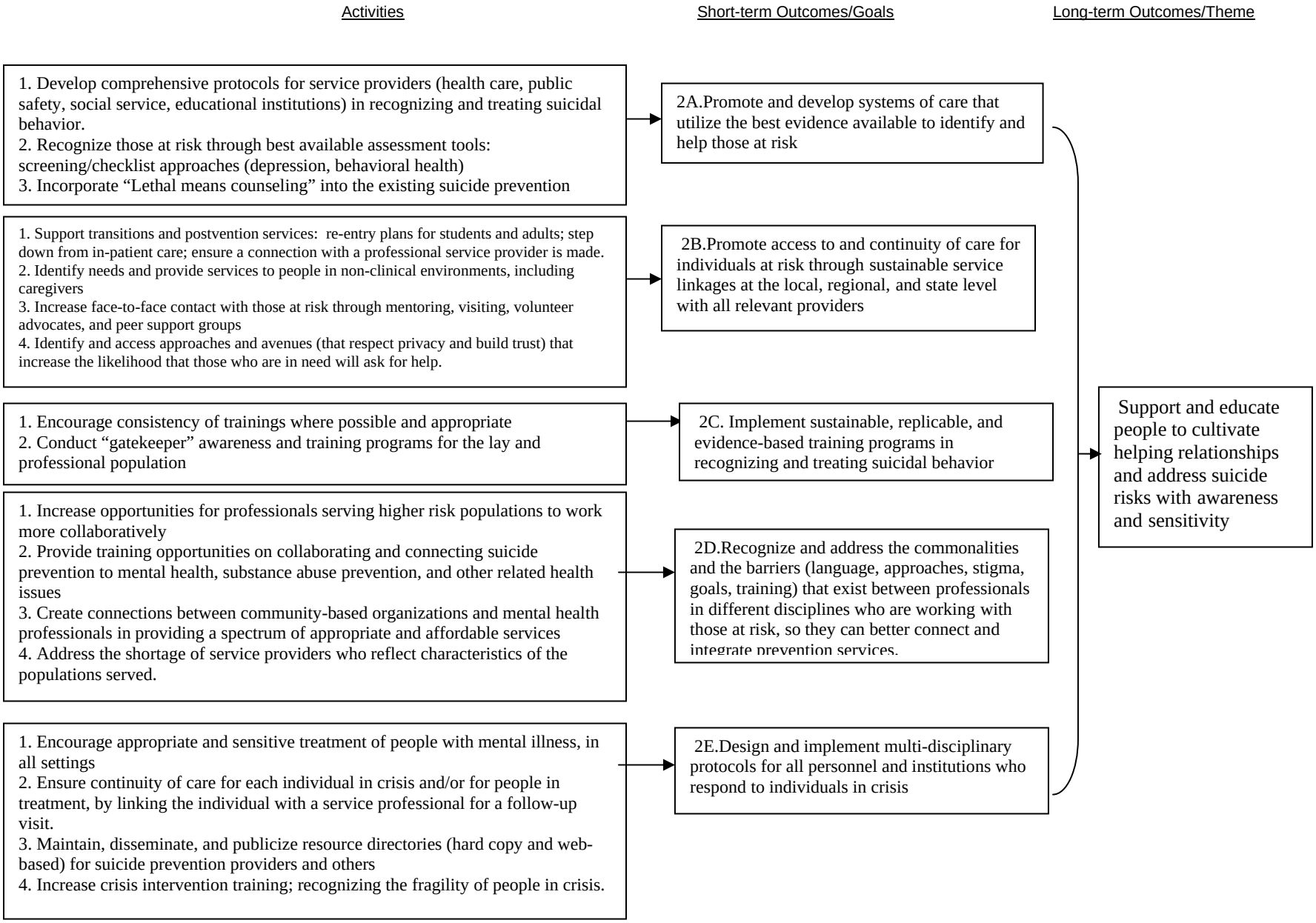
Guiding Principles:

- Suicide affects all ages and must be addressed across the lifespan
- Stigma and discrimination prevents open acknowledgment of mental illness and suicidal behavior, and this inhibits successful intervention, prevention, and recovery
- Some populations are at higher risk of suicide than others; therefore, targeted population-based strategies and models are necessary and appropriate
- Every person should have a safe, caring, and healthy relationship with at least one other person
- Prevention should take into account risk and resiliency of individuals and populations
- All suicide prevention materials, resources, and services must be culturally and linguistically competent, and developmentally and age appropriate
- Consumers and target groups must have input and participate in all levels of suicide prevention planning and decision-making
- Information sharing and collaboration must occur between all stakeholders in suicide prevention
- The best evidence available must be used, to the extent possible, when planning, designing, and implementing suicide prevention efforts
- More research and evaluation of suicide and suicide prevention programs , including innovative approaches and best evidence available, must be undertaken
- To ensure sustainability of suicide prevention efforts, there must be advocacy for diverse funding and other resources
- Comprehensive coverage, accessibility, and continuity of physical and mental health care services should be ensured

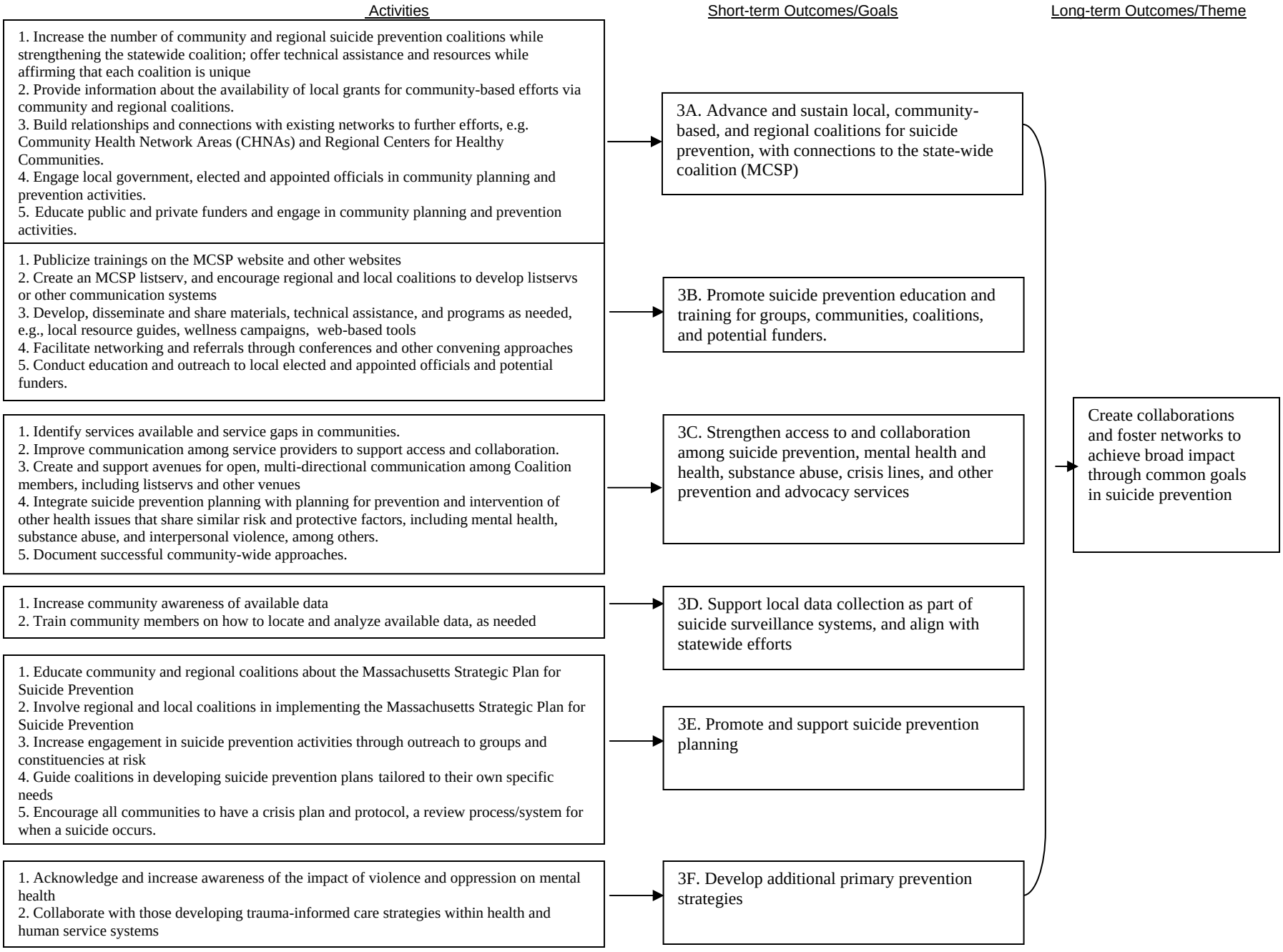
B. Level I-Individual



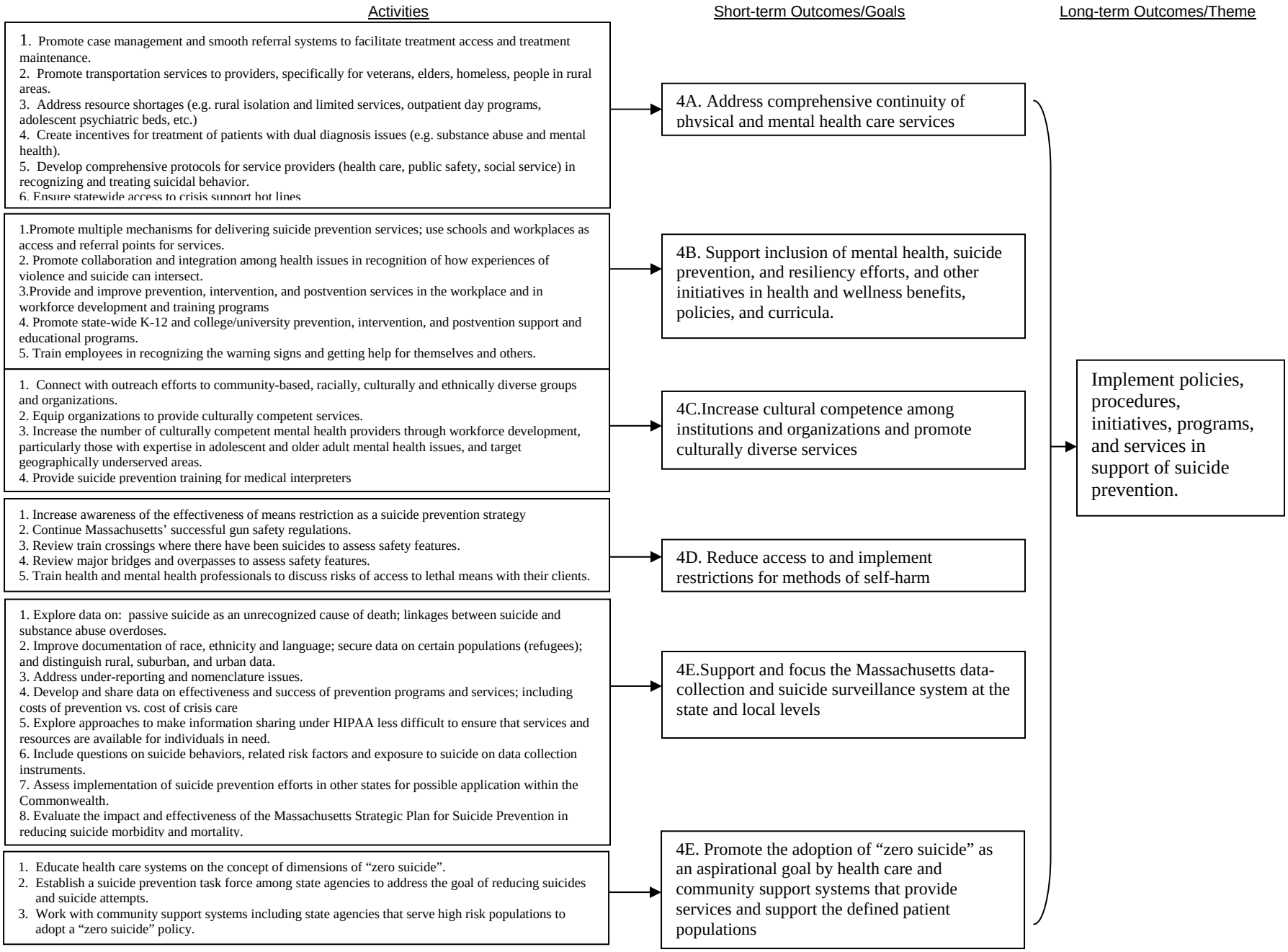
B. Level II-Interpersonal



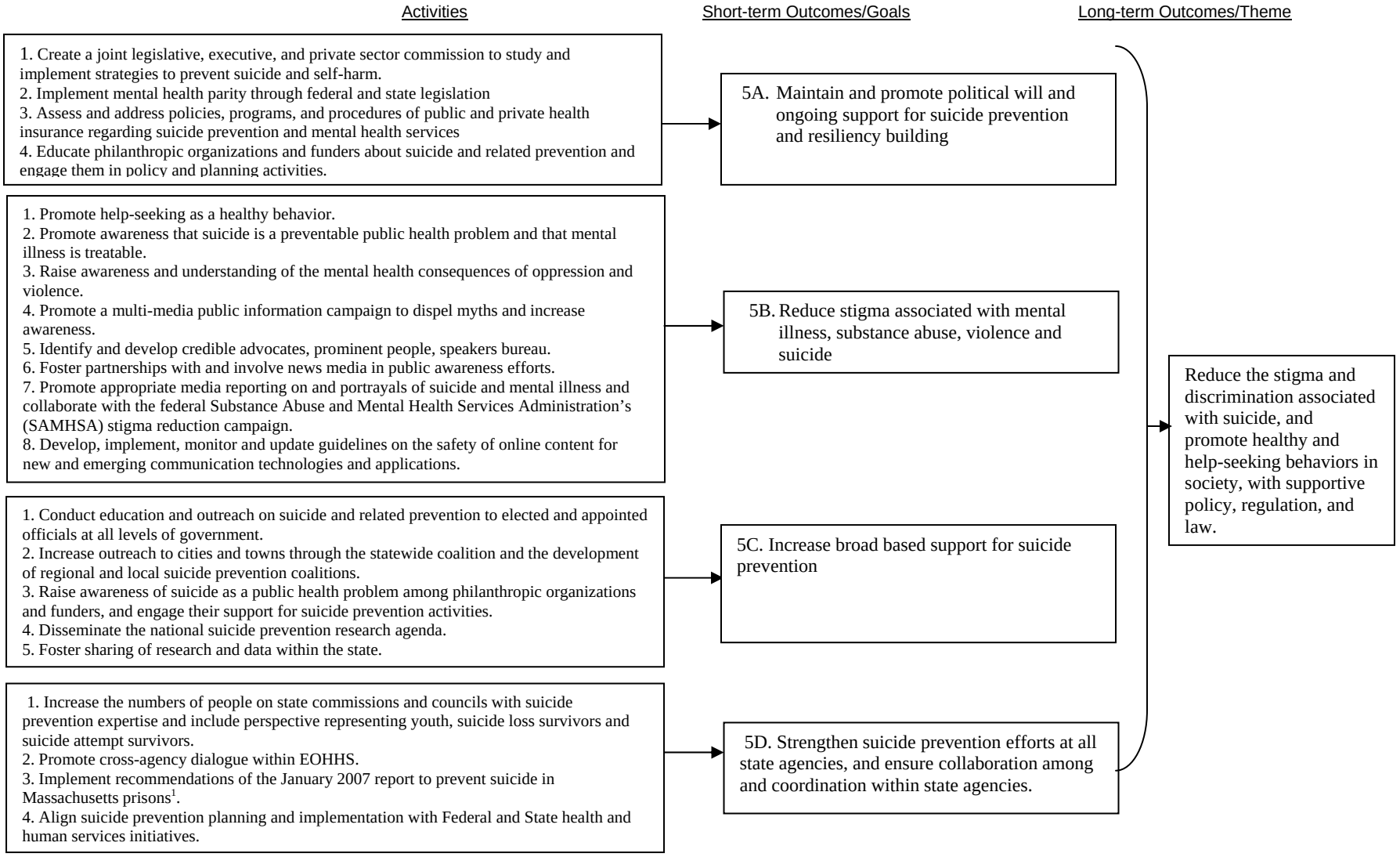
B. Level III-Community and Coalitions



B. Level IV-Institutions and Organizations



B. Level V-Social Structure and Systems

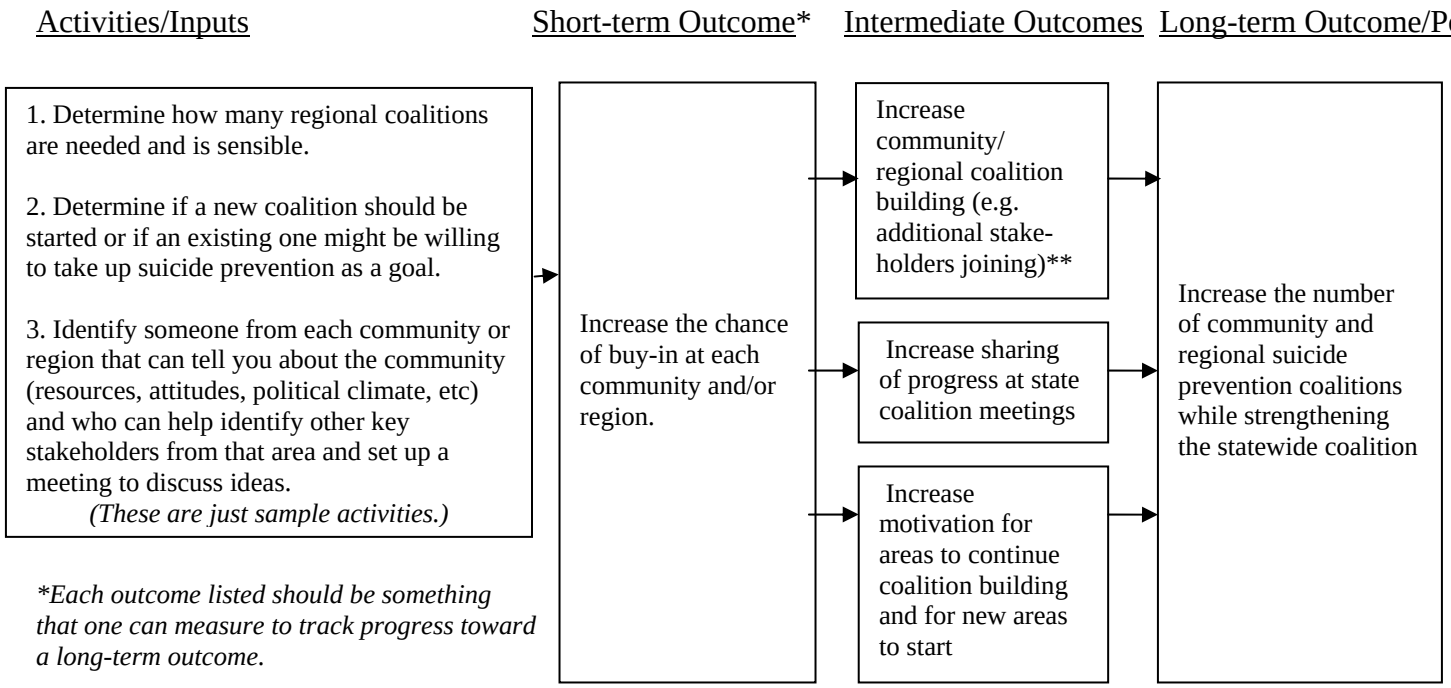


C. Example of a Logic Model for a Possible Action found in Level III, Goal A.

The first step is to ask, "What are your goals and what do you hope to accomplish?" For the purposes of Level III, Goal A, Possible Action 1, we hope to accomplish the following:

"Increase the number of community and regional suicide prevention coalitions while strengthening the statewide coalition"

Ideally, the activities (sometimes called *inputs and resources*) selected will be based on best practices in the field (e.g. practices that other communities have used and found to be effective) and the long-term outcome (sometimes called *outputs*) that one strives towards will be based on a need that was identified in the community or via a collaborative process.



**Each outcome listed should be something that one can measure to track progress toward a long-term outcome.*

*** One may wish to have a subsequent logic model for coalition building and how that will be achieved.*

IX. TWO EXAMPLES OF HOW THE PLAN COULD WORK

A. Introduction

The Massachusetts Strategic Plan for Suicide Prevention (State Plan) does not address the specific targeted needs of specific geographic regions or communities, or of populations known to be at increased risk of suicide (e.g., consumers of mental health services, veterans, gay/lesbian/bisexual, transgender youth, and others). As part of implementing this State Plan, it is our hope that planning groups associated with both populations at increased risk of suicide, and coalitions addressing suicide prevention for regions, or cities and towns will use this Plan as a starting point to develop their own population-specific, more tailored plans.

The following two summaries are provided as examples of how planning can advance suicide prevention for communities. These summaries are not intended as models to be followed, but as samples of how planning can advance suicide prevention for different kinds of communities. The first addresses a community of interest statewide—suicide among older adults, for which a working group developed a plan for services and needed resources. The second example features a geographic community—a suburban town that formed a local coalition and planned activities as a strategy for coping with a series of youth suicides.

The State Plan can assist in identifying priorities as you develop a strategic plan, an annual work plan, or specific action plans for your community or area of interest in suicide prevention. It can help you can chart progress as well as measure your contributions against the overall goals of the overall State Plan.

We look forward to hearing how planning is helping your community or interest group as we begin implementing the Massachusetts Strategic Plan for Suicide Prevention.

B. Older Adult Summary

According to vital records, obtained from death certificates, Massachusetts adults 65 and older account for 15.8% of suicides yet comprise only 13.5% of the population. Historically there has been significant interest in preventing suicide among older adults, and legislative language in the FY 08 budget called for a study to address suicide among elders / older adults.

To develop this report, the Department of Public Health (DPH) pulled together a team representing their healthy aging and suicide prevention staff, the Executive Office of Elder Affairs (EOEA), the Department of Mental Health (DMH), and providers serving older adults throughout the Commonwealth. They are currently working on a plan to address suicide among those older residents of Massachusetts. As part of informing the State Plan, a focus group targeted elder service agencies and older adults.

Current service areas are divided into community services, gatekeeper training and clinical training, and collaboration with EOEA.

Community Services—Older adults were identified as a priority population in a Request for Proposals, and this generated lots of interest from community providers. DPH funds are supporting grants to several community-based agencies serving elders. Services in different communities include: awareness and intervention training for senior service staff; depression screening; care management; elder

diagnostic assessments for homebound seniors; survivor support and outreach for bereaved elders; and specialized survivor support for bereaved gay / lesbian/ bisexual / transgender elders.

General Training—Training has been targeted directly at elder serving agencies through conferences and outreach to elder service programs. Current training in place includes: comprehensive suicide prevention and education; training for gatekeepers and elder service support staff; and training in suicide assessment and screening. The Question, Persuade and Refer curriculum (QPR) trained 40 new trainers serving older adults throughout Massachusetts. In addition, the annual suicide prevention conference featured a track on elder suicide, and suicide prevention workshops were integrated into Massachusetts Council on Aging conferences and the Aging with Dignity conference.

Clinical Training— It has been recognized that there is a shortage of mental health clinicians with expertise in suicide prevention. Clinicians representing elder services in different parts of the state participated in "Assessment and Management of Suicide Risk" training developed by the American Association of Suicidology and the Suicide Prevention Resource Center. Additional training has targeted primary care physicians and nurses, visiting nurses, and other clinicians serving older adults.

Collaboration with EOEA—To support mental health services for older adults DPH provides funding to the EOEA. Services include medication management; home-based mental health counseling; and training towards certification in geriatric mental health.

C. Example of a Massachusetts Community Suicide Prevention Coalition

In response to several youth suicides over several years, a suburban Boston community mobilized a suicide prevention coalition. Members represented local elected and appointed officials, school faculty and administrators, health and mental health services, public safety, clergy, students, parents, the District Attorney's office, and the local preschool consortium. They reached out to the Massachusetts Coalition for Suicide Prevention, and were linked with many suicide prevention resources. They also established cooperative relationships with the town police, fire department, clergy, school, and mental health agencies and individuals to plan for a more coordinated and effective response to individuals in need. This community coalition focused on both school and community based efforts. Their efforts have been featured in several local newspapers and television programs.

In schools, a psychologist worked with high school students at risk for depression or suicide. Faculty and staff were trained in the 'Question, Persuade, and Refer' (QPR) curriculum on identifying warning signs of suicide and options for intervention, and school counselors and nurses received training in self-injury. The coalition also worked with a local drug and alcohol prevention program to provide education and support related to alcohol and drug use among youth.

Several suicide prevention curricula were implemented with students. The Signs of Suicide curricula (SOS) taught 8-11th graders how to respond to a suicide attempt. And a pilot program taught students to resist risky behavior through coping skills such as impulse control, social problem solving, anger management, media resistance, and enhanced communication skills. The coalition also looked at school policy and adopted a crisis management model for contingency planning if a school or community crisis occurs, including when school is not in session.

Outside of the schools, the Coalition conducted a series of focus groups on suicide-related concerns. They implemented a town-wide action campaign to raise awareness on suicide and depression, including: town-wide posting of an informational poster; designating a weekend when all churches and synagogues discussed depression and suicide; and a "One-Town/One-Book" reading and discussion of William Styron's *Darkness Visible* on his struggles with depression. Community and school protocols for emergencies to prevent rumors and provide accurate information were updated.

A variety of community members were QPR-trained, including representatives of the District Court, community and civic organizations, town department employees, clergy, parents, and other interested residents. The coalition also launched a website. They adopted guidelines for appropriate memorials following a suicide or other traumatic death, and met with local journalists to promote responsible media reporting on suicide.

This community coalition continues to focus on preventing youth suicide, but has expanded its focus to include depression and suicide among elders, middle-aged men, and veterans.

APPENDIX A: RESOURCES FOR COMMUNITY AND GROUP SUICIDE PREVENTION

The list below represents a sample of resource materials useful to communities and groups starting to plan for suicide prevention. A comprehensive library of suicide prevention materials is available from the website of the Suicide Prevention Resource Center at www.sprc.org.

Data

Data-Driven prevention planning model
URL: http://www.sprc.org/library/datadriven.pdf
A suicide prevention planning model by Richard Catalano and David Hawkins is outlined in five steps. The model assumes that a broad-based coalition has been formed and is sufficiently organized to support the infrastructure necessary for this plan.

Finding data on suicidal behavior
URL: http://www.sprc.org/library/datasources.pdf
Sources for collecting suicide and suicidal behavior data at both the local and national level are listed.

Means Matter
http://www.hsph.harvard.edu/means-matter/
A website devoted to restricting access to lethal means as an evidence-based suicide prevention strategy. Includes a section on Recommendations for Communities and Suicide Prevention Groups under 'Taking Action'.

National Violent Death Reporting System (NVDRS)
http://www.cdc.gov/ncipc/profiles/nvdrs/default.htm
The National Violent Death Reporting System (NVDRS) seeks to provide communities with a clearer understanding of violent deaths so they can be prevented. NVDRS accomplishes this goal by informing decision makers and program planners about the magnitude, trends, and characteristics of violent deaths so appropriate prevention efforts can be put into place; and evaluating state-based prevention programs and strategies. Suicide is included in violent deaths, and Massachusetts is one of the participating states.

Program Planning and Implementation

Community coalition suicide prevention checklist
URL: http://www.sprc.org/library/ccspchecklist.pdf
This document is a result of a Scientific Consensus Meeting, sponsored by several of the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and Centers for Disease Control and Prevention through grants to the University of Rochester Center for the Study and Prevention of Suicide. The checklist contains ideas for whom to include in coalitions for suicide prevention in different settings.

Feasibility tool for the implementation of prevention programs
URL: http://www.sprc.org/library/feasibility_tool.pdf

Each page contains a chart to fill in to determine the feasibility of different elements of a prevention program, including: Resources, Target Populations, Organizational Climate, Community Climate, Evaluability, and Future Sustainability

Funding your program, determining your needs and developing a plan
URL: http://www.sprc.org/library/fundingtips.pdf
Contains tips, as well as websites for government grants, foundations, and statement research.

Leaving a legacy: Sustaining change in your community
URL: http://www.sprc.org/grantees/pdf/2006/legacywheel2.pdf
State/Tribal/Adolescents at Risk Suicide Prevention Grantee Technical Assistance Meeting, December 12–14, 2006, North Bethesda, MD. Explains the "Legacy Wheel" model of program planning, implementation, and evaluation.

Suicide prevention community assessment tool
URL: http://www.sprc.org/library/catool.pdf
Adapted from: Community Assessment Tool developed by the Suicide Prevention Program at the Massachusetts Department of Public Health. This assessment tool is targeted for "prevention networks," coalitions of change-oriented organizations and individuals working together to promote suicide prevention. It is comprised of four sections intended to gather information on: a) each community addressed; b) all agencies and individuals within the prevention network; c) target populations; and d) community suicide risk factors and prevention resources.

Awareness and Education

National Center for Suicide Prevention Training (NCSPT) workshops.

http://training.sprc.org/

NCSPT provides educational resources to help public officials, service providers, and community-based coalitions develop effective suicide prevention programs and policies. Workshops are free of charge, online, and self-paced. Topics include: Locating, understanding, and presenting youth suicide data; Planning and evaluation for youth suicide prevention; an introduction to gatekeeping; the research evidence for suicide as a preventable public health problem.

Suicide prevention: The public health approach
URL: http://www.sprc.org/library/phasp.pdf
Defines the five main steps of the public health approach and applies it toward suicide prevention.

Warning Signs for Suicide Prevention from The American Association for Suicidology
http://www.sprc.org/featured_resources/bpr/PDF/AASWarningSigns_factsheet.pdf
The warning signs were developed by an expert working group convened by the American Association of Suicidology. Citing the importance of distinguishing warning signs from risk factors, the group defined warning signs as the earliest detectable signs that indicate heightened risk for suicide in the near-term (i.e., within minutes, hours, or days), as opposed to risk factors which suggest longer-term risk (i.e., a year to lifetime.)

APPENDIX B:
DEFINITIONS AND GLOSSARY

Provided on the following pages is a glossary of terms used in the plan.

Some of the terms in this glossary are adapted from one published in the *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001.

Best practices/best evidence available – activities or programs that are in keeping with the best available evidence regarding what is effective

Consumer – A person who currently receives mental health services or who received such services in the past

Culturally appropriate – the ability of an organization or program to be effective across cultures, including the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services

Depression – a constellation of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure; a medical condition requiring diagnosis and treatment

Education – the teaching, learning, and understanding of specific facts, concepts and abstract principles, related to suicide prevention that can be applied in a variety of settings.

Effective – prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial outcome in the target group more than in a comparison group

Evaluation – the systematic investigation of the value and impact of an intervention or program

Evidence-based – programs that have undergone scientific evaluation and have proven to be effective

Gatekeepers (suicide gatekeepers) – individuals trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate; gatekeepers can be non-professionals who work with at-risk populations including administrators, coaches, home health aides, and others

HIPAA – The Health Insurance Portability and Accountability Act of 1996 enacted by the US Congress to ensure security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present or future.

Intervention – a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as strengthening social support in a community)

Means – the instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication)

Means restriction – activities designed to reduce access or availability to means and methods of deliberate self-harm

Methods – actions or techniques which result in an individual inflicting self-harm (i.e., asphyxiation, overdose, jumping)

Mood disorders – mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states, or, if in the opposite direction, depressed emotional states. Included are Depressive Disorders, Bipolar Disorders, mood disorders due to a medical condition, and substance-induced mood disorders

Outcome – a measurable change in the health of an individual or group of people that is attributable to an intervention

Postvention – a strategy or approach that is implemented after a crisis or traumatic event has occurred

Prevention – a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors

Protective factors – factors that make it less likely those individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment

Public information campaigns – efforts designed to dispel myths and provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines, and billboards

Public health approach – the systematic approach using five basic evidence-based steps that are applicable to any health problem that threatens substantial portions of a group or population. The five steps include defining the problem, identifying causes, developing and testing interventions, implementing interventions and evaluating interventions

Resilience – capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes

Risk factors – factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment

Screening – administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment

Social support – assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services, and include support from family, friends, religious communities and other affiliation groups

Stakeholders – entities including organizations, groups, and individuals that are affected by and contribute to actions and decisions

Stigma – an object, idea, or label associated with disgrace and reproach

Suicidal act (also referred to as suicide attempt) – potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death or injuries.

Suicidal behavior – a spectrum of activities related to suicide and self-harm, including self injury, attempted suicide, or suicide

Suicidal ideation – self-reported thoughts of engaging in suicide-related behavior

Suicidality – a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide

Suicide – death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death

Suicide attempt – a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in physical injuries

Suicide attempt survivors – individuals who did not die from an attempt to take their own life

Surveillance – the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings

Survivors/Suicide survivors – family members, significant others, or acquaintances who have experienced the loss by suicide of someone in their life

Training – teaching people to use specific skills, for the specialized tasks of suicide intervention and prevention, which are not generally used in other situations, and can not be used by unqualified individuals.

Warning signs – signals that can be verbal, non-verbal or behaviors that a person uses to indicate that they are at risk of suicide